Contract Number: 22003

AGREEMENT
BETWEEN
the Connecticut State Colleges and Universities
AND
Aetna Life Insurance Company

This Agreement ("Contract") is entered into by and between the Connecticut State Colleges and Universities, a constituent unit of the State of Connecticut System of Higher Education, with an address of 61 Woodland Street, Hartford, CT 06105 (hereinafter "CSCU" or "Institution") and Aetna Life Insurance Company (hereinafter "Aetna" or "Contractor") with a principal place of business at 151 Farmington Avenue, Hartford, CT 06156 for the provision of student accident insurance.

I. GENERAL

Aetna shall provide a Student Accident Insurance Plan ("Accident Plan") for students enrolled at Central Connecticut State University, Eastern Connecticut State University, Southern Connecticut State University, and Western Connecticut State University (each a "University" or collectively "Universities"). The Accident Plan shall provide a benefit of $100,000.00 per accident, both on and off campus, per policy year, for eligible enrolled students. Aetna shall also provide claims administration and related services for the Accident Plan, underwritten by Aetna Life Insurance Company.

The Accident Plan shall be provided in accordance with all applicable Federal and State of Connecticut laws and regulations. Coverage shall be consistent with the Blanket Student Accident Insurance Policy, attached hereto as Attachment A. Any change to this Contract will be effectuated by Amendment to this Contract executed by both parties and approved by the Office of the Attorney General. In the event of a conflict between this Contract and any document associated thereto, including any proposals or attachments (if applicable) to this Contract, this Contract shall govern and control.

In addition to the Accident Plan, Aetna shall offer a Travel Assistance Program that includes Accidental Death and Dismemberment coverage, Medical Evacuation and Repatriation services, Natural Disaster and Political Evacuation services, and other travel related support.

Aetna agrees to make the plans available to part-time students and faculty on a voluntary basis, but enrollment and all fees shall be the responsibility of the part time student or faculty member.

1. **Eligibility**

   a. Full-Time Students – All full-time registered undergraduate and graduate students whose status has been determined to be full time by each university will be automatically enrolled in the mandatory Accident Insurance Plan, which shall include the Travel Assistance Program. Fees for full time students will be billed directly to the Universities.

   b. Part-Time Students - Part-time registered undergraduate and graduate students whose status has been determined to be part time by each University are eligible to enroll voluntarily in the Student Accident Insurance Plan. Part-time students who choose to enroll in the Accident Plan must enroll directly with Aetna and then will be responsible for paying all fees directly to Aetna.

   c. Part-Time Students and Faculty are eligible to enroll in the Travel Assistance Program regardless of whether they are enrolled in the Accident Plan. Part-time students and faculty who choose to enroll in the Travel Assistance Program must enroll directly with Aetna and then will be responsible for paying all fees directly to Aetna.

2. **Customized Web Pages, Student Brochures, and Identification Cards**

   Aetna shall provide customized web pages for each University that include easily accessible Student Accident Plan and Travel Assistance Program brochures, claim forms and instructions, a provider search function, customized student Identification Cards, the approved master policy, and related documents. The website will include instructions for obtaining electronic enrollment forms from the Call Center for part time students and faculty eligible to enroll voluntarily in the Student Accident Plan or Travel Assistance Program.

   Student Accident Plan and Travel Assistance Program brochures will include a brief description of the Accident Plan and the Travel Assistance Program, contact information for Aetna as well as for each University, coverage

periods, rates, and instructions for students to access services and file claims under the Accident Plan and Travel Assistance Program. Aetna will develop and distribute student mailers to provide students with an explanation of benefits and important plan information. All student brochures and mailers are subject to review and written approval by each University.

3. **Call Center**

Aetna shall provide a toll-free customer service telephone number for the Accident Plan. Customer Service Representatives (CSRs) shall be available Monday through Friday, 8:30 a.m. to 5:30 p.m., local time to the caller. CSR's shall be trained to answer questions from students, parents, providers and University staff pertaining to claims status, benefits and all other issues relating to the Accident Plan and the Travel Assistance Program. Outside of call center hours, callers will hear a recorded message with telephone numbers to reach the Travel Assistance Program locally and internationally. Assistance shall be available through the customized web pages twenty-four hours a day, seven days a week.

4. **Dedicated Account Team**

Aetna shall provide a dedicated account team for CSCU including, at minimum, a Director of Client Services to provide overall management, an Account Executive to actively manage the CSCU account, and an Account Representative responsible for providing day to day support to each University. Representatives shall be available to provide information and support to each University and to the CSCU System Office staff. Representatives shall be available to visit campuses on a regular basis, upon mutual agreement of the parties, to meet with University Health Services staff, Athletic Department staff, Bursars, and other administrative staff as requested by each University. Members of the account team shall also be available to meet on a regular basis with CSCU System Office staff to provide enrollment, claim, and other relevant plan statistics. All meetings may be virtual or in person at the option of CSCU and each University, scheduled on mutually agreeable dates and times.

5. **Annual Accident Insurance Plan Coverage Periods**

The Accident Plan and the Travel Assistance Program shall be offered on an annual basis in accordance with the Fall and Spring schedule below.

Coverage Period	Start Date	End Date
Annual	August 1st	July 31st
Fall	August 1st	December 31st
Spring	January 1st	July 31st

6. **Reporting**

The Contractor shall provide each University with, at minimum, an online monthly claims report detailing key claims statistics, as well as an online reporting package that features a comparison of data for three policy years, and enrollment demographic information. The Contractor shall coordinate and provide training for each University to access and use the reports and data. The Contractor shall also provide reports to the CSCU System Office annually, or more frequently upon request, including enrollment and claims statistics by University, and including additional information as may be requested by CSCU.

II. COMPLIANCE

1. **Compliance, Generally**

All goods and services provided to CSCU shall be done so in accordance with any and all applicable local, state, federal, and international laws, regulations and/or requirements and any industry standards, including but not limited to: the Family Educational Rights and Privacy Act (FERPA), Health Insurance Portability and Accountability Act (HIPAA) and Health Information Technology for Economic and Clinical Health Act (HITECH), Government Data Collection and Dissemination Practices Act, Gramm-Leach Bliley Financial Modernization Act (GLB), Payment Card Industry Data Security Standards (PCI-DSS), Americans with Disabilities Act (ADA), and Federal Export Administration Regulations. Any Contractor personnel visiting CSCU facilities will comply with all applicable policies regarding access to, use of, and conduct within such facilities.

2. **Family Educational Rights and Privacy Act**

In all respects, Contractor shall comply with the provisions of the Family Educational Rights and Privacy Act **(**FERPA**).** For purposes of this contract, FERPA includes any amendments or other relevant provisions of federal law, as well as all requirements of Chapter 99 of Title 34 of the Code of Federal Regulations, as

amended from time to time. Nothing in this agreement may be construed to allow Contractor to maintain, use, disclose or share student information in a manner not allowed by federal law or regulation or by this contract. Contractor agrees that it shall not provide any student information obtained under this contract to any party ineligible to receive data protected by FERPA. This section shall survive the termination, cancellation or expiration of the contract.

3. **Confidentiality of Personally Identifiable Information**

The Contractor shall ensure that personally identifiable information ("PII") which is defined as any information that by itself or when combined with other information can be connected to a specific person and may include but is not limited to personal identifiers such as name, address, phone, date of birth, Social Security number, student or personal identification numbers, driver's license numbers, state or federal identification numbers, biometric information, religious or political affiliation, non-directory information, and any other information protected by state or federal privacy laws, will be collected and held confidential and in accordance with this agreement, during and following the term of this Contract, and will be divulged only in accordance with federal law or the State of Connecticut General Statutes.

4. **Data Security**

Data security is of paramount concern to CSCU. Contractor shall utilize, store and process University Data in a secure environment in accordance with commercial best practices, including appropriate administrative, physical, and technical safeguards, to secure such data from unauthorized access, disclosure, alteration, and use. Such measures will be no less protective than those used to secure Contractor's own data of a similar type, and in no event less than reasonable in view of the type and nature of the data involved. At a minimum, Contractor shall use industry-standard and up-to-date security tools and technologies such as anti-virus protections and intrusion detection methods to protect University Data. Contractor shall comply with the CSCU Information Security Policy (IT-004 CSCU Information Security Policy), which can be found at https://www.ct.edu/files/it/BOR_IT-004.pdf

Immediately upon becoming aware of circumstances that could have resulted in unauthorized access to or disclosure or use of CSCU Data, Contractor will notify the CSCU Chief Information Officer, fully investigate the incident, and cooperate fully with CSCU's investigation of and response to and remediation of the incident. Except as otherwise required by law, Contractor will not provide notice of the incident directly to individuals who's PII was involved, regulatory agencies, or other entities, without prior written permission from CSCU.

CSCU reserves the right in its sole discretion to perform audits of Contactor to ensure compliance with all obligations regarding CSCU Data. Contractor shall reasonably cooperate in the performance of such audits. Contractor will make available to CSCU all information necessary to demonstrate compliance with its data processing obligations. Failure to adequately protect CSCU data or comply with the terms of this contract with regard to CSCU data may be grounds to terminate this contract.

III. TERM OF THE AGREEMENT

This Agreement will become effective as of August 1, 2021 or as of the date of signature by CSCU's authorized official and the date of approval by the Office of the Attorney General (OAG), whichever occurs last, shall renew annually and continue in effect until July 31, 2026 with an option to extend for five (5) additional one (1) year periods or any part or combination thereof. Said options shall be exercised upon written amendment executed by both parties and, if applicable, approved by the Office of the Attorney General. This contract may be terminated in accordance with the provisions of Section V.6.

IV. COST

The cost to CSCU Universities for all products and services under this Agreement is based upon the per-student rates listed below and enrollment information provided to Aetna by each University. Enrollment reports will be submitted to Aetna by each University on a mutually agreed upon schedule, generally twice each term. Each University may, at their option, choose to submit reports on a more frequent basis. Enrollment reports shall be reconciled each term and at the end of each plan year to account for students added or removed from the plan. The Universities shall not be charged for students who withdraw from a University provided the student has filed no accident claims during the coverage period in which the student withdraws

The cost is inclusive of all products and services provided to the Universities under this Contract, including customized web pages and related materials, call center services, reporting, and all travel expenses. Part-time students or faculty who choose to enroll in the Accident Plan or the Travel Assistance Program directly with Aetna shall be responsible for paying all fees directly to Aetna, and such fees shall not be included in the cost to the Universities.

1. Mandatory Accident Plan for Full-Time Enrolled Students, Including the Travel Assistance Program

	Annual Effective 8/1/2021 – 7/31/2022	**Fall Term** Effective 8/1/2021 – 12/31/2021	**Spring Term** Effective 1/1/2021 – 7/31/2022
Per Student	$51.00	$21.00	$30.00

2. Voluntary Plans for Part-Time Enrolled Students
(Part-time students will enroll in the Accident Plan directly with Aetna and will be responsible for paying all fees directly to Aetna.)

Coverage Period	**Annual** Effective 8/1/2021 – 7/31/2022	**Fall Term** Effective 8/1/2021 – 12/31/2021	**Spring Term** Effective 1/1/2021 – 7/31/2022
Accident Plan Only Per Student	$43.00	$18.00	$25.00
Travel Assistance Program	$8.00	$3.00	$5.00

3. Voluntary Standalone* Travel Assistance Program for Part-Time Students and Faculty
(Part-time students and faculty will enroll in the Accident Plan directly with Aetna and will be responsible for paying all fees directly to Aetna.)

Coverage Period	**Annual** Effective 8/1/2021 – 7/31/2022	**Fall Term** Effective 8/1/2021 – 12/31/2021	**Spring Term** Effective 1/1/2021 – 7/31/2022
Per Student or Faculty Member	$66.00	$36.00	$36.00

*The Standalone program is available without the Accident Plan

Maximum Amount of Contract: $10,000,000.00

4. **Invoices:** Invoices shall be sent directly to each University within ninety (90) days of the plan effective date. Subsequent invoices will be submitted at mutually agreed-upon intervals. Invoices shall, at a minimum, include the Contractor name, the Purchase Order Number, the Contractor's Federal Employer Identification Number, the billing period, and an itemization of services rendered. The State of Connecticut does not pay taxes; therefore, Contractor invoices should not reflect the inclusion of any taxes on services or work performed under this contract. Payment shall be made to the Contractor within 45 days after receipt and acceptance of properly executed and approved invoices.

5. **Notices:** All notices, demands or requests provided for or permitted to be given pursuant to this Contract must be in writing. All notices, demands and requests shall be deemed to have been properly served if given by personal delivery, or if transmitted by facsimile with confirmed receipt, or if delivered to Federal Express or other reputable express carrier for next business day delivery, charges billed to or prepaid by shipper; or if deposited in the United States mail, registered or certified with return receipt requested, proper postage prepaid, addressed as follows:

If to CSCU: Connecticut State Colleges and Universities
61 Woodland Street
Hartford, CT 06105
Attn: Benjamin Barnes, Chief Financial Officer

If to Aetna Aetna Life Insurance Company
151 Farmington Avenue
Hartford, CT 06156
Attn: Susan Ondrick Turner, Director, Aetna Student Health Account Management

V. GENERAL STATE CONTRACT PROVISIONS:

1. **Statutory Authority.** Connecticut General Statutes §§ 10a-6, 10a-1b, 4a-52a, and/or 10a-151b provide the Institution with authority to enter into contracts in the pursuit of its mission.

2. **Claims Against the State.** The Contractor agrees that the sole and exclusive means for the presentation of any claim against the State of Connecticut or the Institution arising from this Contract shall be in accordance with Chapter 53 of the Connecticut General Statutes (Claims Against the State) and the Contractor further agrees not to initiate any legal proceedings in any state or federal court in addition to, or in lieu of, said Chapter 53 proceedings.

3. **Indemnification**. (a) The Contractor shall indemnify, defend and hold harmless the State and its officers, representatives, agents, servants, employees, successors and assigns from and against any and all (1) claims arising, directly or indirectly, in connection with the Contract, including the acts of commission or omission (collectively, the "Acts") of the Contractor or contractor parties; and (2) liabilities, damages, losses, costs and expenses, including but not limited to, attorneys' and other professionals' fees, arising, directly or indirectly, in connection with claims, Acts or the contract. The Contractor shall use counsel reasonably acceptable to the State in carrying out its obligations under this section. The Contractor's obligations under this section to indemnify, defend and hold harmless against claims includes claims concerning confidentiality of any part of or all of the Contractor's bid, proposal or any records, any intellectual property rights, other proprietary rights of any person or entity, copyrighted or uncopyrighted compositions, secret processes, patented or unpatented inventions, articles or appliances furnished or used in the performance.
   (b) The Contractor shall not be responsible for indemnifying or holding the State harmless from any liability arising due to the negligence of the State or any third party acting under the direct control or supervision of the State.
   (c) The Contractor shall reimburse the State for any and all damages to the real or personal property of the State caused by the Acts of the Contractor or any contractor parties. The State shall give the Contractor reasonable notice of any such claims.
   (d) The Contractor's duties under this section shall remain fully in effect and binding in accordance with the terms and conditions of the Contract, without being lessened or compromised in any way, even where the Contractor is alleged or is found to have merely contributed in part to the Acts giving rise to the claims and/or where the State is alleged or is found to have contributed to the Acts giving rise to the claims.
   (e) The Contractor shall carry and maintain at all times during the term of the Contract, and during the time that any provisions survive the term of the Contract, sufficient general liability insurance to satisfy its obligations under this Contract. The Contractor shall name the State as an additional insured on the policy and shall provide a copy of the policy to the CSCU prior to the effective date of the Contract. The Contractor shall not begin performance until the delivery of the policy to the CSCU. The CSCU shall be entitled to recover under the insurance policy even if a body of competent jurisdiction determines that the CSCU or the State is contributorily negligent.
   (f) This section shall survive the termination of the contract and shall not be limited by reason of any insurance coverage.

4. **Sovereign Immunity**. The parties acknowledge and agree that nothing in this contract shall be construed as a modification, compromise or waiver by the State of any rights or defenses of any immunities provided by Federal law or the laws of the State of Connecticut to the State or any of its officers and employees, which they may have had, now have or will have with respect to all matters arising out of this contract. To the extent that this section conflicts with any other section, this section shall govern.

5. **Forum and Choice of Law.** The parties deem the Contract to have been made in the City of Hartford, State of Connecticut. Both parties agree that it is fair and reasonable for the validity and construction of the contract to be, and it shall be, governed by the laws and court decisions of the State of Connecticut, without giving effect to its principles of conflicts of laws. To the extent that any immunities provided by Federal law or the laws of the State of Connecticut do not bar an action against the State, and to the extent that these courts are courts of competent jurisdiction, for the purpose of venue, the complaint shall be made returnable to the Judicial District of Hartford only or shall be brought in the United States District Court for the District of Connecticut only, and shall not be transferred to any other court, provided, however, that nothing here constitutes a waiver or compromise of the sovereign immunity of the State of Connecticut. The Contractor waives any objection which it may now have or will have to the laying of venue of any claims in any forum and further irrevocably submits to such jurisdiction in any suit, action or proceeding.

6. **Termination.**
   a. Notwithstanding any provisions in this contract, the Institution, through a duly authorized employee, may terminate the Contract whenever the Institution makes a written determination that such termination is in the best interests of the State. The Institution shall notify the Contractor in writing of termination pursuant to this section, which notice shall specify the effective date of termination and the extent to which the Contractor must complete its performance under the contract prior to such date.

b. Notwithstanding any provisions in this contract, the Institution, through a duly authorized employee, may, after making a written determination that the Contractor has breached the contract, terminate the contract in accordance with the following breach provision.
   i. Breach. If either party breaches the contract in any respect, the non-breaching party shall provide written notice of the breach to the breaching party and afford the breaching party an opportunity to cure within ten (10) days from the date that the breaching party receives the notice. In the case of a Contractor breach, any other time period which the Institution sets forth in the notice shall trump the ten (10) days. The right to cure period shall be extended if the non-breaching party is satisfied that the breaching party is making a good faith effort to cure but the nature of the breach is such that it cannot be cured within the right to cure period. The notice may include an effective contract termination date if the breach is not cured by the stated date and, unless otherwise modified by the non-breaching party in writing prior to the termination date, no further action shall be required of any party to effect the termination as of the stated date. If the notice does not set forth an effective contract termination date, then the non-breaching party may terminate the contract by giving the breaching party no less than twenty-four (24) hours' prior written notice. If the Institution believes that the Contractor has not performed according to the contract, the Institution may withhold payment in whole or in part pending resolution of the performance issue, provided that the Institution notifies the Contractor in writing prior to the date that the payment would have been due.

c. The Institution shall send the notice of termination via certified mail, return receipt requested, to the Contractor at the most current address which the Contractor has furnished to the Institution for purposes of correspondence, or by hand delivery. Upon receiving the notice from the Institution, the Contractor shall immediately discontinue all services affected in accordance with the notice, undertake all commercially reasonable efforts to mitigate any losses or damages, and deliver to the Institution all records. The records are deemed to be the property of the Institution and the Contractor shall deliver them to the Institution no later than thirty (30) days after the termination of the contract or fifteen (15) days after the Contractor receives a written request from the Institution for the records. The Contractor shall deliver those records that exist in electronic, magnetic or other intangible form in a non-proprietary format, such as, but not limited to, ASCII or .TXT.

d. Upon receipt of a written notice of termination from the Institution, the Contractor shall cease operations as the Institution directs in the notice, and take all actions that are necessary or appropriate, or that the Institution may reasonably direct, for the protection, and preservation of the goods and any other property. Except for any work which the Institution directs the Contractor to perform in the notice prior to the effective date of termination, and except as otherwise provided in the notice, the Contractor shall terminate or conclude all existing subcontracts and purchase orders and shall not enter into any further subcontracts, purchase orders or commitments.

e. The Institution shall, within forty-five (45) days of the effective date of termination; reimburse the Contractor for its performance rendered and accepted by the Institution in accordance with the terms of this contract, in addition to all actual and reasonable costs incurred after termination in completing those portions of the performance which the notice required the Contractor to complete. However, the Contractor is not entitled to receive and the Institution is not obligated to tender to the Contractor any payments for anticipated or lost profits. Upon request by the Institution, the Contractor shall assign to the Institution, or any replacement Contractor which the Institution designates, all subcontracts, purchase orders and other commitments, deliver to the Institution all records and other information pertaining to its performance, and remove from State premises, whether leased or owned, all of Contractor's property, equipment, waste material and rubbish related to its performance, all as the Institution may request.

f. For breach or violation of any of the provisions in the section concerning representations and warranties, the Institution may terminate the contract in accordance with its terms and revoke any consents to assignments given as if the assignments had never been requested or consented to, without liability to the Contractor or Contractor parties or any third party.

g. Upon termination of the contract, all rights and obligations shall be null and void, so that no party shall have any further rights or obligations to any other party, except with respect to the sections which survive termination. All representations, warranties, agreements and rights of the parties under the contract shall survive such termination to the extent not otherwise limited in the contract and without each one of them having to be specifically mentioned in the contract.

h. Termination of the contract pursuant to this section shall not be deemed to be a breach of contract by the Institution.

7. **Entire Agreement and Amendment.** This written contract shall constitute the entire agreement between the parties and no other terms and conditions in any document, acceptance or acknowledgment shall be effective or binding unless expressly agreed to in writing by the Institution. This contract may not be changed other than by a formal written contract amendment signed by the parties hereto and approved by the Connecticut Attorney General.

8. **Nondiscrimination.**

(a) For purposes of this Section, the following terms are defined as follows:

(1) "Commission" means the Commission on Human Rights and Opportunities;
(2) "Contract" and "contract" include any extension or modification of the Contract or contract;
(3) "Contractor" and "contractor" include any successors or assigns of the Contractor or contractor;
(4) "Gender identity or expression" means a person's gender-related identity, appearance or behavior, whether or not that gender-related identity, appearance or behavior is different from that traditionally associated with the person's physiology or assigned sex at birth, which gender-related identity can be shown by providing evidence including, but not limited to, medical history, care or treatment of the gender-related identity, consistent and uniform assertion of the gender-related identity or any other evidence that the gender-related identity is sincerely held, part of a person's core identity or not being asserted for an improper purpose.
(5) "good faith" means that degree of diligence which a reasonable person would exercise in the performance of legal duties and obligations;
(6) "good faith efforts" shall include, but not be limited to, those reasonable initial efforts necessary to comply with statutory or regulatory requirements and additional or substituted efforts when it is determined that such initial efforts will not be sufficient to comply with such requirements;
(7) "marital status" means being single, married as recognized by the State of Connecticut, widowed, separated or divorced;
(8) "mental disability" means one or more mental disorders, as defined in the most recent edition of the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders", or a record of or regarding a person as having one or more such disorders;
(9) "minority business enterprise" means any small contractor or supplier of materials fifty-one percent or more of the capital stock, if any, or assets of which is owned by a person or persons: (1) who are active in the daily affairs of the enterprise, (2) who have the power to direct the management and policies of the enterprise, and (3) who are members of a minority, as such term is defined in subsection (a) of C.G.S. § 32-9n; and
(10) "public works contract" means any agreement between any individual, firm or corporation and the State or any political subdivision of the State other than a municipality for construction, rehabilitation, conversion, extension, demolition or repair of a public building, highway or other changes or improvements in real property, or which is financed in whole or in part by the State, including, but not limited to, matching expenditures, grants, loans, insurance or guarantees.

For purposes of this Section, the terms "Contract" and "contract" do not include a contract where each contractor is (1) a political subdivision of the state, including, but not limited to, a municipality, unless the contract is a municipal public works contract or quasi-public agency project contract, (2) any other state, including but not limited to any federally recognized Indian tribal governments, as defined in C.G.S. § 1-267, (3) the federal government, (4) a foreign government, or (5) an agency of a subdivision, state or government described in the immediately preceding enumerated items (1), (2), (3), or (4).

(b) (1) The Contractor agrees and warrants that in the performance of the Contract such Contractor will not discriminate or permit discrimination against any person or group of persons on the grounds of race, color, religious creed, age, marital status, national origin, ancestry, sex, gender identity or expression, status as a veteran, intellectual disability, mental disability or physical disability, including, but not limited to, blindness, unless it is shown by such Contractor that such disability prevents performance of the work involved, in any manner prohibited by the laws of the United States or of the State of Connecticut; and the Contractor further agrees to take affirmative action to ensure that applicants with job-related qualifications are employed and that employees are treated when employed without regard to their race, color, religious creed, age, marital status, national origin, ancestry, sex, gender identity or expression, status as a veteran, intellectual disability, mental disability or physical disability, including, but not limited to, blindness, unless it is shown by the Contractor that such disability prevents performance of the work involved; (2) the Contractor agrees, in all solicitations or advertisements for employees placed by or on behalf of the Contractor, to state that it is an "affirmative action-equal opportunity employer" in accordance with regulations adopted by the Commission; (3) the Contractor agrees to provide each labor union or representative of workers with which the Contractor has a collective bargaining Agreement or other contract or understanding and each vendor with which the Contractor has a contract or understanding, a notice to be provided by the Commission, advising the labor union or workers' representative of the Contractor's commitments under this section and to post copies of the notice in conspicuous places available to employees and applicants for employment; (4) the Contractor agrees to comply with each provision of this Section and C.G.S. §§ 46a-68e and 46a-68f and with each regulation or relevant order issued by said Commission pursuant to C.G.S. §§ 46a-56, 46a-68e, 46a-68f and 46a-86; and (5) the Contractor agrees to provide the Commission on Human Rights and Opportunities with such information requested by the Commission, and permit access to pertinent books, records and accounts, concerning the employment practices and procedures of the Contractor as relate to the provisions of this Section and C.G.S. § 46a-56. If the contract is a public works contract, municipal public works contract or contract for a quasi-public agency project, the Contractor agrees and warrants that he or she will make good

faith efforts to employ minority business enterprises as subcontractors and suppliers of materials on such public works or quasi-public agency projects.

(c) Determination of the Contractor's good faith efforts shall include, but shall not be limited to, the following factors: The Contractor's employment and subcontracting policies, patterns and practices; affirmative advertising, recruitment and training; technical assistance activities and such other reasonable activities or efforts as the Commission may prescribe that are designed to ensure the participation of minority business enterprises in public works projects.

(d) The Contractor shall develop and maintain adequate documentation, in a manner prescribed by the Commission, of its good faith efforts.

(e) The Contractor shall include the provisions of subsection (b) of this Section in every subcontract or purchase order entered into in order to fulfill any obligation of a contract with the State and in every subcontract entered into in order to fulfill any obligation of a municipal public works contract for a quasi-public agency project, and such provisions shall be binding on a subcontractor, vendor or manufacturer unless exempted by regulations or orders of the Commission. The Contractor shall take such action with respect to any such subcontract or purchase order as the Commission may direct as a means of enforcing such provisions including sanctions for noncompliance in accordance with C.G.S. § 46a-56, as amended; provided if such Contractor becomes involved in, or is threatened with, litigation with a subcontractor or vendor as a result of such direction by the Commission regarding a State contract, the Contractor may request the State of Connecticut to enter into any such litigation or negotiation prior thereto to protect the interests of the State and the State may so enter.

(f) The Contractor agrees to comply with the regulations referred to in this Section as they exist on the date of this Contract and as they may be adopted or amended from time to time during the term of this Contract and any amendments thereto.

(g) (1) The Contractor agrees and warrants that in the performance of the Contract such Contractor will not discriminate or permit discrimination against any person or group of persons on the grounds of sexual orientation, in any manner prohibited by the laws of the United States or the State of Connecticut, and that employees are treated when employed without regard to their sexual orientation; (2) the Contractor agrees to provide each labor union or representative of workers with which such Contractor has a collective bargaining Agreement or other contract or understanding and each vendor with which such Contractor has a contract or understanding, a notice to be provided by the Commission on Human Rights and Opportunities advising the labor union or workers' representative of the Contractor's commitments under this section, and to post copies of the notice in conspicuous places available to employees and applicants for employment; (3) the Contractor agrees to comply with each provision of this section and with each regulation or relevant order issued by said Commission pursuant to C.G.S. § 46a-56; and (4) the Contractor agrees to provide the Commission on Human Rights and Opportunities with such information requested by the Commission, and permit access to pertinent books, records and accounts, concerning the employment practices and procedures of the Contractor which relate to the provisions of this Section and C.G.S. § 46a-56.

(h) The Contractor shall include the provisions of the foregoing paragraph in every subcontract or purchase order entered into in order to fulfill any obligation of a contract with the State and such provisions shall be binding on a subcontractor, vendor or manufacturer unless exempted by regulations or orders of the Commission. The Contractor shall take such action with respect to any such subcontract or purchase order as the Commission may direct as a means of enforcing such provisions including sanctions for noncompliance in accordance with C.G.S. § 46a-56 as amended; provided, if such Contractor becomes involved in, or is threatened with, litigation with a subcontractor or vendor as a result of such direction by the Commission regarding a State contract, the Contractor may request the State of Connecticut to enter into any such litigation or negotiation prior thereto to protect the interests of the State and the State may so enter.

9. **Executive Orders.** This Contract is subject to the provisions of Executive Order No. Three of Governor Thomas J. Meskill, promulgated June 16, 1971, concerning labor employment practices, Executive Order No. Seventeen of Governor Thomas J. Meskill, promulgated February 15, 1973, concerning the listing of employment openings and Executive Order No. Sixteen of Governor John G. Rowland promulgated August 4, 1999, concerning violence in the workplace, all of which are incorporated into and are made a part of the Contract as if they had been fully set forth in it. The Contract may also be subject to Executive Order No. 14 of Governor M. Jodi Rell, promulgated April 17, 2006, concerning procurement of cleaning products and services and to Executive Order No. 49 of Governor Dannel P. Malloy, promulgated May 22, 2015, mandating disclosure of certain gifts to public employees and contributions to certain candidates for office. If Executive Order 14 and/or Executive Order 49 are applicable, they are deemed to be incorporated into and are made a part of the Contract as if they had been fully set forth in it. At the Contractor's request, the Institution or DAS shall provide a copy of these orders to the Contractor.

10. **Campaign Contribution Restrictions.** For all State contracts as defined in C.G.S. § 9-612 having a value in a calendar year of $50,000 or more or a combination or series of such agreements or contracts having a value of $100,000 or more, the authorized signatory to this Contract expressly acknowledges receipt of the State Elections Enforcement Commission's notice advising state contractors of state campaign contribution and solicitation prohibitions, and will inform its principals of the contents of the notice, as set forth in "Notice to

Executive Branch State Contractors and Prospective State Contractors of Campaign Contribution and Solicitation Limitations" reprinted below.

NOTICE TO EXECUTIVE BRANCH STATE CONTRACTORS AND PROSPECTIVE STATE CONTRACTORS OF CAMPAIGN CONTRIBUTION AND SOLICITATION LIMITATIONS

This notice is provided under the authority of Connecticut General Statutes §9-612(f)(2) and is for the purpose of informing state contractors and prospective state contractors of the following law (italicized words are defined below):

CAMPAIGN CONTRIBUTION AND SOLICITATION LIMITATIONS

No *state contractor, prospective state contractor, principal of a state contractor or principal of a prospective state contractor*, with regard to a *state contract* or *state contract solicitation* with or from a state agency in the executive branch or a quasi-public agency or a holder, or principal of a holder of a valid prequalification certificate, shall make a contribution to (i) an exploratory committee or candidate committee established by a candidate for nomination or election to the office of Governor, Lieutenant Governor, Attorney General, State Comptroller, Secretary of the State or State Treasurer, (ii) a political committee authorized to make contributions or expenditures to or for the benefit of such candidates, or (iii) a party committee (which includes town committees).

In addition, no holder or principal of a holder of a valid prequalification certificate, shall make a contribution to (i) an exploratory committee or candidate committee established by a candidate for nomination or election to the office of State senator or State representative, (ii) a political committee authorized to make contributions or expenditures to or for the benefit of such candidates, or (iii) a party committee.

On and after January 1, 2011, no state contractor, prospective state contractor, principal of a state contractor or principal of a prospective state contractor, with regard to a state contract or state contract solicitation with or from a state agency in the executive branch or a quasi-public agency or a holder, or principal of a holder of a valid prequalification certificate, shall **knowingly** *solicit* contributions from the state contractor's or prospective state contractor's employees or from a *subcontractor* or *principals of the subcontractor* on behalf of (i) an exploratory committee or candidate committee established by a candidate for nomination or election to the office of Governor, Lieutenant Governor, Attorney General, State Comptroller, Secretary of the State or State Treasurer, (ii) a political committee authorized to make contributions or expenditures to or for the benefit of such candidates, or (iii) a party committee.

DUTY TO INFORM

State contractors and prospective state contractors are required to inform their principals of the above prohibitions, as applicable, and the possible penalties and other consequences of any violation thereof.

PENALTIES FOR VIOLATIONS

Contributions or solicitations of contributions made in violation of the above prohibitions may result in the following civil and criminal penalties:

Civil penalties: Up to $2,000 or twice the amount of the prohibited contribution, whichever is greater, against a principal or a contractor. Any state contractor or prospective state contractor which fails to make reasonable efforts to comply with the provisions requiring notice to its principals of these prohibitions and the possible consequences of their violations may also be subject to civil penalties of up to $2,000 or twice the amount of the prohibited contributions made by their principals.

Criminal penalties: Any knowing and willful violation of the prohibition is a Class D felony, which may subject the violator to imprisonment of not more than 5 years, or not more than $5,000 in fines, or both.

CONTRACT CONSEQUENCES

In the case of a state contractor, contributions made or solicited in violation of the above prohibitions may result in the contract being voided.

In the case of a prospective state contractor, contributions made or solicited in violation of the above prohibitions shall result in the contract described in the state contract solicitation not being awarded to the prospective state contractor, unless the State Elections Enforcement Commission determines that mitigating circumstances exist concerning such violation.

The State shall not award any other state contract to anyone found in violation of the above prohibitions for a period of one year after the election for which such contribution is made or solicited, unless the State Elections Enforcement Commission determines that mitigating circumstances exist concerning such violation.

Additional information may be found on the website of the State Elections Enforcement Commission, www.ct.gov/seec. Click on the link to "Lobbyist/Contractor Limitations."

DEFINITIONS

"State contractor" means a person, business entity or nonprofit organization that enters into a state contract. Such person, business entity or nonprofit organization shall be deemed to be a state contractor until December thirty-first of the year in which such contract terminates. "State contractor" does not include a municipality or any other political subdivision of the state, including any entities or associations duly created by the municipality or political subdivision exclusively amongst themselves to further any purpose authorized by statute or charter, or an employee in the executive or legislative branch of state government or a quasi-public agency, whether in the classified or unclassified service and full or part-time, and only in such person's capacity as a state or quasi-public agency employee.

"Prospective state contractor" means a person, business entity or nonprofit organization that (i) submits a response to a state contract solicitation by the state, a state agency or a quasi-public agency, or a proposal in response to a request for proposals by the state, a state agency or a quasi-public agency, until the contract has been entered into, or (ii) holds a valid prequalification certificate issued by the Commissioner of Administrative Services under section 4a-100. "Prospective state contractor" does not include a municipality or any other political subdivision of the state, including any entities or associations duly created by the municipality or political subdivision exclusively amongst themselves to further any purpose authorized by statute or charter, or an employee in the executive or legislative branch of state government or a quasi-public agency, whether in the classified or unclassified service and full or part-time, and only in such person's capacity as a state or quasi-public agency employee.

"Principal of a state contractor or prospective state contractor" means (i) any individual who is a member of the board of directors of, or has an ownership interest of five per cent or more in, a state contractor or prospective state contractor, which is a business entity, except for an individual who is a member of the board of directors of a nonprofit organization**,** (ii) an individual who is employed by a state contractor or prospective state contractor, which is a business entity, as president, treasurer or executive vice president, (iii) an individual who is the chief executive officer of a state contractor or prospective state contractor, which is not a business entity, or if a state contractor or prospective state contractor has no such officer, then the officer who duly possesses comparable powers and duties, (iv) an officer or an employee of any state contractor or prospective state contractor who has *managerial or discretionary responsibilities with respect to a state contract,* (v) the spouse or a *dependent child* who is eighteen years of age or older of an individual described in this subparagraph, or (vi) a political committee established or controlled by an individual described in this subparagraph or the business entity or nonprofit organization that is the state contractor or prospective state contractor.

"State contract" means an agreement or contract with the state or any state agency or any quasi-public agency, let through a procurement process or otherwise, having a value of fifty thousand dollars or more, or a combination or series of such agreements or contracts having a value of one hundred thousand dollars or more in a calendar year, for (i) the rendition of services, (ii) the furnishing of any goods, material, supplies, equipment or any items of any kind, (iii) the construction, alteration or repair of any public building or public work, (iv) the acquisition, sale or lease of any land or building, (v) a licensing arrangement, or (vi) a grant, loan or loan guarantee. "State contract" does not include any agreement or contract with the state, any state agency or any quasi-public agency that is exclusively federally funded, an education loan, a loan to an individual for other than commercial purposes or any agreement or contract between the state or any state agency and the United States Department of the Navy or the United States Department of Defense.

"State contract solicitation" means a request by a state agency or quasi-public agency, in whatever form issued, including, but not limited to, an invitation to bid, request for proposals, request for information or request for quotes, inviting bids, quotes or other types of submittals, through a competitive procurement process or another process authorized by law waiving competitive procurement.

"Managerial or discretionary responsibilities with respect to a state contract" means having direct, extensive and substantive responsibilities with respect to the negotiation of the state contract and not peripheral, clerical or ministerial responsibilities.

"Dependent child" means a child residing in an individual's household who may legally be claimed as a dependent on the federal income tax of such individual.

"Solicit" means (A) requesting that a contribution be made, (B) participating in any fund-raising activities for a candidate committee, exploratory committee, political committee or party committee, including, but not limited to, forwarding tickets to potential contributors, receiving contributions for transmission to any such committee or bundling contributions, (C) serving as chairperson, treasurer or deputy treasurer of any such committee, or (D) establishing a political committee for the sole purpose of soliciting or receiving contributions for any committee. Solicit does not include: (i) making a contribution that is otherwise permitted by Chapter 155 of the Connecticut General Statutes; (ii) informing any person of a position taken by a candidate for public office or a public official, (iii) notifying the person of any activities of, or contact information for, any candidate for public office; or (iv) serving

as a member in any party committee or as an officer of such committee that is not otherwise prohibited in this section.

"Subcontractor" means any person, business entity or nonprofit organization that contracts to perform part or all of the obligations of a state contractor's state contract. Such person, business entity or nonprofit organization shall be deemed to be a subcontractor until December thirty first of the year in which the subcontract terminates. "Subcontractor" does not include (i) a municipality or any other political subdivision of the state, including any entities or associations duly created by the municipality or political subdivision exclusively amongst themselves to further any purpose authorized by statute or charter, or (ii) an employee in the executive or legislative branch of state government or a quasi-public agency, whether in the classified or unclassified service and full or part-time, and only in such person's capacity as a state or quasi-public agency employee.

"Principal of a subcontractor" means (i) any individual who is a member of the board of directors of, or has an ownership interest of five per cent or more in, a subcontractor, which is a business entity, except for an individual who is a member of the board of directors of a nonprofit organization, (ii) an individual who is employed by a subcontractor, which is a business entity, as president, treasurer or executive vice president, (iii) an individual who is the chief executive officer of a subcontractor, which is not a business entity, or if a subcontractor has no such officer, then the officer who duly possesses comparable powers and duties, (iv) an officer or an employee of any subcontractor who has managerial or discretionary responsibilities with respect to a subcontract with a state contractor, (v) the spouse or a dependent child who is eighteen years of age or older of an individual described in this subparagraph, or (vi) a political committee established or controlled by an individual described in this subparagraph or the business entity or nonprofit organization that is the subcontractor.

11. **Contract Assignment**. No right or duty, in whole or in part, of the Contractor under this Agreement may be assigned or delegated without the prior written consent of the institution.

12. **Confidential Information**. The Contractor acknowledges that it may have access to Confidential Information (as hereinafter defined). The Contractor agrees that it will use the Confidential Information solely for the purpose of performing its duties as a consultant and agrees that it will not divulge, furnish, publish or use for its own benefit or for the direct or indirect benefit of any other person or entity, whether or not for monetary gain, any Confidential Information.

    For purposes of this Agreement, the term "Confidential Information" shall mean (i) all information related to the business operations, marketing plans, financial position and (ii) other business information and any other information disclosed to the Contractor. Confidential Information shall not include information which (i) is or becomes part of the public domain through no act or omission attributable to the Contractor, (ii) is released after prior written authorization or (iii) the Contractor receives from any third party who is unrelated to it and who is not under any obligation to maintain the confidentiality of such information.

13. **Summary of State Ethics Laws**. Pursuant to the requirements of section 1-101qq of the Connecticut General Statutes, the summary of State ethic laws developed by the State Ethics Commission pursuant to section 1-81b of the Connecticut General Statutes is incorporated by reference into and made a part of the contract as if the summary had been fully set forth in the contract.

14. **Whistleblower**. This contract may be subject to the provisions of Section 4-61dd of the Connecticut General Statutes. In accordance with this statute, if an officer, employee or appointing authority of the Contractor takes or threatens to take any personnel action against any employee of the Contractor in retaliation for such employee's disclosure of information to any employee of the contracting state or quasi-public agency or the Auditors of Public Accounts or the Attorney General under the provisions of subsection (a) of such statute, the Contractor shall be liable for a civil penalty of not more than five thousand dollars for each offense, up to a maximum of twenty percent (20%) of the value of this contract. Each violation shall be a separate and distinct offense and in the case of a continuing violation, each calendar day's continuance of the violation shall be deemed to be a separate and distinct offense. The State may request that the Attorney General bring a civil action in the Superior Court for the Judicial District of Hartford to seek imposition and recovery of such civil penalty. In accordance with subsection (f) of such statute, each large state contractor, as defined in the statute, shall post a notice of the provisions of the statute relating to large state contractors in a conspicuous place which is readily available for viewing by the employees of the contractor.

15. **Disclosure of Records**. This Contract may be subject to the provisions of section 1-218 of the Connecticut General Statutes. In accordance with this statute, each contract in excess of two million five hundred thousand dollars between a public agency and a person for the performance of a governmental function shall (a) provide that the public agency is entitled to receive a copy of records and files related to the performance of the governmental function, and (b) indicate that such records and files are subject to the Freedom of Information Act (FOIA) and may be disclosed by the public agency pursuant to FOIA. No request to inspect or copy such records or files shall be valid unless the request is made to the public agency in accordance with FOIA. Any complaint by

a person who is denied the right to inspect or copy such records or files shall be brought to the Freedom of Information Commission in accordance with the provisions of sections 1-205 and 1-206 of the Connecticut General Statutes.

16. **Professional Standards**. In rendering services under this contract, the Contractor shall conform to high professional standards of work and business ethic. The Contractor warrants that the services shall be performed: 1) in a professional and workmanlike manner; and 2) in accordance with generally and currently accepted principles and practices. During the term of this contract, the Contractor agrees to provide to Institution in a good and faithful manner, using its best efforts and in a manner that shall promote the interests of Institution, such services as Institution requests, provided in the contract.

VI. ACCEPTANCE OF AGREEMENT

IN WITNESS WHEREOF, the parties have executed this Contract by their duly authorized representatives with full knowledge of and agreement with its terms and conditions.

Connecticut State Colleges and Universities

By: DocuSigned by: Benjamin Barnes D32E97F4914F43C...
Print Name: Benjamin Barnes
Title: Chief Financial Officer
Date: 7/21/2021

By: DocuSigned by: Alice Pritchard 36F0D5CA642044F...
Print Name: Alice Pritchard
Title: Chief of Staff
Date: 7/22/2021

Aetna Life Insurance Company

By: DocuSigned by: Peter Diniaco 15A490CE741A49F...
Print Name: Peter Diniaco
Title: Executive Director of Sales and Account Management
Date: 7/21/2021

By the Connecticut Attorney General (approved as to form)

By: Joseph Rubin, Asst. Dep. A.G. Digitally signed by Joseph Rubin, Asst. Dep. A.G. Date: 2021.07.26 16:41:57 -04'00'
Print Name: _____
Title: _____
Date: _____

Policyholder No. 890429

Blanket Student Accident Insurance Policy

a contract between

Aetna Life Insurance Company
(A Stock Company herein called Aetna)

and

Connecticut State Colleges and Universities: Central, Eastern, Southern and Western - Accident Plan
(Policyholder)

Policy Number:	[GP-890429][GP-8904033][GP-890434][GP-890435]
Date of issue:	July 2, 2021
To Take Effect:	August 1, 2021
Policy delivered in:	Connecticut

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

This Policy takes effect at 12:01 A.M. standard time at the Policyholder's address on August 1, 2021. The **Policy Year** starts on August 1, 2021 and ends at 11:59 P.M. on July 31, 2022.

