

2009 - 2010

Student Health Insurance Plan

Southern Maine Community College

*Underwritten by:
Aetna Life Insurance Company
(ALIC)*

Policy Number 474923

Presented by:
Cross Insurance
217 Main Street
PO Box 3028
Lewiston, ME 04243
800.537.6444
www.crossagency.com/smcc

Where to Find Help

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

For questions about:

- Insurance Benefits
- Enrollment
- Waiver Process
- Claims Processing
- Pre-Certification Requirements

Please contact:

Aetna Student Health
P.O. Box 15708
Boston, MA 02215-0014
(888) 294-6058

Or

Cross Insurance
217 Main St.
PO Box 3028
Lewiston, ME 04243
(800) 537-6444
www.crossagency.com/smcc

For questions about:

ID Cards

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

For lost ID cards, contact:

Aetna Student Health
(888) 294-6058

For questions about:

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

Please contact:

Aetna Pharmacy Management
(800) 238-6279 (Available 24 hours)

For questions about:

- Provider Listings

Please contact:

Aetna Student Health
(888) 294-6058

A complete list of providers can be found at Aetna's **DocFind**[®] Service at either:
www.aetna.com/docfind/custom/studenthealth/index.html or: **www.aetnastudenthealth.com**

For questions about:

On Call International 24/7 Emergency Travel Assistance Services

Please contact:

On Call International at **(866) 525-1956 (within U.S.)**.

If outside the U.S., call collect by dialing **the U.S. access code plus (603) 328-1956**. Please also visit ***www.aetnastudenthealth.com*** and visit your school-specific site for further information.

IMPORTANT NOTE

Please keep this Brochure, as it provides a general summary of your coverage. A complete description of the benefits and full terms and conditions may be found in the Master Policy issued to Southern Maine Community College. If any discrepancy exists between this Brochure and the Policy, the Master Policy will govern and control the payment of benefits. The Master Policy may be viewed at the Office of the Director of Student Life at Southern Maine Community College during business hours.

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

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WHERE TO FIND HELP

Got Questions? Get Answers with Aetna's Navigator®

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

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

How do I register?

- Go to www.aetnastudenthealth.com
- Find your school in the School Directory
- Click on Aetna Navigator® Member Website and then the "Register for Aetna Navigator" link.
- Follow the instructions for the registration process, including selecting a user name, password and security phrase.

Need help with registering onto Aetna Navigator?

Registration assistance is available toll free, Monday through Friday, from 7 a.m. to 9 p.m. Eastern Time at **(800) 225-3375**.

For Questions About:

- Insurance Benefits
- Enrollment
- Claims Processing
- Inpatient Admission Pre-Certification
- ID cards

Please contact:

Aetna Student Health
P.O. Box 15708 Boston, MA
02215-0014
(888) 294-6058

or visit www.aetnastudenthealth.com, click on "**Find Your School**" and enter Southern Maine Community College as your school name.

You will be issued an ID card as soon as possible. This card is for identification only. It is not a guarantee of eligibility or benefits. If you must seek medical attention before the ID card is received, benefits will be payable according to the Policy. *You do not need an ID card to be eligible to receive benefits.*

Worldwide Web Access:

Aetna Student Health www.aetnastudenthealth.com

For General Plan Information:

Aetna Student Health
P.O. Box 15708
Boston, MA 02215-0014
(888) 294-6058 or visit www.aetnastudenthealth.com, click on "**Find Your School**" and enter **Southern Community College**.

In the event of an emergency, call 911.

POLICY PERIOD

1. **Students:** Coverage for all insured students enrolled for the Fall Semester, will become effective at 12:01 AM on **August 16, 2009**, and will terminate at 12:01 AM on **August 16, 2010**.
2. **New Spring Semester students:** Coverage for all insured students enrolled for the Spring Semester, will become effective at 12:01 AM on **January 1, 2010**, and will terminate at 12:01 AM on **August 16, 2010**.
3. **Insured dependents:** Coverage will become effective on the same date the insured student's coverage becomes effective, or the day after the postmarked date when the completed application and premium are sent, if later. Coverage for insured dependents terminates in accordance with the Termination Provisions described in the Master Policy. For more information on Termination of Covered Dependents see pages (35-36) of this Brochure. Examples include, but are not limited to: the date the student's coverage terminates, the date the dependent no longer meets the definition of a dependent.

RATES

2009-2010	Annual Insurance Rates* 8/16/09 – 8/16/10	Spring Insurance Rates 1/1/10 -8/16/10
Enrollment Deadline	9/20/2009	1/31/2010
Student Only	\$331	\$221
Spouse Only	\$985	\$658
Child(ren) Only	\$487	\$326

Southern Maine Community College STUDENT ACCIDENT AND SICKNESS INSURANCE PLAN

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

STUDENT COVERAGE

ELIGIBILITY

All students enrolled in nine or more credit hours at Southern Maine Community College, and who actively attend classes for at least the first 31 days, after the date when coverage becomes effective.

ENROLLMENT

Eligible students will be automatically enrolled in this plan, unless the on line completed Waiver Form has been received by the specified enrollment deadline dates listed in the next section of this Brochure.