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

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

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

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

IMPORTANT NOTICE:

Notice of Non-Discrimination:
Aetna Life Insurance Company does not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation, or health status in the administration of the plan including enrollment and benefit determinations.

Dan Finke
President

Aetna Life Insurance Company
(A Stock Company)

Registrar

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

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STUDENT ACCIDENT INSURANCE

SECTION 1 - SCHEDULE OF BENEFITS

ELIGIBILITY

Student

All FT students matriculating in a degree seeking program are eligible to enroll.

Subject to the terms of the Policy, benefits are available for a **covered person** only for the coverage listed below; and only up to the maximum amounts shown. The *Coverage* section contains a complete description of the benefits available.

BENEFITS PAYABLE

After any applicable **deductible**, the Health Expense Benefits payable in a **policy year** are paid at the Covered Percentage which applies to the type of **covered medical expense** which is incurred. Benefits may vary depending upon whether a **preferred care provider** is used. A **preferred care provider** are health care providers who have agreed to provide services or supplies at a "**negotiated charge"**. A **non-preferred care provider** is a health care provider who is reimbursed based upon the "**recognized charge**".

If any expense is covered under one type of **covered medical expense**, it cannot be covered under any other type.

ACCIDENT EXPENSE BENEFITS OUT-OF-POCKET LIMITS		
	Preferred Care	**Non-Preferred Care**
For the **covered student**	N/A	N/A
For the family	N/A	N/A

ACCIDENT EXPENSE BENEFIT AGGREGATE MAXIMUM EXPENSE BENEFITS	
Aggregate Maximum Accident Expense Benefit Limit per **Accident** per policy year**:**	$100,000

DEDUCTIBLES

ACCIDENT EXPENSE BENEFITS OVERALL AGGREGATE DEDUCTIBLES		
	Preferred Care	**Non-Preferred Care**
Aggregate Deductible Amount per **policy year, covered person:***		
For the **covered student**	N/A	N/A
For the dependent	N/A	N/A
For the family	N/A	N/A
***Per visit/per admission **deductibles** do not apply towards satisfying the **policy year deductible**.		

PRECERTIFICATION

Certain services, such as inpatient **stays**, certain tests, procedures, outpatient surgery, therapies, equipment, and outpatient **prescription drugs** require **precertification** by Aetna.

Refer to the **Precertification** provisions in the Coverage section for a complete description of the **precertification** programs including the types of services, treatments, procedures, visits or supplies that require **precertification**.

STUDENT ACCIDENT INSURANCE

SECTION 1 - SCHEDULE OF BENEFITS (Continued)

OTHER THAN PREVENTIVE CARE EXPENSES

COVERAGE	**BENEFIT AMOUNT**	
	Preferred Care	**Non-Preferred Care**
PRE-ADMISSION TESTING EXPENSE		
Covered Percentage	50%	50%
HOSPITAL EXPENSE		
Covered Percentage	100% of **semi-private rate**	80% of **semi-private rate**
Daily **room and board** Intensive Care Covered Percentage	100%	80%
Miscellaneous Hospital Expense Covered Percentage	100%	80%
SURGICAL EXPENSE		
Covered Percentage	100%	80%
Anesthesia Expense Covered Percentage	100%	80%
Assistant Surgeon Expense Covered Percentage	100%	80%
IN-HOSPITAL NON-SURGICAL PHYSICIAN'S FEES EXPENSE		
Covered Percentage	100%	80%
OUTPATIENT EXPENSE		
Therapy Expense		
Covered Percentage	100%	80%
Outpatient Physician or Specialist Office Visit Expense		
Covered Percentage	100%	80%

Emergency Room Visit Expense – * See the Note below		
Covered Percentage	100%	Paid the same as the Preferred Care level of benefits.
***Note:** Please note that as **non-preferred care providers** are not **preferred care providers** and do not have a contract with Aetna, the provider may not accept payment of the **covered person's** cost share (**deductible** and **coinsurance)**, as payment in full. The **covered person** may receive a bill for the difference between the amount billed by the **non-preferred care provider** and the amount paid by this Plan. If the Emergency Room Facility or **physician** bills the **covered person** for an amount above their cost share, the **covered person** is not responsible for paying that amount. Please send Aetna the bill at the address listed on the member ID card and Aetna will resolve any payment dispute with the **non-preferred care provider** over that amount. Make sure the member ID card number is on the bill.		
Hospital Outpatient Department Expense		
Covered Percentage	100%	80%
Walk-In Clinic Visits Expense (Non-Emergency)		
All Other Services		
Covered Percentage	100%	80%
Ambulatory Surgical Expense		
Covered Percentage	100%	80%
Laboratory and X-Ray Expense		
Covered Percentage	100%	80%
Durable Medical and Surgical Equipment Expense		
Covered Percentage	100%	80%
AMBULANCE EXPENSE		
Ground, Air, Water and Non-Emergency Ambulance Covered Percentage	100%	100%
ACCIDENTAL INJURY TO SOUND NATURAL TEETH EXPENSE		
Covered Percentage	100%	100%
CONSULTANT EXPENSE		
Covered Percentage	100%	80%
LICENSED NURSE EXPENSE		
Covered Percentage	100%	80%

SKILLED NURSING FACILITY EXPENSE		
Covered Percentage	100% of **semi-private rate,** except if **intensive care unit** is **medically necessary**	80% of **semi-private rate,** except if **intensive care unit** is **medically necessary**
REHABILITATION FACILITY EXPENSE		
Covered Percentage	100% of **semi-private rate,** except if **intensive care unit** is **medically necessary**	80% of **semi-private rate,** except if **intensive care unit** is **medically necessary**
NON-ELECTIVE - SECOND SURGICAL OPINION EXPENSE		
Covered Percentage	50%	50%
HOME HEALTH CARE EXPENSE		
Covered Percentage	100%	80%
HIGH COST PROCEDURES EXPENSE		
Covered Percentage	100%	80%
PROSTHETIC DEVICES EXPENSE		
Hearing Aid Expenses		
Hearing Aids Covered Percentage Coverage is limited to covered persons through age 26	100%	80%
All Other Prosthetic Devices		
Covered Percentage	100%	80%
PODIATRIC EXPENSE		
Covered Percentage	50%	50%
ACUPUNCTURE IN LIEU OF ANESTHESIA EXPENSE		
Covered Percentage	50%	50%
TRANSFUSION OR KIDNEY DIALYSIS OF BLOOD EXPENSE		
Covered Percentage	50%	50%
URGENT CARE EXPENSE		
Urgent Care from an **Urgent Care Provider** Covered Percentage	100%	80%

SHORT TERM CARDIAC AND PULMONARY REHABILITATION THERAPIES EXPENSE		
Cardiac Rehabilitation Covered Percentage	100%	80%
Pulmonary Rehabilitation Covered Percentage	100%	80%
SHORT TERM REHABILITATION AND HABILITATION THERAPIES EXPENSE		
Outpatient Cognitive, Physical, Occupational and Speech Rehabilitation and Habilitation Therapy Services (combined) Covered Percentage	100%	80%
CHIROPRACTIC TREATMENT EXPENSE		
Chiropractic Treatment Covered Percentage	100%	80%

SECTION 2 - DEFINITIONS

The following words and phrases when used in the Policy shall have, unless the context clearly indicates otherwise, the meaning given to them below. A definition that appears in this section does not necessarily mean that coverage is provided under the Policy for the services, treatments, procedures, visits or supplies described in the definition.

Some definitions that apply only to a specific benefit may appear in the benefit description in the *Coverage* section.

Aetna
Aetna Life Insurance Company, an affiliate, or a third party vendor under contract with **Aetna**.

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

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

Aggregate Maximum:
The maximum benefit that will be paid under the Policy for all Covered Medical Expenses incurred by a covered person that accumulate during the policy year to the next.

Ambulance
A vehicle that is staffed with medical personnel and equipped to transport a sick or injured person.

Average Wholesale Price (**AWP**)
The current average wholesale price of a **prescription drug** listed in the Facts and Comparisons weekly price updates (or any other similar publication designated by **Aetna**) on the day that a **pharmacy** claim is submitted for adjudication.

Ambulatory Surgical Center:
A freestanding ambulatory surgical facility that:

- Meets licensing standards.
- Is set up, equipped and run to provide general surgery.
- Makes charges.
- Is directed by a staff of **physicians**. At least one of them must be on the premises when surgery is performed and during the recovery period.
- Has at least one certified anesthesiologist at the site when surgery which requires general or spinal anesthesia is performed and during the recovery period.
- Extends surgical staff privileges to:
  - physicians who practice surgery in an area **hospital**; and
  - **dentist**s who perform oral surgery.
- Has at least 2 operating rooms and one recovery room.
- Provides, or arranges with a medical facility in the area for, diagnostic x-ray and lab services needed in connection with surgery.

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

Autism Spectrum Disorder
This means Autism Spectrum Disorder as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

Behavioral Health Provider:
This is a licensed organization or professional providing diagnostic, therapeutic or psychological services for behavioral health conditions.

Behavioral Health Provider:
This is a professional that is properly licensed or certified to provide diagnostic and/or therapeutic services for **mental disorders** and **substance abuse** under the laws of the jurisdiction where the individual practices.

Biosimilar Prescription Drug:
A biological **prescription drug** that is highly similar to a U.S. Food and Drug Administration (FDA) – licensed reference biological **prescription drug** notwithstanding minor differences in clinically inactive components, and for which there are no clinically meaningful differences between the highly similar biological **prescription drug** and the reference biological **prescription drug** in terms of the safety, purity, and potency of the drug.

This is defined in accordance with U.S. Food and Drug Administration (FDA) regulations.

Birthing Center:
A freestanding facility that:

- Meets licensing standards.
- Is set up, equipped and run to provide prenatal care, delivery and immediate postpartum care.
- Makes charges.
- Is directed by at least one physician who is a specialist in obstetrics and gynecology.
- Has a **physician** or certified nurse midwife present at all births and during the immediate postpartum period.
- Extends staff privileges to physicians who practice obstetrics and gynecology in an area **hospital.**
- Has at least 2 beds or 2 birthing rooms for use by patients while in labor and during delivery.
- Provides, during labor, delivery and the immediate postpartum period, full-time skilled nursing services directed by a R.N. or certified nurse midwife.
- Provides, or arranges with a facility in the area for, diagnostic X-ray and lab services for the mother and child.
- Has the capacity to administer a local anesthetic and to perform minor surgery. This includes episiotomy and repair of perineal tear.

- Is equipped and has trained staff to handle medical emergencies and provide immediate support measures to sustain life if complications arise during labor and if a child is born with an abnormality which impairs function or threatens life.
- Accepts only patients with low risk pregnancies.
- Has a written agreement with a hospital in the area for emergency transfer of a patient or a child. Written procedures for such a transfer must be displayed and the staff must be aware of them.
- Provides an ongoing quality assurance program. This includes reviews by physicians who do not own or direct the facility.
- Keeps a medical record on each patient and child.

Body Mass Index
A practical marker that is used to assess the degree of obesity and is calculated by dividing the weight in kilograms by the height in meters squared.

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

Coinsurance
Coinsurance is both the percentage of **covered medical expenses** or **covered dental expenses** that the plan pays, and the percentage of **covered medical expenses** or **covered dental expenses** that you pay. The percentage that the plan pays is referred to as "plan **coinsurance**" or the "payment percentage," and varies by the type of expense. Please refer to the *Schedule of Benefits* for specific information on **coinsurance** amounts.

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

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

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

Complications of Pregnancy also include:

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

Convalescent Facility:
This is an institution that:

- Is licensed to provide, and does provide, the following on an inpatient basis for persons convalescing from disease or injury:
  - professional nursing care by a **R.N.**, or by a **L.P.N.** directed by a full-time **R.N.**; and
  - physical restoration services to help patients to meet a goal of self-care in daily living activities.
- Provides 24 hour a day nursing care by licensed nurses directed by a full-time **R.N.**
- Is supervised full-time by a **physician** or **R.N.**
- Keeps a complete medical record on each patient.

- Has a utilization review plan.
- Is not mainly a place for rest, for the aged, for drug addicts, for alcoholics, for mental retardates, for custodial or educational care, or for care of mental disorders.
- Makes charges.

Copay, Copayment:
The specific dollar amount or percentage required to be paid by the **covered person** or on behalf of the **covered person**. The plan includes various **copays**; and these **copay** amounts or percentages; are specified in the *Schedule of Benefits*.

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

Cosmetic:
These are services or supplies that alter, improve or enhance appearance.

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

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

Covered Medical Expense or Covered Expense:
Medical, **prescription drug**, dental, vision or hearing charges for any treatment, service or supply that is:

- Shown as covered under the Policy;
- Not in excess of the **recognized charges**; or
- Not in excess of the charges that would have been made in the absence of this coverage; and
- Incurred while the 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** while coverage under the Policy is in effect.

Covered Student:
A student of the Policyholder who is insured under the Policy. The term "covered student", as used throughout the Policy, shall also mean part-time students, medical school residents, dental school students, post-doctorate students, fellowship recipients, and visiting scholars.

Custodial Care
Services and supplies that are primarily intended to help a person meet personal needs. **Custodial are** can be prescribed by a **physician** or given by trained medical personnel. It may involve artificial methods such as feeding tubes, ventilators or catheters. Examples of **custodial care** include:

- Routine patient care such as changing dressings, periodic turning and positioning in bed, administering oral medications;
- Care of a stable tracheostomy (including intermittent suctioning);
- Care of a stable colostomy/ileostomy;
- Care of stable gastrostomy/jejunostomy/nasogastric tube (intermittent or continuous feedings);

- Care of a stable indwelling bladder catheter (including emptying/changing containers and clamping tubing);
- Watching or protecting you;
- **Respite care**, adult (or child) day care, or convalescent care;
- Institutional care, including **room and board** for rest cures, adult day care and convalescent care or where the patient has reached the maximum level of physical or mental function and such person is not likely to make further significant improvement;
- Help with the daily living activities, such as walking, grooming, bathing, dressing, getting in or out of bed, toileting, eating or preparing foods;
- Any services that a person without medical or paramedical training could be trained to perform;
- Any service that can be performed by a person without any medical or paramedical training.

Dental Consultant:
A **dentist** who has agreed to provide consulting services in connection with the *Dental Expense* benefit.

Dental Provider:
This is any **dentist**; group; organization; dental facility; or other institution; or person legally qualified to furnish dental services or supplies.

Dental Emergency
Any dental condition that:

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

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

Detoxification
The process by which an alcohol- or drug-intoxicated, or alcohol- or drug-dependent, person is assisted through the period of time necessary to eliminate, by metabolic or other means, the:

- Intoxicating alcohol or drug;
- Alcohol- or drug-dependent factors; or
- Alcohol in combination with drugs;

as determined by a **physician**. The process must keep the physiological risk to the patient at a minimum and, if it takes place in a facility, the facility must meet any applicable licensing standards established by the jurisdiction in which it is located.

Durable Medical and Surgical Equipment:
This means not more than one item of equipment for the same or similar purpose, and the accessories needed to operate it, that is:

- Made to withstand prolonged use;
- Made for and mainly used in the treatment of a disease or **injury;**
- Suited for use in the home;

- Not normally of use to person's who do not have a disease or **injury;**
- Not for use in altering air quality or temperature;
- Not for exercise or training.

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

Elective Treatment:
Services and supplies provided where there is no evidence of pathology, dysfunction, or **sickness** in any part of the body. **Elective treatment** includes; but is not limited to:

- Vasectomy;
- Breast reduction;
- Sexual reassignment surgery;
- Submucous resection and/or other surgical correction for deviated nasal septum, other than necessary treatment of covered acute purulent sinusitis;
- Treatment for weight reduction;
- Learning disabilities (except **Autism Spectrum Disorders**);
- Temporomandibular joint dysfunction (TMJ); and
- Treatment of **infertility**.

Elective treatment does not include services and supplies that are covered as *Preventive Care* benefits in the *Coverage* section of the Policy.

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

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

Emergency Care
This means the treatment given in a **hospital's** emergency room to evaluate, stabilize and treat an **emergency medical condition**.

Emergency Condition:
This is any traumatic injury or condition which:

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

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

- Placing the person's health in serious jeopardy; or
- Serious impairment to bodily function; or
- Serious dysfunction of a body part or organ; or
- In the case of a pregnant woman; serious jeopardy to the health of the fetus.

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
- Approval required by the U.S. Food and Drug Administration (FDA) 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 or investigational**, or for research purposes; or
- It is a type of drug, device, treatment, or procedure that is the subject of a Phase I or Phase II clinical trial or the experimental or research arm of a Phase III clinical trial, using the definition of "phases" indicated in regulations and other official actions and publications of the FDA and Department of Health and Human Services; 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 or investigational**, or for research purposes.

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

Home Health Agency or Home Health Care Agency:
This is

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

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

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

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

Homebound
This means that a **covered person** is confined in their place of residence:

- Due to a **sickness** or **injury** which makes leaving the residence medically contraindicated; or
- Because the act of transport would be a serious risk to the **covered person's** life or health.

Situations where a **covered person** would not be considered **homebound** include (but are not limited to) the following:

- A **covered person** does not often travel from their place of residence because of feebleness or insecurity brought on by advanced age (or otherwise); or
- A **covered person** is wheelchair bound but could safely be transported via wheelchair accessible transportation.

Hospice or Hospice Care
This is care given to a **terminally ill** person by or under arrangements with a **hospice care agency**. The care must be part of a **hospice care program**.

Hospice Care Agency
An agency or organization that meets all of the following requirements:

- Has **hospice care** available 24 hours a day.
- Meets any licensing or certification standards established by the jurisdiction where it is located.
- Provides:
  - **Skilled nursing services**;
  - Medical social services; and
  - Psychological and dietary counseling.
- Provides, or arranges for, other services which include:
  - **Physician** services;
  - Physical and occupational therapy;
  - Part-time home health aide services which mainly consist of caring for **terminally ill** people; and
  - Inpatient care in a facility when needed for pain control and acute and chronic symptom management.
- Has at least the following personnel:
  - One **physician**;
  - One **R.N.**; and
  - One licensed or certified social worker employed by the agency.
- Establishes policies about how **hospice care** is provided;

- Assesses the patient's medical and social needs;
- Develops a **hospice care program** to meet those needs;
- Provides an ongoing quality assurance program. This includes reviews by **physicians**, other than those who own or direct the agency;
- Permits all area medical personnel to utilize its services for their patients;
- Keeps a medical record on each patient;
- Uses volunteers trained in providing services for non-medical needs;
- Has a full-time administrator.

Hospice Care Program
This is a written plan of **hospice care**, which:
- Is established by and reviewed from time to time by a **physician** attending the person, and appropriate personnel of a **hospice care agency**;
- Is designed to provide palliative and supportive care to **terminally ill** persons, and supportive care to their families; and
- Includes an assessment of the person's medical and social needs; and a description of the care to be given to meet those needs.

Hospice Facility
A facility or distinct part of one that meets all of the following requirements:

- Mainly provides inpatient **hospice care** to **terminally ill** persons;
- Charges patients for its services;
- Meets any licensing or certification standards established by the jurisdiction where it is located;
- Keeps a medical record on each patient;
- Provides an ongoing quality assurance program including reviews by **physician**s other than those who own or direct the facility;
- Is run by a staff of **physician**s. At least one staff **physician** must be on call at all times;
- Provides 24-hour-a-day nursing services under the direction of an **R.N.**;
- Has a full-time administrator.

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

Hospital:
This is an institution that:

- Is primarily engaged in providing, on its premises, inpatient medical, surgical and diagnostic services;
- Is supervised by a staff of **physician**s;
- Provides twenty-four (24) hour-a-day **R.N.** service;
- Charges patients for its services;
- Is operating in accordance with the laws of the jurisdiction in which it is located; and
- Does not meet all of the requirements above, but does meet the requirements of the jurisdiction in which it operates for licensing as a **hospital** and is accredited as a **hospital** by the Joint Commission on the Accreditation of Healthcare Organizations.

In no event does **hospital** include a convalescent nursing home or any institution or part of one which is used principally as a convalescent facility, rest facility, nursing facility, facility for the aged, **psychiatric hospital, residential treatment facility** for **substance abuse** or **mental disorders,** extended care facility, intermediate care facility, **skilled nursing facility**, **hospice**, rehabilitative **hospital** or facility primarily for rehabilitative or **custodial care** services.

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

Infertility or Infertile
This is a disease defined by the failure to conceive a pregnancy after 12 months or more of timed intercourse or egg-sperm contact for women under age 35 (or 6 months for women age 35 or older).

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

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

Institute of Excellence (IOE)
A **hospital** or other facility that has contracted with **Aetna** to furnish services or supplies to an **IOE** patient in connection with specific transplants, procedures at a **negotiated charge**. A facility is an **IOE** facility only for those types of transplants or procedures for which it has signed a contract.

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

Intensive Outpatient Program (IOP)
This is a program of at least 2 hours per day and at least six hours per week of clinical treatment provided in a facility or program for treatment of a **mental disorder** or **substance abuse** issue provided under the direction of a **physician.** Services may include group, individual, family or multi-family group psychotherapy, psycho educational services, and adjunctive services such as medication monitoring.

L.P.N.
A licensed practical or vocational nurse.

Jaw Joint Disorder:
This is:

- A Temporomandibular Joint (TMJ) dysfunction or any similar disorder of the jaw joint; or
- A Myofacial Pain Dysfunction (MPD); or
- Any similar disorder in the relationship between the jaw joint and the related muscles and nerves.

Mail Order Pharmacy:
This is an establishment where **prescription drugs** are legally dispensed by mail.

Medically Necessary, Medical Necessity
Health care or dental services, and supplies or **prescription drug**s that a **physician**, other health care provider or **dental provider**, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an **sickness** or **injury** or its symptoms, and that provision of the service, supply or **prescription drug** is:

- In accordance with generally accepted standards of medical or dental practice;
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's **sickness** or **injury**;
- Not primarily for the convenience of the patient, **physician,** or **other health care** or **dental provider;** and
- Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's **sickness** or **injury**.

For these purposes "generally accepted standards of medical or dental practice" means standards that are based on credible scientific evidence published in peer-reviewed literature generally recognized by the relevant medical or dental community, or otherwise consistent with **physician** or dental specialty society recommendations and the views of **physicians** or **dentist**s practicing in relevant clinical areas and any other relevant factors.

Medically Necessary or Medical Necessity
These are health care services that **Aetna** determines that a **provider,** exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating **sickness, injury**, disease or its symptoms, and that **Aetna** determines are:

- In accordance with generally accepted standards of medical practice;
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's **sickness, injury** or disease;
- Not primarily for the convenience of the patient, **physician**, or other health care **provider**; and
- Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's **sickness, injury** or disease.

Generally accepted standards of medical practice means:

- Standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community; and
- Consistent with the standards set forth in policy issues involving clinical judgment.

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

Member Dental Provider:
This is any **dental provider** who has entered in to a written agreement to provide to **covered students** the dental care described under the *Dental Expense Benefit*.

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

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

Mental Disorder
This is a **sickness** commonly understood to be a **mental disorder**, whether or not it has a physiological basis, and for which treatment is generally provided by or under the direction of a **behavioral health provider** such as a **psychiatrist**, a psychologist or a psychiatric social worker. Mental Disorders includes **substance abuse** related disorders.

Morbid Obesity
This means a **body mass index** that is: greater than 40 kilograms per meter squared; or equal to or greater than 35 kilograms per meter squared with a comorbid medical condition, including: hypertension; a cardiopulmonary condition; sleep apnea; or diabetes. **Body mass index** is a practical marker that is used to assess the degree of obesity and is calculated by dividing the weight in kilograms by the height in meters squared.

Negotiated Charge:
As to health care coverage, other than Prescribed Medicine Expense coverage:
The maximum charge a **preferred care provider** has agreed to make as to any service or supply for the purpose of the benefits under the Policy.

As to Prescribed Medicine Expense coverage:
The negotiated charge is the amount Aetna has established for each **prescription drug** obtained from a **preferred pharmacy** under the Policy. This negotiated charge may reflect amounts **Aetna** has agreed to pay directly to the **preferred pharmacy** or to a third party vendor for the **prescription drug**, and may include an additional service or risk charge set by Aetna.

The negotiated charge does not include or reflect any amount Aetna, an affiliate, or a third party vendor, may receive under a rebate arrangement between Aetna, an affiliate or a third party vendor and a drug manufacturer for any **prescription drug**, including **prescription drugs** on the **medication formulary**.

Based on its overall drug purchasing, Aetna may receive rebates from the manufacturers of **prescription drugs** and may receive or pay additional amounts from or to third parties underprice guarantees. These amounts will not change the negotiated charge under the Policy.

Network Provider
A health care provider, **pharmacy,** or **dental provider** who has contracted to furnish services or supplies for a **negotiated charge**; but only if the provider is, with **Aetna**'s consent, included in www.docfind.com as a **network provider** for:

- The service or supply involved; and
- The class of employees to which the **covered person** belongs.

Network Service(s) or Supply(ies)
Health care service or supply that is furnished by a **network provider.**

Non-Member Dental Provider:
A **dental provider** who has not entered into a written agreement with Aetna to provide *Dental Expense* benefits to **covered students**.

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

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

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

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

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

- arise out of (or in the course of) any work for pay or profit; or
- result in any way from an **injury** which does.

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

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

Non-Preferred Care Provider:

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

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

Non-Preferred Drug:
This is a **prescription drug** that does not appear on the **preferred drug list**. This includes **prescription drugs** on the **preferred drug exclusions list** that are approved by medical exception.

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

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

Orthodontic Treatment:
This is any

- Medical service or supply; or
- Dental service or supply;

furnished to prevent or to diagnose or to correct a misalignment:

- Of the teeth; or
- Of the bite; or
- Of the jaws or jaw joint relationship;

whether or not for the purpose of relieving pain.

Not included is:

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

Out-of-Network Service(s) and Supply(ies)
Health care service or supply that is furnished by an **out-of network provider**

Out-of-Network Provider
A health care provider, **pharmacy,** or **dental provider** who has not contracted with **Aetna** to furnish services or supplies at a **negotiated charge**.

Out-of-Pocket Limit
The amount that must be paid by the **covered student** or the **covered student** before **covered medical expenses** will be payable at 100% for the remainder of the **policy year**.

Partial Hospitalization Treatment
This is a plan of medical, psychiatric, nursing, counseling, or therapeutic services to treat **mental disorders** and **substance abuse**.

The plan must meet these tests:

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

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

Physician:
This is a duly licensed member of a medical profession who:

- Has an M.D. or D.O. degree;
- Is properly licensed or certified to provide medical care under the laws of the jurisdiction where the individual practices; and
- Provides medical services which are within the scope of his or her license or certificate.

This also includes a health professional who:

- Is properly licensed or certified to provide medical care under the laws of the jurisdiction where he or she practices;
- Provides medical services which are within the scope of his or her license or certificate;
- Under applicable insurance law, is considered a "**physician**" for purposes of this coverage;
- Has the medical training and clinical expertise suitable to treat the **covered person's** condition;
- Specializes in psychiatry, if your **sickness** or **injury** is caused, to any extent, by **substance abuse** or a **mental disorder**;
- A **physician** is not the **covered person** or related to a **covered person**.

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

Precertification, Precertify, Precertified
A process where Aetna is contacted before certain services are provided, such as **hospitalization** or outpatient services, or **prescription drugs** are prescribed to determine whether the services being recommended or the drugs prescribed are considered **covered medical expenses** under the plan. It is not a guarantee that benefits will be payable if, for example, it is determined at the time the claim is submitted that the **covered person** was not eligible for benefits at that time.

Preferred Care:
This is care provided by

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

Preferred Care Provider:
This is 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 www.docfind.com as a **preferred care provider** for:

- The service or supply involved; and
- The class of **covered persons** of which you are member.

Preferred Drug:
This is a **prescription drug** that appears on the **preferred drug list**.

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

Preferred Drug List:
This is a listing of **prescription drugs** established by Aetna or an affiliate. This list is subject to periodic review and modification by Aetna. A copy of the **preferred drug list** will be available upon the **covered person's** request or may be accessed on the Aetna website at www.aetna.com/formulary.

As used on the preferred drug list:
Tier 1A
This is a group of medications determined by Aetna that may be available at a reduced **copayment/coinsurance** and are noted on the preferred drug list.

Tier 1B
This is a group of medications determined by Aetna that may be available at a reduced **copayment/coinsurance** and are noted on the preferred drug list.

Preferred Pharmacy:
This a **pharmacy**; including a **mail order pharmacy**; which is party to a contract with **Aetna**, an affiliate, or a third party vendor, to dispense drugs to persons covered under the Policy; but only while:

- The contract remains in effect; and
- Such a **pharmacy** dispenses a **prescription drug;** under the terms of its contract with **Aetna**, an affiliate, or a third party vendor.

Preferred Prescription Drug Expense:
This is an expense incurred for a **prescription drug** that:

- Is dispensed by a **Preferred Pharmacy**; or for an **emergency medical condition** only; by a **non-preferred pharmacy**; and
- Is dispensed upon the **Prescription** of a **Prescriber** who is:
  - a **Preferred Care Provider**; or
  - a **Non-Preferred Care Provider**; but only for an **emergency condition;** or on referral of a person's **Primary Care Physician**; or
  - a **dentist** who is a **Non-Preferred Care Provider**; but only one who is not of a type that falls into one or more of the categories of providers listed in the www.docfind.com as **preferred care providers**.

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

Prescription:
*As to **prescription drugs**:*
A written order for the dispensing of a **prescription drug** by a **prescriber**. If it is a verbal order, it must promptly be put in writing by the **pharmacy**.

As to vision care:
A written order for the dispensing of **prescription** lenses or **prescription** contact lenses by an ophthalmologist or optometrist.

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

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

- Selected by a **covered person** from the list of **primary care physicians** in www.docfind.com;
- Responsible for the **covered person's** on-going health care; and
- Shown on Aetna's records as the **covered person's primary care physician**.

For purposes of this definition, a **primary care physician** also includes the **School Health Services**.

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

Psychiatric Hospital
This is an institution that meets all of the following requirements.

- Mainly provides a program for the diagnosis, evaluation, and treatment of **substance abuse** or **mental disorders**;
- Is not mainly a school or a custodial, recreational or training institution;
- Provides infirmary-level medical services. Also, it provides, or arranges with a **hospital** in the area for, any other medical service that may be required;
- Is supervised full-time by a **psychiatrist** who is responsible for patient care and is there regularly;
- Is staffed by **psychiatrists** involved in care and treatment;
- Has a **psychiatrist** present during the whole treatment day;
- Provides, at all times, psychiatric social work and nursing services;
- Provides, at all times, **skilled nursing services** by licensed nurses who are supervised by a full-time **R.N.**;
- Prepares and maintains a written plan of treatment for each patient based on medical, psychological and social needs. The plan must be supervised by a **psychiatrist**;
- Makes charges;
- Meets licensing standards.

Psychiatrist
This is a **physician** who:

- Specializes in psychiatry; or
- Has the training or experience to do the required evaluation and treatment of **substance abuse** or **mental disorders**.

R.N.
A registered nurse.

Recognized Charge
The **covered medical expense** is only the part of a charge which is the **recognized charge**.

As to medical, vision and hearing expenses, the **recognized charge** for each service or supply is the lesser of:
- What the provider bills or submits for that service or supply; and

- for professional services and other services or supplies not mentioned below:
  - 105% of the Medicare Allowable Rate;
  for the Geographic Area where the service is furnished.

- for inpatient charges of hospitals and other facilities:
  - 140% of the Medicare Allowable Rate;
  for the Geographic Area where the service is furnished.

- for outpatient charges of hospitals and other facilities:
  - 140% of the Medicare Allowable Rate;
  for the Geographic Area where the service is furnished.

As to **prescription drug** expenses, the **recognized charge** for each service or supply is the lesser of:
- What the provider bills or submits for that service or supply; and

- 100% of the **Average Wholesale Price** (**AWP**) or other similar resource. **Average Wholesale Price** (**AWP**) is the current average wholesale price of a **prescription drug** listed in the Medispan weekly price updates (or any other similar publication chosen by Aetna).

As to dental expenses, the **recognized charge** for a service or supply is the lesser of:
- What the provider bills or submits for that service or supply; and

- the 80th percentile of the Prevailing Charge Rate;
for the Geographic Area where the service is furnished.

Referral
This is an oral, written or electronic authorization made by your **physician** or **School Health Services** to direct you to a **preferred care provider, or non-preferred care provider** for **medically necessary** services or supplies.

Residential Treatment Facility (Mental Disorders)
This is an institution that must:

- Be accredited by one of the following agencies, commissions or committees for the services being provided: The Joint Commission (TJC), Committee on Accreditation of Rehabilitation Facilities (CARF), American Osteopathic Association's Healthcare Facilities Accreditation Program (HFAP) or the Council on Accreditation (COA); or is credentialed by Aetna;
- Meet all applicable licensing standards established by the jurisdiction in which it is located;
- Perform a comprehensive patient assessment preferably before admission, but at least upon admission;
- Create individualized active treatment plans directed toward the alleviation of the impairment that caused the admission;
- Have the ability to involve family/support systems in the therapeutic process;
- Have the level of skilled intervention and provision of care must be consistent with the patient's **sickness** and risk;
- Provide access to psychiatric care by a **psychiatrist** as **medically necessary** for the provision of such care;
- Provide treatment services that are managed by a **behavioral health provider** who functions under the direction/supervision of a medical director; and
- Not be a Wilderness Treatment Program or any such related or similar program, school and/or education service.

In addition to the above requirements, for residential treatment programs treating **mental disorders**:

- A **behavioral health provider** must be actively on duty 24 hours per day for 7 days a week;
- The patient must be treated by a **psychiatrist** at least once per week; and
- The medical director must be a **psychiatrist**.

Residential Treatment Facility (Substance Abuse)
This is an institution that must:

- Be accredited by one of the following agencies, commissions or committees for the services being provided: The Joint Commission (TJC), Committee on Accreditation of Rehabilitation Facilities (CARF), American Osteopathic Association's Healthcare Facilities Accreditation Program (HFAP), or the Council on Accreditation (COA); or is credentialed by **Aetna**;
- Meet all applicable licensing standards established by the jurisdiction in which it is located;
- Perform a comprehensive patient assessment preferably before admission, but at least upon admission;
- Create individualized active treatment plans directed toward the alleviation of the impairment that caused the admission;
- Have the ability to involve family and/or support systems in the therapeutic process;
- Have the level of skilled intervention and provision of care that is consistent with the patient's **sickness** and risk;
- Provide access to psychiatric care by a **psychiatrist** as **medically necessary** for the provision of such care;
- Provide treatment services that are managed by a **behavioral health provider** who functions under the direction/supervision of a medical director; and
- Not be a Wilderness Treatment Program or any such related or similar program, school and/or education service.

In addition to the above requirements, for chemical dependence residential treatment programs:

- A **behavioral health provider** or an appropriately state certified professional (CADC, CAC, etc.), must be actively on duty during the day and evening therapeutic programming; and
- The medical director must be a **physician** who is an addiction **specialist**.

In addition to the above requirements, for Chemical Dependence Detoxification Programs within a residential setting:

- An **R**.**N**. must be onsite 24 hours per day for 7 days a week; and
- The care must be provided under the direct supervision of a **physician**.

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

Retail pharmacy
A community **pharmacy** which has contracted with **Aetna**, an affiliate, or a third party vendor, to provide covered outpatient **prescription drugs** to **covered persons**.

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

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

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

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

Service Area:
The geographic area; as determined by **Aetna;** in which the **preferred care providers** are located.

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

Skilled Nursing Facility:
This is an institution that meets all of the following requirements:

- It is licensed to provide, and does provide, the following on an inpatient basis for persons convalescing from **sickness** or **injury**:
  - Professional 24-hour nursing care by a n **R.N.,** or by an **L.P.N.**, directed by a full-time **R.N.**; and
  - Physical restoration services to help patients to meet a goal of self-care in daily living activities.
- Is supervised full-time by a **physician** or **R.N.** ;
- Keeps a complete medical record on each patient;
- Has a utilization review plan;
- Is not mainly a place for rest, for the aged, for custodial care, educational care, or for treatment of **mental disorders** or **substance abuse**;
- Charges patients for its services;
- An institution or a distinct part of an institution that meets all of the following requirements:
  - It is licensed or approved under state or local law;
  - Is primarily engaged in providing **skilled nursing services** for residents who require medical or nursing care, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons.
- Qualifies as a **skilled nursing facility** under Medicare or as an institution accredited by:
  - The Joint Commission on Accreditation of Health Care Organizations;
  - The Bureau of Hospitals of the American Osteopathic Association; or
  - The Commission on the Accreditation of Rehabilitative Facilities.

Skilled nursing facility does not include:

- Institutions which provide only:
  - Minimal care;
  - **Custodial care** services;
  - Ambulatory services; or
  - Part-time care services.
- Institutions which primarily provide for the care and treatment of **substance abuse** and **mental disorders**.

Skilled Nursing Services
Services that meet all of the following requirements:

- The services require medical or paramedical training;
- The services are rendered by an **R.N.** or **L.P.N.** within the scope of his or her license; and
- The services are not **custodial care**.

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

Specialist
This is a **physician** who:

- Practices in any generally accepted medical, dental or surgical sub-specialty; and
- Is providing other than routine care.

Specialist Dentist
Any **dentist** who; by virtue of advanced training is board eligible or certified by a Specialty Board as being qualified to practice in a special field of dentistry.

Specialty Care
Health care services or supplies that require the services of a **specialist**.

Specialty Care Drugs:
These are **prescription drugs** including self- **injectable drugs**, infusion drugs, and oral drugs prescribed to address complex, chronic diseases with associated co-morbidities such as:

- Cancer;
- Rheumatoid arthritis;
- Hemophilia;
- Multiple sclerosis; and
- Human immunodeficiency virus infection;

which are listed in the **specialty care drug** list. **Specialty care drugs** also include **biosimilar prescription drugs**.A **covered person** can access the list of these **specialty care drugs** by calling the toll-free Member Services number on the back of the ID card or by logging onto the Aetna Navigator® secure member website at www.Aetna.com.

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

Stay:
This is a full-time inpatient confinement for which a **room and board** charge is made.

Substance Abuse
Any use of alcohol and/or drugs which produces a pattern of pathological use causing impairment in social or occupational functioning or which produces physiological dependency evidenced by physical tolerance or withdrawal. This is defined on Axis I in the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association which is current as of the date services are rendered to a **covered person**.

Surgery or Surgical Procedure
The diagnosis and treatment of **injury**, deformity and **sickness** by manual and instrumental means, such as cutting, abrading, suturing, destruction, ablation, removal, lasering, introduction of a catheter (e.g., heart or bladder catheterization) or scope (e.g., colonoscopy or other types of endoscopy), correction of fracture, reduction of dislocation, application of plaster casts, injection into a joint, injection of sclerosing solution, or otherwise physically changing body tissues and organs.

Surgery Center:
This is a free standing ambulatory surgical facility that:

- Meets licensing standards.
- Is set up, equipped and run to provide general surgery.
- Makes charges.
- Is directed by a staff of **physicians**. At least one of them must be on the premises when surgery is performed and during the recovery period.

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

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

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

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

Surgical Procedure:
This is a:

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

Therapeutic Drug Class:
A group of drugs or medications that have a similar or identical mode of action or exhibit similar or identical outcomes for the treatment of an **injury** or **sickness**.

Terminal Illness or Terminally Ill
This means a medical prognosis of 6 months or less to live.

Totally Disabled:
This means that due to **sickness** or **injury**;

- The **covered student** is not able to engage in most normal activities of a healthy person of the same age and gender.

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

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

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

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

Urgent Care Provider:
This is:

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

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

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

Walk-in clinics are an alternative to a **physician's** office visit for treatment of:

- Unscheduled, non-emergency **sickness** and **injuries;**
- The administration of certain immunizations; and
- Individual screening and counseling services.

STUDENT ACCIDENT INSURANCE

SECTION 3 - ELIGIBILITY, EFFECTIVE DATE OF INDIVIDUAL COVERAGE

Eligible Persons

Students: All classes of students are eligible except:

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

A student is eligible only for the coverage shown in the *Schedule of Benefits* which applies to his or her class.

Students must actively attend classes for at least the first 31 days after the date when coverage becomes effective. Home study; correspondence; Internet classes and television (TV) courses; do not fulfill the eligibility requirements that the student actively attend classes. If Aetna discovers that this eligibility requirement has not been met; its only obligation is to refund premium; less any claims paid.

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

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

Newborns are automatically covered for 61 days after birth. To continue the insurance beyond this initial 61 day period when there is a premium increase, the **covered student** must notify Aetna; or its agent; of the birth; and pay the additional premium required for the child's insurance within the 61 day period. If the **covered student's** coverage ends during this 61 day period after the newborn's birth, the newborn's coverage will end on the same day as the **covered student's** coverage. This applies even if the 61 day period has not expired.

Late Enrollment

If an application and premium payment for insurance are made more than 31 days following the date the Eligible Person become eligible; then his or her insurance will become effective only if and when Aetna gives its written consent or, if such enrollment occurs during a late enrollment period established by the Plan Sponsor; or, if such enrollment occurs due to the loss of prior comparable coverage; for any reason.

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

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

STUDENT ACCIDENT INSURANCE

SECTION 4 - TERMINATION OF COVERAGE, EXTENSION OF BENEFITS

TERMINATION OF STUDENT COVERAGE

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

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

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

EXTENSION OF BENEFITS

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

When Extension of Benefits End

Extension of benefits (other than Basic benefits) will end on the first to occur of the date:

- The **covered student** is no longer **totally disabled,** or becomes covered under any other plan with like benefits.
- The maximum number of months' extension noted above has been reached.
- The **covered person's** Maximum Benefit, if any, is reached.

(This does not apply if coverage ceased because the benefit section ceased for the **covered person's** eligible class.)

STUDENT ACCIDENT INSURANCE

SECTION 5 - GENERAL PROVISIONS

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

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

PREMIUMS DUE - EXPERIENCE RATING. The premium due under this Policy on any premium due date will be the sum of the premium charges for the coverages then provided under this Policy.

If premiums are payable monthly; any insurance becoming effective will be charged for from the first day of the Policy month on or right after the date the insurance takes effect. Premium charges for insurance which terminates will cease as of the first day of the Policy month on or right after the date the insurance terminates. If premiums are payable less often than monthly; premium charges or credits for a fraction of a premium-paying period will be made on a pro rata basis; for the number of Policy months between the date premium charges start or cease; and the end of the premium-paying period. If this Policy is changed to provide more coverage to take effect on a date other than the first day of a premium-paying period; a pro rata premium for the coverage will be due and payable on that date. It will cover the period then starting and ending right before the start of the next premium-paying period.

Aetna may change premium charges due to experience or a change in factors bearing on the risk assumed. Each change shall be made by written notice to the Policyholder by Aetna; or its agent.

No experience reduction or increase in premium rates shall become effective less than 12 months after the effective date of the policy. As used in this section; "policy" shall be deemed to include any policy previously issued by Aetna that has been replaced in whole or in part by this Policy.

The premium charges for any coverage under this Policy may be refigured as of any premium due date, only: By reason of a change in factors bearing on the risk assumed. This must be requested by Aetna.

Once during any continuous 12 month period. The Policyholder must request this. Advance notice of 60 days must be given to Aetna.

They will be refigured using:

- the ages of the covered students;
- the amounts of insurance in force;
- the premium rates; and
- any other pertinent factors.

All facts will be taken as of the date of the refiguring.

At the end of a Policy Year; Aetna may declare an experience credit. The amount of each credit Aetna declares will be returned to the Policyholder. Upon request by the Policyholder; part or all of it will be applied against the payment of premiums or in any other manner as may be agreed to by the Policyholder and Aetna.

If the sum of student contributions which have been made for group insurance exceeds the sum of premiums which have been paid for group insurance (after giving effect to any experience credits), the excess will be applied by the Policyholder for the sole benefit of students. Aetna will not have to see to the use of such excess.

Aetna will not have to refund any premium for a period prior to:
The first day of the Policy Year in which Aetna receives proof that the refund should be made; or
The date 3 months before Aetna receives proof, if this produces a larger refund.

This applies even if the premium was paid in error.

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

RENEWAL OF POLICY. With Aetna’s consent; this Policy may be renewed for like periods by payment of the renewal premium at the premium rate in effect at that time. This renewal premium must be paid within the grace period.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

REIMBURSEMENT AND SUBROGATION. When a **covered person**'s **injury** appears to be someone else's fault, benefits otherwise payable under this Policy for **Covered Medical Expenses** incurred as a result of that **injury** will not be paid unless the **covered person** or his legal representative agrees:

(a) to repay Aetna for such benefits to the extent they are for losses for which compensation is paid to the **covered person** by or on behalf of the person at fault as allowed by any Connecticut law or regulation;

(b) to allow Aetna a lien on such compensation and to hold such compensation in trust for Aetna; and

(c) to execute and give to Aetna any instruments needed to secure the rights under (a) and (b).

Further, when Aetna has paid benefits to or on behalf of the injured **covered person**, Aetna will be subrogated to all rights or recovery that the **covered person** has against the person at fault. These subrogation rights will extend only to recovery of the amount Aetna has paid. The **covered person** must execute and deliver any instruments needed and do whatever else is necessary to secure those rights to Aetna.

RIGHT OF RECOVERY PROVISION

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

As used in this section; 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.

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

Aetna has the right to terminate this Policy only under the following conditions:

- Non-payment of premium.
- Fraud or misrepresentation of a material fact under the terms of the coverage.
- Aetna ceases to offer student blanket health insurance coverage subject to the terms of any Connecticut law or regulation and in line with HIPAA notification requirements.

Aetna will notify the Connecticut Insurance Department as well as all policyholders no later than 90 days before the date that Aetna no longer offers Student Blanket Coverage in Connecticut.

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

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

If:

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

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

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

APPEAL PROCEDURE: Aetna has established a procedure for resolving complaints by **covered persons**. If a **covered person** has a complaint, he or she must follow this procedure:

- An Appeal is defined as a written request for review of a decision which has been denied in whole or in part, after consideration of any relevant information, such as a request for a claim payment, certification, or eligibility, etc. The Aetna address is on your Identification Card.
- An Appeal must be submitted within 60 days of the date Aetna provides notice of denial.
- An acknowledgement letter will be sent to the **covered person** within 5 days of Aetna's receipt of the Appeal. This letter may request additional information. If so, the additional information must be submitted to Aetna within 15 days of the date of the letter.
- The **covered person** will be sent a response within 30 days of Aetna's receipt of the Appeal. The response will be based on the information provided with or subsequent to the Appeal.
- If the Appeal concerns an eligibility issue, and if additional information is not submitted to Aetna after receipt of Aetna's response, the decision is considered Aetna's final response 60 days after receipt of the Appeal. For all other Appeals, if additional information is to be submitted to Aetna after receipt of Aetna's response, it must be submitted within 15 days of the date of Aetna's response letter.
- Aetna's final response will be sent within 30 days from the date of Aetna's first response letter.
- If additional time is needed to resolve the Appeal, Aetna will provide a written notification indicating that additional time is needed, explaining why such time is needed and setting a new date for a response. The additional time shall not be extended beyond another 30 days.
- In an emergency situation involving admission to or services from an acute care **hospital**, if the **covered person's physician** or the **hospital** determines that the **covered person** faces a life-threatening or other serious **injury** situation, they may submit a written request for an expedited review. A response shall be given to the provider within 3 hours of Aetna's receipt of the request and all necessary information. If a response is not provided within this timeframe the request is considered approved.
- In all other urgent or emergency situations, the Appeal procedure may be initiated by a telephone call. A verbal response to the telephone call shall be given to the provider within 2 business days, provided that all necessary information is available. Written notice of the decision will be sent within 2 business days of Aetna's verbal response. If the **covered person** is dissatisfied with Aetna's response, the Appeal procedure outlined above may be utilized. The Aetna's telephone number is on the **covered person's** Identification Card.
- Aetna will keep the records of any complaint for three years.

If, after completing the Appeal procedure outlined above, the **covered person's physician** or the **hospital** are still dissatisfied with Aetna's response, the **covered person** may appeal the decision to the Connecticut Insurance Department. This must be done within 30 days of receipt of Aetna's final response.

RESCISSION OF COVERAGE. Aetna may rescind the covered person's coverage if the covered person, or the person seeking coverage on the covered person's behalf:

- Performs an act, practice or omission that constitutes fraud; or
- Makes an intentional misrepresentation of material fact.

The covered person will be given 30 days advance written notice of any rescission of coverage.

As to medical. pediatric dental, pediatric vision care, and prescription drug coverage only, the covered person has the right to an internal appeal with Aetna and/or the right to a third party review conducted by an independent External Review Organization if the covered person's coverage under this Policy is rescinded retroactive to its Effective Date.

STUDENT ACCIDENT INSURANCE PROVISIONS CONCERNING

SECTION 6 - COVERAGE

PRECERTIFICATION

Understanding Precertification

Certain services, such as inpatient **stays**, certain tests, procedures, **outpatient surgery, therapies and equipment,** and prescribed medications require **precertification** by Aetna. **Precertification** is a process that helps the **covered person** and their **physician** determine whether the services being recommended are **covered medical expenses** under the plan. It also allows Aetna to help the **covered person's** provider coordinate the **covered person's** transition from an inpatient setting to an outpatient setting (called discharge planning), and to register the **covered person** for specialized programs or case management when appropriate.

Precertification is not the same requirement as a plan's *Referral Requirement*. A plan's referral requirement and process is separate from the plan's **precertification** requirement and process. Refer to the *Schedule of Benefits* for the plan's *Referral Requirement*. The plan's *Referral Requirement* must be followed in addition to the plan **precertification** process.

The **covered person** does need to **precertify** services provided by a **non-preferred care provider.**

Preferred care providers will be responsible for obtaining necessary **precertification** for the **covered person**. Since **precertification** is the provider's responsibility, there is no additional out-of-pocket cost to the **covered person** as a result of a **preferred care provider's** failure to **precertify** services.

When a **covered person** goes to a **non-preferred care provider** it is the **covered person's** responsibility to obtain **precertification** from Aetna for any services, treatments, procedures, visits or supplies on the **precertification** list below. If the **covered person** does not **precertify**, *benefits may be reduced*. The list of services requiring **precertification** appears later in this section.

If the **covered person's** outpatient **hospice care** has been **precertified**, and the **covered person** subsequently requires a **hospital stay** for pain control or acute symptom management, that **hospital** stay does not have to be **precertified**.

Important Information:
Please read the following sections in their entirety for important information on the precertification process, and any impact it may have on a covered person's coverage.

The Precertification Process

Prior to being hospitalized or receiving certain other medical services, treatments, procedures, visits or supplies there are certain **precertification** procedures that must be followed.

The **covered person** is responsible for obtaining **precertification** for services, treatments, procedures, visits or supplies provided by a **non-preferred care provider**. The **covered person** or a member of their family, a **hospital** staff member, or the attending **physician**, must notify Aetna to **precertify** the admission or medical services, treatments, procedures, visits or supplies prior to receiving any of the services, treatments, procedures, visits or supplies that require **precertification** pursuant to the Policy in accordance with the following timelines:

Precertification should be secured within the timeframes specified below. To obtain **precertification**, call Aetna at the telephone number listed on the **covered person's** ID card. This call must be made as follows:

Your Precertification Telephone Call to Aetna	
For non-emergency admissions:	It is the **covered person's** responsibility to call and request **precertification** at least 15 days before the date they are scheduled to be admitted.
For an **emergency admission**:	The **covered person**, their **physician** or the facility must call within 24 hours or as soon as reasonably possible after the **covered person** has been admitted.
For an **urgent admission**:	The **covered person**, their **physician** or the facility will need to call before the **covered person** is scheduled to be admitted. An urgent admission is a **hospital** admission by a **physician** due to the onset of or change in a **sickness**; the diagnosis of a **sickness**; or an **injury**.
For outpatient non-emergency medical services requiring **precertification**,	The **covered person** or their **physician** must call at least 15 days before the outpatient services, treatments, procedures, visits or supplies are provided or scheduled.
For prenatal care and delivery	As soon as possible after the attending **physician** confirms pregnancy and again within 24 hours of the birth or as soon thereafter as possible. No penalty will be applied for the first 48 hours after delivery for a routine delivery and 96 hours for a cesarean delivery.

Aetna will provide a written notification to the **covered person** and their **physician** of the **precertification** decision**,** where required under applicable State law. If the **covered person**'s **precertified** services, treatments, procedures, visits or supplies are approved**,** the approval is valid for 30 days as long as the **covered person** remains enrolled in the plan**.** Premium that is due and unpaid at the time the **precertified** services, treatments, procedures, visits or supplies are performed must be paid in full within the required timeframe.

When a **covered person** has an inpatient admission to a facility, Aetna will notify the **covered person**, their **physician** and the facility about their **precertified** length of **stay**. If the **covered person's physician** recommends that their **stay** be extended, additional days will need to be certified. The **covered person**, their **physician**, or the facility will need to call Aetna at the number on the **covered person**'s ID card as soon as reasonably possible, but no later than the final authorized day. Aetna will review and process the request for an extended **stay**. The **covered person** and their **physician** will receive a notification of an approval or denial.

If **precertification** determines that the **stay,** services, treatments, procedures, visits or supplies are not **covered medical expenses**, the notification will explain why and how Aetna's decision can be appealed. The **covered person** or their provider may request a review of the **precertification** decision pursuant to the *Appeals Procedure, Exhaustion of Process and External Review* section.

If the **covered person's physician** recommends that their **precertified**, in-patient or out-patient services, treatments, procedures, visits, or supplies be extended beyond what has been originally approved, additional services, treatments, procedures, visits or supplies will need to be **precertified**. The **covered person**, their **physician**, or the facility (in the case of an admission) will need to call Aetna at the number on the **covered person's** ID card as soon as reasonably possible, but no later than the final authorized day or service. Aetna will

review and process the request for an extended **stay or service**. The **covered person** and their **physician** will receive a notification of an approval or denial.

If **precertification** determines that the **stay,** services, treatments, procedures, visits, or supplies are not **covered medical expenses**, the notification will explain why and how Aetna's decision can be appealed. The **covered person** or their provider may request a review of the **precertification** decision pursuant to the *Appeals Procedure, Exhaustion of Process and External Review* section.

Services and Supplies Which Require Precertification

Precertification is required for the following types of **stays,** services, treatments, procedures, visits or supplies:

Inpatient and Outpatient Care
• Ambulance (Emergency transportation by airplane) • Ambulance (Non-emergency transportation) • Autologous chondrocyte implantation, Carticel® • Bariatric surgery (Bariatric surgery is not covered under the Policy unless specifically described in the Policy.) • BRCA genetic testing • Cardiac rhythm implantable devices • Chiropractic treatment • Clinical Trials • Cochlear device and/or implantation • Cognitive skills development • Complex imaging (high cost procedures) • Dental implants and oral appliances • Drugs and medical injectables* • Dorsal column (lumbar) neurostimulators: trial or implantation • Durable Medical and Surgical Equipment (DME). • Electric or motorized wheelchairs and scooters • Gastrointestinal (GI) tract imaging through capsule endoscopy • Gender reassignment (sex change) surgery • Home health care related services (ie. private duty nursing, maternity management home care and home uterine activity monitoring) • Home hemodialysis and home peritoneal dialysis equipment and medical supplies • Home hospice care • Hyperbaric oxygen therapy • Infertility treatment (Comprehensive and ART infertility treatment is not covered under the plan unless specifically described in the Policy.) • Injectables (immunoglobulins, growth hormones, Multiple Sclerosis medications, Osteoporosis medications, Botox, Hepatitis C medications)

- Inpatient Confinements (surgical and non-surgical; **hospital**, **skilled nursing facility**, **rehabilitation facility**, **residential treatment facility** for **mental disorders** and **substance abuse**, **hospice** care.
- Inpatient **Mental disorders** treatment
- Inpatient **Substance abuse** treatment
- Kidney Dialysis visits
- Knee surgery
- Limb Prosthetics
- **Non-Preferred Care** freestanding ambulatory surgical facility services when referred by a **Preferred Care Provider**.
- Occupational therapy (outpatient)
- Oncotype DX
- Orthognatic surgery procedures, bone grafts, osteotomies and surgical management of the temporomandibular joint
- Osseointegrated implant
- Osteochondral allograft/knee
- Outpatient back surgery not performed in a **physician's** office
- Physical therapy (outpatient)
- Pre-implantation genetic testing
- Pediatric congenital heart surgery
- Proton beam radiotherapy
- Radiation oncology
- Radiology imaging
- Reconstructive or other procedures that may be considered **cosmetic. Cosmetic** services and supplies are not covered under the plan unless specifically described in the Policy.
- Referral or use of **Non-Preferred Care Providers** for non-emergency services, unless the covered person understands and consents to the use of a **Non-Preferred Care Provider** under their under **Non-Preferred Care** benefits when available in their plan
- Services as directed by "School Student Health Center" in the event the Policyholder becomes a "medical home" or Aetna is asked to support clinical review of a campus health outbreak (i.e. meningitis, H1N1, etc.)
- Sleep studies
- Special programs (i.e. Beginning Right® maternity program)
- Spinal procedures
- Transplant services
- Uvulopalatopharyngoplasty, including laser-assisted procedures
- Ventricular assist devices

- Wrist surgery

For a current listing of the drugs and medical **injectables that require **precertification**, contact Member Services by logging onto the **Aetna** website at www. aetna.com or calling the toll-free number on the back of the ID card.*

How Failure to Precertify Affects The Covered Person's Benefits

A **precertification** benefit reduction or penalty will be applied to the benefits paid if the **covered person** fails to obtain a required **precertification** prior to incurring **covered medical expenses** from a **non-preferred care provider**. This means Aetna *will reduce the amount paid towards the* **covered person**'s *coverage.*

The **covered person** is responsible for obtaining the necessary **precertification** from Aetna prior to receiving services, treatments, procedures, visits or supplies from a **non-preferred care provider**. The **covered person**'s provider may **precertify** their services, treatments, procedures, visits or supplies; however the **covered person** should verify with Aetna prior to the services, treatments, procedures, visits or supplies, that the provider has obtained **precertification** from Aetna. If the **covered person's** services, treatments, procedures, visits or supplies is not **precertified** by the **covered person** or their provider, *the benefit payable may be significantly reduced .*

How The Covered Person's Hospital Inpatient Benefits Are Affected

If the **covered person's stay** has not been recommended by their **non-preferred care provide**r, *their benefits may be reduced* if the necessary **precertification** is not obtained, as illustrated in the chart below.

If **precertification** is:	and Aetna determines that the **stay**, or any day of the **stay** is:	then **room and board** expenses are:	and all other inpatient facility expenses are:
requested and approved	approved,	covered;	covered.
requested and denied	denied	not covered; may be appealed	covered not covered, may be appealed.
not requested	but would have been approved if requested,	covered after a penalty is applied*;	covered.
not requested	would have been denied if requested,	not covered; may be appealed	covered, after a penalty is applied*.

How The Covered Person's Benefits for Inpatient and Outpatient Services, Treatments, Procedures, Visits or Supplies are Affected

The chart below illustrates the effect on the **covered person's** benefits if necessary **precertification** for inpatient and outpatient services, treatments, procedures, visits or supplies is not obtained.

If **precertification** is:	then the expenses are:
• requested and approved by Aetna	• covered.
• requested and denied	• not covered, may be appealed.
• not requested, but would have been covered if requested	• covered after a **precertification** benefit reduction or penalty is applied.*
• not requested, would not have been covered if requested.	• not covered, may be appealed.

It is important to remember that any additional out-of-pocket expenses incurred because the **covered person's precertification** requirement was not met will not count toward the **covered person's deductible**, **coinsurance** or **out of pocket limit**.

*Refer to the *Schedule of Benefits* for the amount of **precertification** benefit reduction or penalty that applies to the **covered person's** plan.

PRECERTIFICATION (continued)

Prescribed Medicines Expense

Understanding Precertification for Certain Outpatient Prescription Drugs

Precertification is required for certain outpatient **prescription drugs**. **Prescribers** must contact Aetna or an affiliate to request and obtain coverage for such **prescription drugs**. The list of drugs requiring precertification is subject to periodic review and modification by Aetna. An updated copy of the list of drugs requiring precertification shall be available upon request or may be accessed on line and can be found in the Aetna **preferred drug list** available online at www.aetna.com/formulary.

Failure to **precertify** will result in a penalty (see the *Schedule of Benefits*). The **covered person** must contact the **prescriber** or pharmacist if the drug being considered requires **precertification**.

How to Obtain Precertification

If an outpatient **prescription drug** requires **precertification** and the **covered person** uses a **preferred pharmacy** the **prescriber** is required to obtain **precertification** for the **covered person**.

When a **covered person** uses a **non-preferred pharmacy**, the **covered person** can begin the **precertification** process by having the **prescriber** call Aetna at the number on their ID card. Aetna will let the **prescriber** know if the **prescription drug** is **precertified**. If **precertification** is denied Aetna will notify the **covered person** how the decision can be appealed.

MEDICAL EXPENSE BENEFITS

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

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

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

The *Schedule of Benefits* shows the **deductible;** covered percentages; and maximum benefits that apply to **covered medical expenses** described in this Section.

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

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

Covered medical expense incurred for services and supplies:

(a) must be **medically necessary**;
(b) must be prescribed or ordered by the attending **physician, dental provider** or vision professional;

All Accident Expense Benefits are subject to all of the terms of the Policy.

Proof must be received that the **covered medical expenses** were solely the result of an **injury** sustained by the **covered person**. The first such expense must be incurred within 30 days after the date of the **accident** causing the **injury**. Aetna will pay for **covered medical expenses**, which are the direct result of the **accident**, and from no other cause and up to the **aggregate maximum** benefit shown on the *Schedule of Benefits*.

PRE-ADMISSION TESTING EXPENSE

Covered medical expenses include charges incurred by a **covered person** for pre-admission testing charges made by a **hospital**, **surgery center**, licensed diagnostic lab facility, or **physician**, in its own behalf, to test a person while an outpatient before scheduled surgery if:

- The tests are related to the scheduled surgery;
- The tests are done within the 7 days prior to the scheduled surgery;

- The person undergoes the scheduled surgery in a **hospital** or **surgery center**; this does not apply if the tests show that surgery should not be done because of his physical condition;
- The charge for the surgery is a **covered medical expense** under this Plan;
- The tests are done while the person is not confined as an inpatient in a **hospital**;
- The charges for the tests would have been covered if the person was confined as an inpatient in a **hospital**;
- The test results appear in the person's medical record kept by the **hospital** or **surgery center** where the surgery is to be done; and
- The tests are not repeated in or by the **hospital** or **surgery center** where the surgery is done.

If the person cancels the scheduled surgery, benefits are paid at the cost-sharing that applies to *Laboratory and X-Ray Expense* benefits.

The *Schedule of Benefits* shows any **copay**, **deductible**, covered percentage and maximum benefit that may apply to the *Pre-Admission Testing Expense* benefit.

HOSPITAL EXPENSE

Hospital Room and Board Expense

Covered medical expenses include charges incurred by a **covered person** for the period of confinement as an inpatient; including: expense for an **intensive care unit**; and for a **birthing center** for treatment in connection with pregnancy. However, the covered **room and board** expense does not include any charge in excess of the daily **room and board** maximum.

Miscellaneous Hospital Expense

Miscellaneous **hospital** expense include, but are not limited to, expenses incurred during a **hospital confinement** for:

- Anesthesia and operating room;
- Laboratory tests and X-rays;
- Oxygen tent; and
- Drugs; medicines; dressings.

The *Schedule of Benefits* shows any **copay**, **deductible**, covered percentage, and maximum benefit that may apply to the *Hospital Expense* benefit.

SURGICAL EXPENSE

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

The *Schedule of Benefits* shows any **copay**, **deductible**, covered percentage and maximum benefit that may apply to *Surgical Expense* benefits.

If the **physician** performs both the **surgical procedure** and the anesthesia service, benefits for the anesthesia service will be reduced by 50%.

When surgery is performed in the outpatient department of a **hospital**, **covered medical expenses** include **hospital** services provided within 24 hours of the covered surgical procedure.

Anesthetic Expense
If, in connection with such operation, the **covered person** requires the services of an anesthetist who is not employed or retained by the **hospital** in which the operation is performed, the expenses incurred will be **covered medical expenses**.

Assistant Surgeon Expense
If, in connection with such operation, the **covered person** requires the services of an assistant surgeon, the expenses incurred will be **covered medical expenses**.

IN-HOSPITAL NON-SURGICAL PHYSICIAN'S EXPENSE

Covered medical expenses include hospital charges incurred by a **covered person** who is confined as an inpatient in a **hospital** for a surgical procedure for the services of a **physician** who is not the **physician** who may have performed surgery on the **covered person.**

The *Schedule of Benefits* shows any **copay, deductible,** covered percentage, and maximum benefit that may apply to the *In-Hospital Non-Surgical Physician's Expense* benefit.

Therapy Expense

Covered medical expenses also include, but are not limited to, expenses incurred by a **covered person** for:

- Chemotherapy, including anti-nausea drugs used in conjunction with the chemotherapy;
- Radiation therapy;
- Tests and procedures; and
- Expenses incurred at a radiological facility.

Covered medical expenses also include expenses for the administration of chemotherapy and visits by a health care professional to administer the chemotherapy.

The *Schedule of Benefits* shows any **copay, deductible,** covered percentage and maximum benefit that may apply to these benefits under the *Therapy Expense* benefit.

Outpatient Physician or Specialist Office Visit Expense

C**overed medical expenses** include the charges made by the **physician** or **specialist** if a **covered person** requires the services of a **physician** or **specialist** in the **physician**'**s** or **specialist's** office while not confined as an inpatient in a **hospital**.

The *Schedule of Benefits* shows any **copay, deductible,** covered percentage and maximum benefit that may apply to these benefits under the *Outpatient Physician or Specialist Office Expense* benefit.

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

Emergency Room Visit Expense

Covered medical expenses incurred by a **covered person** for services received in the emergency room of a **hospital** while the **covered person** is not a full-time inpatient of the **hospital.** The treatment received must be **emergency care** for an **emergency medical condition**. There is no coverage for **elective treatment**, routine care or care for a non-emergency **sickness**.

As to **emergency care** incurred for the treatment of an **emergency medical condition** or psychiatric condition, any **referral** requirement will not apply and any expenses incurred for **non-preferred care** will be paid at the same cost-sharing level as if they had been incurred for **preferred care**.

The **emergency care** benefit covers:

- Use of emergency room facilities;
- Emergency room staff **physicians** services;
- **Hospital** nursing staff services; and
- Staff radiologists and pathologists services.

Covered persons must contact their **physician** after receiving treatment for an **emergency medical condition**.

The *Schedule of Benefits* shows any **copay, deductible,** covered percentage and maximum benefit that may apply to these benefits under the *Outpatient Expense* benefit.

Hospital Outpatient Department Expense

Covered medical expenses include charges incurred by a **covered person** for the use of:

- Diagnostic X-ray and laboratory services;
- Consultants or specialists; or
- An operating room, if charges are incurred in a **hospital** outpatient department**.**

The *Schedule of Benefits* shows any **copay, deductible,** covered percentage and maximum benefit that may apply to these benefits under the *Outpatient Expense* benefit.

Walk-In Clinic Visits Expense

Covered medical expenses include charges made by **preferred care,** and **non-preferred care providers** that are **walk-in clinics** for:

- Unscheduled, non-emergency **sicknesses** and **injuries**;
- The administration of certain immunizations administered within the scope of the clinic's license; and
- Individual screening and counseling services to aid a **covered person**:
  - To stop the use of tobacco products;
  - In weight reduction due to obesity and/or a healthy diet;
  - In stress management.

  The stress management counseling sessions will:

  - Help a **covered person** to identify the life events which cause the **covered person** stress (the physical and mental strain on a **covered person's** body.); and
  - Teach a **covered person** techniques and changes in behavior to reduce the stress.

The *Schedule of Benefits* shows any **copay, deductible,** covered percentage and maximum benefit that may apply to these benefits under the *Walk-In Clinical Visits Expense* benefit.

Limitations:
Unless specified above, not covered under this benefit are charges incurred for services and supplies furnished in a group setting for screening and counseling services.

Important Information:
- **Not all services are available at all walk-in clinics. The types of services offered will vary by the provider and location of the clinic.**
- **For a complete description of the screening and counseling services provided on the use of tobacco products and to aid in weight reduction due to obesity, refer to the *Preventive Care Benefits* section and the *Screening and Counseling Services* benefit for a description of these services.**
- **These services may also be obtained from a covered person's physician.**

Ambulatory Surgical Expense

Covered medical expenses include expenses incurred by a **covered person** for outpatient surgery performed in an **ambulatory surgical center. Covered medical expenses** must be incurred on the day of the surgery or within 24-96 hours after the surgery.

The *Schedule of Benefits* shows any **copay, deductible,** covered percentage and maximum benefit that may apply to these benefits under the *Ambulatory Surgical Expense* benefit.

Laboratory, X-Ray Visits

Covered medical expenses include charges incurred by a **covered person** for:

- Diagnostic X-rays;
- Laboratory services

incurred on an outpatient basis.

The *Schedule of Benefits* shows any **copay, deductible,** covered percentage and maximum benefit that may apply to these benefits under the *Laboratory and X-ray Visits Expense* benefit.

Durable Medical and Surgical Equipment Expense

Benefits are payable for **covered medical expenses** incurred by a **covered person** as a result of renting **durable medical and surgical equipment**. In lieu of rental, the following may be covered:

- The initial purchase of such equipment if Aetna is shown that long term care is planned, and that such equipment either cannot be rented or is likely to cost less to purchase than to rent;
- Repair of purchased equipment;
- Replacement of purchased equipment if Aetna is shown that it is needed due to a change in the person's physical condition, or it is likely to cost less to purchase a replacement than to repair existing equipment or to rent like equipment; or
- The purchase of orthopedic appliances and braces or non-dental prosthetic devices to replace natural body parts.

Durable medical and surgical equipment would include:

- Artificial arms and legs, including accessories;
- Leg braces, including attached shoes (but not corrective shoes);
- Arm braces;
- Back braces;
- Neck braces;
- Surgical supports;
- Scalp hair prostheses required as the result of hair loss due to **injury**, **sickness**, or treatment of **sickness**; and
- Head halters.

Coverage for such items includes the fitting; adjustment; and repair of such devices.
All equipment and supplies must be prescribed by a **physician.**

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

Aetna reserves the right to limit the payment of charges up to the most cost efficient and least restrictive level of service or item which can be safely and effectively provided. The decision to rent or purchase is at the discretion of **Aetna**.

The plan limits coverage to one item of equipment, for the same or similar purpose and the accessories needed to operate the item. A **covered person** is responsible for the entire cost of any additional pieces of the same or similar equipment the **covered person** purchases or rents for personal convenience or mobility.

The *Schedule of Benefits* shows any **copay, deductible,** covered percentage and maximum benefit that may apply to these benefits under the *Durable Medical and Surgical Equipment Expense* benefit.

AMBULANCE EXPENSE

Covered medical expenses include charges made by a professional **ambulance** as follows:

Ground Ambulance
Covered medical expenses include charges for transportation:

- To the first **hospital** where treatment is given in a medical emergency;
- From one **hospital** to another **hospital** in a medical emergency when the first **hospital** does not have the required services or facilities to treat the **covered person's** condition;
- From **hospital** to home or to another facility when other means of transportation would be considered unsafe due to the **covered person's** medical condition;
- From home to **hospital** for covered inpatient or outpatient treatment when other means of transportation would be considered unsafe due to the **covered person's** medical condition. Transport is limited to 200 miles; and
- During a covered inpatient **stay** at a **hospital**, **skilled nursing facility** or acute rehabilitation **hospital**, to transport a **covered person** for inpatient or outpatient **medically necessary** treatment when an **ambulance** is required to safely and adequately transport the **covered person**.

Air or Water Ambulance
Covered medical expenses include charges for transportation to a **hospital** by air or water **ambulance** when:

- Ground **ambulance** transportation is not available and the **covered person's** condition is unstable, requires medical supervision and rapid transport; and
- Transportation from one **hospital** to another **hospital** in a medical emergency when the first **hospital** does not have the required services or facilities to treat the **covered person** when the **covered person's** condition is unstable, requires medical supervision and rapid transport.

The *Schedule of Benefits* shows any **copay**, **deductible**, covered percentage, and maximum benefit that may apply to the *Ambulance Expense* benefit.

ACCIDENTAL INJURY TO SOUND NATURAL TEETH EXPENSE

Covered medical expenses include charges incurred by a **covered person** for services of a **dentist** or dental surgeon as a result of an **injury** to **sound natural teeth.**

The *Schedule of Benefits* shows any **copay**, **deductible**, covered percentage, and maximum benefit that may apply to the *Accidental Injury to Sound Natural Teeth Expense* benefit.

CONSULTANT EXPENSE

Covered medical expenses include the charges incurred by **covered person** in connection with the services of a consultant The services must be requested by the attending **physician** to confirm or determine a diagnosis.

Coverage may be extended to include treatment by the consultant.

The *Schedule of Benefits* shows any **copay**, **deductible**, covered percentage and maximum benefit that may apply to the *Consultant Expense* benefit.

LICENSED NURSE EXPENSE

Covered medical expenses include charges incurred by a **covered person** who is confined in a **hospital** as a resident bed-patient and requires the services of a registered nurse or licensed practical nurse.

The *Schedule of Benefits* shows any **copay**, **deductible**, covered percentage and maximum benefit that may apply to **covered medical expenses** for the *Licensed Nurse Expense* benefit.

Not more than the Daily Maximum Benefit per shift as shown in the *Schedule of Benefits* will be paid. For purposes of determining this maximum, a shift means 8 consecutive hours.

REHABILITATION FACILITY EXPENSES

Covered medical expenses include charges incurred by a **covered person** for confinement as a full time inpatient in a rehabilitation facility. Confinement in the rehabilitation facility must follow within 24-48 hours of, and be for the same or related cause(s) as; a period of **hospital** or **skilled nursing facility** confinement. Not more than the maximum days of confinement will be covered.

Covered medical expenses will not include any charge in excess of the rehabilitation facility's daily **room and board** maximum for semi-private accommodations or expenses for confinement in excess of the maximum number of days of confinement.

The *Schedule of Benefits* shows any **copay**, **deductible**, coinsurance percentage, and maximum benefit that may apply to **covered medical expenses** for the *Rehabilitation Facility Expense* benefit.

NON-ELECTIVE SURGICAL - SECOND OPINION EXPENSE

Covered medical expenses include charges incurred for a second opinion consultation by a **specialist** on the need for non-elective **surgery** which has been recommended by the **covered person's physician**. The **specialist** must be board certified in the medical field relating to the surgical procedure being proposed. Coverage will also be provided for any expenses incurred for required X-rays and diagnostic tests done in connection with that consultation. Aetna must receive a written report on the second opinion consultation.

The Policy will also provide coverage for charges made for a third surgical opinion. This will be done when the second one does not confirm the recommendation of the first **physician** who proposed to perform the surgery.

The *Schedule of Benefits* shows any **copay**, **deductible**, coinsurance percentage, and maximum benefit that may apply to **covered medical expenses** for the *Non-Elective Surgical - Second Opinion Expense* benefit.

HOME HEALTH CARE EXPENSE

Covered medical expenses include charges incurred by a **covered person** for **home health care** services made by a **home health agency** pursuant to a **home health care plan**; but only if all of the following conditions are met:

(a) The services are furnished by, or under arrangements made by; a licensed **home health agency**.
(b) The services are given under a home care plan. This plan must be established pursuant to the written order of a **physician**, and the **physician** must renew that plan every 60 days. Such **physician** must certify that the proper treatment of the condition would require inpatient confinement in a **hospital** or **skilled nursing facility** if the services and supplies were not provided under the **home health care plan,** or in the case of a terminal patient with less than 6 months left to live. The **physician** must examine the **covered person** at least once a month.
(c) Except as specifically provided in the **home health care** services, the services are delivered in the patient's place of residence on a part-time; intermittent visiting basis while the patient is confined.
(d) The care starts within 7 days after discharge from a **hospital** as an inpatient, however this condition does not apply if the **covered person** has been diagnosed with a terminal illness..
(e) The care is for the same condition that caused the **hospital confinement** or for a condition related to it.

Home Health Care Services

Home health care services include:

(1) Part-time or intermittent nursing care by: a registered nurse (R.N.), a licensed Practical nurse (L.P.N.), or under the supervision of an **R.N.** if the services of an R.N. are not available. These services need to be provided during intermittent visits of four hours or less, subject to the visit maximums shown in the *Schedule of Benefits*. Intermittent visits are considered periodic and recurring visits that skilled nurses made to ensure the **covered person**'s proper care, which means they are not on site for more than four hours at a time.

(2) Part time or intermittent **home health aide** services; that consist primarily of care of a medical or therapeutic nature by other than an **R.N**. These services need to be provided during intermittent visits of four hours or less, subject to the visit maximums shown in the *Schedule of Benefits*.

(3) Physical, occupational speech or respiratory therapy.

(4) Medical supplies, drugs and medicines, and laboratory services. However, these items are covered only to the extent they would be covered if the patient was confined to a **hospital**.

(5) Medical social services by licensed or trained social workers.

(6) Nutritional counseling.

(7) Skilled behavioral health care services provided in the home by a **behavioral health provider** when ordered by a **physician** and directly related to an active treatment plan of care established by the **physician**. All of the following must be met:
- The skilled behavioral health care is appropriate for the active treatment of a condition, **sickness** or disease to avoid placing the **covered person** at risk for serious complications.
- The services are in lieu of a continued confinement in a **hospital** or **residential treatment facility**, or receiving outpatient services outside of the home.
- The **covered person** is homebound because of **sickness** or **injury**.
- The services provided are not primarily for comfort or convenience or custodial in nature.
- The services are intermittent or hourly in nature.
- The services are not for Applied Behavior Analysis.

Benefits for home health care visits are payable up to the home health care maximum. Each visit by a nurse, **behavioral health provider**, or therapist is one visit.

In figuring the **policy year** maximum visits, each visit of a:

- nurse or therapist, of up to 4 hours, is one visit and
- **behavioral health provider,** of up to 1 hour, is one visit.

This maximum will not apply to care given by an **R.N.** or **L.P.N.** when:

- Care is provided within 7 days of discharge from a **hospital** or **skilled nursing facility** as a full-time inpatient; and
- Care is needed to transition from the **hospital** or **skilled nursing facility** to home care.

When the above criteria are met, **covered medical expenses** include up to 12 hours of continuous care by an **R.N.** or **L.P.N.** per day.

Whether or not someone is available to give care does not determine whether the services are covered for home health care. The absence of a person to perform a non-skilled or **custodial care** service does not cause the service to become covered. If the **covered person** is a minor or an adult who is dependent upon others for non-skilled care (e.g., bathing, eating, toileting), home health care services will only be covered during times when:

- there is a family member or caregiver present in the home, and
- the family member or caregiver can meet the **covered person's** non-skilled needs.

Important Information:

- **This plan covers home short-term physical, speech, or occupational therapy when the above home health care criteria are met. The *Short Term Rehabilitation Services Expense* benefits lists the conditions and limitations for certain services.**
- **The plan does *not* cover custodial care, even if care is provided by a nursing professional and family member or other caretakers cannot provide the necessary care.**

Limitations:
Covered medical expenses will not include:

- Services by a person who resides in the **covered person's** home, or is a member of the **covered person's** immediate family
- Homemaker or housekeeper services;
- Maintenance therapy;
- Dialysis treatment;
- Purchase or rental of dialysis equipment;
- Food or home delivered services; or
- **Custodial care**.

The *Schedule of Benefits* shows any **copay**, **deductible**, coinsurance percentage, and maximum benefit that may apply to *Home Health Care Expense* benefits.

HIGH COST PROCEDURES EXPENSE

Covered medical expenses include charges incurred by a **covered person** as a result of certain high cost procedures provided on an outpatient basis. Such expenses may be incurred in the following:

(a) A **physician's** office;
(b) **Hospital** outpatient department; or emergency room;
(c) Clinical laboratory; or
(d) Radiological facility, or other similar facility; which meets any licensed or certification standards established by the jurisdiction where it is located.

Covered medical expenses for high cost procedures include; but are not limited to; charges for the following procedures and services:

- Computerized Axial Tomography (C.A.T.) scans;
- Magnetic Resonance Imaging (MRI);
- Positron Emission Tomography (PET) Scans;

The *Schedule of Benefits* shows any **copay, deductible**, covered percentage and maximum benefit that may apply to *High Cost Procedures Expense* benefit**.**

PROSTHETIC DEVICES EXPENSE

Covered medical expenses include charges made for internal and external prosthetic devices and special appliances, if the device or appliance improves or restores body part function that has been lost or damaged by **sickness, injury** or congenital defect. **Covered medical expenses** also include instruction and incidental supplies needed to use a covered prosthetic device.

The plan covers the first prosthesis a **covered person** need s that temporarily or permanently replaces all or part of an body part lost or impaired as a result of **sickness** or **injury** or congenital defects as described in the list of covered devices below for an:

- Internal body part or organ; or
- External body part.

Covered medical expenses also include replacement of a prosthetic device if:

- The replacement is needed because of a change in the **covered person's** physical condition; or normal growth or wear and tear; or
- It is likely to cost less to buy a new one than to repair the existing one; or
- The existing one cannot be made serviceable.

The list of covered devices includes, but is not limited to:

- An artificial arm, leg, hip, knee or eye;
- Eye lens;
- An external breast prosthesis and the first bra made solely for use with it after a mastectomy;
- A breast implant after a mastectomy;
- Ostomy supplies, urinary catheters and external urinary collection devices;
- Speech generating device;
- Orthopedic shoes; foot orthotics; or other devices to support the feet but only when required for the treatment of, or to prevent complications of, diabetes;
- A cardiac pacemaker and pacemaker defibrillators; and
- A durable brace that is custom made for and fitted for the **covered person**.

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

- Eye exams;
- Eyeglasses;
- Vision aids;
- Cochlear implants;
- Hearing aids;
- Communication aids; and
- Orthopedic shoes; foot orthotics; or other devices to support the feet unless required for the treatment of, or to prevent complications of, diabetes.

Hearing Aid Expenses
Covered medical expenses for hearing care includes charges for hearing exams, prescribed hearing aids and hearing aid expenses as described below. This benefit is subject to an age limit as shown on the *Schedule of Benefits*

Hearing aid means:

- Any wearable, non-disposable instrument or device designed to aid or compensate for impaired human hearing; and
- Parts, attachments or accessories.

Covered medical expenses include the following:

- Charges for an audiometric hearing exam and evaluation for a hearing aid prescription performed by:
  - a **physician** certified as an otolaryngologist or otologist; or
  - an audiologist who (1) is legally qualified in audiology; or (2) holds a certificate of Clinical Competence in Audiology from the American Speech and Hearing Association in the absence of any licensing requirements; and who performs the exam at the written direction of a legally qualified otolaryngologist or otologist.
- Charges for electronic hearing aids, installed in accordance with a **prescription** written during a covered hearing exam;
- Any other related services necessary to access, select and adjust or fit a hearing aid.

Covered medical expenses for hearing aids will not include per 12 consecutive month period:

- Charges for more than one hearing aid per ear; and
- Charges in excess of any maximum amount shown on the *Schedule of Benefits*.

Hearing Aids Alternate Treatment Rule

Sometimes there are several types of hearing aids that can be used to treat a medical condition, all of which provide acceptable results. When alternate hearing aids can be used, the plan's coverage may be limited to the cost of the least expensive device that is:

- Customarily used nationwide for treatment, and
- Deemed by the medical profession to be appropriate for treatment of the condition in question. The device must meet broadly accepted standards of medical practice, taking into account the **covered person's** physical condition.

The **covered person** should review the differences in the cost of alternate treatment with the **covered person's physician**. Of course, the **covered person** and their **physician** can still choose the more costly treatment method. The **covered person is** responsible for any charges in excess of what the plan will cover.

This *Alternate Treatment Rule* provision will not operate to deny benefits as mandated by any applicable state statute or regulation.

Limitations:

No benefits are payable under this benefit for charges incurred for:

- A service or supply which is received while the person is not a **covered person** under this Plan;
- A replacement of:
  - a hearing aid that is lost, stolen or broken; or
  - a hearing aid installed within the prior 12-48 month period.
- Replacement parts or repairs for a hearing aid;
- Batteries or cords;
- A hearing aid that does not meet the specifications prescribed for correction of hearing loss:
- Any ear or hearing exam performed by a **physician** who is not certified as an otolaryngologist or otologist;
- Any hearing care service or supply which is a **covered medical expense** in whole or in part under any other part of this Plan;
- Any hearing care service or supply which does not meet professionally accepted standards;

- Any hearing exam:
  - required by an employer as a condition of employment; or
  - which an employer is required to provide under a labor agreement; or
  - which is required by any law of government.
- Hearing exams given during a **stay** in a **hospital** or other facility, except those provided to newborns as part of the overall **hospital stay**; and
- Any tests, appliances and devices for the improvement of hearing including hearing aid batteries and auxiliary equipment or to enhance other forms of communication to compensate for hearing loss or devices that simulate speech.

The *Schedule of Benefits* shows any **copay**, **deductible**, covered percentage and maximum benefit that may apply to the *Prosthetic Device Expense* benefit.

PODIATRIC EXPENSE

Covered medical expenses include charges incurred by a **covered person** for podiatric services; provided on an outpatient basis following an **injury**.

Coverage also includes routine foot care, such as trimming of corns, calluses, and nails.

The *Schedule of Benefits* shows any **copay**, **deductible**, covered percentage and maximum benefit that may apply to *Podiatric Expense* benefits.

Limitations
Unless specified above, not covered under this benefit are charges incurred for routine foot care, such as trimming of corns, calluses, and nails.

SKILLED NURSING FACILITY EXPENSE

Covered medical expenses include charges made by a **skilled nursing facility** during a **covered person's stay** for the following services and supplies:

- **Room and board**, up to the **semi-private room rate**. The plan will cover up to the private room rate if it is needed due to an infectious **sickness** or a weak or compromised immune system;
- Use of special treatment rooms;
- Radiological services and lab work;
- Physical, occupational, or speech therapy;
- Oxygen and other gas therapy;
- Other medical services and general nursing services usually given by a **skilled nursing facility** (this does not include charges made for private or special nursing, or **physician's** services); and
- Medical supplies.

A **covered person** must meet the following conditions:

- The **covered person** is currently receiving inpatient **hospital** care, or inpatient sub-acute care, and
- The **skilled nursing facility** admission will take the place of an admission to, or continued **stay** in, a **hospital** or sub-acute facility; or it will take the place of three or more **skilled nursing services** visits per week at home; and
- There is a reasonable expectation that the **covered person's** condition will improve sufficiently to permit discharge to the **covered person's** home within a reasonable amount of time; and
- The **sickness** or **injury** is severe enough to require constant or frequent **skilled nursing** care on a 24-hour basis.

Important Information:
- **Refer to the *Schedule of Benefits* for details about skilled nursing facility cost-sharing and maximums.**
- **Admissions to a skilled nursing facility must be precertified by Aetna. Refer to the *Precertification* provision in this section for details about precertification.**
- **This plan covers home short-term physical, speech, or occupational therapy when the above skilled nursing facility criteria are met. The *Short Term Rehabilitation Services* Expense benefit lists the conditions and limitations for certain services.**

The *Schedule of Benefits* shows any **copay**, **deductible**, covered percentage, and maximum benefit that may apply to the *Skilled Nursing Facility Expense* benefit.

ACUPUNCTURE IN LIEU OF ANESTHESIA EXPENSE

Covered medical expenses include charges incurred by a **covered person** for acupuncture therapy when acupuncture is used in lieu of other anesthesia for a surgical or dental procedure covered under this Plan.

The acupuncture must be administered by a health care provider who is a legally qualified **physician**; practicing within the scope of their license.

The *Schedule of Benefits* shows any **copay, deductible,** covered percentage, and maximum benefit that may apply to the *Acupuncture In Lieu of Anesthesia Expense* benefit.

TRANSFUSION OR KIDNEY DIALYSIS OF BLOOD EXPENSE

Covered medical expenses include charges incurred by a **covered person** for the transfusion or kidney dialysis of blood, including the cost of:

- Whole blood;
- Blood components; and
- The administration of whole blood and blood components.

The *Schedule of Benefits* shows any **copay**, **deductible**, covered percentage and maximum benefit that may apply to the *Transfusion or Kidney Dialysis of Blood Expense* benefit.

URGENT CARE EXPENSE

Covered medical expenses include charges incurred by a **covered person** for treatment by an **urgent care provider**. A **covered person** should not seek medical care or treatment from an **urgent care provider** if their **sickness; injury**; or condition; is an **emergency condition**. The **covered person** should go directly to the emergency room of a **hospital** or call 911 (or the local equivalent) for ambulance and medical assistance.

Urgent Care
Covered medical expenses include charges incurred by a **covered person** for an **urgent care provider** to evaluate and treat an **urgent condition**.

The *Schedule of Benefits* shows any **copay**, **deductible**, covered percentage and maximum benefit that may apply to *Urgent Care Expense* benefits.

SHORT-TERM CARDIAC AND PULMONARY REHABILITATION THERAPY SERVICES EXPENSE

Covered medical expenses include charges made by a **hospital** for short-term rehabilitation therapy services, as described below, when prescribed by a **physician**. The services have to be performed by:

- A licensed or certified physical or occupational therapist; or
- A **physician**.

Charges for the following short term rehabilitation expenses are covered:

Cardiac and Pulmonary Rehabilitation Benefits
Cardiac rehabilitation benefits are available as part of an inpatient hospital stay. A course of outpatient cardiac rehabilitation appropriate for a **covered person's** condition is covered for a cardiac condition that can be changed.

The plan will cover charges in accordance with a treatment plan as determined by a **covered person's** risk level when recommended by a **physician**.

Pulmonary rehabilitation benefits are available as part of an inpatient hospital stay. A course of outpatient pulmonary rehabilitation appropriate for a **covered person's** condition is covered for the treatment of reversible pulmonary disease states.

The *Schedule of Benefits* shows any **copay**, **deductible**, covered percentage and maximum benefit that may apply to *Short-Term Cardiac and Pulmonary Expense* benefits.

Limitations:
Unless specifically covered above, *not* covered under this benefit are charges for:

- Any services unless provided in accordance with a specific treatment plan;
- Services not performed by a **physician** or under the direct supervision of a **physician**; or
- Services provided by a **physician** or physical or occupational therapist who resides in the **covered person's** home or who is a member of the **covered person's** family, or a member of the **covered person's** spouse's family, or the **covered person's** domestic partner.

SHORT-TERM REHABILIATION SERVICES EXPENSE

Covered medical expenses include charges for short-term rehabilitation services, as described below, when prescribed by a **physician**.

The services have to be performed by:

- A licensed or certified physical, occupational or speech therapist;
- A **hospital**, **skilled nursing facility**, or **hospice facility**;
- A **home health care agency**; or
- A **physician.**

Short-term rehabilitation services must follow a specific treatment plan that:

- Details the treatment, and specifies frequency and duration;
- Provides for ongoing reviews and is renewed only if continued therapy is appropriate; and
- Allows therapy services, provided in a **covered person's** home, if the **covered person** is **homebound**.

Short-Term Rehabilitation Services - Outpatient Cognitive Therapy, Physical Therapy, Occupational Therapy and Speech Therapy
Inpatient rehabilitation benefits for the services listed will be paid as part of the inpatient **hospital** and **skilled nursing facility** benefits.

- Physical therapy (except for services provided in an educational or training setting) is covered provided that the therapy is expected to significantly improve or restore physical functions lost as a result of an acute **sickness**, **injury** or **surgical procedure**,
- Occupational therapy, (except for vocational rehabilitation, employment counseling, and services provided in an educational or training setting), is covered provided that the therapy is expected to:
  - significantly improve or restore physical functions lost as a result of an acute **sickness**, **injury** or **surgical procedure**; or
  - to reteach skills that significantly improve independence in the activities of daily living.
- Speech therapy is covered provided that the therapy is expected to:
  - significantly improve or restore the speech function or correct a speech impairment as a result of an acute **sickness, injury** or **surgical procedure**; or
  - improve delays in speech function development as a result of a gross anatomical defect present at birth.

  Speech function is the ability to express thoughts, speak words and form sentences. Speech impairment is difficulty with expressing one's thoughts with spoken words.
- Cognitive therapy associated with physical rehabilitation is covered when the cognitive deficits have been acquired as a result of neurologic impairment due to trauma, stroke, or encephalopathy, and when the therapy is part of a treatment plan intended to restore previous cognitive function.

A "visit" consists of no more than one hour of therapy. **Covered medical expenses** include charges for two therapy visits of no more than one hour in a 24-hour period.

The *Schedule of Benefits* shows any **copay**, **deductible**, covered percentage and maximum benefit that may apply to *Short-Term Rehabilitation Services Expense* benefits.

CHIROPRACTIC TREATMENT EXPENSE

Covered medical expenses include charges made by a **physician** on an outpatient basis for manipulative (adjustive) treatment or other physical treatment for conditions caused by (or related to) biomechanical or nerve conduction disorders of the spine.

Benefits are subject to the maximum shown in the *Schedule of Benefits*. However, this maximum does not apply to expenses incurred during a **covered person's hospital stay.**

The *Schedule of Benefits* shows any **copay**, **deductible**, covered percentage and maximum benefit that may apply to *Chiropractic Treatment Expense* benefits.

SECTION 7 - EXCLUSIONS AND LIMITATIONS

GENERAL EXCLUSIONS AND LIMITATIONS

Not every healthcare service or supply is covered by the plan, even if prescribed, recommended, or approved by your **physician,** dental **provider,** or vision care professional. The plan covers only those services and supplies that are **medically necessary** and covered in the Policy. In addition, some services and supplies are specifically limited or excluded.

This section describes expenses that are not covered or subject to special limitations. Charges made for the following are not covered except to the extent listed under the Policy or by amendment attached to the Policy.

The exclusions listed below apply to all coverage under the Policy.

Additional limitations and exclusions apply to pediatric dental services covered under the medical plan. Those additional limitations and exclusions are listed separately at the end of this section.

The Policy does not cover the following expenses:

- Expense incurred for dental treatment, services and supplies except for those resulting from **injury** to **sound natural teeth** or for extraction of impacted wisdom teeth and those as specially covered under the Policy.

- Expense incurred for services normally provided without charge by the Policyholder's **school health services**; infirmary or **hospital**; or by health care providers employed by the Policyholder.

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

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

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

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

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

- Expense incurred for **elective treatment** or elective surgery except as specifically covered under the Policy and provided while the Policy is in effect.

- Expense incurred for **cosmetic** surgery; reconstructive surgery; or other services and supplies which improve; alter; or enhance appearance; whether or not for psychological or emotional reasons; except to the extend needed to:
  Improve the function of a part of the body that:
  is not a tooth or structure that supports the teeth; and
  is malformed:
  as a result of a severe birth defect; including harelip; webbed fingers; or toes; or
  as direct result of:
  disease; or
  surgery performed to treat a disease or **injury**.

  Repair an **injury** (including reconstructive surgery for prosthetic device for a **covered person** who has undergone a mastectomy;) which occurs while the **covered person** is covered under the Policy. Surgery must be performed:
  - in the **policy year** of the accident which causes the **injury**; or
  - in the next **policy year**.

- Expense incurred for any services rendered by a member of the **covered person**'s immediate family or a person who lives in the **covered person**'s home.

- Expense for or related to artificial insemination; in-vitro fertilization; or embryo transfer procedures; male elective sterilization; or elective abortion unless specifically covered under the Policy.

- Expenses for treatment of **injury** or **sickness** to the extent that payment is made; as a judgment or settlement; by any person deemed responsible for the **injury** or **sickness** (or their insurers), to the extent allowed by law.

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

- Expense incurred for **custodial care.**

- Expense incurred for the removal of an organ from a **covered person** for the purpose of donating or selling the organ to any person or organization except as specifically covered in the Policy. This limitation does not apply to a donation by a **covered person** to a spouse; child; brother; sister; or parent.

- Expenses incurred for the repair or replacement of existing artificial limbs; orthopedic braces; or orthotic devices except as specifically covered in the Policy.

- Expense incurred for, or in connection with, drugs, devices, procedures, or treatments that are, as determined by Aetna to be, **experimental or investigational** except as specifically covered under the Policy.

- **Expenses incurred for gastric bypass; and any restrictive procedures; for weight loss except screening and** counseling services specifically covered under the Policy.

- Expenses incurred for breast reduction/mammoplasty.

- Expenses incurred for gynecomastia (male breasts).

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

- Expense incurred for acupuncture except as specifically covered under the Policy.

- Expense incurred for alternative; holistic medicine; and/or therapy; including but not limited to; yoga and hypnotherapy unless specifically covered under the Policy.

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

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

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

- Expense incurred for hearing exams, hearing aids; the fitting; or **prescription** of hearing aids except as specifically covered under the Policy. Not covered are:
  - Any hearing service or supply that does not meet professionally accepted standards;
  - Hearing exams given during a **stay** in a **hospital** or other facility;
  - Any tests, appliances, and devices for the improvement of hearing, including aids, hearing aids and amplifiers, or to enhance other forms of communication to compensate for hearing loss or devices that simulate speech; and
  - Routine hearing exams, except for routine hearing screenings as specifically described under *Preventive Care Benefits*.

- Expense for care or services covered under Medicare Part A or Part B, and the **covered person** is enrolled in Medicare Part A or Part B.

- Expense for telephone consultations; charges for failure to keep a scheduled visit; or charges for completion of a claim form.

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

- Expense incurred for any non-emergency charges incurred outside of the United States 1) if you traveled to such location to obtain **prescription drugs**, or supplies, even if otherwise covered under this Policy, or 2) such drugs or supplies are unavailable or illegal in the United States, or 3) the purchase of such **prescription drugs** or supplies outside the United States is considered illegal.

- Expense for services or supplies provided for the treatment of obesity and/or weight control except screening and counseling services as specifically covered under the Policy. Not covered is any treatment, drug service or supply intended to decrease or increase body weight, control weight or treat obesity, including **morbid obesity**, regardless of the existence of comorbid conditions, including but not limited to:
  - Liposuction, banding, gastric stapling, gastric by-pass and other forms of bariatric **surgery**;
  - **surgical procedures,** medical treatments, weight control/loss programs and other services and supplies that are primarily intended to treat, or are related to the treatment of obesity, including **morbid obesity**;

- Drugs, stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food or food supplements, appetite suppressants and other medications;
- Counseling, coaching, training, hypnosis, or other forms of therapy; and
- Exercise programs, exercise equipment, membership to health or fitness clubs, recreational therapy, or other forms of activity or activity enhancement.

- Expense for incidental surgeries; and standby charges of a **physician**.

- Expense incurred for **injury** resulting from the play or practice of intercollegiate sports, participating in sports clubs; or intramural athletic activities; is excluded after 104 weeks from the date of accident.

- Expense incurred for **non-preferred care** charges that are not **recognized charges**.

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

- Expense incurred for routine physical exams, routine eye exams, routine dental exams, routine hearing exams and other preventive services and supplies, except as specifically covered in the Policy.

Expense incurred for a treatment; service; **prescription drug,** or supply; which is not **medically necessary;** as determined by Aetna; for the diagnosis, care, or treatment of the **sickness** or **injury** involved, the restoration of physiological functions, or covered preventive services. This includes behavioral health services that are not primarily aimed at treatment of **sickness**, **injury**, restoration of physiological functions or that do not have a physiological or organic basis. This applies even if they are prescribed; recommended; or approved; by the person's attending **physician, dentist,** or vision **provider**.

- Expenses incurred for vision-related services and supplies, except as specifically covered in the Policy.

  In addition, the plan does not cover:
  - Special supplies such as non-**prescription** sunglasses;
  - Vision service or supply which does not meet professionally accepted standards;
  - Special vision procedures, such as orthoptics or vision training;
  - Eye exams during a **stay** in a **hospital** or other facility for health care;
  - Eyeglasses or duplicate or spare eyeglasses or lenses or frames;
  - Replacement of lenses or frames that are lost or stolen or broken;
  - Acuity tests; and
  - Eye **surgery** for the correction of vision, including radial keratotomy, LASIK and similar procedures;
  - Services to treat errors of refraction.

- Expense incurred for **preferred care** charges in excess of the **negotiated charge**.

- Nursing and home health aide services or therapeutic support services provided outside of the home (such as in conjunction with school, vacation, work or recreational activities).

- Expense incurred in relation to genetics: Except as specifically covered in the Policy, the plan does not cover any treatment, device, drug, service or supply to alter the body's genes, genetic make-up, or the expression of the body's genes except for the correction of congenital birth defects.

- Expense incurred for therapies and tests: Any of the following treatments or procedures including but not limited to:
  - Aromatherapy;
  - Bio-feedback and bioenergetic therapy;
  - Carbon dioxide therapy;
  - Chelation therapy (except for heavy metal poisoning);
  - Computer-aided tomography (CAT) scanning of the entire body;
  - Early intensive behavioral interventions (including Applied Behavior Analysis, Denver, LEAP, TEACHH, Rutgers programs) except as specifically covered in the *What the Medical Plan Covers* Section;
  - Educational therapy;
  - Gastric irrigation;
  - Hair analysis;
  - Hyperbaric therapy, except for the treatment of decompression or to promote healing of wounds;
  - Hypnosis, and hypnotherapy, except when performed by a **physician** as a form of anesthesia in connection with covered **surgery**;
  - Lovaas therapy;
  - Massage therapy;
  - Megavitamin therapy;
  - Primal therapy;
  - Psychodrama;
  - Purging;
  - Recreational therapy;
  - Rolfing;
  - Sensory or auditory integration therapy;
  - Sleep therapy;
  - Thermograms and thermography.

Additional Pediatric Dental Services Exclusions and Limitations

The Pediatric Dental Services benefit is subject to the following additional exclusions and limitations:

- Expenses incurred for any instruction for diet, plaque control and oral hygiene.

- Expenses incurred for dental services and supplies that are covered in whole or in part under any other part of this plan.

- Expenses incurred for **jaw joint disorder** treatment, services and supplies, except as specifically covered in the Policy, to alter bite or the alignment or operation of the jaw, including temporomandibular joint disorder (TMJ) treatment, orthognathic surgery, and treatment of malocclusion or devices to alter bite or alignment.

- Expenses incurred for **orthodontic treatment** except as specifically covered in the Orthodontic Treatment Rule section of the Policy.

- Expenses incurred for routine dental exams and other preventive services and supplies, except as specifically covered in the Policy.

Any exclusion above will not apply to the extent that coverage is specifically provided by name in the Policy; or coverage of the charges is required under any law that applies to the coverage.

EXCESS PROVISION

This Plan is an excess only Plan. As an excess only Plan, this Plan pays its Covered Medical Expenses after any other medical coverage. This Plan's liability will be determined without consideration to any limitation clause or clauses regarding other coverage contained in any other medical coverage. Benefits Payable under this Plan shall be limited to the Plan's Covered Medical Expense and reduced by the amount paid or payable by any other medical coverage. However, consideration will be given to the other medical coverage's liability due to a provider contract or other reasons when calculating this Plan's Benefits Payable. This Plan's applied **deductible** will be credited back into the Benefits Payable when both plans would apply a **deductible**.

For the purposes of calculating a benefit under this Plan, the liability of the other medical coverage shall be considered and shall not depend upon whether timely application for benefits from other medical coverage is made by **you** or on **your** behalf. If any other medical coverage provides benefits on an excess only basis, the coverage for the Covered Member which has been in effect the longest shall pay benefits first.

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

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

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

IMPORTANT HEALTH CARE REFORM INFORMATION

Some language changes in response to the federal Affordable Care Act (ACA) may not be included in the enclosed certificate of coverage. This may be because the language is still pending regulatory review and approval. However, please note that for new plans on or after January 1, 2014, and for non-grandfathered plans that renew on a date on or after January 1, 2014, Aetna is administering medical and outpatient prescription drug coverage in compliance with the following applicable components of the ACA.

The following is a summary of the recent changes under the ACA.

For details on any benefit maximums and the cost sharing under your plan, log onto the Aetna website www.aetna.com, call the Member Services number on the back of your ID card, or refer to the Summary of Benefit and Coverage document you have received.

1. Subject to any allowed applicable age, family history and frequency guidelines for preventive services covered under the plan, (which may be in-network only for plans that use a provider network) the following services are included in those considered preventive:

    - Coverage of comprehensive lactation support and counseling, and the costs of renting or purchasing breastfeeding equipment extended for the duration of breastfeeding.
    - In accordance with the recommendations of the United States Preventive Services Task Force, and when prescribed by a physician:
        i. aspirin for men and women age 45 and over;
        ii. folic acid for women planning or capable of pregnancy;
        iii. routine iron supplementation for asymptomatic children ages 6 to 12 months;
        iv. vitamin D supplementation for men and women age 65 and older;
        v. fluoride supplementation for children from age 6 months through age 5;
        vi. genetic counseling, evaluation and lab tests for routine breast cancer susceptibility gene (BRCA) testing;
        vii. Food and Drug Administration (FDA) approved female over-the-counter contraceptives, and an office visit for contraceptive administration and/or removal of a contraceptive device

2. The medical in-network out-of-pocket maximum for a plan that does use a provider network , and the out-of-pocket maximums for a plan that does not use a provider network - cannot exceed $6,350 per person and $12,700 per family for your 2014 plan year. If your medical plan is packaged with a plan that covers outpatient prescription drugs, the outpatient prescription drug plan may:
    a. not include out-of-pocket maximums; or
    b. have separate maximums from the medical plan up to these same amounts; or
    c. have maximums that are combined with the medical plan up to these same amounts.

3. Any annual or lifetime dollar maximum benefit that applies to "Essential Health Benefits" (as defined by the ACA and included in the plan) no longer applies. Essential Health Benefits will continue to be subject to any coinsurance, copays, deductibles, other types of maximums (e.g., day and visit maximums), referral and certification rules, and any exclusions and limitations that apply to these types of covered medical expenses under your plan.

4. If your Plan includes a pre-existing condition limitation or exclusion provision, including one that may apply to transplant coverage, then this limitation or exclusion no longer applies.

5. If your Plan includes a waiting or probationary period, (the period of time that must pass before your coverage can become effective), this period of time cannot be greater than 90 days.

APPEALS PROCEDURE

Definitions

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

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

- The **covered person's** eligibility for coverage.
- Plan limitations or exclusions.
- The results of any Utilization Review activities.
- A decision that the service or supply is **experimental or investigational**.
- A decision that the service or supply is not **medically necessary**.

An **adverse benefit determination** also means the termination of a **covered person's** coverage back to the original effective date (rescission) as it applies under any rescission provision appearing in the Policy, but within 2 years of your application for any fraud or material misrepresentation on the application, subject to Connecticut regulation.

Appeal: A written request to Aetna to reconsider an **adverse benefit determination**.

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

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

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

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

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

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

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

Urgent Care Claim: Any claim for medical care or treatment in which a delay in treatment could:

- Seriously jeopardize the **covered person's** life or health;
- Jeopardize the **covered person's** ability to regain maximum function;

- Cause the **covered person** to suffer severe pain that cannot be adequately managed without the requested medical care or treatment; or
- For a substance abuse disorder or for a co-occurring mental disorder, or mental disorder requiring inpatient services, partial hospitalization, residential treatment or intensive outpatient services necessary to prevent an inpatient setting; and
- In the case of a pregnant woman, cause serious jeopardy to the health of the fetus.

Full and Fair Review of Claim Determinations and Appeals

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

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

Claim Determinations – Health Coverage

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

Urgent Care Claims

Aetna will notify the **covered person** of an **urgent care** claim decision as soon as possible, but not later than 72 hours after the claim is made. With respect to mental health or substance abuse disorders, the decision will be made within 24 hours.

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

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

Pre-Service Claims

Aetna will notify the **covered person** of a **pre-service** claim decision as soon as possible, but not later than 15 calendar days after the claim is made. Aetna may determine that due to matters beyond its control an extension of this 15 calendar day claim decision period is required. Such an extension, of not longer than 15 additional calendar days, will be allowed if Aetna notifies the **covered person** within the first 15 calendar day period. If this extension is needed because Aetna needs more information to make a claim decision, the notice of the extension shall specifically describe the required information. The **covered person** will have 45 calendar days, from the date of the notice, to provide Aetna with the required information.

Post-Service Claims

Aetna will notify the **covered person** of a **post-service** claim decision as soon as possible, but not later than 30 calendar days after the claim is made. Aetna may determine that due to matters beyond its control an extension of this 30 calendar day claim decision period is required. Such an extension, of not longer than 15 additional calendar days, will be allowed if Aetna notifies the **covered person** within the first 30 calendar day period. If this extension is needed because Aetna needs more information to make a claim decision, the notice of the extension shall specifically describe the required information. The patient will have 45 calendar days, from the date of the notice, to provide Aetna with the required information.

Concurrent Care Claim Extension

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

Concurrent Care Claim Reduction or Termination

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

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

Complaints

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

Appeals of Adverse Benefit Determinations

The **covered person** may submit an **appeal** if Aetna gives notice of an **adverse benefit determination**. This Plan provides for one level or two levels (Level Two only applies to dental, vision and hearing claims) of **appeal**. A **final adverse benefit determination** notice may also provide an option to request an **External Review** *(if available)***.**

An appeal of an adverse benefit determination will be evaluated and reviewed by a clinical peer, not involved in the original determination. A clinical peer is:

- A physician or other health care professional who holds a non-restricted license in a state of the US and in the same or similar specialty as typically manages the medical condition, procedure or treatment under review.
- For urgent care reviews concerning child or adolescent substance use disorder or mental disorder, holds a national board certification in child and adolescent psychiatry or a doctoral level psychology degree with training and clinical experience in the treatment of child and adolescent substance use and mental disorder as applicable.
- For urgent care reviews concerning adult substance use or mental disorder, holds a national board certification in psychiatry, or a doctoral level psychology degree with training and clinical experience in the treatment of adult substance use and mental disorders, as applicable.

The **covered person** has 180 calendar days with respect to Health Claims following the receipt of notice of an **adverse benefit determination** to request their Level One **appeal**. The **covered person's appeal** must be submitted in writing and must include:

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

The **covered person** can send their written **appeal** to Member Services at the address shown on their ID Card.

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

The **covered person** may be allowed to provide evidence or testimony during the **appeal** process in accordance with the guidelines established by the Federal Department of Health and Human Services.

Appeal – Medical and Prescription Drug Claims

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

Urgent Care Claims (May Include Concurrent Care Claim Reduction or Termination)
Aetna shall issue a decision within 72 hours of receipt of the request for an **appeal**. Appeals pertaining to mental health or substance abuse disorder services will be made as soon as possible, but not later than 24 hours after receipt of the request to keep the **covered person** from requiring an inpatient setting.

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

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

Level One Appeal –Dental, Vision and Hearing Claims

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

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

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

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

Level Two Appeal - Dental, Vision and Hearing Claims

A Level Two **appeal** applies only to dental, vision and hearing claims. If Aetna upholds an **adverse benefit determination** at the first level of **appeal**, and the reason for the decision was based on **medical necessity** or **experimental or investigational** reasons, the **covered person** or their authorized representative has the right to file a Level Two **appeal**. The **appeal** must be submitted within 60 calendar days following the receipt of a decision of a Level One **appeal**.

A review of a Level Two **appeal** of an **adverse benefit determination** of an **urgent care claim, a Pre-Service Claim, or a Post-Service Claim** shall be provided by Aetna personnel. They shall not have been involved in making the **adverse benefit determination**.

Urgent Care Claims (May Include Concurrent Care Claim Reduction or Termination)
Aetna shall issue a decision within 36 hours of receipt of the request for a Level Two **appeal**.

Pre-Service Claims (May Include Concurrent Care Claim Reduction or Termination)
Aetna shall issue a decision within 15 calendar days of receipt of the request for a Level Two **appeal**.

Post-Service Claims
Aetna shall issue a decision within 30 calendar days of receipt of the request for a Level Two **appeal**.

Exhaustion of Process

Aetna encourages **covered persons** to exhaust the applicable Level One and Level Two processes of the Appeal Procedure before they:

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

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

Under certain circumstances the **covered person** may seek simultaneous review through the internal Appeals Procedure and **External Review** processes—these include **Urgent Care Claims** and situations where the **covered person** is receiving an ongoing course of treatment. Exhaustion of the applicable process of the Appeal Procedure is not required under these circumstances.

The **covered person** may contact the Department of Insurance for assistance regarding any Complaint/Grievance or Appeal at the following address:

State of Connecticut Insurance Department
Consumer Affairs Department
P.O. Box 816
Hartford, CT 06142-0816
1-860-297-3900 or 1-800-203-3447
cid.ca@ct.gov

Or, the Office of Healthcare Advocate, at:

State of Connecticut
Office of the Healthcare Advocate
P.O. Box 1543
Hartford, CT 06144
1-866-297-3992
Healthcare.advocate@ct.gov

External Review

The **covered person** may receive an **adverse benefit determination** or **final adverse benefit determination.**

In these situations, the **covered person** may request an **External Review** if they or their provider disagrees with Aetna's decision.

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

- The **covered person** has received an **adverse benefit determination** notice by Aetna**,** and Aetna did not adhere to all claim determination and **appeal** requirements of the Federal Department of Health and Human Services.
- The **covered person** has received a **final adverse benefit determination** notice by Aetna.
- The **covered person** qualifies for a faster review as explained below.
- As to dental, vision and hearing claims only, the cost of the initial service, supply or treatment in question for which the **covered person** is responsible exceeds $500.

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

The **covered person** must submit the *Request for External Review Form* to the Connecticut Insurance Department within 120 calendar days of the date they received the **adverse benefit determination** or **final adverse benefit determination** notice. The **covered person** also must include a copy of the notice and all other pertinent information that supports their request.

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

Mail the application for External Review to:

Connecticut Insurance Department
Attention: External Review
P.O. Box 816
Hartford, CT 06142-0816

For overnight delivery only, mail the application to:

Connecticut Insurance Department
Attention: External Review
153 Market Street, 7th Floor
Hartford, CT 06103

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

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

The **covered person** may also receive a faster review if the **final adverse benefit determination** relates to an admission; availability of care; continued **stay;** or health service for which they received **emergency care**, but have not been discharged from a facility, and mental health and substance abuse disorders.

Faster reviews are decided within 72 hours after Aetna receives the request, except in the case of experimental or investigational reviews which have a 5 day timeframe, and in the case of an expedited review involving a substance abuse disorder, or for a co-occurring mental disorder, or mental disorder requiring inpatient services, partial hospitalization, residential treatment or intensive outpatient services necessary to prevent an inpatient setting, the review will be decided as expeditiously as the **covered person's** medical condition requires, but not later than 24 hours after the ERO receives the request to conduct this review.

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

The **covered person** is responsible for the cost of compiling and sending the information that they wish to be reviewed by the ERO to Aetna. Aetna is responsible for the cost of sending this information to the ERO and for the cost of the external review except for dental, vision and hearing claims.

For more information about the Appeals Procedure or **External Review** processes, the **covered person** may call the Member Services telephone number shown on their ID card, or contact the Connecticut Department of Insurance at the information given above.

Aetna Life Insurance Company

Hartford, Connecticut 06156

Student Accident Insurance

Policy Amendment

Policyholder: **Connecticut State Colleges and Universities: Central, Eastern, Southern and Western - Accident Plan**

Policy No.: [GP-890429][GP-8904033][GP-890434][GP-890435]

Effective Date: This Amendment is effective on the later of:

August 1, 2021; or
The date a person becomes a **covered person** under the Student Accident Policy.

The Student Accident Insurance Policy (Policy) noted above has been changed.

Except as modified or superseded by this Amendment, all other terms and conditions in the Policy remain unchanged and in full force and effect.

The following is a summary of the changes in the Policy. This amendment is effective on the date(s) shown above.

The "Discontinuance of Policy" provision appearing in the *General Provisions* section of the Policy is hereby deleted and replaced with the following:

DISCONTINUANCE OF POLICY - The Policyholder may terminate the Policy as to any or all coverage of all or any class of students. The Policyholder must give **Aetna** written notice of the termination. The termination date shall not be earlier than 31 days after the date of the notice unless it is agreed to by the Policyholder and **Aetna**. The notice must state when such termination shall occur. It must be a date after the notice. It shall not be effective during a period for which a premium has been paid to **Aetna** as to the coverage.

Aetna has the right to terminate this Policy only under the following conditions:

- Non-payment of premium.
- Fraud or intentional misrepresentation of a material fact under the terms of the coverage.
- Aetna ceases to offer student blanket health insurance coverage subject to the terms of any Connecticut law or regulation and in line with HIPAA notification requirements.

Aetna will notify the Connecticut Insurance Department as well as all policyholders no later than 90 days before the date that Aetna no longer offers Student Blanket Coverage in Connecticut.

As to non-payment of premium, **Aetna** has the right to terminate the Policy as to all or any class of students of a Policyholder at any time after the end of the grace period if the premium for student coverage has not been paid. **Aetna** must give written notice of the termination date. This right is subject to the terms of any laws or regulations.

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

If:

- The Policy terminates as to any of the students of a Policyholder; and
- Premiums have not been paid for the period the Policy was in force for those students;

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

This amendment makes no other changes to the Policy.

Dan Finke
President

Aetna Life Insurance Company
(A Stock Company)

Amendment: 1
Issue Date: July 2, 2021

Aetna Life Insurance Company

Hartford, Connecticut 06156

Student Accident Insurance

Policy Amendment

Policyholder: **Connecticut State Colleges and Universities: Central, Eastern, Southern and Western - Accident Plan**

Policy No.: [GP-890429][GP-8904033][GP-890434][GP-890435]

Effective Date: This Amendment is effective on the later of:

August 1, 2021; or
The date a person becomes a **covered person** under the Student Accident Policy.

The Student Accident Insurance Policy (Policy) noted above has been changed.

Except as modified or superseded by this Amendment, all other terms and conditions in the Policy remain unchanged and in full force and effect.

The following is a summary of the changes in the Policy. This amendment is effective on the date(s) shown above.

1. The following "**Important Notice**" has been added to the *Emergency Room Visit Expense* benefit description in the Schedule of Benefits:

> **Important Notice:**
> A separate **hospital** emergency room visit benefit **deductible** or **copay** applies for each visit to an emergency room for **emergency care**. If a **covered person** is admitted to a **hospital** as an inpatient immediately following a visit to an emergency room, the emergency room visit benefit **deductible** or **copay** is waived.
>
> **Covered medical expenses** that are applied to the emergency room visit benefit **deductible** or **copay** cannot be applied to any other benefit **deductible** or **copay** under the plan. Likewise, **covered medical expenses** that are applied to any of the plan's other benefit **deductibles** or **copays** cannot be applied to the emergency room visit benefit **deductible** or **copay**.
>
> Similarly, services rendered in the emergency room that are not included in the **hospital** emergency room visit benefit may be subject to **coinsurance** rates that are different from the **coinsurance** rate applicable to the **hospital** emergency room visit benefit.
>
> Similarly, services rendered in the emergency room that are not included in the **hospital** emergency room visit benefit may be subject to **coinsurance.**

2. Any references to the term “harelip” within the Policy are hereby changed to “cleft lip/cleft palate”.

3. The *Prescribed Medicines Expense Exclusions and Limitations* section of the Policy has changed. The following has been added under *Limitations*:

   - **Aetna** retains the right to review all requests for reimbursement and, within its reasonable authority to, make reimbursement determinations subject to the *Appeals Procedure, Exhaustion of Process, and External Review* section of the Policy.
   - **Aetna** reserves the right to include only one manufacturer’s product on the **preferred drug list** when the same or similar drug (that is, a drug with the same active ingredient), supply or equipment is made by two or more different manufacturers.
   - **Aetna** reserves the right to include only one dosage or form of a drug on the **preferred drug list** when the same drug (that is, a drug with the same active ingredient) is available in different dosages or forms from the same or different manufacturers. The product in the dosage or form that is listed on our **preferred drug list** will be covered at the applicable benefit **deductible**, **copay** or **coinsurance**.

This amendment makes no other changes to the Policy.

Dan Finke
President

Aetna Life Insurance Company
(A Stock Company)

Amendment: 2
Issue Date: July 2, 2021

Aetna Life Insurance Company

Hartford, Connecticut 06156

Student Accident Insurance

Policy Amendment

Policyholder: **Connecticut State Colleges and Universities: Central, Eastern, Southern and Western - Accident Plan**

Policy No.: [GP-890429][GP-8904033][GP-890434][GP-890435]
Effective Date: This Amendment is effective on the later of:

August 1, 2021; or
The date a person becomes a **covered person** under the Student Accident Policy.

The Student Accident Insurance Policy (Policy) noted above has been changed.

Except as modified or superseded by this Amendment, all other terms and conditions in the Policy remain unchanged and in full force and effect.

The following is a summary of the changes in the Policy. This amendment is effective on the date(s) shown above.

1. The following has been added to the *Benefits Payable* provision in the Schedule of Benefits:

   If a service or supply that a **covered person** needs is covered under the Plan but not available from a **Preferred Care Provider**, **covered persons** should contact *Member Services* for assistance at the toll-free number on the back of the ID card. In this situation, **Aetna** may issue a pre-approval for a **covered person** to obtain the service or supply from a **Non-Preferred Care Provider.** When a pre-approval is issued by **Aetna**, **covered medical expenses** are reimbursed at the **Preferred Care** network level of benefits.

2. The following definition(s) are added to the *Definitions* section of the Policy:

   Habilitation Therapy Services
   Health care services that help a **covered person** keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

   Religious Policyholder
   This term is defined as:

   - The inculcation of religious values is the purpose of the entity.
   - The entity primarily enrolls persons who share the religious tenets of the entity.
   - The entity serves primarily persons who share the religious tenets of the entity.

- The entity is a nonprofit organization pursuant to Section 6033(a)(2)(A)(i) or (iii) of the Internal Revenue Code of 1986, as amended.

3. The definition of *Emergency Medical Condition* currently appearing in the *Definitions* section of the Policy is hereby deleted and replaced with the following:

   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, 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;
     - one who is having contractions and there is inadequate time to effect a safe transfer to another **hospital** before delivery; or
     - a transfer may pose a threat to the health or safety of the woman or the unborn child.

4. The following definition replaces the same definition appearing in the *Definitions* section of the Policy:

   Biosimilar Prescription Drug

   A biological **prescription drug** that is highly similar to a U.S. Food and Drug Administration (FDA) licensed reference biological **prescription drug** notwithstanding minor differences for which there are no clinically meaningful differences between the highly similar biological **prescription drug** and the reference biological **prescription drug** in terms of the safety, purity, and potency of the drug,(as defined in accordance with the U.S. Food and Drug Administration (FDA) regulations).

This amendment makes no other changes to the Policy.

Dan Finke
President

Aetna Life Insurance Company
(A Stock Company)

Amendment: 3
Issue Date: July 2, 2021

Aetna Life Insurance Company

Hartford, Connecticut 06156

Student Accident Insurance

Policy Amendment

Policyholder: **Connecticut State Colleges and Universities: Central, Eastern, Southern and Western - Accident Plan**

Policy No.: [GP-890429][GP-8904033][GP-890434][GP-890435]

Effective Date: This Amendment is effective on the later of:

August 1, 2021; or
The date a person becomes a **covered person** under the Student Accident Policy.

The Student Accident Insurance Policy (Policy) noted above has been changed.

Except as modified or superseded by this Amendment, all other terms and conditions in the Policy remain unchanged and in full force and effect.

The following is a summary of the changes in the Policy. This amendment is effective on the date(s) shown above.

The *Precertification* provision in the *Coverage* section of the Policy has changed. The list of "*Services and Supplies Which Require Precertification*" is hereby deleted in its entirety and replaced with the following:

Inpatient and Outpatient Care
• Amytal Interview • Applied Behavior Analysis (ABA) • Bariatric **Surgery** • Biofeedback • Cardiac **Surgeries** • Clinical Trials • Complex Imaging • **Cosmetic Surgery** • Electric or Motorized Wheelchairs and Scooters • Gender Reassignment (Sex Change) Treatment • Genetic Testing

- **Home health care** related services (ie. private duty nursing including psychiatric **home health care** services)
- Hyperbaric Oxygen Therapy
- Implants and Trials (cochlear, dental, neurostimulators, cardiac, osseointegrated)
- **Infertility** Services (except Basic **Infertility**)
- Inpatient Services: Observation stays greater than 24 hours, inpatient **hospital** non-surgical, inpatient **hospital** surgical confinements, maternity confinements which exceed the standard length of stay (LOS), newborn confinements which exceed the standard length of stay (LOS), rehabilitation facility, **skilled nursing facility**, **hospice stays** in a **hospital**
- **Intensive Outpatient Programs (IOP)** – (**mental disorder** and **substance abuse** diagnoses)
- Kidney Dialysis
- Knee Surgeries
- Lower Limb Prosthetics
- Medical Injectables*
- Non-Emergency Ambulance Services (including fixed wing aircraft)
- **Non-Preferred Care** at a freestanding **ambulatory surgical center**
- **Non-Preferred Care Providers** for non-emergency services, being requested at an **network provider** benefit level
- Orthognatic Surgery Procedures (bone grafts, osteotomies and surgical management of the temporomandibular joint)
- Outpatient back **surgery** not performed in a **physician's** office
- Outpatient **Detoxification**
- Outpatient Electroconvulsive Therapy (ECT)
- **Partial Hospitalization Treatment** Programs (PHP) – (**mental disorder** and **substance abuse** diagnoses)
- Power Morcellator
- Proton Beam Radiotherapy
- Psychological Testing/Adult Neuropsychological Testing
- Radiation Therapy
- **Residential Treatment Facility** or Residential Treatment Center admissions
- Sleep Studies
- Transplant services (pre-transplant, evaluation and post-transplant)
- Uvulopalatopharyngoplasty, including laser-assisted procedures

This amendment makes no other changes to the Policy.

Dan Finke
President

Aetna Life Insurance Company
(A Stock Company)

Amendment: 4
Issue Date: July 2, 2021

Aetna Life Insurance Company

Hartford, Connecticut 06156

Student Accident Insurance

Policy Amendment

Policyholder: **Connecticut State Colleges and Universities: Central, Eastern, Southern and Western - Accident Plan**

Policy No.: [GP-890429][GP-8904033][GP-890434][GP-890435]

Effective Date: This Amendment is effective on the later of:

August 1, 2021; or
The date a person becomes a **covered person** under the Student Accident Policy.

The Student Accident policy noted above has been changed.

The following is a summary of the changes in the Policy. This amendment is effective on the date(s) shown above.

1. The **Appeals of Adverse Benefit Determinations** provision that appears in the Appeals Procedure, Exhaustion of Process and External Review section of the Policy is deleted and replaced with the following:

Appeals of Adverse Benefit Determinations

When the **covered person** receives an **adverse benefit determination** that was based on **medical necessity**, **Aetna** must notify the **covered person's physician** or other health care professional of the opportunity to confer, at the **physician** or other health care professional's request, with a **clinical peer** of **Aetna**. This conference will not be considered a **grievance** of the **adverse benefit determination** as long the **covered person** or the **covered person's** authorized representative has not submitted an **appeal** to **Aetna.**

This Plan provides for one level or two levels (Level Two only applies to dental, vision and hearing claims) of **appeal**. A **final adverse benefit determination** notice may also provide an option to request an **External Review** *(if available)***.**

An appeal of an adverse benefit determination will be evaluated and reviewed by a clinical peer, not involved in the original determination. A clinical peer is:

- A physician or other health care professional who holds a non-restricted license in a state of the US and in the same or similar specialty as typically manages the medical condition, procedure or treatment under review.
- For urgent care reviews concerning child or adolescent substance use disorder or mental disorder, holds a national board certification in child and adolescent psychiatry or a doctoral level psychology degree with

training and clinical experience in the treatment of child and adolescent substance use and mental disorder as applicable.
- For urgent care reviews concerning adult substance use or mental disorder, holds a national board certification in psychiatry, or a doctoral level psychology degree with training and clinical experience in the treatment of adult substance use and mental disorders, as applicable.

The **covered person** has 180 calendar days with respect to Health Claims following the receipt of notice of an **adverse benefit determination** to request their Level One **appeal**. The **covered person's appeal** may be submitted orally or must be submitted in writing and must include:

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

The **covered person** can send their written **appeal** to Member Services at the address shown on their ID Card, or call in their **appeal** to Member Services using the telephone number shown on their ID Card.

The **covered person** may send their written **appeal** to the address shown on the notice of **adverse benefit determination**, or they may call in their **appeal** using the telephone number listed on the notice.

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

The **covered person** may be allowed to provide evidence or testimony during the **appeal** process in accordance with the guidelines established by the Federal Department of Health and Human Services.

This amendment makes no other changes to the Policy.

Dan Finke
President

Aetna Life Insurance Company
(A Stock Company)

Amendment: 5
Issue Date: July 2, 2021

Aetna Life Insurance Company

Hartford, Connecticut 06156

Student Accident Insurance

Policy Amendment

Policyholder: **Connecticut State Colleges and Universities: Central, Eastern, Southern and Western - Accident Plan**
Plan

Policy No.: [GP-890429][GP-8904033][GP-890434][GP-890435]

Effective Date: This Amendment is effective on the later of:

August 1, 2021; or
The date a person becomes a **covered person** under the Student Accident Policy.

The Student Accident policy noted above has been changed.

The following is a summary of the changes in the Policy. This amendment is effective on the date(s) shown above.

1. The following has been added to the ***Payment of Benefits*** provision that appears in the General Provisions section of the Policy:

Surprise Bills

A surprise bill is a bill you get for **eligible health services** that were not emergency services**.** The bill is from an **out- of-network provider** who performed services while you were in a network hospital or facility.

1. These services were in addition to those performed by a **network provider**.
2. You may have **precertified** the procedure or service, but you did not knowingly choose to receive services from an **out-of-network provider**.

A surprise bill is not a bill for services received when a **network provider** was available and you knowingly choose to use an **out-of-network provider.**

Contact Member Services if you receive a surprise bill. You only have to pay the same coinsurance, copayment, deductible or other out-of-pocket expense that you would pay if you had used a **network provider.**

This amendment makes no other changes to the Policy.

Dan Finke
President

Aetna Life Insurance Company
(A Stock Company)

Amendment: 6
Issue Date: July 2, 2021

Aetna Life Insurance Company

Hartford, Connecticut 06156

Student Accident Insurance

Policy Amendment

Policyholder: **Connecticut State Colleges and Universities: Central, Eastern, Southern and Western - Accident Plan**

Policy No.: [GP-890429][GP-8904033][GP-890434][GP-890435]

Effective Date: This Amendment is effective on the later of:

August 1, 2021; or
The date a person becomes a **covered person** under the Student Accident Policy.

The Student Accident policy noted above has been changed.

The following is a summary of the changes in the Policy. This amendment is effective on the date(s) shown above.

1. The **Outpatient Physician or Specialist Office Visit Expense** provision that appears in the Covered Benefits section of the Policy is deleted and replaced with the following:

   Outpatient Physician or Specialist Office Visit Expense

   C**overed medical expenses** include the charges made by the **physician** or **specialist** if a **covered person** requires the services of a **physician** or **specialist** in the **physician**'**s** or **specialist's** office while not confined as an inpatient in a **hospital**. The *Schedule of Benefits* shows any **copay, deductible,** covered percentage and maximum benefit that may apply to these benefits under the *Outpatient Expense* benefit.

   Covered medical expenses also include **e-visits** and **telemedicine** only when a **covered person** gets a telephone or internet-based consult through an authorized internet service vendor who conducts **telemedicine** consultations. You may search online for the most current list of participating providers in your area by using DocFind, Aetna's online provider directory at www.aetna.com. **E-visits** and **telemedicine** are not the same as office visits and may have different cost sharing. The *Schedule of Benefits* shows any **copay**, **deductible**, covered percentage and maximum benefit that may apply to these benefits.

2. The following definition has been added to the Definitions section of the Policy:

   Telemedicine
   A telephone or internet-based consult with a **provider** that offers these services.

This amendment makes no other changes to the Policy.

Dan Finke
President

Aetna Life Insurance Company
(A Stock Company)

Amendment: 7
Issue Date: July 2, 2021

Aetna Life Insurance Company

Hartford, Connecticut 06156

Student Accident Insurance

Policy Amendment

Policyholder: Connecticut State Colleges and Universities: Central, Eastern, Southern and Western - Accident Plan

Policy No.: [GP-890429][GP-8904033][GP-890434][GP-890435]

Effective Date: This Amendment is effective on the later of:

August 1, 2021; or
The date a person becomes a **covered person** under the Student Accident Policy.

The Student Accident policy noted above has been changed.

The following is a summary of the changes in the Policy. This amendment is effective on the date(s) shown above.

1. The *Other Than Preventive Care Expense Benefits* section of the Schedule of Benefits has been changed. The cost-sharing and maximums below replace the cost-sharing and maximums that currently appear in the Schedule of Benefits for these benefits:

COVERAGE	**BENEFIT AMOUNT**	
	Preferred Care	**Non-Preferred Care**
PRE-ADMISSION TESTING EXPENSE		
	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
NON-ELECTIVE - SECOND SURGICAL OPINION EXPENSE		
	Payable in accordance with the type of expense incurred and the place where service is provided	Payable in accordance with the type of expense incurred and the place where service is provided
PODIATRIC EXPENSE		
	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.

ACUPUNCTURE IN LIEU OF ANESTHESIA EXPENSE		
	Payable in accordance with the type of expense incurred and the place where service is provided	Payable in accordance with the type of expense incurred and the place where service is provided
TRANSFUSION OR KIDNEY DIALYSIS OF BLOOD EXPENSE		
	Payable in accordance with the type of expense incurred and the place where service is provided	Payable in accordance with the type of expense incurred and the place where service is provided

This amendment makes no other changes to the Policy.

Dan Finke
President

Aetna Life Insurance Company
(A Stock Company)

Amendment: 8
Issue Date: July 2, 2021

Aetna Life Insurance Company

Hartford, Connecticut 06156

Student Accident Insurance

Policy Amendment

Policyholder: **Connecticut State Colleges and Universities: Central, Eastern, Southern and Western - Accident Plan**

Policy No.: [GP-890429][GP-8904033][GP-890434][GP-890435]

Effective Date: This Amendment is effective on the later of:

August 1, 2021; or
The date a person becomes a **covered person** under the Student Accident Policy.

The Student Accident policy noted above has been changed.

The following is a summary of the changes in the Policy. This amendment is effective on the date(s) shown above.

1. The following ***Short Term Cardiac and Pulmonary Rehabilitation Therapy Services Expense*** benefit replaces the same benefit appearing in the ***Coverage*** section of the Policy:

   SHORT TERM CARDIAC AND PULMONARY REHABILIATION THERAPY SERVICES EXPENSE

   Inpatient rehabilitation benefits for the services listed will be paid as part of the *Hospital Expense* and *Skilled Nursing Facility Expense* benefits.

   Cardiac Rehabilitation Benefits
   - Cardiac rehabilitation benefits received at a **hospital**, **skilled nursing facility**, or **physician's** office. This Plan will cover charges in accordance with a treatment plan as determined by a **covered person's** risk level when recommended by a **physician**.

   Pulmonary Rehabilitation Benefits
   - Pulmonary rehabilitation benefits are available as part of an inpatient **hospital stay**. A limited course of outpatient pulmonary rehabilitation is covered for the treatment of reversible pulmonary disease states.

   Limitations
   Unless specifically covered above, not covered under this benefit are charges for:
   - Any services which are **covered medical expenses** in whole or in part under any other student plan sponsored by the Policyholder.
   - Any services unless provided in accordance with a specific treatment plan.
   - Services not performed by a **physician** or under the direct supervision of a **physician**.

- Services provided by a **physician** who resides in a **covered person's** home; or who is a member of the **covered person's** family, or a member of the **covered student's** spouse's family or the **covered student's** domestic partner's family.

The *Schedule of Benefits* shows any **copay**, **deductible**, covered percentage and maximum benefit that may apply to *Short-Term Cardiac and Pulmonary Rehabilitation Therapy Services Expense* benefits.

2. The following ***Short Term Rehabilitation Services Expense*** benefit replaces the ***Short Term Rehabilitation and Habilitation Therapies Expense*** benefit appearing in the ***Coverage*** section of the Policy:

SHORT-TERM REHABILITATION SERVICES EXPENSE

Covered medical expenses include charges for short-term rehabilitation services, as described below, when prescribed by a **physician.**

The services have to be performed by:
- A licensed or certified physical, occupational, or speech therapist;
- A **hospital**, **skilled nursing facility**, or **hospice facility**;
- A **home health care agency**; or
- A **physician**.

Short-term rehabilitation services have to follow a specific treatment plan, ordered by a **physician,** that:
- Details the treatment, and specifies frequency and duration;
- Provides for ongoing reviews and is renewed only if continued therapy is appropriate; and
- Allows therapy services, provided in a **covered person's** home, if the **covered person** is **homebound**.

Outpatient Cognitive Therapy, Physical Therapy, Occupational Therapy and Speech Therapy Rehabilitation Benefits.

Inpatient rehabilitation benefits for the services listed will be paid as part of the *Hospital Expense* and *Skilled Nursing Facility Expense* benefits.

- Physical therapy is covered for non-chronic conditions and acute **injuries**, provided the therapy is expected to:
  - significantly improve, develop or restore physical functions lost; or
  - improves any impaired function;

  as a result of an acute **injury** or surgical procedure. Physical therapy does not include educational training or services designed to develop physical function.
- Occupational therapy (except for vocational rehabilitation or employment counseling) is covered for non-chronic conditions and acute **injuries**, provided the therapy is expected to:
  - significantly improve, develop or restore physical functions lost or impaired as a result of an acute **injury** or surgical procedure; or
  - improve an impaired function as a result of an acute **injury** or surgical procedure; or
  - to relearn skills to significantly improve independence in the activities of daily living.

  Occupational therapy does not include educational training.
- Speech therapy is covered for non-chronic conditions and acute **injuries** provided the therapy is expected to:
  - significantly improve or restore the speech function or correct a speech impairment resulting from **injury** or surgical procedure; or

- improve delays in speech function development as a result of a gross anatomical defect present at birth.

Speech function is the ability to express thoughts, speak words and form sentences. Speech impairment is difficulty with expressing one's thoughts with spoken words.

- Cognitive rehabilitation is covered when the cognitive deficits have been acquired as a result of neurologic impairment due to trauma, stroke, or encephalopathy, and when the therapy is part of a treatment plan intended to restore previous cognitive function.

Habilitation Therapy Services

Covered medical expenses include habilitation therapy services a **physician** prescribes. The services have to be performed by a:

- licensed or certified physical, occupational or speech therapist;
- **hospital**, **skilled nursing facility**, or **hospice facility**;
- **home health care agency**; or
- **physician.**

Habilitation therapy services have to follow a specific treatment plan, ordered by a **physician**, that:

- details the treatment, and specifies frequency and duration;
- provides for ongoing reviews and is renewed only if continued therapy is appropriate; and
- allows therapy services, provided in the **covered person's** home, if a **covered person** is **homebound**.

Covered medical expenses for habilitation therapy services include:

- physical therapy, if it is expected to develop any impaired function;
- occupational therapy (except for vocational rehabilitation or employment counseling), if it is expected to:
  - Develop any impaired function; or
  - Relearn skills to significantly develop the **covered person's** independence in the activities of daily living;
- speech therapy, if it is expected to develop speech function as a result of delayed development; and
- early intensive behavioral interventions such as Applied Behavioral Analysis (ABA). Applied Behavioral Analysis is an educational service that is the process of applying interventions that:
  - systematically change behavior; and
  - are responsible for the observable improvement in behavior.

Speech function is the ability to express thoughts, speak words and form sentences).

Limitations

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

- educational services for Down's Syndrome and Cerebral Palsy, for example, as they are considered both developmental and/or chronic in nature;
- any services which are **covered medical expenses** in whole or in part under any other student plan sponsored by the Policyholder;
- any services unless provided in accordance with a specific treatment plan;
- services provided during a **stay** in a **hospital**, **skilled nursing facility**, **home health agency** or **hospice facility**, except as stated above;
- services not performed by a **physician** or under the direct supervision of a **physician**;
- treatment covered as part of the *Chiropractic Treatment Expense* benefit. This applies whether or not benefits have been paid under the *Chiropractic Treatment Expense* benefit;

- services provided by a **physician** or physical, occupational or speech therapist who resides in the **covered person's** home; or who is a member of the **covered person's** family, or a member of the **covered student's** spouse's family or the **covered student's** domestic partner's family; and
- special education to instruct a person whose speech has been lost or impaired, to function without that ability. This includes lessons in sign language.

The *Schedule of Benefits* shows any **copay**, **deductible**, covered percentage and maximum benefit that may apply to *Short-Term Rehabilitation Services Expense* benefits.

Wherever there is a reference to *Short Term Rehabilitation and Habilitation Therapies Expense* in the Policy, it is hereby changed to *Short Term Rehabilitation Services*.

This amendment makes no other changes to the Policy.

Dan Finke
President

Aetna Life Insurance Company
(A Stock Company)

Amendment: 9
Issue Date: July 2, 2021

Aetna Life Insurance Company

Hartford, Connecticut 06156

Student Accident Insurance

Policy Amendment

Policyholder: **Connecticut State Colleges and Universities: Central, Eastern, Southern and Western - Accident Plan**

Policy No.: [GP-890429][GP-8904033][GP-890434][GP-890435]

Effective Date: This Amendment is effective on the later of:

August 1, 2021; or
The date a person becomes a **covered person** under the Student Accident Policy.

The Student Accident policy noted above has been changed.

The following is a summary of the changes in the Policy. This amendment is effective on the date(s) shown above.

1. The following **Important Notices** have been added to the face page of the Policy:

   IMPORTANT NOTICES:
   - **Notice of Non-Discrimination:**
     Aetna Life Insurance Company does not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation, or health status in the administration of the plan including enrollment and benefit determinations.
   - **Sanctioned Countries:**
     If coverage provided by this policy violates or will violate any economic or trade sanctions, the coverage is immediately considered invalid. For example, Aetna companies cannot make payments for health care or other claims or services if it violates a financial sanction regulation. This includes sanctions related to a blocked person or a country under sanction by the United States, unless permitted under a written Office of Foreign Asset Control (OFAC) license.

     For more information, visit http://www.treasury.gov/resource-center/sanctions/Pages/default.aspx.

2. The ***Definition*** section of the Policy has been revised as follows:

a. The following definition has been added:

Medicare
The health insurance provided by Title XVIII of the Social Security Act, as amended. It includes Health Maintenance Organization (HMO) or similar coverage that is an authorized alternative to Parts A and B of **Medicare.**

b. The definition of **Recognized Charge** has been replaced with the definition below:

Recognized Charge:
The amount of a **non-preferred care provider's** charge that is eligible for coverage. A **covered person** is responsible for all amounts above the **recognized charge**. The **recognized charge** may be less than the **provider's** full charge.

The plan's **recognized charge** applies to all **non-preferred care covered medical expenses** except **non-preferred care emergency care**. It applies even to charges from a **non-preferred care provider** in a **hospital** that is a **preferred care provider**. In all cases, the **recognized charge** is determined based on the Geographic Area where a **covered person** receives the service or supply.

Except as otherwise specified below, the **recognized charge** for each service or supply is the lesser of what the **provider** bills and:

- For professional services and other services or supplies not mentioned below:
  - 105% of the Medicare Allowable Rates.

- For services of **hospitals** and other facilities:
  - 140% of the Medicare Allowable Rates.

- For **prescription drugs**:
  - 100% of the Average Wholesale Price, (AWP).

- For dental expenses, the **recognized charge** for a service or supply is the lesser of:
  - What the **provider** bills or submits for that service or supply; and
  - the 80th percentile of the Prevailing Charge Rates.

The **recognized charge** is the **negotiated charge** for **providers** with whom **Aetna** has a direct contract but are not **preferred care providers** or, if there is no direct contract, with whom **Aetna** has a contract through any third party that is not an affiliate of **Aetna.**

If the ID card displays the National Advantage Program (NAP) logo, the **recognized charge** is the rate **Aetna** has negotiated with the NAP **provider**. The **non-preferred care** cost sharing applies when a **covered person** gets care from NAP **providers**, except for **emergency care**.

A NAP **provider** is a **provider** with whom **Aetna** has a contract through any third party that is not an affiliate of **Aetna** or through the **Coventry National** or **First Health Networks**. However, a NAP **provider** listed in the NAP directory is not a **preferred care provider**.

Aetna has the right to apply **Aetna** reimbursement policies. Those policies may further reduce the **recognized charge**. These policies take into account factors such as:

- The duration and complexity of a service;
- When multiple procedures are billed at the same time, whether additional overhead is required;
- Whether an assistant surgeon is necessary for the service;
- If follow-up care is included;

- Whether other characteristics modify or make a particular service unique;
- When a charge includes more than one claim line, whether any services described by a claim line are part of, or incidental to, the primary service provided; and
- The educational level, licensure, or length of training of the **provider**.

Aetna reimbursement policies are based on **Aetna's** review of:
- The Centers for Medicare and Medicaid Services' (CMS) National Correct Coding Initiative (NCCI) and other external materials that say what billing and coding practices are and are not appropriate;
- Generally accepted standards of medical and dental practice; and
- The views of **physicians** and **dentists** practicing in the relevant clinical areas.

Aetna uses commercial software to administer some of these policies. Some policies are different for professional services than for facility services.

Special Terms Used In This Definition:
As used above, Average Wholesale Price (AWP), Geographic Area, Prevailing Charge Rates, and Medicare Allowable Rates are defined as follows:

Average Wholesale Price (AWP)

This is the current average wholesale price of a **prescription drug** listed in the Facts and Comparisons Medi-span weekly price updates (or any other similar publication chosen by **Aetna**).

Geographic Area
The Geographic area made up of the first three digits of the U.S. Postal Service zip codes. If **Aetna** determines that more data is needed for a particular service or supply, **Aetna** may base rates on a wider Geographic Area such as an entire state.

Medicare Allowable Rates
Except as specified below, these are the rates CMS establishes for services and supplies provided to Medicare enrollees. **Aetna** updates its systems with these revised rates within 180 days of receiving them from CMS. If Medicare does not have a rate, **Aetna** will determine the rate as follows:
- Use the same method CMS uses to set Medicare rates;
- Look at what other **providers** charge;
- Look at how much work it takes to perform a service; and
- Look at other things as needed to decide what rate is reasonable for a particular service or supply.

Exceptions:
- For inpatient services, **Aetna's** Medicare Allowable Rate excludes amounts CMS allocates for Operating Indirect Medical Education (IME) and Direct Graduate Medical Education (DGME). **Aetna's** rate also excludes other payments which CMS may make directly to **hospitals**, and for any retroactive adjustments made by CMS.
- For anesthesia, the Medicare Allowable Rate is 5% greater than the general Medicare Allowable Rate.
- For laboratory, the Medicare Allowable Rate is 20% lower than the general Medicare Allowable Rate.
- For DME, the Medicare Allowable Rate is 5% lower than the general Medicare Allowable Rate.

Prevailing Charge Rates: The percentile value reported in a database prepared by FAIR Health, a nonprofit company. FAIR Health changes these rates periodically. **Aetna** updates its systems with these changes within 180 days after receiving them from FAIR Health. If the FAIR Health database becomes

unavailable, **Aetna** has the right to substitute an alternative database that **Aetna** believes is comparable.

Additional Information:

Get the most value out of the benefits. Use the "Estimate the Cost of Care" tool on Aetna Navigator®. **Aetna**'s secure member website at www.aetna.com may contain additional information which may help a **covered person** to determine the cost of a service or supply. Log on to Aetna Navigator® to access the "Estimate the Cost of Care" feature. Within this feature, view **Aetna's** "Cost of Care" and "Member Payment Estimator" tools.

3. The ***Effective Date of Insurance*** provision in the ***Eligibility and Effective Date of Coverage*** section in the Policy has been revised. The paragraph that applies to adopted children has been replaced with the following paragraph:

   Coverage is provided for a child legally placed for adoption with a **covered student** from the moment of placement; for an initial period of 31 days; provided the child lives in the household of the **covered student;** and is dependent upon the **covered student** for support. Notification of placement of such child and payment of any additional premium; if necessary; is required within 31 days from placement. To continue the insurance beyond this initial 31 day period; the **covered student** must notify Aetna or its agent of the placement of such child; and pay any additional premium required for the child's insurance within the 31 day period. If the **covered student's** coverage ends during the 31 day period after the adopted child's placement, the adopted child's coverage will end on the same day as the **covered student's** coverage. This applies even if the 31 day period has not expired.

4. The ***Eligible Persons*** provision in the ***Eligibility and Effective Date of Coverage*** section in the Policy has been revised to add the following:

   Medicare:
   A person eligible for **Medicare** at the time of enrollment under the Policyholder's plan is not eligible for coverage.

   If a **covered person** becomes eligible for **Medicare** after he or she is enrolled in the Policyholder's plan, such Medicare eligibility will not result in the termination of coverage under the plan.

   As used within this provision, persons are "eligible for **Medicare"** if they are entitled to benefits under Part A (receiving free Part A) or enrolled in Part B or Premium Part A.

This amendment makes no other changes to the Policy.

Dan Finke
President

Aetna Life Insurance Company
(A Stock Company)

Amendment: 10
GR-96134-A1-DefMedVision Pol
ED. 3-15

Aetna Life Insurance Company

Hartford, Connecticut 06156

Student Accident Insurance

Policy Amendment

Policyholder: Connecticut State Colleges and Universities: Central, Eastern, Southern and Western - Accident Plan

Policy No.: [GP-890429][GP-8904033][GP-890434][GP-890435]

Effective Date: This Amendment is effective on the later of:

August 1, 2021; or
The date a person becomes a **covered person** under the Student Accident Policy.

The Student Accident policy noted above has been changed.

The following is a summary of the changes in the Policy. This amendment is effective on the date(s) shown above.

1. The ***Precertification*** provision that applies to the ***Prescribed Medicines Expense Benefit*** in the ***Coverage*** section of the Policy has been revised. The following has been added to the ***Medical Exception*** paragraph:

   "A **covered person**, a **covered person's** designee or a **covered person's prescriber** may seek an expedited medical exception process to obtain coverage for non-covered drugs in exigent circumstances. An "exigent circumstance" exists when a **covered person** is suffering from a health condition that may seriously jeopardize a **covered person's** life, health, or ability to regain maximum function or when a **covered person** is undergoing a current course of treatment using a non-formulary drug.

   The request for an expedited review of an exigent circumstance may be submitted by contacting **Aetna's** *Precertification Department* at 1-855-240-0535, faxing the request to 1-877-269-9916 or submitting the request in writing to:

   CVS Health ATTN: Aetna PA
   1300 E Campbell Road
   Richardson, TX 75081.

   Aetna will make a coverage determination within 24 hours after receipt of the request and will notify the **covered person**, the **covered person's** designee or the **covered person's prescriber** of Aetna's decision."

This amendment makes no other changes to the Policy.

Dan Finke
President

Aetna Life Insurance Company
(A Stock Company)

Amendment: 11
Issue Date: July 2, 2021

Assistive Technology

Persons using assistive technology may not be able to fully access the following information. For assistance, please call the number listed on your ID card at no cost.

Smartphone or Tablet

To view documents from your smartphone or tablet, the free WinZip app is required. It may be available from your App Store.

Non-Discrimination

Aetna complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Aetna does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Aetna:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages

If you need these services, contact our Civil Rights Coordinator.

If you believe that Aetna has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Civil Rights Coordinator, PO Box 14462, Lexington, KY 40512, 1-800-648-7817, TTY 711, Fax 859-425-3379, CRCoordinator@aetna.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company, Coventry Health Care plans and their affiliates.

Language Assistance

TTY: 711

For language assistance in your language call the number listed on your ID card at no cost. (English)

Para obtener asistencia lingüística en español, llame sin cargo al número que figura en su tarjeta de identificación. (Spanish)

欲取得繁體中文語言協助，請撥打您 ID 卡上所列的號碼，無需付費。(Chinese)

Pour une assistance linguistique en français appeler le numéro indiqué sur votre carte d'identité sans frais. (French)

Para sa tulong sa wika na nasa Tagalog, tawagan ang nakalistang numero sa iyong ID card nang walang bayad. (Tagalog)

Benötigen Sie Hilfe oder Informationen auf Deutsch? Rufen Sie kostenlos die auf Ihrer Versicherungskarte aufgeführte Nummer an. (German)

للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني المذكور في بطاقتك التعريفية. (Arabic)

Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo a yo endike nan kat idantifikasyon ou gratis. (French Creole)

Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente il numero riportato sulla Sua scheda identificativa. (Italian)

日本語で援助をご希望の方は、IDカードに記載されている番号まで無料でお電話ください。(Japanese)

한국어로 언어 지원을 받고 싶으시면 보험 ID 카드에 수록된 무료 통화번호로 전화해 주십시오. (Korean)

برای راهنمایی به زبان فارسی، بدون هیچ هزینه ای با شماره ای که بر روی کارت شناسایی شما آمده است تماس بگیرید. انگلیسی (Persian)

Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer podany na karcie ID. (Polish)

Para obter assistência linguística em português ligue para o número grátis listado no seu cartão de identificação. (Portuguese)

Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру, указанному в вашей ID-карте удостоверения личности. (Russian)

Để được hỗ trợ ngôn ngữ bằng (ngôn ngữ), hãy gọi miễn phí đến số được ghi trên thẻ ID của quý vị. (Vietnamese)

Policyholder No. 890429

Blanket Student Accident Insurance Policy

a contract between

Aetna Life Insurance Company
(A Stock Company herein called Aetna)

and

Connecticut State Colleges and Universities: Central, Eastern, Southern and Western - Accident Plan
(Policyholder)

Policy Number:	[GP-890429][GP-8904033][GP-890434][GP-890435]
Date of issue:	July 2, 2021
To Take Effect:	August 1, 2021
Policy delivered in:	Connecticut

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

This Policy takes effect at 12:01 A.M. standard time at the Policyholder's address on August 1, 2021. The **Policy Year** starts on August 1, 2021 and ends at 11:59 P.M. on July 31, 2022.

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

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

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

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

IMPORTANT NOTICE:

Notice of Non-Discrimination:
Aetna Life Insurance Company does not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation, or health status in the administration of the plan including enrollment and benefit determinations.

Dan Finke
President

Aetna Life Insurance Company
(A Stock Company)

Registrar

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

TABLE OF CONTENTS

STUDENT ACCIDENT INSURANCE

SECTION 1 - SCHEDULE OF BENEFITS

ELIGIBILITY

Student

All FT students matriculating in a degree seeking program are eligible to enroll.

Subject to the terms of the Policy, benefits are available for a **covered person** only for the coverage listed below; and only up to the maximum amounts shown. The *Coverage* section contains a complete description of the benefits available.

BENEFITS PAYABLE

After any applicable **deductible**, the Health Expense Benefits payable in a **policy year** are paid at the Covered Percentage which applies to the type of **covered medical expense** which is incurred. Benefits may vary depending upon whether a **preferred care provider** is used. A **preferred care provider** are health care providers who have agreed to provide services or supplies at a "**negotiated charge"**. A **non-preferred care provider** is a health care provider who is reimbursed based upon the "**recognized charge**".

If any expense is covered under one type of **covered medical expense**, it cannot be covered under any other type.

ACCIDENT EXPENSE BENEFITS OUT-OF-POCKET LIMITS		
	Preferred Care	**Non-Preferred Care**
For the **covered student**	N/A	N/A
For the family	N/A	N/A

ACCIDENT EXPENSE BENEFIT AGGREGATE MAXIMUM EXPENSE BENEFITS	
Aggregate Maximum Accident Expense Benefit Limit per **Accident** per policy year**:**	$100,000

DEDUCTIBLES

ACCIDENT EXPENSE BENEFITS OVERALL AGGREGATE DEDUCTIBLES		
	Preferred Care	**Non-Preferred Care**
Aggregate Deductible Amount per **policy year, covered person:***		
For the **covered student**	N/A	N/A
For the dependent	N/A	N/A
For the family	N/A	N/A
***Per visit/per admission **deductibles** do not apply towards satisfying the **policy year deductible**.		

PRECERTIFICATION

Certain services, such as inpatient **stays**, certain tests, procedures, outpatient surgery, therapies, equipment, and outpatient **prescription drugs** require **precertification** by Aetna.

Refer to the **Precertification** provisions in the Coverage section for a complete description of the **precertification** programs including the types of services, treatments, procedures, visits or supplies that require **precertification**.

STUDENT ACCIDENT INSURANCE

SECTION 1 - SCHEDULE OF BENEFITS (Continued)

OTHER THAN PREVENTIVE CARE EXPENSES

COVERAGE	**BENEFIT AMOUNT**	
	Preferred Care	**Non-Preferred Care**
PRE-ADMISSION TESTING EXPENSE		
Covered Percentage	50%	50%
HOSPITAL EXPENSE		
Covered Percentage	100% of **semi-private rate**	80% of **semi-private rate**
Daily **room and board** Intensive Care Covered Percentage	100%	80%
Miscellaneous Hospital Expense Covered Percentage	100%	80%
SURGICAL EXPENSE		
Covered Percentage	100%	80%
Anesthesia Expense Covered Percentage	100%	80%
Assistant Surgeon Expense Covered Percentage	100%	80%
IN-HOSPITAL NON-SURGICAL PHYSICIAN'S FEES EXPENSE		
Covered Percentage	100%	80%
OUTPATIENT EXPENSE		
Therapy Expense		
Covered Percentage	100%	80%
Outpatient Physician or Specialist Office Visit Expense		
Covered Percentage	100%	80%

Emergency Room Visit Expense – * See the Note below		
Covered Percentage	100%	Paid the same as the Preferred Care level of benefits.
***Note:** Please note that as **non-preferred care providers** are not **preferred care providers** and do not have a contract with Aetna, the provider may not accept payment of the **covered person's** cost share (**deductible** and **coinsurance)**, as payment in full. The **covered person** may receive a bill for the difference between the amount billed by the **non-preferred care provider** and the amount paid by this Plan. If the Emergency Room Facility or **physician** bills the **covered person** for an amount above their cost share, the **covered person** is not responsible for paying that amount. Please send Aetna the bill at the address listed on the member ID card and Aetna will resolve any payment dispute with the **non-preferred care provider** over that amount. Make sure the member ID card number is on the bill.		
Hospital Outpatient Department Expense		
Covered Percentage	100%	80%
Walk-In Clinic Visits Expense (Non-Emergency)		
All Other Services		
Covered Percentage	100%	80%
Ambulatory Surgical Expense		
Covered Percentage	100%	80%
Laboratory and X-Ray Expense		
Covered Percentage	100%	80%
Durable Medical and Surgical Equipment Expense		
Covered Percentage	100%	80%
AMBULANCE EXPENSE		
Ground, Air, Water and Non-Emergency Ambulance Covered Percentage	100%	100%
ACCIDENTAL INJURY TO SOUND NATURAL TEETH EXPENSE		
Covered Percentage	100%	100%
CONSULTANT EXPENSE		
Covered Percentage	100%	80%
LICENSED NURSE EXPENSE		
Covered Percentage	100%	80%

SKILLED NURSING FACILITY EXPENSE		
Covered Percentage	100% of **semi-private rate,** except if **intensive care unit** is **medically necessary**	80% of **semi-private rate,** except if **intensive care unit** is **medically necessary**
REHABILITATION FACILITY EXPENSE		
Covered Percentage	100% of **semi-private rate,** except if **intensive care unit** is **medically necessary**	80% of **semi-private rate,** except if **intensive care unit** is **medically necessary**
NON-ELECTIVE - SECOND SURGICAL OPINION EXPENSE		
Covered Percentage	50%	50%
HOME HEALTH CARE EXPENSE		
Covered Percentage	100%	80%
HIGH COST PROCEDURES EXPENSE		
Covered Percentage	100%	80%
PROSTHETIC DEVICES EXPENSE		
Hearing Aid Expenses		
Hearing Aids Covered Percentage Coverage is limited to covered persons through age 26	100%	80%
All Other Prosthetic Devices		
Covered Percentage	100%	80%
PODIATRIC EXPENSE		
Covered Percentage	50%	50%
ACUPUNCTURE IN LIEU OF ANESTHESIA EXPENSE		
Covered Percentage	50%	50%
TRANSFUSION OR KIDNEY DIALYSIS OF BLOOD EXPENSE		
Covered Percentage	50%	50%
URGENT CARE EXPENSE		
Urgent Care from an **Urgent Care Provider** Covered Percentage	100%	80%

SHORT TERM CARDIAC AND PULMONARY REHABILITATION THERAPIES EXPENSE		
Cardiac Rehabilitation Covered Percentage	100%	80%
Pulmonary Rehabilitation Covered Percentage	100%	80%
SHORT TERM REHABILITATION AND HABILITATION THERAPIES EXPENSE		
Outpatient Cognitive, Physical, Occupational and Speech Rehabilitation and Habilitation Therapy Services (combined) Covered Percentage	100%	80%
CHIROPRACTIC TREATMENT EXPENSE		
Chiropractic Treatment Covered Percentage	100%	80%

SECTION 2 - DEFINITIONS

The following words and phrases when used in the Policy shall have, unless the context clearly indicates otherwise, the meaning given to them below. A definition that appears in this section does not necessarily mean that coverage is provided under the Policy for the services, treatments, procedures, visits or supplies described in the definition.

Some definitions that apply only to a specific benefit may appear in the benefit description in the *Coverage* section.

Aetna
Aetna Life Insurance Company, an affiliate, or a third party vendor under contract with **Aetna**.

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

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

Aggregate Maximum:
The maximum benefit that will be paid under the Policy for all Covered Medical Expenses incurred by a covered person that accumulate during the policy year to the next.

Ambulance
A vehicle that is staffed with medical personnel and equipped to transport a sick or injured person.

Average Wholesale Price (**AWP**)
The current average wholesale price of a **prescription drug** listed in the Facts and Comparisons weekly price updates (or any other similar publication designated by **Aetna**) on the day that a **pharmacy** claim is submitted for adjudication.

Ambulatory Surgical Center:
A freestanding ambulatory surgical facility that:

- Meets licensing standards.
- Is set up, equipped and run to provide general surgery.
- Makes charges.
- Is directed by a staff of **physicians**. At least one of them must be on the premises when surgery is performed and during the recovery period.
- Has at least one certified anesthesiologist at the site when surgery which requires general or spinal anesthesia is performed and during the recovery period.
- Extends surgical staff privileges to:
  - physicians who practice surgery in an area **hospital**; and
  - **dentist**s who perform oral surgery.
- Has at least 2 operating rooms and one recovery room.
- Provides, or arranges with a medical facility in the area for, diagnostic x-ray and lab services needed in connection with surgery.

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

Autism Spectrum Disorder
This means Autism Spectrum Disorder as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

Behavioral Health Provider:
This is a licensed organization or professional providing diagnostic, therapeutic or psychological services for behavioral health conditions.

Behavioral Health Provider:
This is a professional that is properly licensed or certified to provide diagnostic and/or therapeutic services for **mental disorders** and **substance abuse** under the laws of the jurisdiction where the individual practices.

Biosimilar Prescription Drug:
A biological **prescription drug** that is highly similar to a U.S. Food and Drug Administration (FDA) – licensed reference biological **prescription drug** notwithstanding minor differences in clinically inactive components, and for which there are no clinically meaningful differences between the highly similar biological **prescription drug** and the reference biological **prescription drug** in terms of the safety, purity, and potency of the drug.

This is defined in accordance with U.S. Food and Drug Administration (FDA) regulations.

Birthing Center:
A freestanding facility that:

- Meets licensing standards.
- Is set up, equipped and run to provide prenatal care, delivery and immediate postpartum care.
- Makes charges.
- Is directed by at least one physician who is a specialist in obstetrics and gynecology.
- Has a **physician** or certified nurse midwife present at all births and during the immediate postpartum period.
- Extends staff privileges to physicians who practice obstetrics and gynecology in an area **hospital.**
- Has at least 2 beds or 2 birthing rooms for use by patients while in labor and during delivery.
- Provides, during labor, delivery and the immediate postpartum period, full-time skilled nursing services directed by a R.N. or certified nurse midwife.
- Provides, or arranges with a facility in the area for, diagnostic X-ray and lab services for the mother and child.
- Has the capacity to administer a local anesthetic and to perform minor surgery. This includes episiotomy and repair of perineal tear.

- Is equipped and has trained staff to handle medical emergencies and provide immediate support measures to sustain life if complications arise during labor and if a child is born with an abnormality which impairs function or threatens life.
- Accepts only patients with low risk pregnancies.
- Has a written agreement with a hospital in the area for emergency transfer of a patient or a child. Written procedures for such a transfer must be displayed and the staff must be aware of them.
- Provides an ongoing quality assurance program. This includes reviews by physicians who do not own or direct the facility.
- Keeps a medical record on each patient and child.

Body Mass Index
A practical marker that is used to assess the degree of obesity and is calculated by dividing the weight in kilograms by the height in meters squared.

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

Coinsurance
Coinsurance is both the percentage of **covered medical expenses** or **covered dental expenses** that the plan pays, and the percentage of **covered medical expenses** or **covered dental expenses** that you pay. The percentage that the plan pays is referred to as "plan **coinsurance**" or the "payment percentage," and varies by the type of expense. Please refer to the *Schedule of Benefits* for specific information on **coinsurance** amounts.

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

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

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

Complications of Pregnancy also include:

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

Convalescent Facility:
This is an institution that:

- Is licensed to provide, and does provide, the following on an inpatient basis for persons convalescing from disease or injury:
  - professional nursing care by a **R.N.**, or by a **L.P.N.** directed by a full-time **R.N.**; and
  - physical restoration services to help patients to meet a goal of self-care in daily living activities.
- Provides 24 hour a day nursing care by licensed nurses directed by a full-time **R.N.**
- Is supervised full-time by a **physician** or **R.N.**
- Keeps a complete medical record on each patient.

- Has a utilization review plan.
- Is not mainly a place for rest, for the aged, for drug addicts, for alcoholics, for mental retardates, for custodial or educational care, or for care of mental disorders.
- Makes charges.

Copay, Copayment:
The specific dollar amount or percentage required to be paid by the **covered person** or on behalf of the **covered person**. The plan includes various **copays**; and these **copay** amounts or percentages; are specified in the *Schedule of Benefits*.

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

Cosmetic:
These are services or supplies that alter, improve or enhance appearance.

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

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

Covered Medical Expense or Covered Expense:
Medical, **prescription drug**, dental, vision or hearing charges for any treatment, service or supply that is:

- Shown as covered under the Policy;
- Not in excess of the **recognized charges**; or
- Not in excess of the charges that would have been made in the absence of this coverage; and
- Incurred while the 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** while coverage under the Policy is in effect.

Covered Student:
A student of the Policyholder who is insured under the Policy. The term "covered student", as used throughout the Policy, shall also mean part-time students, medical school residents, dental school students, post-doctorate students, fellowship recipients, and visiting scholars.

Custodial Care
Services and supplies that are primarily intended to help a person meet personal needs. **Custodial are** can be prescribed by a **physician** or given by trained medical personnel. It may involve artificial methods such as feeding tubes, ventilators or catheters. Examples of **custodial care** include:

- Routine patient care such as changing dressings, periodic turning and positioning in bed, administering oral medications;
- Care of a stable tracheostomy (including intermittent suctioning);
- Care of a stable colostomy/ileostomy;
- Care of stable gastrostomy/jejunostomy/nasogastric tube (intermittent or continuous feedings);

- Care of a stable indwelling bladder catheter (including emptying/changing containers and clamping tubing);
- Watching or protecting you;
- **Respite care**, adult (or child) day care, or convalescent care;
- Institutional care, including **room and board** for rest cures, adult day care and convalescent care or where the patient has reached the maximum level of physical or mental function and such person is not likely to make further significant improvement;
- Help with the daily living activities, such as walking, grooming, bathing, dressing, getting in or out of bed, toileting, eating or preparing foods;
- Any services that a person without medical or paramedical training could be trained to perform;
- Any service that can be performed by a person without any medical or paramedical training.

Dental Consultant:
A **dentist** who has agreed to provide consulting services in connection with the *Dental Expense* benefit.

Dental Provider:
This is any **dentist**; group; organization; dental facility; or other institution; or person legally qualified to furnish dental services or supplies.

Dental Emergency
Any dental condition that:

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

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

Detoxification
The process by which an alcohol- or drug-intoxicated, or alcohol- or drug-dependent, person is assisted through the period of time necessary to eliminate, by metabolic or other means, the:

- Intoxicating alcohol or drug;
- Alcohol- or drug-dependent factors; or
- Alcohol in combination with drugs;

as determined by a **physician**. The process must keep the physiological risk to the patient at a minimum and, if it takes place in a facility, the facility must meet any applicable licensing standards established by the jurisdiction in which it is located.

Durable Medical and Surgical Equipment:
This means not more than one item of equipment for the same or similar purpose, and the accessories needed to operate it, that is:

- Made to withstand prolonged use;
- Made for and mainly used in the treatment of a disease or **injury;**
- Suited for use in the home;

- Not normally of use to person's who do not have a disease or **injury;**
- Not for use in altering air quality or temperature;
- Not for exercise or training.

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

Elective Treatment:
Services and supplies provided where there is no evidence of pathology, dysfunction, or **sickness** in any part of the body. **Elective treatment** includes; but is not limited to:

- Vasectomy;
- Breast reduction;
- Sexual reassignment surgery;
- Submucous resection and/or other surgical correction for deviated nasal septum, other than necessary treatment of covered acute purulent sinusitis;
- Treatment for weight reduction;
- Learning disabilities (except **Autism Spectrum Disorders**);
- Temporomandibular joint dysfunction (TMJ); and
- Treatment of **infertility**.

Elective treatment does not include services and supplies that are covered as *Preventive Care* benefits in the *Coverage* section of the Policy.

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

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

Emergency Care
This means the treatment given in a **hospital's** emergency room to evaluate, stabilize and treat an **emergency medical condition**.

Emergency Condition:
This is any traumatic injury or condition which:

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

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

- Placing the person's health in serious jeopardy; or
- Serious impairment to bodily function; or
- Serious dysfunction of a body part or organ; or
- In the case of a pregnant woman; serious jeopardy to the health of the fetus.

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
- Approval required by the U.S. Food and Drug Administration (FDA) 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 or investigational**, or for research purposes; or
- It is a type of drug, device, treatment, or procedure that is the subject of a Phase I or Phase II clinical trial or the experimental or research arm of a Phase III clinical trial, using the definition of "phases" indicated in regulations and other official actions and publications of the FDA and Department of Health and Human Services; 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 or investigational**, or for research purposes.

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

Home Health Agency or Home Health Care Agency:
This is

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

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

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

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

Homebound
This means that a **covered person** is confined in their place of residence:

- Due to a **sickness** or **injury** which makes leaving the residence medically contraindicated; or
- Because the act of transport would be a serious risk to the **covered person's** life or health.

Situations where a **covered person** would not be considered **homebound** include (but are not limited to) the following:

- A **covered person** does not often travel from their place of residence because of feebleness or insecurity brought on by advanced age (or otherwise); or
- A **covered person** is wheelchair bound but could safely be transported via wheelchair accessible transportation.

Hospice or Hospice Care
This is care given to a **terminally ill** person by or under arrangements with a **hospice care agency**. The care must be part of a **hospice care program**.

Hospice Care Agency
An agency or organization that meets all of the following requirements:

- Has **hospice care** available 24 hours a day.
- Meets any licensing or certification standards established by the jurisdiction where it is located.
- Provides:
  - **Skilled nursing services**;
  - Medical social services; and
  - Psychological and dietary counseling.
- Provides, or arranges for, other services which include:
  - **Physician** services;
  - Physical and occupational therapy;
  - Part-time home health aide services which mainly consist of caring for **terminally ill** people; and
  - Inpatient care in a facility when needed for pain control and acute and chronic symptom management.
- Has at least the following personnel:
  - One **physician**;
  - One **R.N.**; and
  - One licensed or certified social worker employed by the agency.
- Establishes policies about how **hospice care** is provided;

- Assesses the patient's medical and social needs;
- Develops a **hospice care program** to meet those needs;
- Provides an ongoing quality assurance program. This includes reviews by **physicians**, other than those who own or direct the agency;
- Permits all area medical personnel to utilize its services for their patients;
- Keeps a medical record on each patient;
- Uses volunteers trained in providing services for non-medical needs;
- Has a full-time administrator.

Hospice Care Program
This is a written plan of **hospice care**, which:
- Is established by and reviewed from time to time by a **physician** attending the person, and appropriate personnel of a **hospice care agency**;
- Is designed to provide palliative and supportive care to **terminally ill** persons, and supportive care to their families; and
- Includes an assessment of the person's medical and social needs; and a description of the care to be given to meet those needs.

Hospice Facility
A facility or distinct part of one that meets all of the following requirements:

- Mainly provides inpatient **hospice care** to **terminally ill** persons;
- Charges patients for its services;
- Meets any licensing or certification standards established by the jurisdiction where it is located;
- Keeps a medical record on each patient;
- Provides an ongoing quality assurance program including reviews by **physician**s other than those who own or direct the facility;
- Is run by a staff of **physician**s. At least one staff **physician** must be on call at all times;
- Provides 24-hour-a-day nursing services under the direction of an **R.N.**;
- Has a full-time administrator.

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

Hospital:
This is an institution that:

- Is primarily engaged in providing, on its premises, inpatient medical, surgical and diagnostic services;
- Is supervised by a staff of **physician**s;
- Provides twenty-four (24) hour-a-day **R.N.** service;
- Charges patients for its services;
- Is operating in accordance with the laws of the jurisdiction in which it is located; and
- Does not meet all of the requirements above, but does meet the requirements of the jurisdiction in which it operates for licensing as a **hospital** and is accredited as a **hospital** by the Joint Commission on the Accreditation of Healthcare Organizations.

In no event does **hospital** include a convalescent nursing home or any institution or part of one which is used principally as a convalescent facility, rest facility, nursing facility, facility for the aged, **psychiatric hospital, residential treatment facility** for **substance abuse** or **mental disorders,** extended care facility, intermediate care facility, **skilled nursing facility**, **hospice**, rehabilitative **hospital** or facility primarily for rehabilitative or **custodial care** services.

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

Infertility or Infertile
This is a disease defined by the failure to conceive a pregnancy after 12 months or more of timed intercourse or egg-sperm contact for women under age 35 (or 6 months for women age 35 or older).

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

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

Institute of Excellence (IOE)
A **hospital** or other facility that has contracted with **Aetna** to furnish services or supplies to an **IOE** patient in connection with specific transplants, procedures at a **negotiated charge**. A facility is an **IOE** facility only for those types of transplants or procedures for which it has signed a contract.

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

Intensive Outpatient Program (IOP)
This is a program of at least 2 hours per day and at least six hours per week of clinical treatment provided in a facility or program for treatment of a **mental disorder** or **substance abuse** issue provided under the direction of a **physician.** Services may include group, individual, family or multi-family group psychotherapy, psycho educational services, and adjunctive services such as medication monitoring.

L.P.N.
A licensed practical or vocational nurse.

Jaw Joint Disorder:
This is:

- A Temporomandibular Joint (TMJ) dysfunction or any similar disorder of the jaw joint; or
- A Myofacial Pain Dysfunction (MPD); or
- Any similar disorder in the relationship between the jaw joint and the related muscles and nerves.

Mail Order Pharmacy:
This is an establishment where **prescription drugs** are legally dispensed by mail.

Medically Necessary, Medical Necessity
Health care or dental services, and supplies or **prescription drug**s that a **physician**, other health care provider or **dental provider**, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an **sickness** or **injury** or its symptoms, and that provision of the service, supply or **prescription drug** is:

- In accordance with generally accepted standards of medical or dental practice;
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's **sickness** or **injury**;
- Not primarily for the convenience of the patient, **physician,** or **other health care** or **dental provider;** and
- Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's **sickness** or **injury**.

For these purposes "generally accepted standards of medical or dental practice" means standards that are based on credible scientific evidence published in peer-reviewed literature generally recognized by the relevant medical or dental community, or otherwise consistent with **physician** or dental specialty society recommendations and the views of **physicians** or **dentist**s practicing in relevant clinical areas and any other relevant factors.

Medically Necessary or Medical Necessity
These are health care services that **Aetna** determines that a **provider,** exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating **sickness, injury**, disease or its symptoms, and that **Aetna** determines are:

- In accordance with generally accepted standards of medical practice;
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's **sickness, injury** or disease;
- Not primarily for the convenience of the patient, **physician**, or other health care **provider**; and
- Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's **sickness, injury** or disease.

Generally accepted standards of medical practice means:

- Standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community; and
- Consistent with the standards set forth in policy issues involving clinical judgment.

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

Member Dental Provider:
This is any **dental provider** who has entered in to a written agreement to provide to **covered students** the dental care described under the *Dental Expense Benefit*.

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

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

Mental Disorder
This is a **sickness** commonly understood to be a **mental disorder**, whether or not it has a physiological basis, and for which treatment is generally provided by or under the direction of a **behavioral health provider** such as a **psychiatrist**, a psychologist or a psychiatric social worker. Mental Disorders includes **substance abuse** related disorders.

Morbid Obesity
This means a **body mass index** that is: greater than 40 kilograms per meter squared; or equal to or greater than 35 kilograms per meter squared with a comorbid medical condition, including: hypertension; a cardiopulmonary condition; sleep apnea; or diabetes. **Body mass index** is a practical marker that is used to assess the degree of obesity and is calculated by dividing the weight in kilograms by the height in meters squared.

Negotiated Charge:
As to health care coverage, other than Prescribed Medicine Expense coverage:
The maximum charge a **preferred care provider** has agreed to make as to any service or supply for the purpose of the benefits under the Policy.

As to Prescribed Medicine Expense coverage:
The negotiated charge is the amount Aetna has established for each **prescription drug** obtained from a **preferred pharmacy** under the Policy. This negotiated charge may reflect amounts **Aetna** has agreed to pay directly to the **preferred pharmacy** or to a third party vendor for the **prescription drug**, and may include an additional service or risk charge set by Aetna.

The negotiated charge does not include or reflect any amount Aetna, an affiliate, or a third party vendor, may receive under a rebate arrangement between Aetna, an affiliate or a third party vendor and a drug manufacturer for any **prescription drug**, including **prescription drugs** on the **medication formulary**.

Based on its overall drug purchasing, Aetna may receive rebates from the manufacturers of **prescription drugs** and may receive or pay additional amounts from or to third parties underprice guarantees. These amounts will not change the negotiated charge under the Policy.

Network Provider
A health care provider, **pharmacy,** or **dental provider** who has contracted to furnish services or supplies for a **negotiated charge**; but only if the provider is, with **Aetna**'s consent, included in www.docfind.com as a **network provider** for:

- The service or supply involved; and
- The class of employees to which the **covered person** belongs.

Network Service(s) or Supply(ies)
Health care service or supply that is furnished by a **network provider.**

Non-Member Dental Provider:
A **dental provider** who has not entered into a written agreement with Aetna to provide *Dental Expense* benefits to **covered students**.

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

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

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

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

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

- arise out of (or in the course of) any work for pay or profit; or
- result in any way from an **injury** which does.

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

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

Non-Preferred Care Provider:

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

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

Non-Preferred Drug:
This is a **prescription drug** that does not appear on the **preferred drug list**. This includes **prescription drugs** on the **preferred drug exclusions list** that are approved by medical exception.

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

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

Orthodontic Treatment:
This is any

- Medical service or supply; or
- Dental service or supply;

furnished to prevent or to diagnose or to correct a misalignment:

- Of the teeth; or
- Of the bite; or
- Of the jaws or jaw joint relationship;

whether or not for the purpose of relieving pain.

Not included is:

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

Out-of-Network Service(s) and Supply(ies)
Health care service or supply that is furnished by an **out-of network provider**

Out-of-Network Provider
A health care provider, **pharmacy,** or **dental provider** who has not contracted with **Aetna** to furnish services or supplies at a **negotiated charge**.

Out-of-Pocket Limit
The amount that must be paid by the **covered student** or the **covered student** before **covered medical expenses** will be payable at 100% for the remainder of the **policy year**.

Partial Hospitalization Treatment
This is a plan of medical, psychiatric, nursing, counseling, or therapeutic services to treat **mental disorders** and **substance abuse**.

The plan must meet these tests:

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

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

Physician:
This is a duly licensed member of a medical profession who:

- Has an M.D. or D.O. degree;
- Is properly licensed or certified to provide medical care under the laws of the jurisdiction where the individual practices; and
- Provides medical services which are within the scope of his or her license or certificate.

This also includes a health professional who:

- Is properly licensed or certified to provide medical care under the laws of the jurisdiction where he or she practices;
- Provides medical services which are within the scope of his or her license or certificate;
- Under applicable insurance law, is considered a "**physician**" for purposes of this coverage;
- Has the medical training and clinical expertise suitable to treat the **covered person's** condition;
- Specializes in psychiatry, if your **sickness** or **injury** is caused, to any extent, by **substance abuse** or a **mental disorder**;
- A **physician** is not the **covered person** or related to a **covered person**.

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

Precertification, Precertify, Precertified
A process where Aetna is contacted before certain services are provided, such as **hospitalization** or outpatient services, or **prescription drugs** are prescribed to determine whether the services being recommended or the drugs prescribed are considered **covered medical expenses** under the plan. It is not a guarantee that benefits will be payable if, for example, it is determined at the time the claim is submitted that the **covered person** was not eligible for benefits at that time.

Preferred Care:
This is care provided by

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

Preferred Care Provider:
This is 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 www.docfind.com as a **preferred care provider** for:

- The service or supply involved; and
- The class of **covered persons** of which you are member.

Preferred Drug:
This is a **prescription drug** that appears on the **preferred drug list**.

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

Preferred Drug List:
This is a listing of **prescription drugs** established by Aetna or an affiliate. This list is subject to periodic review and modification by Aetna. A copy of the **preferred drug list** will be available upon the **covered person's** request or may be accessed on the Aetna website at www.aetna.com/formulary.

As used on the preferred drug list:
Tier 1A
This is a group of medications determined by Aetna that may be available at a reduced **copayment/coinsurance** and are noted on the preferred drug list.

Tier 1B
This is a group of medications determined by Aetna that may be available at a reduced **copayment/coinsurance** and are noted on the preferred drug list.

Preferred Pharmacy:
This a **pharmacy**; including a **mail order pharmacy**; which is party to a contract with **Aetna**, an affiliate, or a third party vendor, to dispense drugs to persons covered under the Policy; but only while:

- The contract remains in effect; and
- Such a **pharmacy** dispenses a **prescription drug;** under the terms of its contract with **Aetna**, an affiliate, or a third party vendor.

Preferred Prescription Drug Expense:
This is an expense incurred for a **prescription drug** that:

- Is dispensed by a **Preferred Pharmacy**; or for an **emergency medical condition** only; by a **non-preferred pharmacy**; and
- Is dispensed upon the **Prescription** of a **Prescriber** who is:
  - a **Preferred Care Provider**; or
  - a **Non-Preferred Care Provider**; but only for an **emergency condition;** or on referral of a person's **Primary Care Physician**; or
  - a **dentist** who is a **Non-Preferred Care Provider**; but only one who is not of a type that falls into one or more of the categories of providers listed in the www.docfind.com as **preferred care providers**.

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

Prescription:
*As to **prescription drugs**:*
A written order for the dispensing of a **prescription drug** by a **prescriber**. If it is a verbal order, it must promptly be put in writing by the **pharmacy**.

As to vision care:
A written order for the dispensing of **prescription** lenses or **prescription** contact lenses by an ophthalmologist or optometrist.

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

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

- Selected by a **covered person** from the list of **primary care physicians** in www.docfind.com;
- Responsible for the **covered person's** on-going health care; and
- Shown on Aetna's records as the **covered person's primary care physician**.

For purposes of this definition, a **primary care physician** also includes the **School Health Services**.

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

Psychiatric Hospital
This is an institution that meets all of the following requirements.

- Mainly provides a program for the diagnosis, evaluation, and treatment of **substance abuse** or **mental disorders**;
- Is not mainly a school or a custodial, recreational or training institution;
- Provides infirmary-level medical services. Also, it provides, or arranges with a **hospital** in the area for, any other medical service that may be required;
- Is supervised full-time by a **psychiatrist** who is responsible for patient care and is there regularly;
- Is staffed by **psychiatrists** involved in care and treatment;
- Has a **psychiatrist** present during the whole treatment day;
- Provides, at all times, psychiatric social work and nursing services;
- Provides, at all times, **skilled nursing services** by licensed nurses who are supervised by a full-time **R.N.**;
- Prepares and maintains a written plan of treatment for each patient based on medical, psychological and social needs. The plan must be supervised by a **psychiatrist**;
- Makes charges;
- Meets licensing standards.

Psychiatrist
This is a **physician** who:

- Specializes in psychiatry; or
- Has the training or experience to do the required evaluation and treatment of **substance abuse** or **mental disorders**.

R.N.
A registered nurse.

Recognized Charge
The **covered medical expense** is only the part of a charge which is the **recognized charge**.

As to medical, vision and hearing expenses, the **recognized charge** for each service or supply is the lesser of:
- What the provider bills or submits for that service or supply; and

- for professional services and other services or supplies not mentioned below:
  - 105% of the Medicare Allowable Rate;
  for the Geographic Area where the service is furnished.

- for inpatient charges of hospitals and other facilities:
  - 140% of the Medicare Allowable Rate;
  for the Geographic Area where the service is furnished.

- for outpatient charges of hospitals and other facilities:
  - 140% of the Medicare Allowable Rate;
  for the Geographic Area where the service is furnished.

As to **prescription drug** expenses, the **recognized charge** for each service or supply is the lesser of:
- What the provider bills or submits for that service or supply; and

- 100% of the **Average Wholesale Price** (**AWP**) or other similar resource. **Average Wholesale Price** (**AWP**) is the current average wholesale price of a **prescription drug** listed in the Medispan weekly price updates (or any other similar publication chosen by Aetna).

As to dental expenses, the **recognized charge** for a service or supply is the lesser of:
- What the provider bills or submits for that service or supply; and

- the 80th percentile of the Prevailing Charge Rate;
for the Geographic Area where the service is furnished.

Referral
This is an oral, written or electronic authorization made by your **physician** or **School Health Services** to direct you to a **preferred care provider, or non-preferred care provider** for **medically necessary** services or supplies.

Residential Treatment Facility (Mental Disorders)
This is an institution that must:

- Be accredited by one of the following agencies, commissions or committees for the services being provided: The Joint Commission (TJC), Committee on Accreditation of Rehabilitation Facilities (CARF), American Osteopathic Association's Healthcare Facilities Accreditation Program (HFAP) or the Council on Accreditation (COA); or is credentialed by Aetna;
- Meet all applicable licensing standards established by the jurisdiction in which it is located;
- Perform a comprehensive patient assessment preferably before admission, but at least upon admission;
- Create individualized active treatment plans directed toward the alleviation of the impairment that caused the admission;
- Have the ability to involve family/support systems in the therapeutic process;
- Have the level of skilled intervention and provision of care must be consistent with the patient's **sickness** and risk;
- Provide access to psychiatric care by a **psychiatrist** as **medically necessary** for the provision of such care;
- Provide treatment services that are managed by a **behavioral health provider** who functions under the direction/supervision of a medical director; and
- Not be a Wilderness Treatment Program or any such related or similar program, school and/or education service.

In addition to the above requirements, for residential treatment programs treating **mental disorders**:

- A **behavioral health provider** must be actively on duty 24 hours per day for 7 days a week;
- The patient must be treated by a **psychiatrist** at least once per week; and
- The medical director must be a **psychiatrist**.

Residential Treatment Facility (Substance Abuse)
This is an institution that must:

- Be accredited by one of the following agencies, commissions or committees for the services being provided: The Joint Commission (TJC), Committee on Accreditation of Rehabilitation Facilities (CARF), American Osteopathic Association's Healthcare Facilities Accreditation Program (HFAP), or the Council on Accreditation (COA); or is credentialed by **Aetna**;
- Meet all applicable licensing standards established by the jurisdiction in which it is located;
- Perform a comprehensive patient assessment preferably before admission, but at least upon admission;
- Create individualized active treatment plans directed toward the alleviation of the impairment that caused the admission;
- Have the ability to involve family and/or support systems in the therapeutic process;
- Have the level of skilled intervention and provision of care that is consistent with the patient's **sickness** and risk;
- Provide access to psychiatric care by a **psychiatrist** as **medically necessary** for the provision of such care;
- Provide treatment services that are managed by a **behavioral health provider** who functions under the direction/supervision of a medical director; and
- Not be a Wilderness Treatment Program or any such related or similar program, school and/or education service.

In addition to the above requirements, for chemical dependence residential treatment programs:

- A **behavioral health provider** or an appropriately state certified professional (CADC, CAC, etc.), must be actively on duty during the day and evening therapeutic programming; and
- The medical director must be a **physician** who is an addiction **specialist**.

In addition to the above requirements, for Chemical Dependence Detoxification Programs within a residential setting:

- An **R**.**N**. must be onsite 24 hours per day for 7 days a week; and
- The care must be provided under the direct supervision of a **physician**.

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

Retail pharmacy
A community **pharmacy** which has contracted with **Aetna**, an affiliate, or a third party vendor, to provide covered outpatient **prescription drugs** to **covered persons**.

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

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

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

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

Service Area:
The geographic area; as determined by **Aetna;** in which the **preferred care providers** are located.

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

Skilled Nursing Facility:
This is an institution that meets all of the following requirements:

- It is licensed to provide, and does provide, the following on an inpatient basis for persons convalescing from **sickness** or **injury**:
  - Professional 24-hour nursing care by a n **R.N.,** or by an **L.P.N.**, directed by a full-time **R.N.**; and
  - Physical restoration services to help patients to meet a goal of self-care in daily living activities.
- Is supervised full-time by a **physician** or **R.N.** ;
- Keeps a complete medical record on each patient;
- Has a utilization review plan;
- Is not mainly a place for rest, for the aged, for custodial care, educational care, or for treatment of **mental disorders** or **substance abuse**;
- Charges patients for its services;
- An institution or a distinct part of an institution that meets all of the following requirements:
  - It is licensed or approved under state or local law;
  - Is primarily engaged in providing **skilled nursing services** for residents who require medical or nursing care, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons.
- Qualifies as a **skilled nursing facility** under Medicare or as an institution accredited by:
  - The Joint Commission on Accreditation of Health Care Organizations;
  - The Bureau of Hospitals of the American Osteopathic Association; or
  - The Commission on the Accreditation of Rehabilitative Facilities.

Skilled nursing facility does not include:

- Institutions which provide only:
  - Minimal care;
  - **Custodial care** services;
  - Ambulatory services; or
  - Part-time care services.
- Institutions which primarily provide for the care and treatment of **substance abuse** and **mental disorders**.

Skilled Nursing Services
Services that meet all of the following requirements:

- The services require medical or paramedical training;
- The services are rendered by an **R.N.** or **L.P.N.** within the scope of his or her license; and
- The services are not **custodial care**.

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

Specialist
This is a **physician** who:

- Practices in any generally accepted medical, dental or surgical sub-specialty; and
- Is providing other than routine care.

Specialist Dentist
Any **dentist** who; by virtue of advanced training is board eligible or certified by a Specialty Board as being qualified to practice in a special field of dentistry.

Specialty Care
Health care services or supplies that require the services of a **specialist**.

Specialty Care Drugs:
These are **prescription drugs** including self- **injectable drugs**, infusion drugs, and oral drugs prescribed to address complex, chronic diseases with associated co-morbidities such as:

- Cancer;
- Rheumatoid arthritis;
- Hemophilia;
- Multiple sclerosis; and
- Human immunodeficiency virus infection;

which are listed in the **specialty care drug** list. **Specialty care drugs** also include **biosimilar prescription drugs**.A **covered person** can access the list of these **specialty care drugs** by calling the toll-free Member Services number on the back of the ID card or by logging onto the Aetna Navigator® secure member website at www.Aetna.com.

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

Stay:
This is a full-time inpatient confinement for which a **room and board** charge is made.

Substance Abuse
Any use of alcohol and/or drugs which produces a pattern of pathological use causing impairment in social or occupational functioning or which produces physiological dependency evidenced by physical tolerance or withdrawal. This is defined on Axis I in the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association which is current as of the date services are rendered to a **covered person**.

Surgery or Surgical Procedure
The diagnosis and treatment of **injury**, deformity and **sickness** by manual and instrumental means, such as cutting, abrading, suturing, destruction, ablation, removal, lasering, introduction of a catheter (e.g., heart or bladder catheterization) or scope (e.g., colonoscopy or other types of endoscopy), correction of fracture, reduction of dislocation, application of plaster casts, injection into a joint, injection of sclerosing solution, or otherwise physically changing body tissues and organs.

Surgery Center:
This is a free standing ambulatory surgical facility that:

- Meets licensing standards.
- Is set up, equipped and run to provide general surgery.
- Makes charges.
- Is directed by a staff of **physicians**. At least one of them must be on the premises when surgery is performed and during the recovery period.

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

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

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

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

Surgical Procedure:
This is a:

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

Therapeutic Drug Class:
A group of drugs or medications that have a similar or identical mode of action or exhibit similar or identical outcomes for the treatment of an **injury** or **sickness**.

Terminal Illness or Terminally Ill
This means a medical prognosis of 6 months or less to live.

Totally Disabled:
This means that due to **sickness** or **injury**;

- The **covered student** is not able to engage in most normal activities of a healthy person of the same age and gender.

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

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

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

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

Urgent Care Provider:
This is:

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

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

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

Walk-in clinics are an alternative to a **physician's** office visit for treatment of:

- Unscheduled, non-emergency **sickness** and **injuries;**
- The administration of certain immunizations; and
- Individual screening and counseling services.

STUDENT ACCIDENT INSURANCE

SECTION 3 - ELIGIBILITY, EFFECTIVE DATE OF INDIVIDUAL COVERAGE

Eligible Persons

Students: All classes of students are eligible except:

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

A student is eligible only for the coverage shown in the *Schedule of Benefits* which applies to his or her class.

Students must actively attend classes for at least the first 31 days after the date when coverage becomes effective. Home study; correspondence; Internet classes and television (TV) courses; do not fulfill the eligibility requirements that the student actively attend classes. If Aetna discovers that this eligibility requirement has not been met; its only obligation is to refund premium; less any claims paid.

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

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

Newborns are automatically covered for 61 days after birth. To continue the insurance beyond this initial 61 day period when there is a premium increase, the **covered student** must notify Aetna; or its agent; of the birth; and pay the additional premium required for the child's insurance within the 61 day period. If the **covered student's** coverage ends during this 61 day period after the newborn's birth, the newborn's coverage will end on the same day as the **covered studen**t**'s** coverage. This applies even if the 61 day period has not expired.

Late Enrollment

If an application and premium payment for insurance are made more than 31 days following the date the Eligible Person become eligible; then his or her insurance will become effective only if and when Aetna gives its written consent or, if such enrollment occurs during a late enrollment period established by the Plan Sponsor; or, if such enrollment occurs due to the loss of prior comparable coverage; for any reason.

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

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

SECTION 4 - TERMINATION OF COVERAGE, EXTENSION OF BENEFITS

TERMINATION OF STUDENT COVERAGE

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

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

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

EXTENSION OF BENEFITS

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

When Extension of Benefits End

Extension of benefits (other than Basic benefits) will end on the first to occur of the date:

- The **covered student** is no longer **totally disabled,** or becomes covered under any other plan with like benefits.
- The maximum number of months' extension noted above has been reached.
- The **covered person's** Maximum Benefit, if any, is reached.

(This does not apply if coverage ceased because the benefit section ceased for the **covered person's** eligible class.)

SECTION 5 - GENERAL PROVISIONS

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

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

PREMIUMS DUE - EXPERIENCE RATING. The premium due under this Policy on any premium due date will be the sum of the premium charges for the coverages then provided under this Policy.

If premiums are payable monthly; any insurance becoming effective will be charged for from the first day of the Policy month on or right after the date the insurance takes effect. Premium charges for insurance which terminates will cease as of the first day of the Policy month on or right after the date the insurance terminates. If premiums are payable less often than monthly; premium charges or credits for a fraction of a premium-paying period will be made on a pro rata basis; for the number of Policy months between the date premium charges start or cease; and the end of the premium-paying period. If this Policy is changed to provide more coverage to take effect on a date other than the first day of a premium-paying period; a pro rata premium for the coverage will be due and payable on that date. It will cover the period then starting and ending right before the start of the next premium-paying period.

Aetna may change premium charges due to experience or a change in factors bearing on the risk assumed. Each change shall be made by written notice to the Policyholder by Aetna; or its agent.

No experience reduction or increase in premium rates shall become effective less than 12 months after the effective date of the policy. As used in this section; "policy" shall be deemed to include any policy previously issued by Aetna that has been replaced in whole or in part by this Policy.

The premium charges for any coverage under this Policy may be refigured as of any premium due date, only: By reason of a change in factors bearing on the risk assumed. This must be requested by Aetna.

Once during any continuous 12 month period. The Policyholder must request this. Advance notice of 60 days must be given to Aetna.

They will be refigured using:

- the ages of the covered students;
- the amounts of insurance in force;
- the premium rates; and
- any other pertinent factors.

All facts will be taken as of the date of the refiguring.

At the end of a Policy Year; Aetna may declare an experience credit. The amount of each credit Aetna declares will be returned to the Policyholder. Upon request by the Policyholder; part or all of it will be applied against the payment of premiums or in any other manner as may be agreed to by the Policyholder and Aetna.

If the sum of student contributions which have been made for group insurance exceeds the sum of premiums which have been paid for group insurance (after giving effect to any experience credits), the excess will be applied by the Policyholder for the sole benefit of students. Aetna will not have to see to the use of such excess.

Aetna will not have to refund any premium for a period prior to:
The first day of the Policy Year in which Aetna receives proof that the refund should be made; or
The date 3 months before Aetna receives proof, if this produces a larger refund.

This applies even if the premium was paid in error.

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

RENEWAL OF POLICY. With Aetna’s consent; this Policy may be renewed for like periods by payment of the renewal premium at the premium rate in effect at that time. This renewal premium must be paid within the grace period.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

REIMBURSEMENT AND SUBROGATION. When a **covered person**'s **injury** appears to be someone else's fault, benefits otherwise payable under this Policy for **Covered Medical Expenses** incurred as a result of that **injury** will not be paid unless the **covered person** or his legal representative agrees:

(a) to repay Aetna for such benefits to the extent they are for losses for which compensation is paid to the **covered person** by or on behalf of the person at fault as allowed by any Connecticut law or regulation;

(b) to allow Aetna a lien on such compensation and to hold such compensation in trust for Aetna; and

(c) to execute and give to Aetna any instruments needed to secure the rights under (a) and (b).

Further, when Aetna has paid benefits to or on behalf of the injured **covered person**, Aetna will be subrogated to all rights or recovery that the **covered person** has against the person at fault. These subrogation rights will extend only to recovery of the amount Aetna has paid. The **covered person** must execute and deliver any instruments needed and do whatever else is necessary to secure those rights to Aetna.

RIGHT OF RECOVERY PROVISION

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

As used in this section; 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.

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

Aetna has the right to terminate this Policy only under the following conditions:

- Non-payment of premium.
- Fraud or misrepresentation of a material fact under the terms of the coverage.
- Aetna ceases to offer student blanket health insurance coverage subject to the terms of any Connecticut law or regulation and in line with HIPAA notification requirements.

Aetna will notify the Connecticut Insurance Department as well as all policyholders no later than 90 days before the date that Aetna no longer offers Student Blanket Coverage in Connecticut.

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

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

If:

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

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

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

APPEAL PROCEDURE: Aetna has established a procedure for resolving complaints by **covered persons**. If a **covered person** has a complaint, he or she must follow this procedure:

- An Appeal is defined as a written request for review of a decision which has been denied in whole or in part, after consideration of any relevant information, such as a request for a claim payment, certification, or eligibility, etc. The Aetna address is on your Identification Card.
- An Appeal must be submitted within 60 days of the date Aetna provides notice of denial.
- An acknowledgement letter will be sent to the **covered person** within 5 days of Aetna's receipt of the Appeal. This letter may request additional information. If so, the additional information must be submitted to Aetna within 15 days of the date of the letter.
- The **covered person** will be sent a response within 30 days of Aetna's receipt of the Appeal. The response will be based on the information provided with or subsequent to the Appeal.
- If the Appeal concerns an eligibility issue, and if additional information is not submitted to Aetna after receipt of Aetna's response, the decision is considered Aetna's final response 60 days after receipt of the Appeal. For all other Appeals, if additional information is to be submitted to Aetna after receipt of Aetna's response, it must be submitted within 15 days of the date of Aetna's response letter.
- Aetna's final response will be sent within 30 days from the date of Aetna's first response letter.
- If additional time is needed to resolve the Appeal, Aetna will provide a written notification indicating that additional time is needed, explaining why such time is needed and setting a new date for a response. The additional time shall not be extended beyond another 30 days.
- In an emergency situation involving admission to or services from an acute care **hospital**, if the **covered person's physician** or the **hospital** determines that the **covered person** faces a life-threatening or other serious **injury** situation, they may submit a written request for an expedited review. A response shall be given to the provider within 3 hours of Aetna's receipt of the request and all necessary information. If a response is not provided within this timeframe the request is considered approved.
- In all other urgent or emergency situations, the Appeal procedure may be initiated by a telephone call. A verbal response to the telephone call shall be given to the provider within 2 business days, provided that all necessary information is available. Written notice of the decision will be sent within 2 business days of Aetna's verbal response. If the **covered person** is dissatisfied with Aetna's response, the Appeal procedure outlined above may be utilized. The Aetna's telephone number is on the **covered person's** Identification Card.
- Aetna will keep the records of any complaint for three years.

If, after completing the Appeal procedure outlined above, the **covered person's physician** or the **hospital** are still dissatisfied with Aetna's response, the **covered person** may appeal the decision to the Connecticut Insurance Department. This must be done within 30 days of receipt of Aetna's final response.

RESCISSION OF COVERAGE. Aetna may rescind the covered person's coverage if the covered person, or the person seeking coverage on the covered person's behalf:

- Performs an act, practice or omission that constitutes fraud; or
- Makes an intentional misrepresentation of material fact.

The covered person will be given 30 days advance written notice of any rescission of coverage.

As to medical. pediatric dental, pediatric vision care, and prescription drug coverage only, the covered person has the right to an internal appeal with Aetna and/or the right to a third party review conducted by an independent External Review Organization if the covered person's coverage under this Policy is rescinded retroactive to its Effective Date.

STUDENT ACCIDENT INSURANCE PROVISIONS CONCERNING

SECTION 6 - COVERAGE

PRECERTIFICATION

Understanding Precertification

Certain services, such as inpatient **stays**, certain tests, procedures, **outpatient surgery, therapies and equipment,** and prescribed medications require **precertification** by Aetna. **Precertification** is a process that helps the **covered person** and their **physician** determine whether the services being recommended are **covered medical expenses** under the plan. It also allows Aetna to help the **covered person's** provider coordinate the **covered person's** transition from an inpatient setting to an outpatient setting (called discharge planning), and to register the **covered person** for specialized programs or case management when appropriate.

Precertification is not the same requirement as a plan's *Referral Requirement*. A plan's referral requirement and process is separate from the plan's **precertification** requirement and process. Refer to the *Schedule of Benefits* for the plan's *Referral Requirement*. The plan's *Referral Requirement* must be followed in addition to the plan **precertification** process.

The **covered person** does need to **precertify** services provided by a **non-preferred care provider.**

Preferred care providers will be responsible for obtaining necessary **precertification** for the **covered person**. Since **precertification** is the provider's responsibility, there is no additional out-of-pocket cost to the **covered person** as a result of a **preferred care provider's** failure to **precertify** services.

When a **covered person** goes to a **non-preferred care provider** it is the **covered person's** responsibility to obtain **precertification** from Aetna for any services, treatments, procedures, visits or supplies on the **precertification** list below. If the **covered person** does not **precertify**, *benefits may be reduced*. The list of services requiring **precertification** appears later in this section.

If the **covered person's** outpatient **hospice care** has been **precertified**, and the **covered person** subsequently requires a **hospital stay** for pain control or acute symptom management, that **hospital** stay does not have to be **precertified**.

Important Information:
Please read the following sections in their entirety for important information on the precertification process, and any impact it may have on a covered person's coverage.

The Precertification Process

Prior to being hospitalized or receiving certain other medical services, treatments, procedures, visits or supplies there are certain **precertification** procedures that must be followed.

The **covered person** is responsible for obtaining **precertification** for services, treatments, procedures, visits or supplies provided by a **non-preferred care provider**. The **covered person** or a member of their family, a **hospital** staff member, or the attending **physician**, must notify Aetna to **precertify** the admission or medical services, treatments, procedures, visits or supplies prior to receiving any of the services, treatments, procedures, visits or supplies that require **precertification** pursuant to the Policy in accordance with the following timelines:

Precertification should be secured within the timeframes specified below. To obtain **precertification**, call Aetna at the telephone number listed on the **covered person's** ID card. This call must be made as follows:

Your Precertification Telephone Call to Aetna	
For non-emergency admissions:	It is the **covered person's** responsibility to call and request **precertification** at least 15 days before the date they are scheduled to be admitted.
For an **emergency admission**:	The **covered person**, their **physician** or the facility must call within 24 hours or as soon as reasonably possible after the **covered person** has been admitted.
For an **urgent admission**:	The **covered person**, their **physician** or the facility will need to call before the **covered person** is scheduled to be admitted. An urgent admission is a **hospital** admission by a **physician** due to the onset of or change in a **sickness**; the diagnosis of a **sickness**; or an **injury**.
For outpatient non-emergency medical services requiring **precertification**,	The **covered person** or their **physician** must call at least 15 days before the outpatient services, treatments, procedures, visits or supplies are provided or scheduled.
For prenatal care and delivery	As soon as possible after the attending **physician** confirms pregnancy and again within 24 hours of the birth or as soon thereafter as possible. No penalty will be applied for the first 48 hours after delivery for a routine delivery and 96 hours for a cesarean delivery.

Aetna will provide a written notification to the **covered person** and their **physician** of the **precertification** decision**,** where required under applicable State law. If the **covered person**'s **precertified** services, treatments, procedures, visits or supplies are approved**,** the approval is valid for 30 days as long as the **covered person** remains enrolled in the plan**.** Premium that is due and unpaid at the time the **precertified** services, treatments, procedures, visits or supplies are performed must be paid in full within the required timeframe.

When a **covered person** has an inpatient admission to a facility, Aetna will notify the **covered person**, their **physician** and the facility about their **precertified** length of **stay**. If the **covered person's physician** recommends that their **stay** be extended, additional days will need to be certified. The **covered person**, their **physician**, or the facility will need to call Aetna at the number on the **covered person**'s ID card as soon as reasonably possible, but no later than the final authorized day. Aetna will review and process the request for an extended **stay**. The **covered person** and their **physician** will receive a notification of an approval or denial.

If **precertification** determines that the **stay,** services, treatments, procedures, visits or supplies are not **covered medical expenses**, the notification will explain why and how Aetna's decision can be appealed. The **covered person** or their provider may request a review of the **precertification** decision pursuant to the *Appeals Procedure, Exhaustion of Process and External Review* section.

If the **covered person's physician** recommends that their **precertified**, in-patient or out-patient services, treatments, procedures, visits, or supplies be extended beyond what has been originally approved, additional services, treatments, procedures, visits or supplies will need to be **precertified**. The **covered person**, their **physician**, or the facility (in the case of an admission) will need to call Aetna at the number on the **covered person's** ID card as soon as reasonably possible, but no later than the final authorized day or service. Aetna will

review and process the request for an extended **stay or service**. The **covered person** and their **physician** will receive a notification of an approval or denial.

If **precertification** determines that the **stay,** services, treatments, procedures, visits, or supplies are not **covered medical expenses**, the notification will explain why and how Aetna's decision can be appealed. The **covered person** or their provider may request a review of the **precertification** decision pursuant to the *Appeals Procedure, Exhaustion of Process and External Review* section.

Services and Supplies Which Require Precertification

Precertification is required for the following types of **stays,** services, treatments, procedures, visits or supplies:

Inpatient and Outpatient Care
• Ambulance (Emergency transportation by airplane) • Ambulance (Non-emergency transportation) • Autologous chondrocyte implantation, Carticel® • Bariatric surgery (Bariatric surgery is not covered under the Policy unless specifically described in the Policy.) • BRCA genetic testing • Cardiac rhythm implantable devices • Chiropractic treatment • Clinical Trials • Cochlear device and/or implantation • Cognitive skills development • Complex imaging (high cost procedures) • Dental implants and oral appliances • Drugs and medical injectables* • Dorsal column (lumbar) neurostimulators: trial or implantation • Durable Medical and Surgical Equipment (DME). • Electric or motorized wheelchairs and scooters • Gastrointestinal (GI) tract imaging through capsule endoscopy • Gender reassignment (sex change) surgery • Home health care related services (ie. private duty nursing, maternity management home care and home uterine activity monitoring) • Home hemodialysis and home peritoneal dialysis equipment and medical supplies • Home hospice care • Hyperbaric oxygen therapy • Infertility treatment (Comprehensive and ART infertility treatment is not covered under the plan unless specifically described in the Policy.) • Injectables (immunoglobulins, growth hormones, Multiple Sclerosis medications, Osteoporosis medications, Botox, Hepatitis C medications)

- Inpatient Confinements (surgical and non-surgical; **hospital**, **skilled nursing facility**, **rehabilitation facility**, **residential treatment facility** for **mental disorders** and **substance abuse**, **hospice** care.
- Inpatient **Mental disorders** treatment
- Inpatient **Substance abuse** treatment
- Kidney Dialysis visits
- Knee surgery
- Limb Prosthetics
- **Non-Preferred Care** freestanding ambulatory surgical facility services when referred by a **Preferred Care Provider**.
- Occupational therapy (outpatient)
- Oncotype DX
- Orthognatic surgery procedures, bone grafts, osteotomies and surgical management of the temporomandibular joint
- Osseointegrated implant
- Osteochondral allograft/knee
- Outpatient back surgery not performed in a **physician's** office
- Physical therapy (outpatient)
- Pre-implantation genetic testing
- Pediatric congenital heart surgery
- Proton beam radiotherapy
- Radiation oncology
- Radiology imaging
- Reconstructive or other procedures that may be considered **cosmetic. Cosmetic** services and supplies are not covered under the plan unless specifically described in the Policy.
- Referral or use of **Non-Preferred Care Providers** for non-emergency services, unless the covered person understands and consents to the use of a **Non-Preferred Care Provider** under their under **Non-Preferred Care** benefits when available in their plan
- Services as directed by "School Student Health Center" in the event the Policyholder becomes a "medical home" or Aetna is asked to support clinical review of a campus health outbreak (i.e. meningitis, H1N1, etc.)
- Sleep studies
- Special programs (i.e. Beginning Right® maternity program)
- Spinal procedures
- Transplant services
- Uvulopalatopharyngoplasty, including laser-assisted procedures
- Ventricular assist devices

- Wrist surgery

For a current listing of the drugs and medical **injectables that require **precertification**, contact Member Services by logging onto the **Aetna** website at www. aetna.com or calling the toll-free number on the back of the ID card.*

How Failure to Precertify Affects The Covered Person's Benefits

A **precertification** benefit reduction or penalty will be applied to the benefits paid if the **covered person** fails to obtain a required **precertification** prior to incurring **covered medical expenses** from a **non-preferred care provider**. This means Aetna *will reduce the amount paid towards the* **covered person**'s *coverage.*

The **covered person** is responsible for obtaining the necessary **precertification** from Aetna prior to receiving services, treatments, procedures, visits or supplies from a **non-preferred care provider**. The **covered person**'s provider may **precertify** their services, treatments, procedures, visits or supplies; however the **covered person** should verify with Aetna prior to the services, treatments, procedures, visits or supplies, that the provider has obtained **precertification** from Aetna. If the **covered person's** services, treatments, procedures, visits or supplies is not **precertified** by the **covered person** or their provider, *the benefit payable may be significantly reduced .*

How The Covered Person's Hospital Inpatient Benefits Are Affected

If the **covered person's stay** has not been recommended by their **non-preferred care provide**r, *their benefits may be reduced* if the necessary **precertification** is not obtained, as illustrated in the chart below.

If **precertification** is:	and Aetna determines that the **stay**, or any day of the **stay** is:	then **room and board** expenses are:	and all other inpatient facility expenses are:
requested and approved	approved,	covered;	covered.
requested and denied	denied	not covered; may be appealed	covered not covered, may be appealed.
not requested	but would have been approved if requested,	covered after a penalty is applied*;	covered.
not requested	would have been denied if requested,	not covered; may be appealed	covered, after a penalty is applied*.

How The Covered Person's Benefits for Inpatient and Outpatient Services, Treatments, Procedures, Visits or Supplies are Affected

The chart below illustrates the effect on the **covered person's** benefits if necessary **precertification** for inpatient and outpatient services, treatments, procedures, visits or supplies is not obtained.

If **precertification** is:	then the expenses are:
• requested and approved by Aetna	• covered.
• requested and denied	• not covered, may be appealed.
• not requested, but would have been covered if requested	• covered after a **precertification** benefit reduction or penalty is applied.*
• not requested, would not have been covered if requested.	• not covered, may be appealed.

It is important to remember that any additional out-of-pocket expenses incurred because the **covered person's precertification** requirement was not met will not count toward the **covered person's deductible**, **coinsurance** or **out of pocket limit**.

*Refer to the *Schedule of Benefits* for the amount of **precertification** benefit reduction or penalty that applies to the **covered person's** plan.

PRECERTIFICATION (continued)

Prescribed Medicines Expense

Understanding Precertification for Certain Outpatient Prescription Drugs

Precertification is required for certain outpatient **prescription drugs**. **Prescribers** must contact Aetna or an affiliate to request and obtain coverage for such **prescription drugs**. The list of drugs requiring precertification is subject to periodic review and modification by Aetna. An updated copy of the list of drugs requiring precertification shall be available upon request or may be accessed on line and can be found in the Aetna **preferred drug list** available online at www.aetna.com/formulary.

Failure to **precertify** will result in a penalty (see the *Schedule of Benefits*). The **covered person** must contact the **prescriber** or pharmacist if the drug being considered requires **precertification**.

How to Obtain Precertification

If an outpatient **prescription drug** requires **precertification** and the **covered person** uses a **preferred pharmacy** the **prescriber** is required to obtain **precertification** for the **covered person**.

When a **covered person** uses a **non-preferred pharmacy**, the **covered person** can begin the **precertification** process by having the **prescriber** call Aetna at the number on their ID card. Aetna will let the **prescriber** know if the **prescription drug** is **precertified**. If **precertification** is denied Aetna will notify the **covered person** how the decision can be appealed.

MEDICAL EXPENSE BENEFITS

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

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

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

The *Schedule of Benefits* shows the **deductible;** covered percentages; and maximum benefits that apply to **covered medical expenses** described in this Section.

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

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

Covered medical expense incurred for services and supplies:

(a) must be **medically necessary**;
(b) must be prescribed or ordered by the attending **physician, dental provider** or vision professional;

All Accident Expense Benefits are subject to all of the terms of the Policy.

Proof must be received that the **covered medical expenses** were solely the result of an **injury** sustained by the **covered person**. The first such expense must be incurred within 30 days after the date of the **accident** causing the **injury**. Aetna will pay for **covered medical expenses**, which are the direct result of the **accident**, and from no other cause and up to the **aggregate maximum** benefit shown on the *Schedule of Benefits*.

PRE-ADMISSION TESTING EXPENSE

Covered medical expenses include charges incurred by a **covered person** for pre-admission testing charges made by a **hospital**, **surgery center**, licensed diagnostic lab facility, or **physician**, in its own behalf, to test a person while an outpatient before scheduled surgery if:

- The tests are related to the scheduled surgery;
- The tests are done within the 7 days prior to the scheduled surgery;

- The person undergoes the scheduled surgery in a **hospital** or **surgery center**; this does not apply if the tests show that surgery should not be done because of his physical condition;
- The charge for the surgery is a **covered medical expense** under this Plan;
- The tests are done while the person is not confined as an inpatient in a **hospital**;
- The charges for the tests would have been covered if the person was confined as an inpatient in a **hospital**;
- The test results appear in the person's medical record kept by the **hospital** or **surgery center** where the surgery is to be done; and
- The tests are not repeated in or by the **hospital** or **surgery center** where the surgery is done.

If the person cancels the scheduled surgery, benefits are paid at the cost-sharing that applies to *Laboratory and X-Ray Expense* benefits.

The *Schedule of Benefits* shows any **copay**, **deductible**, covered percentage and maximum benefit that may apply to the *Pre-Admission Testing Expense* benefit.

HOSPITAL EXPENSE

Hospital Room and Board Expense

Covered medical expenses include charges incurred by a **covered person** for the period of confinement as an inpatient; including: expense for an **intensive care unit**; and for a **birthing center** for treatment in connection with pregnancy. However, the covered **room and board** expense does not include any charge in excess of the daily **room and board** maximum.

Miscellaneous Hospital Expense

Miscellaneous **hospital** expense include, but are not limited to, expenses incurred during a **hospital confinement** for:

- Anesthesia and operating room;
- Laboratory tests and X-rays;
- Oxygen tent; and
- Drugs; medicines; dressings.

The *Schedule of Benefits* shows any **copay**, **deductible**, covered percentage, and maximum benefit that may apply to the *Hospital Expense* benefit.

SURGICAL EXPENSE

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

The *Schedule of Benefits* shows any **copay**, **deductible**, covered percentage and maximum benefit that may apply to *Surgical Expense* benefits.

If the **physician** performs both the **surgical procedure** and the anesthesia service, benefits for the anesthesia service will be reduced by 50%.

When surgery is performed in the outpatient department of a **hospital**, **covered medical expenses** include **hospital** services provided within 24 hours of the covered surgical procedure.

Anesthetic Expense
If, in connection with such operation, the **covered person** requires the services of an anesthetist who is not employed or retained by the **hospital** in which the operation is performed, the expenses incurred will be **covered medical expenses**.

Assistant Surgeon Expense
If, in connection with such operation, the **covered person** requires the services of an assistant surgeon, the expenses incurred will be **covered medical expenses**.

IN-HOSPITAL NON-SURGICAL PHYSICIAN'S EXPENSE

Covered medical expenses include hospital charges incurred by a **covered person** who is confined as an inpatient in a **hospital** for a surgical procedure for the services of a **physician** who is not the **physician** who may have performed surgery on the **covered person.**

The *Schedule of Benefits* shows any **copay, deductible,** covered percentage, and maximum benefit that may apply to the *In-Hospital Non-Surgical Physician's Expense* benefit.

Therapy Expense

Covered medical expenses also include, but are not limited to, expenses incurred by a **covered person** for:

- Chemotherapy, including anti-nausea drugs used in conjunction with the chemotherapy;
- Radiation therapy;
- Tests and procedures; and
- Expenses incurred at a radiological facility.

Covered medical expenses also include expenses for the administration of chemotherapy and visits by a health care professional to administer the chemotherapy.

The *Schedule of Benefits* shows any **copay, deductible,** covered percentage and maximum benefit that may apply to these benefits under the *Therapy Expense* benefit.

Outpatient Physician or Specialist Office Visit Expense

C**overed medical expenses** include the charges made by the **physician** or **specialist** if a **covered person** requires the services of a **physician** or **specialist** in the **physician**'**s** or **specialist's** office while not confined as an inpatient in a **hospital**.

The *Schedule of Benefits* shows any **copay, deductible,** covered percentage and maximum benefit that may apply to these benefits under the *Outpatient Physician or Specialist Office Expense* benefit.

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

Emergency Room Visit Expense

Covered medical expenses incurred by a **covered person** for services received in the emergency room of a **hospital** while the **covered person** is not a full-time inpatient of the **hospital.** The treatment received must be **emergency care** for an **emergency medical condition**. There is no coverage for **elective treatment**, routine care or care for a non-emergency **sickness**.

As to **emergency care** incurred for the treatment of an **emergency medical condition** or psychiatric condition, any **referral** requirement will not apply and any expenses incurred for **non-preferred care** will be paid at the same cost-sharing level as if they had been incurred for **preferred care**.

The **emergency care** benefit covers:

- Use of emergency room facilities;
- Emergency room staff **physicians** services;
- **Hospital** nursing staff services; and
- Staff radiologists and pathologists services.

Covered persons must contact their **physician** after receiving treatment for an **emergency medical condition**.

The *Schedule of Benefits* shows any **copay, deductible,** covered percentage and maximum benefit that may apply to these benefits under the *Outpatient Expense* benefit.

Hospital Outpatient Department Expense

Covered medical expenses include charges incurred by a **covered person** for the use of:

- Diagnostic X-ray and laboratory services;
- Consultants or specialists; or
- An operating room, if charges are incurred in a **hospital** outpatient department**.**

The *Schedule of Benefits* shows any **copay, deductible,** covered percentage and maximum benefit that may apply to these benefits under the *Outpatient Expense* benefit.

Walk-In Clinic Visits Expense

Covered medical expenses include charges made by **preferred care,** and **non-preferred care providers** that are **walk-in clinics** for:

- Unscheduled, non-emergency **sicknesses** and **injuries**;
- The administration of certain immunizations administered within the scope of the clinic's license; and
- Individual screening and counseling services to aid a **covered person**:
  - To stop the use of tobacco products;
  - In weight reduction due to obesity and/or a healthy diet;
  - In stress management.

  The stress management counseling sessions will:

  - Help a **covered person** to identify the life events which cause the **covered person** stress (the physical and mental strain on a **covered person's** body.); and
  - Teach a **covered person** techniques and changes in behavior to reduce the stress.

The *Schedule of Benefits* shows any **copay, deductible,** covered percentage and maximum benefit that may apply to these benefits under the *Walk-In Clinical Visits Expense* benefit.

Limitations:
Unless specified above, not covered under this benefit are charges incurred for services and supplies furnished in a group setting for screening and counseling services.

Important Information:
- **Not all services are available at all walk-in clinics. The types of services offered will vary by the provider and location of the clinic.**
- **For a complete description of the screening and counseling services provided on the use of tobacco products and to aid in weight reduction due to obesity, refer to the *Preventive Care Benefits* section and the *Screening and Counseling Services* benefit for a description of these services.**
- **These services may also be obtained from a covered person's physician.**

Ambulatory Surgical Expense

Covered medical expenses include expenses incurred by a **covered person** for outpatient surgery performed in an **ambulatory surgical center. Covered medical expenses** must be incurred on the day of the surgery or within 24-96 hours after the surgery.

The *Schedule of Benefits* shows any **copay, deductible,** covered percentage and maximum benefit that may apply to these benefits under the *Ambulatory Surgical Expense* benefit.

Laboratory, X-Ray Visits

Covered medical expenses include charges incurred by a **covered person** for:

- Diagnostic X-rays;
- Laboratory services

incurred on an outpatient basis.

The *Schedule of Benefits* shows any **copay, deductible,** covered percentage and maximum benefit that may apply to these benefits under the *Laboratory and X-ray Visits Expense* benefit.

Durable Medical and Surgical Equipment Expense

Benefits are payable for **covered medical expenses** incurred by a **covered person** as a result of renting **durable medical and surgical equipment**. In lieu of rental, the following may be covered:

- The initial purchase of such equipment if Aetna is shown that long term care is planned, and that such equipment either cannot be rented or is likely to cost less to purchase than to rent;
- Repair of purchased equipment;
- Replacement of purchased equipment if Aetna is shown that it is needed due to a change in the person's physical condition, or it is likely to cost less to purchase a replacement than to repair existing equipment or to rent like equipment; or
- The purchase of orthopedic appliances and braces or non-dental prosthetic devices to replace natural body parts.

Durable medical and surgical equipment would include:

- Artificial arms and legs, including accessories;
- Leg braces, including attached shoes (but not corrective shoes);
- Arm braces;
- Back braces;
- Neck braces;
- Surgical supports;
- Scalp hair prostheses required as the result of hair loss due to **injury**, **sickness**, or treatment of **sickness**; and
- Head halters.

Coverage for such items includes the fitting; adjustment; and repair of such devices.
All equipment and supplies must be prescribed by a **physician.**

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

Aetna reserves the right to limit the payment of charges up to the most cost efficient and least restrictive level of service or item which can be safely and effectively provided. The decision to rent or purchase is at the discretion of **Aetna**.

The plan limits coverage to one item of equipment, for the same or similar purpose and the accessories needed to operate the item. A **covered person** is responsible for the entire cost of any additional pieces of the same or similar equipment the **covered person** purchases or rents for personal convenience or mobility.

The *Schedule of Benefits* shows any **copay, deductible,** covered percentage and maximum benefit that may apply to these benefits under the *Durable Medical and Surgical Equipment Expense* benefit.

AMBULANCE EXPENSE

Covered medical expenses include charges made by a professional **ambulance** as follows:

Ground Ambulance
Covered medical expenses include charges for transportation:

- To the first **hospital** where treatment is given in a medical emergency;
- From one **hospital** to another **hospital** in a medical emergency when the first **hospital** does not have the required services or facilities to treat the **covered person's** condition;
- From **hospital** to home or to another facility when other means of transportation would be considered unsafe due to the **covered person's** medical condition;
- From home to **hospital** for covered inpatient or outpatient treatment when other means of transportation would be considered unsafe due to the **covered person's** medical condition. Transport is limited to 200 miles; and
- During a covered inpatient **stay** at a **hospital**, **skilled nursing facility** or acute rehabilitation **hospital**, to transport a **covered person** for inpatient or outpatient **medically necessary** treatment when an **ambulance** is required to safely and adequately transport the **covered person**.

Air or Water Ambulance
Covered medical expenses include charges for transportation to a **hospital** by air or water **ambulance** when:

- Ground **ambulance** transportation is not available and the **covered person's** condition is unstable, requires medical supervision and rapid transport; and
- Transportation from one **hospital** to another **hospital** in a medical emergency when the first **hospital** does not have the required services or facilities to treat the **covered person** when the **covered person's** condition is unstable, requires medical supervision and rapid transport.

The *Schedule of Benefits* shows any **copay**, **deductible**, covered percentage, and maximum benefit that may apply to the *Ambulance Expense* benefit.

ACCIDENTAL INJURY TO SOUND NATURAL TEETH EXPENSE

Covered medical expenses include charges incurred by a **covered person** for services of a **dentist** or dental surgeon as a result of an **injury** to **sound natural teeth.**

The *Schedule of Benefits* shows any **copay**, **deductible**, covered percentage, and maximum benefit that may apply to the *Accidental Injury to Sound Natural Teeth Expense* benefit.

CONSULTANT EXPENSE

Covered medical expenses include the charges incurred by **covered person** in connection with the services of a consultant The services must be requested by the attending **physician** to confirm or determine a diagnosis.

Coverage may be extended to include treatment by the consultant.

The *Schedule of Benefits* shows any **copay**, **deductible**, covered percentage and maximum benefit that may apply to the *Consultant Expense* benefit.

LICENSED NURSE EXPENSE

Covered medical expenses include charges incurred by a **covered person** who is confined in a **hospital** as a resident bed-patient and requires the services of a registered nurse or licensed practical nurse.

The *Schedule of Benefits* shows any **copay**, **deductible**, covered percentage and maximum benefit that may apply to **covered medical expenses** for the *Licensed Nurse Expense* benefit.

Not more than the Daily Maximum Benefit per shift as shown in the *Schedule of Benefits* will be paid. For purposes of determining this maximum, a shift means 8 consecutive hours.

REHABILITATION FACILITY EXPENSES

Covered medical expenses include charges incurred by a **covered person** for confinement as a full time inpatient in a rehabilitation facility. Confinement in the rehabilitation facility must follow within 24-48 hours of, and be for the same or related cause(s) as; a period of **hospital** or **skilled nursing facility** confinement. Not more than the maximum days of confinement will be covered.

Covered medical expenses will not include any charge in excess of the rehabilitation facility's daily **room and board** maximum for semi-private accommodations or expenses for confinement in excess of the maximum number of days of confinement.

The *Schedule of Benefits* shows any **copay**, **deductible**, coinsurance percentage, and maximum benefit that may apply to **covered medical expenses** for the *Rehabilitation Facility Expense* benefit.

NON-ELECTIVE SURGICAL - SECOND OPINION EXPENSE

Covered medical expenses include charges incurred for a second opinion consultation by a **specialist** on the need for non-elective **surgery** which has been recommended by the **covered person's physician**. The **specialist** must be board certified in the medical field relating to the surgical procedure being proposed. Coverage will also be provided for any expenses incurred for required X-rays and diagnostic tests done in connection with that consultation. Aetna must receive a written report on the second opinion consultation.

The Policy will also provide coverage for charges made for a third surgical opinion. This will be done when the second one does not confirm the recommendation of the first **physician** who proposed to perform the surgery.

The *Schedule of Benefits* shows any **copay**, **deductible**, coinsurance percentage, and maximum benefit that may apply to **covered medical expenses** for the *Non-Elective Surgical - Second Opinion Expense* benefit.

HOME HEALTH CARE EXPENSE

Covered medical expenses include charges incurred by a **covered person** for **home health care** services made by a **home health agency** pursuant to a **home health care plan**; but only if all of the following conditions are met:

(a) The services are furnished by, or under arrangements made by; a licensed **home health agency**.
(b) The services are given under a home care plan. This plan must be established pursuant to the written order of a **physician**, and the **physician** must renew that plan every 60 days. Such **physician** must certify that the proper treatment of the condition would require inpatient confinement in a **hospital** or **skilled nursing facility** if the services and supplies were not provided under the **home health care plan,** or in the case of a terminal patient with less than 6 months left to live. The **physician** must examine the **covered person** at least once a month.
(c) Except as specifically provided in the **home health care** services, the services are delivered in the patient's place of residence on a part-time; intermittent visiting basis while the patient is confined.
(d) The care starts within 7 days after discharge from a **hospital** as an inpatient, however this condition does not apply if the **covered person** has been diagnosed with a terminal illness..
(e) The care is for the same condition that caused the **hospital confinement** or for a condition related to it.

Home Health Care Services

Home health care services include:

(1) Part-time or intermittent nursing care by: a registered nurse (R.N.), a licensed Practical nurse (L.P.N.), or under the supervision of an **R.N.** if the services of an R.N. are not available. These services need to be provided during intermittent visits of four hours or less, subject to the visit maximums shown in the *Schedule of Benefits*. Intermittent visits are considered periodic and recurring visits that skilled nurses made to ensure the **covered person**'s proper care, which means they are not on site for more than four hours at a time.

(2) Part time or intermittent **home health aide** services; that consist primarily of care of a medical or therapeutic nature by other than an **R.N**. These services need to be provided during intermittent visits of four hours or less, subject to the visit maximums shown in the *Schedule of Benefits*.

(3) Physical, occupational speech or respiratory therapy.

(4) Medical supplies, drugs and medicines, and laboratory services. However, these items are covered only to the extent they would be covered if the patient was confined to a **hospital**.

(5) Medical social services by licensed or trained social workers.

(6) Nutritional counseling.

(7) Skilled behavioral health care services provided in the home by a **behavioral health provider** when ordered by a **physician** and directly related to an active treatment plan of care established by the **physician**. All of the following must be met:
- The skilled behavioral health care is appropriate for the active treatment of a condition, **sickness** or disease to avoid placing the **covered person** at risk for serious complications.
- The services are in lieu of a continued confinement in a **hospital** or **residential treatment facility**, or receiving outpatient services outside of the home.
- The **covered person** is homebound because of **sickness** or **injury**.
- The services provided are not primarily for comfort or convenience or custodial in nature.
- The services are intermittent or hourly in nature.
- The services are not for Applied Behavior Analysis.

Benefits for home health care visits are payable up to the home health care maximum. Each visit by a nurse, **behavioral health provider**, or therapist is one visit.

In figuring the **policy year** maximum visits, each visit of a:

- nurse or therapist, of up to 4 hours, is one visit and
- **behavioral health provider,** of up to 1 hour, is one visit.

This maximum will not apply to care given by an **R.N.** or **L.P.N.** when:

- Care is provided within 7 days of discharge from a **hospital** or **skilled nursing facility** as a full-time inpatient; and
- Care is needed to transition from the **hospital** or **skilled nursing facility** to home care.

When the above criteria are met, **covered medical expenses** include up to 12 hours of continuous care by an **R.N.** or **L.P.N.** per day.

Whether or not someone is available to give care does not determine whether the services are covered for home health care. The absence of a person to perform a non-skilled or **custodial care** service does not cause the service to become covered. If the **covered person** is a minor or an adult who is dependent upon others for non-skilled care (e.g., bathing, eating, toileting), home health care services will only be covered during times when:

- there is a family member or caregiver present in the home, and
- the family member or caregiver can meet the **covered person's** non-skilled needs.

Important Information:

- **This plan covers home short-term physical, speech, or occupational therapy when the above home health care criteria are met. The *Short Term Rehabilitation Services Expense* benefits lists the conditions and limitations for certain services.**
- **The plan does *not* cover custodial care, even if care is provided by a nursing professional and family member or other caretakers cannot provide the necessary care.**

Limitations:
Covered medical expenses will not include:

- Services by a person who resides in the **covered person's** home, or is a member of the **covered person's** immediate family
- Homemaker or housekeeper services;
- Maintenance therapy;
- Dialysis treatment;
- Purchase or rental of dialysis equipment;
- Food or home delivered services; or
- **Custodial care**.

The *Schedule of Benefits* shows any **copay**, **deductible**, coinsurance percentage, and maximum benefit that may apply to *Home Health Care Expense* benefits.

HIGH COST PROCEDURES EXPENSE

Covered medical expenses include charges incurred by a **covered person** as a result of certain high cost procedures provided on an outpatient basis. Such expenses may be incurred in the following:

(a) A **physician's** office;
(b) **Hospital** outpatient department; or emergency room;
(c) Clinical laboratory; or
(d) Radiological facility, or other similar facility; which meets any licensed or certification standards established by the jurisdiction where it is located.

Covered medical expenses for high cost procedures include; but are not limited to; charges for the following procedures and services:

- Computerized Axial Tomography (C.A.T.) scans;
- Magnetic Resonance Imaging (MRI);
- Positron Emission Tomography (PET) Scans;

The *Schedule of Benefits* shows any **copay, deductible**, covered percentage and maximum benefit that may apply to *High Cost Procedures Expense* benefit**.**

PROSTHETIC DEVICES EXPENSE

Covered medical expenses include charges made for internal and external prosthetic devices and special appliances, if the device or appliance improves or restores body part function that has been lost or damaged by **sickness, injury** or congenital defect. **Covered medical expenses** also include instruction and incidental supplies needed to use a covered prosthetic device.

The plan covers the first prosthesis a **covered person** need s that temporarily or permanently replaces all or part of an body part lost or impaired as a result of **sickness** or **injury** or congenital defects as described in the list of covered devices below for an:

- Internal body part or organ; or
- External body part.

Covered medical expenses also include replacement of a prosthetic device if:

- The replacement is needed because of a change in the **covered person's** physical condition; or normal growth or wear and tear; or
- It is likely to cost less to buy a new one than to repair the existing one; or
- The existing one cannot be made serviceable.

The list of covered devices includes, but is not limited to:

- An artificial arm, leg, hip, knee or eye;
- Eye lens;
- An external breast prosthesis and the first bra made solely for use with it after a mastectomy;
- A breast implant after a mastectomy;
- Ostomy supplies, urinary catheters and external urinary collection devices;
- Speech generating device;
- Orthopedic shoes; foot orthotics; or other devices to support the feet but only when required for the treatment of, or to prevent complications of, diabetes;
- A cardiac pacemaker and pacemaker defibrillators; and
- A durable brace that is custom made for and fitted for the **covered person**.

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

- Eye exams;
- Eyeglasses;
- Vision aids;
- Cochlear implants;
- Hearing aids;
- Communication aids; and
- Orthopedic shoes; foot orthotics; or other devices to support the feet unless required for the treatment of, or to prevent complications of, diabetes.

Hearing Aid Expenses
Covered medical expenses for hearing care includes charges for hearing exams, prescribed hearing aids and hearing aid expenses as described below. This benefit is subject to an age limit as shown on the *Schedule of Benefits*

Hearing aid means:

- Any wearable, non-disposable instrument or device designed to aid or compensate for impaired human hearing; and
- Parts, attachments or accessories.

Covered medical expenses include the following:

- Charges for an audiometric hearing exam and evaluation for a hearing aid prescription performed by:
  - a **physician** certified as an otolaryngologist or otologist; or
  - an audiologist who (1) is legally qualified in audiology; or (2) holds a certificate of Clinical Competence in Audiology from the American Speech and Hearing Association in the absence of any licensing requirements; and who performs the exam at the written direction of a legally qualified otolaryngologist or otologist.
- Charges for electronic hearing aids, installed in accordance with a **prescription** written during a covered hearing exam;
- Any other related services necessary to access, select and adjust or fit a hearing aid.

Covered medical expenses for hearing aids will not include per 12 consecutive month period:

- Charges for more than one hearing aid per ear; and
- Charges in excess of any maximum amount shown on the *Schedule of Benefits*.

Hearing Aids Alternate Treatment Rule

Sometimes there are several types of hearing aids that can be used to treat a medical condition, all of which provide acceptable results. When alternate hearing aids can be used, the plan's coverage may be limited to the cost of the least expensive device that is:

- Customarily used nationwide for treatment, and
- Deemed by the medical profession to be appropriate for treatment of the condition in question. The device must meet broadly accepted standards of medical practice, taking into account the **covered person's** physical condition.

The **covered person** should review the differences in the cost of alternate treatment with the **covered person's physician**. Of course, the **covered person** and their **physician** can still choose the more costly treatment method. The **covered person is** responsible for any charges in excess of what the plan will cover.

This *Alternate Treatment Rule* provision will not operate to deny benefits as mandated by any applicable state statute or regulation.

Limitations:

No benefits are payable under this benefit for charges incurred for:

- A service or supply which is received while the person is not a **covered person** under this Plan;
- A replacement of:
  - a hearing aid that is lost, stolen or broken; or
  - a hearing aid installed within the prior 12-48 month period.
- Replacement parts or repairs for a hearing aid;
- Batteries or cords;
- A hearing aid that does not meet the specifications prescribed for correction of hearing loss:
- Any ear or hearing exam performed by a **physician** who is not certified as an otolaryngologist or otologist;
- Any hearing care service or supply which is a **covered medical expense** in whole or in part under any other part of this Plan;
- Any hearing care service or supply which does not meet professionally accepted standards;

- Any hearing exam:
  - required by an employer as a condition of employment; or
  - which an employer is required to provide under a labor agreement; or
  - which is required by any law of government.
- Hearing exams given during a **stay** in a **hospital** or other facility, except those provided to newborns as part of the overall **hospital stay**; and
- Any tests, appliances and devices for the improvement of hearing including hearing aid batteries and auxiliary equipment or to enhance other forms of communication to compensate for hearing loss or devices that simulate speech.

The *Schedule of Benefits* shows any **copay**, **deductible**, covered percentage and maximum benefit that may apply to the *Prosthetic Device Expense* benefit.

PODIATRIC EXPENSE

Covered medical expenses include charges incurred by a **covered person** for podiatric services; provided on an outpatient basis following an **injury**.

Coverage also includes routine foot care, such as trimming of corns, calluses, and nails.

The *Schedule of Benefits* shows any **copay**, **deductible**, covered percentage and maximum benefit that may apply to *Podiatric Expense* benefits.

Limitations
Unless specified above, not covered under this benefit are charges incurred for routine foot care, such as trimming of corns, calluses, and nails.

SKILLED NURSING FACILITY EXPENSE

Covered medical expenses include charges made by a **skilled nursing facility** during a **covered person's stay** for the following services and supplies:

- **Room and board**, up to the **semi-private room rate**. The plan will cover up to the private room rate if it is needed due to an infectious **sickness** or a weak or compromised immune system;
- Use of special treatment rooms;
- Radiological services and lab work;
- Physical, occupational, or speech therapy;
- Oxygen and other gas therapy;
- Other medical services and general nursing services usually given by a **skilled nursing facility** (this does not include charges made for private or special nursing, or **physician's** services); and
- Medical supplies.

A **covered person** must meet the following conditions:

- The **covered person** is currently receiving inpatient **hospital** care, or inpatient sub-acute care, and
- The **skilled nursing facility** admission will take the place of an admission to, or continued **stay** in, a **hospital** or sub-acute facility; or it will take the place of three or more **skilled nursing services** visits per week at home; and
- There is a reasonable expectation that the **covered person's** condition will improve sufficiently to permit discharge to the **covered person's** home within a reasonable amount of time; and
- The **sickness** or **injury** is severe enough to require constant or frequent **skilled nursing** care on a 24-hour basis.

Important Information:
- **Refer to the *Schedule of Benefits* for details about skilled nursing facility cost-sharing and maximums.**
- **Admissions to a skilled nursing facility must be precertified by Aetna. Refer to the *Precertification* provision in this section for details about precertification.**
- **This plan covers home short-term physical, speech, or occupational therapy when the above skilled nursing facility criteria are met. The *Short Term Rehabilitation Services* Expense benefit lists the conditions and limitations for certain services.**

The *Schedule of Benefits* shows any **copay**, **deductible**, covered percentage, and maximum benefit that may apply to the *Skilled Nursing Facility Expense* benefit.

ACUPUNCTURE IN LIEU OF ANESTHESIA EXPENSE

Covered medical expenses include charges incurred by a **covered person** for acupuncture therapy when acupuncture is used in lieu of other anesthesia for a surgical or dental procedure covered under this Plan.

The acupuncture must be administered by a health care provider who is a legally qualified **physician**; practicing within the scope of their license.

The *Schedule of Benefits* shows any **copay, deductible,** covered percentage, and maximum benefit that may apply to the *Acupuncture In Lieu of Anesthesia Expense* benefit.

TRANSFUSION OR KIDNEY DIALYSIS OF BLOOD EXPENSE

Covered medical expenses include charges incurred by a **covered person** for the transfusion or kidney dialysis of blood, including the cost of:

- Whole blood;
- Blood components; and
- The administration of whole blood and blood components.

The *Schedule of Benefits* shows any **copay**, **deductible**, covered percentage and maximum benefit that may apply to the *Transfusion or Kidney Dialysis of Blood Expense* benefit.

URGENT CARE EXPENSE

Covered medical expenses include charges incurred by a **covered person** for treatment by an **urgent care provider**. A **covered person** should not seek medical care or treatment from an **urgent care provider** if their **sickness; injury**; or condition; is an **emergency condition**. The **covered person** should go directly to the emergency room of a **hospital** or call 911 (or the local equivalent) for ambulance and medical assistance.

Urgent Care
Covered medical expenses include charges incurred by a **covered person** for an **urgent care provider** to evaluate and treat an **urgent condition**.

The *Schedule of Benefits* shows any **copay**, **deductible**, covered percentage and maximum benefit that may apply to *Urgent Care Expense* benefits.

SHORT-TERM CARDIAC AND PULMONARY REHABILITATION THERAPY SERVICES EXPENSE

Covered medical expenses include charges made by a **hospital** for short-term rehabilitation therapy services, as described below, when prescribed by a **physician**. The services have to be performed by:

- A licensed or certified physical or occupational therapist; or
- A **physician**.

Charges for the following short term rehabilitation expenses are covered:

Cardiac and Pulmonary Rehabilitation Benefits
Cardiac rehabilitation benefits are available as part of an inpatient hospital stay. A course of outpatient cardiac rehabilitation appropriate for a **covered person's** condition is covered for a cardiac condition that can be changed.

The plan will cover charges in accordance with a treatment plan as determined by a **covered person's** risk level when recommended by a **physician**.

Pulmonary rehabilitation benefits are available as part of an inpatient hospital stay. A course of outpatient pulmonary rehabilitation appropriate for a **covered person's** condition is covered for the treatment of reversible pulmonary disease states.

The *Schedule of Benefits* shows any **copay**, **deductible**, covered percentage and maximum benefit that may apply to *Short-Term Cardiac and Pulmonary Expense* benefits.

Limitations:
Unless specifically covered above, *not* covered under this benefit are charges for:

- Any services unless provided in accordance with a specific treatment plan;
- Services not performed by a **physician** or under the direct supervision of a **physician**; or
- Services provided by a **physician** or physical or occupational therapist who resides in the **covered person's** home or who is a member of the **covered person's** family, or a member of the **covered person's** spouse's family, or the **covered person's** domestic partner.

SHORT-TERM REHABILIATION SERVICES EXPENSE

Covered medical expenses include charges for short-term rehabilitation services, as described below, when prescribed by a **physician**.

The services have to be performed by:

- A licensed or certified physical, occupational or speech therapist;
- A **hospital**, **skilled nursing facility**, or **hospice facility**;
- A **home health care agency**; or
- A **physician.**

Short-term rehabilitation services must follow a specific treatment plan that:

- Details the treatment, and specifies frequency and duration;
- Provides for ongoing reviews and is renewed only if continued therapy is appropriate; and
- Allows therapy services, provided in a **covered person's** home, if the **covered person** is **homebound**.

Short-Term Rehabilitation Services - Outpatient Cognitive Therapy, Physical Therapy, Occupational Therapy and Speech Therapy
Inpatient rehabilitation benefits for the services listed will be paid as part of the inpatient **hospital** and **skilled nursing facility** benefits.

- Physical therapy (except for services provided in an educational or training setting) is covered provided that the therapy is expected to significantly improve or restore physical functions lost as a result of an acute **sickness**, **injury** or **surgical procedure**,
- Occupational therapy, (except for vocational rehabilitation, employment counseling, and services provided in an educational or training setting), is covered provided that the therapy is expected to:
  - significantly improve or restore physical functions lost as a result of an acute **sickness**, **injury** or **surgical procedure**; or
  - to reteach skills that significantly improve independence in the activities of daily living.
- Speech therapy is covered provided that the therapy is expected to:
  - significantly improve or restore the speech function or correct a speech impairment as a result of an acute **sickness, injury** or **surgical procedure**; or
  - improve delays in speech function development as a result of a gross anatomical defect present at birth.

  Speech function is the ability to express thoughts, speak words and form sentences. Speech impairment is difficulty with expressing one's thoughts with spoken words.
- Cognitive therapy associated with physical rehabilitation is covered when the cognitive deficits have been acquired as a result of neurologic impairment due to trauma, stroke, or encephalopathy, and when the therapy is part of a treatment plan intended to restore previous cognitive function.

A "visit" consists of no more than one hour of therapy. **Covered medical expenses** include charges for two therapy visits of no more than one hour in a 24-hour period.

The *Schedule of Benefits* shows any **copay**, **deductible**, covered percentage and maximum benefit that may apply to *Short-Term Rehabilitation Services Expense* benefits.

CHIROPRACTIC TREATMENT EXPENSE

Covered medical expenses include charges made by a **physician** on an outpatient basis for manipulative (adjustive) treatment or other physical treatment for conditions caused by (or related to) biomechanical or nerve conduction disorders of the spine.

Benefits are subject to the maximum shown in the *Schedule of Benefits*. However, this maximum does not apply to expenses incurred during a **covered person's hospital stay.**

The *Schedule of Benefits* shows any **copay**, **deductible**, covered percentage and maximum benefit that may apply to *Chiropractic Treatment Expense* benefits.

STUDENT ACCIDENT INSURANCE

SECTION 7 - EXCLUSIONS AND LIMITATIONS

GENERAL EXCLUSIONS AND LIMITATIONS

Not every healthcare service or supply is covered by the plan, even if prescribed, recommended, or approved by your **physician,** dental **provider,** or vision care professional. The plan covers only those services and supplies that are **medically necessary** and covered in the Policy. In addition, some services and supplies are specifically limited or excluded.

This section describes expenses that are not covered or subject to special limitations. Charges made for the following are not covered except to the extent listed under the Policy or by amendment attached to the Policy.

The exclusions listed below apply to all coverage under the Policy.

Additional limitations and exclusions apply to pediatric dental services covered under the medical plan. Those additional limitations and exclusions are listed separately at the end of this section.

The Policy does not cover the following expenses:

- Expense incurred for dental treatment, services and supplies except for those resulting from **injury** to **sound natural teeth** or for extraction of impacted wisdom teeth and those as specially covered under the Policy.

- Expense incurred for services normally provided without charge by the Policyholder's **school health services**; infirmary or **hospital**; or by health care providers employed by the Policyholder.

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

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

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

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

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

- Expense incurred for **elective treatment** or elective surgery except as specifically covered under the Policy and provided while the Policy is in effect.

- Expense incurred for **cosmetic** surgery; reconstructive surgery; or other services and supplies which improve; alter; or enhance appearance; whether or not for psychological or emotional reasons; except to the extend needed to:
  Improve the function of a part of the body that:
  is not a tooth or structure that supports the teeth; and
  is malformed:
  as a result of a severe birth defect; including harelip; webbed fingers; or toes; or
  as direct result of:
  disease; or
  surgery performed to treat a disease or **injury**.

  Repair an **injury** (including reconstructive surgery for prosthetic device for a **covered person** who has undergone a mastectomy;) which occurs while the **covered person** is covered under the Policy. Surgery must be performed:
  - in the **policy year** of the accident which causes the **injury**; or
  - in the next **policy year**.

- Expense incurred for any services rendered by a member of the **covered person**'s immediate family or a person who lives in the **covered person**'s home.

- Expense for or related to artificial insemination; in-vitro fertilization; or embryo transfer procedures; male elective sterilization; or elective abortion unless specifically covered under the Policy.

- Expenses for treatment of **injury** or **sickness** to the extent that payment is made; as a judgment or settlement; by any person deemed responsible for the **injury** or **sickness** (or their insurers), to the extent allowed by law.

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

- Expense incurred for **custodial care.**

- Expense incurred for the removal of an organ from a **covered person** for the purpose of donating or selling the organ to any person or organization except as specifically covered in the Policy. This limitation does not apply to a donation by a **covered person** to a spouse; child; brother; sister; or parent.

- Expenses incurred for the repair or replacement of existing artificial limbs; orthopedic braces; or orthotic devices except as specifically covered in the Policy.

- Expense incurred for, or in connection with, drugs, devices, procedures, or treatments that are, as determined by Aetna to be, **experimental or investigational** except as specifically covered under the Policy.

- **Expenses incurred for gastric bypass; and any restrictive procedures; for weight loss except screening and** counseling services specifically covered under the Policy.

- Expenses incurred for breast reduction/mammoplasty.

- Expenses incurred for gynecomastia (male breasts).

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

- Expense incurred for acupuncture except as specifically covered under the Policy.

- Expense incurred for alternative; holistic medicine; and/or therapy; including but not limited to; yoga and hypnotherapy unless specifically covered under the Policy.

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

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

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

- Expense incurred for hearing exams, hearing aids; the fitting; or **prescription** of hearing aids except as specifically covered under the Policy. Not covered are:
  - Any hearing service or supply that does not meet professionally accepted standards;
  - Hearing exams given during a **stay** in a **hospital** or other facility;
  - Any tests, appliances, and devices for the improvement of hearing, including aids, hearing aids and amplifiers, or to enhance other forms of communication to compensate for hearing loss or devices that simulate speech; and
  - Routine hearing exams, except for routine hearing screenings as specifically described under *Preventive Care Benefits*.

- Expense for care or services covered under Medicare Part A or Part B, and the **covered person** is enrolled in Medicare Part A or Part B.

- Expense for telephone consultations; charges for failure to keep a scheduled visit; or charges for completion of a claim form.

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

- Expense incurred for any non-emergency charges incurred outside of the United States 1) if you traveled to such location to obtain **prescription drugs**, or supplies, even if otherwise covered under this Policy, or 2) such drugs or supplies are unavailable or illegal in the United States, or 3) the purchase of such **prescription drugs** or supplies outside the United States is considered illegal.

- Expense for services or supplies provided for the treatment of obesity and/or weight control except screening and counseling services as specifically covered under the Policy. Not covered is any treatment, drug service or supply intended to decrease or increase body weight, control weight or treat obesity, including **morbid obesity**, regardless of the existence of comorbid conditions, including but not limited to:
  - Liposuction, banding, gastric stapling, gastric by-pass and other forms of bariatric **surgery**;
  - **surgical procedures,** medical treatments, weight control/loss programs and other services and supplies that are primarily intended to treat, or are related to the treatment of obesity, including **morbid obesity**;

- Drugs, stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food or food supplements, appetite suppressants and other medications;
- Counseling, coaching, training, hypnosis, or other forms of therapy; and
- Exercise programs, exercise equipment, membership to health or fitness clubs, recreational therapy, or other forms of activity or activity enhancement.

- Expense for incidental surgeries; and standby charges of a **physician**.

- Expense incurred for **injury** resulting from the play or practice of intercollegiate sports, participating in sports clubs; or intramural athletic activities; is excluded after 104 weeks from the date of accident.

- Expense incurred for **non-preferred care** charges that are not **recognized charges**.

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

- Expense incurred for routine physical exams, routine eye exams, routine dental exams, routine hearing exams and other preventive services and supplies, except as specifically covered in the Policy.

Expense incurred for a treatment; service; **prescription drug,** or supply; which is not **medically necessary;** as determined by Aetna; for the diagnosis, care, or treatment of the **sickness** or **injury** involved, the restoration of physiological functions, or covered preventive services. This includes behavioral health services that are not primarily aimed at treatment of **sickness**, **injury**, restoration of physiological functions or that do not have a physiological or organic basis. This applies even if they are prescribed; recommended; or approved; by the person's attending **physician, dentist,** or vision **provider**.

- Expenses incurred for vision-related services and supplies, except as specifically covered in the Policy.

  In addition, the plan does not cover:
  - Special supplies such as non-**prescription** sunglasses;
  - Vision service or supply which does not meet professionally accepted standards;
  - Special vision procedures, such as orthoptics or vision training;
  - Eye exams during a **stay** in a **hospital** or other facility for health care;
  - Eyeglasses or duplicate or spare eyeglasses or lenses or frames;
  - Replacement of lenses or frames that are lost or stolen or broken;
  - Acuity tests; and
  - Eye **surgery** for the correction of vision, including radial keratotomy, LASIK and similar procedures;
  - Services to treat errors of refraction.

- Expense incurred for **preferred care** charges in excess of the **negotiated charge**.

- Nursing and home health aide services or therapeutic support services provided outside of the home (such as in conjunction with school, vacation, work or recreational activities).

- Expense incurred in relation to genetics: Except as specifically covered in the Policy, the plan does not cover any treatment, device, drug, service or supply to alter the body's genes, genetic make-up, or the expression of the body's genes except for the correction of congenital birth defects.

- Expense incurred for therapies and tests: Any of the following treatments or procedures including but not limited to:
  - Aromatherapy;
  - Bio-feedback and bioenergetic therapy;
  - Carbon dioxide therapy;
  - Chelation therapy (except for heavy metal poisoning);
  - Computer-aided tomography (CAT) scanning of the entire body;
  - Early intensive behavioral interventions (including Applied Behavior Analysis, Denver, LEAP, TEACHH, Rutgers programs) except as specifically covered in the *What the Medical Plan Covers* Section;
  - Educational therapy;
  - Gastric irrigation;
  - Hair analysis;
  - Hyperbaric therapy, except for the treatment of decompression or to promote healing of wounds;
  - Hypnosis, and hypnotherapy, except when performed by a **physician** as a form of anesthesia in connection with covered **surgery**;
  - Lovaas therapy;
  - Massage therapy;
  - Megavitamin therapy;
  - Primal therapy;
  - Psychodrama;
  - Purging;
  - Recreational therapy;
  - Rolfing;
  - Sensory or auditory integration therapy;
  - Sleep therapy;
  - Thermograms and thermography.

Additional Pediatric Dental Services Exclusions and Limitations

The Pediatric Dental Services benefit is subject to the following additional exclusions and limitations:

- Expenses incurred for any instruction for diet, plaque control and oral hygiene.

- Expenses incurred for dental services and supplies that are covered in whole or in part under any other part of this plan.

- Expenses incurred for **jaw joint disorder** treatment, services and supplies, except as specifically covered in the Policy, to alter bite or the alignment or operation of the jaw, including temporomandibular joint disorder (TMJ) treatment, orthognathic surgery, and treatment of malocclusion or devices to alter bite or alignment.

- Expenses incurred for **orthodontic treatment** except as specifically covered in the Orthodontic Treatment Rule section of the Policy.

- Expenses incurred for routine dental exams and other preventive services and supplies, except as specifically covered in the Policy.

Any exclusion above will not apply to the extent that coverage is specifically provided by name in the Policy; or coverage of the charges is required under any law that applies to the coverage.

EXCESS PROVISION

This Plan is an excess only Plan. As an excess only Plan, this Plan pays its Covered Medical Expenses after any other medical coverage. This Plan's liability will be determined without consideration to any limitation clause or clauses regarding other coverage contained in any other medical coverage. Benefits Payable under this Plan shall be limited to the Plan's Covered Medical Expense and reduced by the amount paid or payable by any other medical coverage. However, consideration will be given to the other medical coverage's liability due to a provider contract or other reasons when calculating this Plan's Benefits Payable. This Plan's applied **deductible** will be credited back into the Benefits Payable when both plans would apply a **deductible**.

For the purposes of calculating a benefit under this Plan, the liability of the other medical coverage shall be considered and shall not depend upon whether timely application for benefits from other medical coverage is made by **you** or on **your** behalf. If any other medical coverage provides benefits on an excess only basis, the coverage for the Covered Member which has been in effect the longest shall pay benefits first.

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

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

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

IMPORTANT HEALTH CARE REFORM INFORMATION

Some language changes in response to the federal Affordable Care Act (ACA) may not be included in the enclosed certificate of coverage. This may be because the language is still pending regulatory review and approval. However, please note that for new plans on or after January 1, 2014, and for non-grandfathered plans that renew on a date on or after January 1, 2014, Aetna is administering medical and outpatient prescription drug coverage in compliance with the following applicable components of the ACA.

The following is a summary of the recent changes under the ACA.

For details on any benefit maximums and the cost sharing under your plan, log onto the Aetna website www.aetna.com, call the Member Services number on the back of your ID card, or refer to the Summary of Benefit and Coverage document you have received.

1. Subject to any allowed applicable age, family history and frequency guidelines for preventive services covered under the plan, (which may be in-network only for plans that use a provider network) the following services are included in those considered preventive:

    - Coverage of comprehensive lactation support and counseling, and the costs of renting or purchasing breastfeeding equipment extended for the duration of breastfeeding.
    - In accordance with the recommendations of the United States Preventive Services Task Force, and when prescribed by a physician:
        i. aspirin for men and women age 45 and over;
        ii. folic acid for women planning or capable of pregnancy;
        iii. routine iron supplementation for asymptomatic children ages 6 to 12 months;
        iv. vitamin D supplementation for men and women age 65 and older;
        v. fluoride supplementation for children from age 6 months through age 5;
        vi. genetic counseling, evaluation and lab tests for routine breast cancer susceptibility gene (BRCA) testing;
        vii. Food and Drug Administration (FDA) approved female over-the-counter contraceptives, and an office visit for contraceptive administration and/or removal of a contraceptive device

2. The medical in-network out-of-pocket maximum for a plan that does use a provider network , and the out-of-pocket maximums for a plan that does not use a provider network - cannot exceed $6,350 per person and $12,700 per family for your 2014 plan year. If your medical plan is packaged with a plan that covers outpatient prescription drugs, the outpatient prescription drug plan may:
    a. not include out-of-pocket maximums; or
    b. have separate maximums from the medical plan up to these same amounts; or
    c. have maximums that are combined with the medical plan up to these same amounts.

3. Any annual or lifetime dollar maximum benefit that applies to "Essential Health Benefits" (as defined by the ACA and included in the plan) no longer applies. Essential Health Benefits will continue to be subject to any coinsurance, copays, deductibles, other types of maximums (e.g., day and visit maximums), referral and certification rules, and any exclusions and limitations that apply to these types of covered medical expenses under your plan.

4. If your Plan includes a pre-existing condition limitation or exclusion provision, including one that may apply to transplant coverage, then this limitation or exclusion no longer applies.

5. If your Plan includes a waiting or probationary period, (the period of time that must pass before your coverage can become effective), this period of time cannot be greater than 90 days.

APPEALS PROCEDURE

Definitions

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

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

- The **covered person's** eligibility for coverage.
- Plan limitations or exclusions.
- The results of any Utilization Review activities.
- A decision that the service or supply is **experimental or investigational**.
- A decision that the service or supply is not **medically necessary**.

An **adverse benefit determination** also means the termination of a **covered person's** coverage back to the original effective date (rescission) as it applies under any rescission provision appearing in the Policy, but within 2 years of your application for any fraud or material misrepresentation on the application, subject to Connecticut regulation.

Appeal: A written request to Aetna to reconsider an **adverse benefit determination**.

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

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

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

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

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

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

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

Urgent Care Claim: Any claim for medical care or treatment in which a delay in treatment could:

- Seriously jeopardize the **covered person's** life or health;
- Jeopardize the **covered person's** ability to regain maximum function;

- Cause the **covered person** to suffer severe pain that cannot be adequately managed without the requested medical care or treatment; or
- For a substance abuse disorder or for a co-occurring mental disorder, or mental disorder requiring inpatient services, partial hospitalization, residential treatment or intensive outpatient services necessary to prevent an inpatient setting; and
- In the case of a pregnant woman, cause serious jeopardy to the health of the fetus.

Full and Fair Review of Claim Determinations and Appeals

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

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

Claim Determinations – Health Coverage

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

Urgent Care Claims

Aetna will notify the **covered person** of an **urgent care** claim decision as soon as possible, but not later than 72 hours after the claim is made. With respect to mental health or substance abuse disorders, the decision will be made within 24 hours.

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

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

Pre-Service Claims

Aetna will notify the **covered person** of a **pre-service** claim decision as soon as possible, but not later than 15 calendar days after the claim is made. Aetna may determine that due to matters beyond its control an extension of this 15 calendar day claim decision period is required. Such an extension, of not longer than 15 additional calendar days, will be allowed if Aetna notifies the **covered person** within the first 15 calendar day period. If this extension is needed because Aetna needs more information to make a claim decision, the notice of the extension shall specifically describe the required information. The **covered person** will have 45 calendar days, from the date of the notice, to provide Aetna with the required information.

Post-Service Claims

Aetna will notify the **covered person** of a **post-service** claim decision as soon as possible, but not later than 30 calendar days after the claim is made. Aetna may determine that due to matters beyond its control an extension of this 30 calendar day claim decision period is required. Such an extension, of not longer than 15 additional calendar days, will be allowed if Aetna notifies the **covered person** within the first 30 calendar day period. If this extension is needed because Aetna needs more information to make a claim decision, the notice of the extension shall specifically describe the required information. The patient will have 45 calendar days, from the date of the notice, to provide Aetna with the required information.

Concurrent Care Claim Extension

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

Concurrent Care Claim Reduction or Termination

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

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

Complaints

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

Appeals of Adverse Benefit Determinations

The **covered person** may submit an **appeal** if Aetna gives notice of an **adverse benefit determination**. This Plan provides for one level or two levels (Level Two only applies to dental, vision and hearing claims) of **appeal**. A **final adverse benefit determination** notice may also provide an option to request an **External Review** *(if available)***.**

An appeal of an adverse benefit determination will be evaluated and reviewed by a clinical peer, not involved in the original determination. A clinical peer is:

- A physician or other health care professional who holds a non-restricted license in a state of the US and in the same or similar specialty as typically manages the medical condition, procedure or treatment under review.
- For urgent care reviews concerning child or adolescent substance use disorder or mental disorder, holds a national board certification in child and adolescent psychiatry or a doctoral level psychology degree with training and clinical experience in the treatment of child and adolescent substance use and mental disorder as applicable.
- For urgent care reviews concerning adult substance use or mental disorder, holds a national board certification in psychiatry, or a doctoral level psychology degree with training and clinical experience in the treatment of adult substance use and mental disorders, as applicable.

The **covered person** has 180 calendar days with respect to Health Claims following the receipt of notice of an **adverse benefit determination** to request their Level One **appeal**. The **covered person's appeal** must be submitted in writing and must include:

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

The **covered person** can send their written **appeal** to Member Services at the address shown on their ID Card.

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

The **covered person** may be allowed to provide evidence or testimony during the **appeal** process in accordance with the guidelines established by the Federal Department of Health and Human Services.

Appeal – Medical and Prescription Drug Claims

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

Urgent Care Claims (May Include Concurrent Care Claim Reduction or Termination)
Aetna shall issue a decision within 72 hours of receipt of the request for an **appeal**. Appeals pertaining to mental health or substance abuse disorder services will be made as soon as possible, but not later than 24 hours after receipt of the request to keep the **covered person** from requiring an inpatient setting.

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

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

Level One Appeal –Dental, Vision and Hearing Claims

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

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

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

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

Level Two Appeal - Dental, Vision and Hearing Claims

A Level Two **appeal** applies only to dental, vision and hearing claims. If Aetna upholds an **adverse benefit determination** at the first level of **appeal**, and the reason for the decision was based on **medical necessity** or **experimental or investigational** reasons, the **covered person** or their authorized representative has the right to file a Level Two **appeal**. The **appeal** must be submitted within 60 calendar days following the receipt of a decision of a Level One **appeal**.

A review of a Level Two **appeal** of an **adverse benefit determination** of an **urgent care claim, a Pre-Service Claim, or a Post-Service Claim** shall be provided by Aetna personnel. They shall not have been involved in making the **adverse benefit determination**.

Urgent Care Claims (May Include Concurrent Care Claim Reduction or Termination)
Aetna shall issue a decision within 36 hours of receipt of the request for a Level Two **appeal**.

Pre-Service Claims (May Include Concurrent Care Claim Reduction or Termination)
Aetna shall issue a decision within 15 calendar days of receipt of the request for a Level Two **appeal**.

Post-Service Claims
Aetna shall issue a decision within 30 calendar days of receipt of the request for a Level Two **appeal**.

Exhaustion of Process

Aetna encourages **covered persons** to exhaust the applicable Level One and Level Two processes of the Appeal Procedure before they:

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

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

Under certain circumstances the **covered person** may seek simultaneous review through the internal Appeals Procedure and **External Review** processes—these include **Urgent Care Claims** and situations where the **covered person** is receiving an ongoing course of treatment. Exhaustion of the applicable process of the Appeal Procedure is not required under these circumstances.

The **covered person** may contact the Department of Insurance for assistance regarding any Complaint/Grievance or Appeal at the following address:

State of Connecticut Insurance Department
Consumer Affairs Department
P.O. Box 816
Hartford, CT 06142-0816
1-860-297-3900 or 1-800-203-3447
cid.ca@ct.gov

Or, the Office of Healthcare Advocate, at:

State of Connecticut
Office of the Healthcare Advocate
P.O. Box 1543
Hartford, CT 06144
1-866-297-3992
Healthcare.advocate@ct.gov

External Review

The **covered person** may receive an **adverse benefit determination** or **final adverse benefit determination.**

In these situations, the **covered person** may request an **External Review** if they or their provider disagrees with Aetna's decision.

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

- The **covered person** has received an **adverse benefit determination** notice by Aetna**,** and Aetna did not adhere to all claim determination and **appeal** requirements of the Federal Department of Health and Human Services.
- The **covered person** has received a **final adverse benefit determination** notice by Aetna.
- The **covered person** qualifies for a faster review as explained below.
- As to dental, vision and hearing claims only, the cost of the initial service, supply or treatment in question for which the **covered person** is responsible exceeds $500.

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

The **covered person** must submit the *Request for External Review Form* to the Connecticut Insurance Department within 120 calendar days of the date they received the **adverse benefit determination** or **final adverse benefit determination** notice. The **covered person** also must include a copy of the notice and all other pertinent information that supports their request.

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

Mail the application for External Review to:

Connecticut Insurance Department
Attention: External Review
P.O. Box 816
Hartford, CT 06142-0816

For overnight delivery only, mail the application to:

Connecticut Insurance Department
Attention: External Review
153 Market Street, 7th Floor
Hartford, CT 06103

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

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

The **covered person** may also receive a faster review if the **final adverse benefit determination** relates to an admission; availability of care; continued **stay;** or health service for which they received **emergency care**, but have not been discharged from a facility, and mental health and substance abuse disorders.

Faster reviews are decided within 72 hours after Aetna receives the request, except in the case of experimental or investigational reviews which have a 5 day timeframe, and in the case of an expedited review involving a substance abuse disorder, or for a co-occurring mental disorder, or mental disorder requiring inpatient services, partial hospitalization, residential treatment or intensive outpatient services necessary to prevent an inpatient setting, the review will be decided as expeditiously as the **covered person's** medical condition requires, but not later than 24 hours after the ERO receives the request to conduct this review.

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

The **covered person** is responsible for the cost of compiling and sending the information that they wish to be reviewed by the ERO to Aetna. Aetna is responsible for the cost of sending this information to the ERO and for the cost of the external review except for dental, vision and hearing claims.

For more information about the Appeals Procedure or **External Review** processes, the **covered person** may call the Member Services telephone number shown on their ID card, or contact the Connecticut Department of Insurance at the information given above.

Aetna Life Insurance Company

Hartford, Connecticut 06156

Student Accident Insurance

Policy Amendment

Policyholder: **Connecticut State Colleges and Universities: Central, Eastern, Southern and Western - Accident Plan**

Policy No.: [GP-890429][GP-8904033][GP-890434][GP-890435]

Effective Date: This Amendment is effective on the later of:

August 1, 2021; or
The date a person becomes a **covered person** under the Student Accident Policy.

The Student Accident Insurance Policy (Policy) noted above has been changed.

Except as modified or superseded by this Amendment, all other terms and conditions in the Policy remain unchanged and in full force and effect.

The following is a summary of the changes in the Policy. This amendment is effective on the date(s) shown above.

The "Discontinuance of Policy" provision appearing in the *General Provisions* section of the Policy is hereby deleted and replaced with the following:

DISCONTINUANCE OF POLICY - The Policyholder may terminate the Policy as to any or all coverage of all or any class of students. The Policyholder must give **Aetna** written notice of the termination. The termination date shall not be earlier than 31 days after the date of the notice unless it is agreed to by the Policyholder and **Aetna**. The notice must state when such termination shall occur. It must be a date after the notice. It shall not be effective during a period for which a premium has been paid to **Aetna** as to the coverage.

Aetna has the right to terminate this Policy only under the following conditions:

- Non-payment of premium.
- Fraud or intentional misrepresentation of a material fact under the terms of the coverage.
- Aetna ceases to offer student blanket health insurance coverage subject to the terms of any Connecticut law or regulation and in line with HIPAA notification requirements.

Aetna will notify the Connecticut Insurance Department as well as all policyholders no later than 90 days before the date that Aetna no longer offers Student Blanket Coverage in Connecticut.

As to non-payment of premium, **Aetna** has the right to terminate the Policy as to all or any class of students of a Policyholder at any time after the end of the grace period if the premium for student coverage has not been paid. **Aetna** must give written notice of the termination date. This right is subject to the terms of any laws or regulations.

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

If:

- The Policy terminates as to any of the students of a Policyholder; and
- Premiums have not been paid for the period the Policy was in force for those students;

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

This amendment makes no other changes to the Policy.

Dan Finke
President

Aetna Life Insurance Company
(A Stock Company)

Amendment: 1
Issue Date: July 2, 2021

Aetna Life Insurance Company

Hartford, Connecticut 06156

Student Accident Insurance

Policy Amendment

Policyholder: **Connecticut State Colleges and Universities: Central, Eastern, Southern and Western - Accident Plan**

Policy No.: [GP-890429][GP-8904033][GP-890434][GP-890435]

Effective Date: This Amendment is effective on the later of:

August 1, 2021; or
The date a person becomes a **covered person** under the Student Accident Policy.

The Student Accident Insurance Policy (Policy) noted above has been changed.

Except as modified or superseded by this Amendment, all other terms and conditions in the Policy remain unchanged and in full force and effect.

The following is a summary of the changes in the Policy. This amendment is effective on the date(s) shown above.

1. The following "**Important Notice**" has been added to the *Emergency Room Visit Expense* benefit description in the Schedule of Benefits:

> **Important Notice:**
> A separate **hospital** emergency room visit benefit **deductible** or **copay** applies for each visit to an emergency room for **emergency care**. If a **covered person** is admitted to a **hospital** as an inpatient immediately following a visit to an emergency room, the emergency room visit benefit **deductible** or **copay** is waived.
>
> **Covered medical expenses** that are applied to the emergency room visit benefit **deductible** or **copay** cannot be applied to any other benefit **deductible** or **copay** under the plan. Likewise, **covered medical expenses** that are applied to any of the plan's other benefit **deductibles** or **copays** cannot be applied to the emergency room visit benefit **deductible** or **copay**.
>
> Similarly, services rendered in the emergency room that are not included in the **hospital** emergency room visit benefit may be subject to **coinsurance** rates that are different from the **coinsurance** rate applicable to the **hospital** emergency room visit benefit.
>
> Similarly, services rendered in the emergency room that are not included in the **hospital** emergency room visit benefit may be subject to **coinsurance.**

2. Any references to the term “harelip” within the Policy are hereby changed to “cleft lip/cleft palate”.

3. The *Prescribed Medicines Expense Exclusions and Limitations* section of the Policy has changed. The following has been added under *Limitations*:

   - **Aetna** retains the right to review all requests for reimbursement and, within its reasonable authority to, make reimbursement determinations subject to the *Appeals Procedure, Exhaustion of Process, and External Review* section of the Policy.
   - **Aetna** reserves the right to include only one manufacturer’s product on the **preferred drug list** when the same or similar drug (that is, a drug with the same active ingredient), supply or equipment is made by two or more different manufacturers.
   - **Aetna** reserves the right to include only one dosage or form of a drug on the **preferred drug list** when the same drug (that is, a drug with the same active ingredient) is available in different dosages or forms from the same or different manufacturers. The product in the dosage or form that is listed on our **preferred drug list** will be covered at the applicable benefit **deductible**, **copay** or **coinsurance**.

This amendment makes no other changes to the Policy.

Dan Finke
President

Aetna Life Insurance Company
(A Stock Company)

Amendment: 2
Issue Date: July 2, 2021

Aetna Life Insurance Company

Hartford, Connecticut 06156

Student Accident Insurance

Policy Amendment

Policyholder: **Connecticut State Colleges and Universities: Central, Eastern, Southern and Western - Accident Plan**

Policy No.: [GP-890429][GP-8904033][GP-890434][GP-890435]
Effective Date: This Amendment is effective on the later of:

August 1, 2021; or
The date a person becomes a **covered person** under the Student Accident Policy.

The Student Accident Insurance Policy (Policy) noted above has been changed.

Except as modified or superseded by this Amendment, all other terms and conditions in the Policy remain unchanged and in full force and effect.

The following is a summary of the changes in the Policy. This amendment is effective on the date(s) shown above.

1. The following has been added to the *Benefits Payable* provision in the Schedule of Benefits:

   If a service or supply that a **covered person** needs is covered under the Plan but not available from a **Preferred Care Provider**, **covered persons** should contact *Member Services* for assistance at the toll-free number on the back of the ID card. In this situation, **Aetna** may issue a pre-approval for a **covered person** to obtain the service or supply from a **Non-Preferred Care Provider.** When a pre-approval is issued by **Aetna**, **covered medical expenses** are reimbursed at the **Preferred Care** network level of benefits.

2. The following definition(s) are added to the *Definitions* section of the Policy:

   Habilitation Therapy Services
   Health care services that help a **covered person** keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

   Religious Policyholder
   This term is defined as:

   - The inculcation of religious values is the purpose of the entity.
   - The entity primarily enrolls persons who share the religious tenets of the entity.
   - The entity serves primarily persons who share the religious tenets of the entity.

- The entity is a nonprofit organization pursuant to Section 6033(a)(2)(A)(i) or (iii) of the Internal Revenue Code of 1986, as amended.

3. The definition of *Emergency Medical Condition* currently appearing in the *Definitions* section of the Policy is hereby deleted and replaced with the following:

   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, 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;
     - one who is having contractions and there is inadequate time to effect a safe transfer to another **hospital** before delivery; or
     - a transfer may pose a threat to the health or safety of the woman or the unborn child.

4. The following definition replaces the same definition appearing in the *Definitions* section of the Policy:

   Biosimilar Prescription Drug

   A biological **prescription drug** that is highly similar to a U.S. Food and Drug Administration (FDA) licensed reference biological **prescription drug** notwithstanding minor differences for which there are no clinically meaningful differences between the highly similar biological **prescription drug** and the reference biological **prescription drug** in terms of the safety, purity, and potency of the drug,(as defined in accordance with the U.S. Food and Drug Administration (FDA) regulations).

This amendment makes no other changes to the Policy.

Dan Finke
President

Aetna Life Insurance Company
(A Stock Company)

Amendment: 3
Issue Date: July 2, 2021

Aetna Life Insurance Company

Hartford, Connecticut 06156

Student Accident Insurance

Policy Amendment

Policyholder: **Connecticut State Colleges and Universities: Central, Eastern, Southern and Western - Accident Plan**

Policy No.: [GP-890429][GP-8904033][GP-890434][GP-890435]

Effective Date: This Amendment is effective on the later of:

August 1, 2021; or
The date a person becomes a **covered person** under the Student Accident Policy.

The Student Accident Insurance Policy (Policy) noted above has been changed.

Except as modified or superseded by this Amendment, all other terms and conditions in the Policy remain unchanged and in full force and effect.

The following is a summary of the changes in the Policy. This amendment is effective on the date(s) shown above.

The *Precertification* provision in the *Coverage* section of the Policy has changed. The list of "*Services and Supplies Which Require Precertification*" is hereby deleted in its entirety and replaced with the following:

Inpatient and Outpatient Care
• Amytal Interview • Applied Behavior Analysis (ABA) • Bariatric **Surgery** • Biofeedback • Cardiac **Surgeries** • Clinical Trials • Complex Imaging • **Cosmetic Surgery** • Electric or Motorized Wheelchairs and Scooters • Gender Reassignment (Sex Change) Treatment • Genetic Testing

- **Home health care** related services (ie. private duty nursing including psychiatric **home health care** services)
- Hyperbaric Oxygen Therapy
- Implants and Trials (cochlear, dental, neurostimulators, cardiac, osseointegrated)
- **Infertility** Services (except Basic **Infertility**)
- Inpatient Services: Observation stays greater than 24 hours, inpatient **hospital** non-surgical, inpatient **hospital** surgical confinements, maternity confinements which exceed the standard length of stay (LOS), newborn confinements which exceed the standard length of stay (LOS), rehabilitation facility, **skilled nursing facility**, **hospice stays** in a **hospital**
- **Intensive Outpatient Programs (IOP)** – (**mental disorder** and **substance abuse** diagnoses)
- Kidney Dialysis
- Knee Surgeries
- Lower Limb Prosthetics
- Medical Injectables*
- Non-Emergency Ambulance Services (including fixed wing aircraft)
- **Non-Preferred Care** at a freestanding **ambulatory surgical center**
- **Non-Preferred Care Providers** for non-emergency services, being requested at an **network provider** benefit level
- Orthognatic Surgery Procedures (bone grafts, osteotomies and surgical management of the temporomandibular joint)
- Outpatient back **surgery** not performed in a **physician's** office
- Outpatient **Detoxification**
- Outpatient Electroconvulsive Therapy (ECT)
- **Partial Hospitalization Treatment** Programs (PHP) – (**mental disorder** and **substance abuse** diagnoses)
- Power Morcellator
- Proton Beam Radiotherapy
- Psychological Testing/Adult Neuropsychological Testing
- Radiation Therapy
- **Residential Treatment Facility** or Residential Treatment Center admissions
- Sleep Studies
- Transplant services (pre-transplant, evaluation and post-transplant)
- Uvulopalatopharyngoplasty, including laser-assisted procedures

This amendment makes no other changes to the Policy.

Dan Finke
President

Aetna Life Insurance Company
(A Stock Company)

Amendment: 4
Issue Date: July 2, 2021

Aetna Life Insurance Company

Hartford, Connecticut 06156

Student Accident Insurance

Policy Amendment

Policyholder: **Connecticut State Colleges and Universities: Central, Eastern, Southern and Western - Accident Plan**

Policy No.: [GP-890429][GP-8904033][GP-890434][GP-890435]

Effective Date: This Amendment is effective on the later of:

August 1, 2021; or
The date a person becomes a **covered person** under the Student Accident Policy.

The Student Accident policy noted above has been changed.

The following is a summary of the changes in the Policy. This amendment is effective on the date(s) shown above.

1. The **Appeals of Adverse Benefit Determinations** provision that appears in the Appeals Procedure, Exhaustion of Process and External Review section of the Policy is deleted and replaced with the following:

Appeals of Adverse Benefit Determinations

When the **covered person** receives an **adverse benefit determination** that was based on **medical necessity**, **Aetna** must notify the **covered person's physician** or other health care professional of the opportunity to confer, at the **physician** or other health care professional's request, with a **clinical peer** of **Aetna**. This conference will not be considered a **grievance** of the **adverse benefit determination** as long the **covered person** or the **covered person's** authorized representative has not submitted an **appeal** to **Aetna.**

This Plan provides for one level or two levels (Level Two only applies to dental, vision and hearing claims) of **appeal**. A **final adverse benefit determination** notice may also provide an option to request an **External Review** *(if available)***.**

An appeal of an adverse benefit determination will be evaluated and reviewed by a clinical peer, not involved in the original determination. A clinical peer is:

- A physician or other health care professional who holds a non-restricted license in a state of the US and in the same or similar specialty as typically manages the medical condition, procedure or treatment under review.
- For urgent care reviews concerning child or adolescent substance use disorder or mental disorder, holds a national board certification in child and adolescent psychiatry or a doctoral level psychology degree with

training and clinical experience in the treatment of child and adolescent substance use and mental disorder as applicable.
- For urgent care reviews concerning adult substance use or mental disorder, holds a national board certification in psychiatry, or a doctoral level psychology degree with training and clinical experience in the treatment of adult substance use and mental disorders, as applicable.

The **covered person** has 180 calendar days with respect to Health Claims following the receipt of notice of an **adverse benefit determination** to request their Level One **appeal**. The **covered person's appeal** may be submitted orally or must be submitted in writing and must include:

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

The **covered person** can send their written **appeal** to Member Services at the address shown on their ID Card, or call in their **appeal** to Member Services using the telephone number shown on their ID Card.

The **covered person** may send their written **appeal** to the address shown on the notice of **adverse benefit determination**, or they may call in their **appeal** using the telephone number listed on the notice.

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

The **covered person** may be allowed to provide evidence or testimony during the **appeal** process in accordance with the guidelines established by the Federal Department of Health and Human Services.

This amendment makes no other changes to the Policy.

Dan Finke
President

Aetna Life Insurance Company
(A Stock Company)

Amendment: 5
Issue Date: July 2, 2021

Aetna Life Insurance Company

Hartford, Connecticut 06156

Student Accident Insurance

Policy Amendment

Policyholder: **Connecticut State Colleges and Universities: Central, Eastern, Southern and Western - Accident Plan**
Plan

Policy No.: [GP-890429][GP-8904033][GP-890434][GP-890435]

Effective Date: This Amendment is effective on the later of:

August 1, 2021; or
The date a person becomes a **covered person** under the Student Accident Policy.

The Student Accident policy noted above has been changed.

The following is a summary of the changes in the Policy. This amendment is effective on the date(s) shown above.

1. The following has been added to the ***Payment of Benefits*** provision that appears in the General Provisions section of the Policy:

Surprise Bills

A surprise bill is a bill you get for **eligible health services** that were not emergency services**.** The bill is from an **out- of-network provider** who performed services while you were in a network hospital or facility.

1. These services were in addition to those performed by a **network provider**.
2. You may have **precertified** the procedure or service, but you did not knowingly choose to receive services from an **out-of-network provider**.

A surprise bill is not a bill for services received when a **network provider** was available and you knowingly choose to use an **out-of-network provider.**

Contact Member Services if you receive a surprise bill. You only have to pay the same coinsurance, copayment, deductible or other out-of-pocket expense that you would pay if you had used a **network provider.**

This amendment makes no other changes to the Policy.

Dan Finke
President

Aetna Life Insurance Company
(A Stock Company)

Amendment: 6
Issue Date: July 2, 2021

Aetna Life Insurance Company

Hartford, Connecticut 06156

Student Accident Insurance

Policy Amendment

Policyholder: **Connecticut State Colleges and Universities: Central, Eastern, Southern and Western - Accident Plan**

Policy No.: [GP-890429][GP-8904033][GP-890434][GP-890435]

Effective Date: This Amendment is effective on the later of:

August 1, 2021; or
The date a person becomes a **covered person** under the Student Accident Policy.

The Student Accident policy noted above has been changed.

The following is a summary of the changes in the Policy. This amendment is effective on the date(s) shown above.

1. The **Outpatient Physician or Specialist Office Visit Expense** provision that appears in the Covered Benefits section of the Policy is deleted and replaced with the following:

   Outpatient Physician or Specialist Office Visit Expense

   C**overed medical expenses** include the charges made by the **physician** or **specialist** if a **covered person** requires the services of a **physician** or **specialist** in the **physician**'**s** or **specialist's** office while not confined as an inpatient in a **hospital**. The *Schedule of Benefits* shows any **copay, deductible,** covered percentage and maximum benefit that may apply to these benefits under the *Outpatient Expense* benefit.

   Covered medical expenses also include **e-visits** and **telemedicine** only when a **covered person** gets a telephone or internet-based consult through an authorized internet service vendor who conducts **telemedicine** consultations. You may search online for the most current list of participating providers in your area by using DocFind, Aetna's online provider directory at www.aetna.com. **E-visits** and **telemedicine** are not the same as office visits and may have different cost sharing. The *Schedule of Benefits* shows any **copay**, **deductible**, covered percentage and maximum benefit that may apply to these benefits.

2. The following definition has been added to the Definitions section of the Policy:

   Telemedicine
   A telephone or internet-based consult with a **provider** that offers these services.

This amendment makes no other changes to the Policy.

Dan Finke
President

Aetna Life Insurance Company
(A Stock Company)

Amendment: 7
Issue Date: July 2, 2021

Aetna Life Insurance Company

Hartford, Connecticut 06156

Student Accident Insurance

Policy Amendment

Policyholder: Connecticut State Colleges and Universities: Central, Eastern, Southern and Western - Accident Plan

Policy No.: [GP-890429][GP-8904033][GP-890434][GP-890435]

Effective Date: This Amendment is effective on the later of:

August 1, 2021; or
The date a person becomes a **covered person** under the Student Accident Policy.

The Student Accident policy noted above has been changed.

The following is a summary of the changes in the Policy. This amendment is effective on the date(s) shown above.

1. The *Other Than Preventive Care Expense Benefits* section of the Schedule of Benefits has been changed. The cost-sharing and maximums below replace the cost-sharing and maximums that currently appear in the Schedule of Benefits for these benefits:

COVERAGE	**BENEFIT AMOUNT**	
	Preferred Care	**Non-Preferred Care**
PRE-ADMISSION TESTING EXPENSE		
	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
NON-ELECTIVE - SECOND SURGICAL OPINION EXPENSE		
	Payable in accordance with the type of expense incurred and the place where service is provided	Payable in accordance with the type of expense incurred and the place where service is provided
PODIATRIC EXPENSE		
	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.

ACUPUNCTURE IN LIEU OF ANESTHESIA EXPENSE		
	Payable in accordance with the type of expense incurred and the place where service is provided	Payable in accordance with the type of expense incurred and the place where service is provided
TRANSFUSION OR KIDNEY DIALYSIS OF BLOOD EXPENSE		
	Payable in accordance with the type of expense incurred and the place where service is provided	Payable in accordance with the type of expense incurred and the place where service is provided

This amendment makes no other changes to the Policy.

Dan Finke
President

Aetna Life Insurance Company
(A Stock Company)

Amendment: 8
Issue Date: July 2, 2021

Aetna Life Insurance Company

Hartford, Connecticut 06156

Student Accident Insurance

Policy Amendment

Policyholder: **Connecticut State Colleges and Universities: Central, Eastern, Southern and Western - Accident Plan**

Policy No.: [GP-890429][GP-8904033][GP-890434][GP-890435]

Effective Date: This Amendment is effective on the later of:

August 1, 2021; or
The date a person becomes a **covered person** under the Student Accident Policy.

The Student Accident policy noted above has been changed.

The following is a summary of the changes in the Policy. This amendment is effective on the date(s) shown above.

1. The following ***Short Term Cardiac and Pulmonary Rehabilitation Therapy Services Expense*** benefit replaces the same benefit appearing in the ***Coverage*** section of the Policy:

   SHORT TERM CARDIAC AND PULMONARY REHABILIATION THERAPY SERVICES EXPENSE

   Inpatient rehabilitation benefits for the services listed will be paid as part of the *Hospital Expense* and *Skilled Nursing Facility Expense* benefits.

   Cardiac Rehabilitation Benefits
   - Cardiac rehabilitation benefits received at a **hospital**, **skilled nursing facility**, or **physician's** office. This Plan will cover charges in accordance with a treatment plan as determined by a **covered person's** risk level when recommended by a **physician**.

   Pulmonary Rehabilitation Benefits
   - Pulmonary rehabilitation benefits are available as part of an inpatient **hospital stay**. A limited course of outpatient pulmonary rehabilitation is covered for the treatment of reversible pulmonary disease states.

   Limitations
   Unless specifically covered above, not covered under this benefit are charges for:
   - Any services which are **covered medical expenses** in whole or in part under any other student plan sponsored by the Policyholder.
   - Any services unless provided in accordance with a specific treatment plan.
   - Services not performed by a **physician** or under the direct supervision of a **physician**.

- Services provided by a **physician** who resides in a **covered person's** home; or who is a member of the **covered person's** family, or a member of the **covered student's** spouse's family or the **covered student's** domestic partner's family.

The *Schedule of Benefits* shows any **copay**, **deductible**, covered percentage and maximum benefit that may apply to *Short-Term Cardiac and Pulmonary Rehabilitation Therapy Services Expense* benefits.

2. The following ***Short Term Rehabilitation Services Expense*** benefit replaces the ***Short Term Rehabilitation and Habilitation Therapies Expense*** benefit appearing in the ***Coverage*** section of the Policy:

SHORT-TERM REHABILITATION SERVICES EXPENSE

Covered medical expenses include charges for short-term rehabilitation services, as described below, when prescribed by a **physician.**

The services have to be performed by:
- A licensed or certified physical, occupational, or speech therapist;
- A **hospital**, **skilled nursing facility**, or **hospice facility**;
- A **home health care agency**; or
- A **physician**.

Short-term rehabilitation services have to follow a specific treatment plan, ordered by a **physician,** that:
- Details the treatment, and specifies frequency and duration;
- Provides for ongoing reviews and is renewed only if continued therapy is appropriate; and
- Allows therapy services, provided in a **covered person's** home, if the **covered person** is **homebound**.

Outpatient Cognitive Therapy, Physical Therapy, Occupational Therapy and Speech Therapy Rehabilitation Benefits.

Inpatient rehabilitation benefits for the services listed will be paid as part of the *Hospital Expense* and *Skilled Nursing Facility Expense* benefits.

- Physical therapy is covered for non-chronic conditions and acute **injuries**, provided the therapy is expected to:
  - significantly improve, develop or restore physical functions lost; or
  - improves any impaired function;

  as a result of an acute **injury** or surgical procedure. Physical therapy does not include educational training or services designed to develop physical function.
- Occupational therapy (except for vocational rehabilitation or employment counseling) is covered for non-chronic conditions and acute **injuries**, provided the therapy is expected to:
  - significantly improve, develop or restore physical functions lost or impaired as a result of an acute **injury** or surgical procedure; or
  - improve an impaired function as a result of an acute **injury** or surgical procedure; or
  - to relearn skills to significantly improve independence in the activities of daily living.

  Occupational therapy does not include educational training.
- Speech therapy is covered for non-chronic conditions and acute **injuries** provided the therapy is expected to:
  - significantly improve or restore the speech function or correct a speech impairment resulting from **injury** or surgical procedure; or

- improve delays in speech function development as a result of a gross anatomical defect present at birth.

Speech function is the ability to express thoughts, speak words and form sentences. Speech impairment is difficulty with expressing one's thoughts with spoken words.

- Cognitive rehabilitation is covered when the cognitive deficits have been acquired as a result of neurologic impairment due to trauma, stroke, or encephalopathy, and when the therapy is part of a treatment plan intended to restore previous cognitive function.

Habilitation Therapy Services

Covered medical expenses include habilitation therapy services a **physician** prescribes. The services have to be performed by a:

- licensed or certified physical, occupational or speech therapist;
- **hospital**, **skilled nursing facility**, or **hospice facility**;
- **home health care agency**; or
- **physician.**

Habilitation therapy services have to follow a specific treatment plan, ordered by a **physician**, that:

- details the treatment, and specifies frequency and duration;
- provides for ongoing reviews and is renewed only if continued therapy is appropriate; and
- allows therapy services, provided in the **covered person's** home, if a **covered person** is **homebound**.

Covered medical expenses for habilitation therapy services include:

- physical therapy, if it is expected to develop any impaired function;
- occupational therapy (except for vocational rehabilitation or employment counseling), if it is expected to:
  - Develop any impaired function; or
  - Relearn skills to significantly develop the **covered person's** independence in the activities of daily living;
- speech therapy, if it is expected to develop speech function as a result of delayed development; and
- early intensive behavioral interventions such as Applied Behavioral Analysis (ABA). Applied Behavioral Analysis is an educational service that is the process of applying interventions that:
  - systematically change behavior; and
  - are responsible for the observable improvement in behavior.

  Speech function is the ability to express thoughts, speak words and form sentences).

Limitations

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

- educational services for Down's Syndrome and Cerebral Palsy, for example, as they are considered both developmental and/or chronic in nature;
- any services which are **covered medical expenses** in whole or in part under any other student plan sponsored by the Policyholder;
- any services unless provided in accordance with a specific treatment plan;
- services provided during a **stay** in a **hospital**, **skilled nursing facility**, **home health agency** or **hospice facility**, except as stated above;
- services not performed by a **physician** or under the direct supervision of a **physician**;
- treatment covered as part of the *Chiropractic Treatment Expense* benefit. This applies whether or not benefits have been paid under the *Chiropractic Treatment Expense* benefit;

- services provided by a **physician** or physical, occupational or speech therapist who resides in the **covered person's** home; or who is a member of the **covered person's** family, or a member of the **covered student's** spouse's family or the **covered student's** domestic partner's family; and
- special education to instruct a person whose speech has been lost or impaired, to function without that ability. This includes lessons in sign language.

The *Schedule of Benefits* shows any **copay**, **deductible**, covered percentage and maximum benefit that may apply to *Short-Term Rehabilitation Services Expense* benefits.

Wherever there is a reference to *Short Term Rehabilitation and Habilitation Therapies Expense* in the Policy, it is hereby changed to *Short Term Rehabilitation Services*.

This amendment makes no other changes to the Policy.

Dan Finke
President

Aetna Life Insurance Company
(A Stock Company)

Amendment: 9
Issue Date: July 2, 2021

Aetna Life Insurance Company

Hartford, Connecticut 06156

Student Accident Insurance

Policy Amendment

Policyholder: **Connecticut State Colleges and Universities: Central, Eastern, Southern and Western - Accident Plan**

Policy No.: [GP-890429][GP-8904033][GP-890434][GP-890435]

Effective Date: This Amendment is effective on the later of:

August 1, 2021; or
The date a person becomes a **covered person** under the Student Accident Policy.

The Student Accident policy noted above has been changed.

The following is a summary of the changes in the Policy. This amendment is effective on the date(s) shown above.

1. The following **Important Notices** have been added to the face page of the Policy:

   IMPORTANT NOTICES:
   - **Notice of Non-Discrimination:**
     Aetna Life Insurance Company does not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation, or health status in the administration of the plan including enrollment and benefit determinations.
   - **Sanctioned Countries:**
     If coverage provided by this policy violates or will violate any economic or trade sanctions, the coverage is immediately considered invalid. For example, Aetna companies cannot make payments for health care or other claims or services if it violates a financial sanction regulation. This includes sanctions related to a blocked person or a country under sanction by the United States, unless permitted under a written Office of Foreign Asset Control (OFAC) license.

     For more information, visit http://www.treasury.gov/resource-center/sanctions/Pages/default.aspx.

2. The ***Definition*** section of the Policy has been revised as follows:

a. The following definition has been added:

Medicare
The health insurance provided by Title XVIII of the Social Security Act, as amended. It includes Health Maintenance Organization (HMO) or similar coverage that is an authorized alternative to Parts A and B of **Medicare.**

b. The definition of **Recognized Charge** has been replaced with the definition below:

Recognized Charge:
The amount of a **non-preferred care provider's** charge that is eligible for coverage. A **covered person** is responsible for all amounts above the **recognized charge**. The **recognized charge** may be less than the **provider's** full charge.

The plan's **recognized charge** applies to all **non-preferred care covered medical expenses** except **non-preferred care emergency care**. It applies even to charges from a **non-preferred care provider** in a **hospital** that is a **preferred care provider**. In all cases, the **recognized charge** is determined based on the Geographic Area where a **covered person** receives the service or supply.

Except as otherwise specified below, the **recognized charge** for each service or supply is the lesser of what the **provider** bills and:

- For professional services and other services or supplies not mentioned below:
  - 105% of the Medicare Allowable Rates.

- For services of **hospitals** and other facilities:
  - 140% of the Medicare Allowable Rates.

- For **prescription drugs**:
  - 100% of the Average Wholesale Price, (AWP).

- For dental expenses, the **recognized charge** for a service or supply is the lesser of:
  - What the **provider** bills or submits for that service or supply; and
  - the 80th percentile of the Prevailing Charge Rates.

The **recognized charge** is the **negotiated charge** for **providers** with whom **Aetna** has a direct contract but are not **preferred care providers** or, if there is no direct contract, with whom **Aetna** has a contract through any third party that is not an affiliate of **Aetna.**

If the ID card displays the National Advantage Program (NAP) logo, the **recognized charge** is the rate **Aetna** has negotiated with the NAP **provider**. The **non-preferred care** cost sharing applies when a **covered person** gets care from NAP **providers**, except for **emergency care**.

A NAP **provider** is a **provider** with whom **Aetna** has a contract through any third party that is not an affiliate of **Aetna** or through the **Coventry National** or **First Health Networks**. However, a NAP **provider** listed in the NAP directory is not a **preferred care provider**.

Aetna has the right to apply **Aetna** reimbursement policies. Those policies may further reduce the **recognized charge**. These policies take into account factors such as:

- The duration and complexity of a service;
- When multiple procedures are billed at the same time, whether additional overhead is required;
- Whether an assistant surgeon is necessary for the service;
- If follow-up care is included;

- Whether other characteristics modify or make a particular service unique;
- When a charge includes more than one claim line, whether any services described by a claim line are part of, or incidental to, the primary service provided; and
- The educational level, licensure, or length of training of the **provider**.

Aetna reimbursement policies are based on **Aetna's** review of:
- The Centers for Medicare and Medicaid Services' (CMS) National Correct Coding Initiative (NCCI) and other external materials that say what billing and coding practices are and are not appropriate;
- Generally accepted standards of medical and dental practice; and
- The views of **physicians** and **dentists** practicing in the relevant clinical areas.

Aetna uses commercial software to administer some of these policies. Some policies are different for professional services than for facility services.

Special Terms Used In This Definition:
As used above, Average Wholesale Price (AWP), Geographic Area, Prevailing Charge Rates, and Medicare Allowable Rates are defined as follows:

Average Wholesale Price (AWP)

This is the current average wholesale price of a **prescription drug** listed in the Facts and Comparisons Medi-span weekly price updates (or any other similar publication chosen by **Aetna**).

Geographic Area
The Geographic area made up of the first three digits of the U.S. Postal Service zip codes. If **Aetna** determines that more data is needed for a particular service or supply, **Aetna** may base rates on a wider Geographic Area such as an entire state.

Medicare Allowable Rates
Except as specified below, these are the rates CMS establishes for services and supplies provided to Medicare enrollees. **Aetna** updates its systems with these revised rates within 180 days of receiving them from CMS. If Medicare does not have a rate, **Aetna** will determine the rate as follows:
- Use the same method CMS uses to set Medicare rates;
- Look at what other **providers** charge;
- Look at how much work it takes to perform a service; and
- Look at other things as needed to decide what rate is reasonable for a particular service or supply.

Exceptions:
- For inpatient services, **Aetna's** Medicare Allowable Rate excludes amounts CMS allocates for Operating Indirect Medical Education (IME) and Direct Graduate Medical Education (DGME). **Aetna's** rate also excludes other payments which CMS may make directly to **hospitals**, and for any retroactive adjustments made by CMS.
- For anesthesia, the Medicare Allowable Rate is 5% greater than the general Medicare Allowable Rate.
- For laboratory, the Medicare Allowable Rate is 20% lower than the general Medicare Allowable Rate.
- For DME, the Medicare Allowable Rate is 5% lower than the general Medicare Allowable Rate.

Prevailing Charge Rates: The percentile value reported in a database prepared by FAIR Health, a nonprofit company. FAIR Health changes these rates periodically. **Aetna** updates its systems with these changes within 180 days after receiving them from FAIR Health. If the FAIR Health database becomes

unavailable, **Aetna** has the right to substitute an alternative database that **Aetna** believes is comparable.

Additional Information:

Get the most value out of the benefits. Use the "Estimate the Cost of Care" tool on Aetna Navigator®. **Aetna**'s secure member website at www.aetna.com may contain additional information which may help a **covered person** to determine the cost of a service or supply. Log on to Aetna Navigator® to access the "Estimate the Cost of Care" feature. Within this feature, view **Aetna's** "Cost of Care" and "Member Payment Estimator" tools.

3. The ***Effective Date of Insurance*** provision in the ***Eligibility and Effective Date of Coverage*** section in the Policy has been revised. The paragraph that applies to adopted children has been replaced with the following paragraph:

   Coverage is provided for a child legally placed for adoption with a **covered student** from the moment of placement; for an initial period of 31 days; provided the child lives in the household of the **covered student;** and is dependent upon the **covered student** for support. Notification of placement of such child and payment of any additional premium; if necessary; is required within 31 days from placement. To continue the insurance beyond this initial 31 day period; the **covered student** must notify Aetna or its agent of the placement of such child; and pay any additional premium required for the child's insurance within the 31 day period. If the **covered student's** coverage ends during the 31 day period after the adopted child's placement, the adopted child's coverage will end on the same day as the **covered student's** coverage. This applies even if the 31 day period has not expired.

4. The ***Eligible Persons*** provision in the ***Eligibility and Effective Date of Coverage*** section in the Policy has been revised to add the following:

   Medicare:
   A person eligible for **Medicare** at the time of enrollment under the Policyholder's plan is not eligible for coverage.

   If a **covered person** becomes eligible for **Medicare** after he or she is enrolled in the Policyholder's plan, such Medicare eligibility will not result in the termination of coverage under the plan.

   As used within this provision, persons are "eligible for **Medicare"** if they are entitled to benefits under Part A (receiving free Part A) or enrolled in Part B or Premium Part A.

This amendment makes no other changes to the Policy.

Dan Finke
President

Aetna Life Insurance Company
(A Stock Company)

Amendment: 10
GR-96134-A1-DefMedVision Pol
ED. 3-15

Aetna Life Insurance Company

Hartford, Connecticut 06156

Student Accident Insurance

Policy Amendment

Policyholder: Connecticut State Colleges and Universities: Central, Eastern, Southern and Western - Accident Plan

Policy No.: [GP-890429][GP-8904033][GP-890434][GP-890435]

Effective Date: This Amendment is effective on the later of:

August 1, 2021; or
The date a person becomes a **covered person** under the Student Accident Policy.

The Student Accident policy noted above has been changed.

The following is a summary of the changes in the Policy. This amendment is effective on the date(s) shown above.

1. The ***Precertification*** provision that applies to the ***Prescribed Medicines Expense Benefit*** in the ***Coverage*** section of the Policy has been revised. The following has been added to the ***Medical Exception*** paragraph:

   "A **covered person**, a **covered person's** designee or a **covered person's prescriber** may seek an expedited medical exception process to obtain coverage for non-covered drugs in exigent circumstances. An "exigent circumstance" exists when a **covered person** is suffering from a health condition that may seriously jeopardize a **covered person's** life, health, or ability to regain maximum function or when a **covered person** is undergoing a current course of treatment using a non-formulary drug.

   The request for an expedited review of an exigent circumstance may be submitted by contacting **Aetna's** *Precertification Department* at 1-855-240-0535, faxing the request to 1-877-269-9916 or submitting the request in writing to:

   CVS Health ATTN: Aetna PA
   1300 E Campbell Road
   Richardson, TX 75081.

   Aetna will make a coverage determination within 24 hours after receipt of the request and will notify the **covered person**, the **covered person's** designee or the **covered person's prescriber** of Aetna's decision."

This amendment makes no other changes to the Policy.

Dan Finke
President

Aetna Life Insurance Company
(A Stock Company)

Amendment: 11
Issue Date: July 2, 2021

Assistive Technology

Persons using assistive technology may not be able to fully access the following information. For assistance, please call the number listed on your ID card at no cost.

Smartphone or Tablet

To view documents from your smartphone or tablet, the free WinZip app is required. It may be available from your App Store.

Non-Discrimination

Aetna complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Aetna does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Aetna:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages

If you need these services, contact our Civil Rights Coordinator.

If you believe that Aetna has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Civil Rights Coordinator, PO Box 14462, Lexington, KY 40512, 1-800-648-7817, TTY 711, Fax 859-425-3379, CRCoordinator@aetna.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company, Coventry Health Care plans and their affiliates.

Language Assistance

TTY: 711

For language assistance in your language call the number listed on your ID card at no cost. (English)

Para obtener asistencia lingüística en español, llame sin cargo al número que figura en su tarjeta de identificación. (Spanish)

欲取得繁體中文語言協助，請撥打您 ID 卡上所列的號碼，無需付費。(Chinese)

Pour une assistance linguistique en français appeler le numéro indiqué sur votre carte d'identité sans frais. (French)

Para sa tulong sa wika na nasa Tagalog, tawagan ang nakalistang numero sa iyong ID card nang walang bayad. (Tagalog)

Benötigen Sie Hilfe oder Informationen auf Deutsch? Rufen Sie kostenlos die auf Ihrer Versicherungskarte aufgeführte Nummer an. (German)

للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني المذكور في بطاقتك التعريفية. (Arabic)

Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo a yo endike nan kat idantifikasyon ou gratis. (French Creole)

Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente il numero riportato sulla Sua scheda identificativa. (Italian)

日本語で援助をご希望の方は、IDカードに記載されている番号まで無料でお電話ください。(Japanese)

한국어로 언어 지원을 받고 싶으시면 보험 ID 카드에 수록된 무료 통화번호로 전화해 주십시오. (Korean)

برای راهنمایی به زبان فارسی، بدون هیچ هزینه ای با شماره ای که بر روی کارت شناسایی شما آمده است تماس بگیرید. انگلیسی (Persian)

Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer podany na karcie ID. (Polish)

Para obter assistência linguística em português ligue para o número grátis listado no seu cartão de identificação. (Portuguese)

Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру, указанному в вашей ID-карте удостоверения личности. (Russian)

Để được hỗ trợ ngôn ngữ bằng (ngôn ngữ), hãy gọi miễn phí đến số được ghi trên thẻ ID của quý vị. (Vietnamese)