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

WAIVER PROCESS/PROCEDURE

Eligible students will automatically be enrolled in this plan, unless a completed on line waiver form, showing proof of comparable coverage, is submitted by the deadline below. Students will be required to either waive or enroll at the beginning of each new academic year. Students who registered for fewer than 9 credit hours in the Fall semester and who were not required to waive by the Fall deadline will need to waive by the Spring deadline if they will be enrolled in 9 or more credit hours in the Spring

Student	Waiver Deadline Date
Annual	9/20/2009
Spring Semester	1/31/2010

To Waive or Enroll

- Go to www.aetnastudenthealth.com
- Click on “Find Your School.”
- Enter your school name and then click on “Search.”
- Click on the “Waive/Enroll” button

NOTE: International Students must be covered by a United States based Company that provides a medical plan of comparable coverage to waive the Southern Maine Community College Student Health Insurance Plan.

PREMIUM REFUND POLICY

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

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

DEPENDENT COVERAGE

ELIGIBILITY

Covered students may also enroll their lawful spouse, and dependent children under 25 years of age. Dependent children must be unmarried, have no dependent of their own, and be either 1) a resident of Maine or 2) be enrolled as a full-time student.

<i>Dependent Enrollment Deadlines</i>	
<i>Annual Policy</i>	<i>September 20, 2009</i>
<i>Spring Semester*</i>	<i>January 31, 2010</i>

**** Spring Semester open only to newly enrolled students and their dependents.***

ENROLLMENT - Dependents

To enroll the dependent(s) of a covered student, please complete the application on line at www.aetnastudenthealth.com. Your application must be submitted before **September 20, 2009**, then there will be no break in coverage. The Fall enrollment deadline is **September 20, 2009**. Dependent enrollment applications will not be accepted after **September 20, 2009**, unless there is a significant life change that directly affects their insurance coverage. (An example of a significant life change would be loss of health coverage under another health plan.) **The Spring enrollment deadline is January 31, 2010**. The completed Enrollment form and premium must be sent to Aetna Student Health.

To Enroll your Dependent

- Go to www.aetnastudenthealth.com
- Click on "Find Your School."
- Enter your school name and then click on "Search."
- Click on the "Dependent Enrollment" button

NEWBORN INFANT AND ADOPTED CHILD COVERAGE

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

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

Please note: Previously Covered Persons must re-enroll for dependent coverage by September 20, 2009 for the Fall Semester, and by January 31, 2010 for the Spring Semester, in order to avoid a break in coverage for conditions which existed in prior policy years. Once a break in continuous coverage occurs, a condition existing during such a break which is a Pre-Existing Condition will not be payable. See Continuously Insured Section of this Brochure.

For information or general questions on dependent enrollment, contact Aetna Student Health at, **(888) 294-6058**.

CONTINUOUSLY INSURED

Persons who have remained continuously insured under this Policy or other policies will be covered for any Pre-Existing Condition, which manifests itself while continuously insured, except for expenses payable under prior policies in the absence of this Policy. Previously Covered Persons must re-enroll for coverage, including dependent coverage, by **September 20, 2009**, for the Fall Semester, and by **January 31, 2010**, for the Spring Semester in order to avoid a break in coverage for conditions which existed in prior policy years. Once a break in continuous coverage occurs, the Pre-Existing Conditions Limitation will apply (see page 9).

Note special provision. For the continually insured provision to apply, the policyholder must apply for new coverage within 90 days of the termination date of the previous plan. Any individuals who were covered by the previous plan within 90 days of the termination date must be allowed continuation of coverage under the new plan. These means that a continuation of coverage time period could be up to 180 days. Please see policy document for more information on this provision.

PREFERRED PROVIDER NETWORK

Aetna Student Health has arranged for you to access a Preferred Provider Network in your local community. Acute care facilities and mental health networks are available nationally if you require hospitalization outside the immediate area of the Southern Maine Community College campus.

To maximize your savings and reduce your out-of-pocket expenses, select a Preferred Provider. It is to your advantage to use a Preferred Provider because savings may be achieved from the Negotiated Charges these providers have agreed to accept as payment for their services. Preferred Providers are independent contractors, and are neither employees nor agents of Southern Maine Community College, Cross Insurance, Aetna Student Health, or Aetna.

You may also obtain information regarding Preferred Providers by contacting Aetna Student Health at (888) 294-6058 or through the Internet by accessing DocFind at www.aetna.com/docfind/custom/studenthealth/index.html

1. Click on “Enter DocFind”
2. Select zip code, city, or county
3. Enter criteria
4. Select Provider Category
5. Select Provider Type
6. Select Plan Type – Student Health Plans
7. Select “Start Search” or “More Options”
8. “More Options” enter criteria and “Search”

**Preferred providers are independent contractors and are neither employees nor agents of Southern Maine Community College, Cross Insurance, Aetna Student Health, or Aetna.*

PRE-CERTIFICATION PROGRAM

Pre-certification simply means calling Aetna Student Health prior to treatment to obtain approval for a medical procedure or service. Pre-certification may be done by you, your doctor, a hospital administrator, or one of your relatives. All requests for certification must be obtained by contacting Aetna Student Health at (888) 294 – 6058 (attention Managed Care Department).

The following inpatient and outpatient services or supplies require pre-certification:

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

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

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

The patient, Physician or hospital must telephone at least **three (3) business days** prior to the planned admission or prior to the date the services are scheduled to begin.

Notification of Emergency Admissions:

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

PRE-EXISTING CONDITIONS/CONTINUOUSLY INSURED PROVISIONS

Pre-existing Condition

A preexisting condition is an injury or disease that was present before your first day of coverage under a group health insurance plan. If you received medical advice, treatment or services for that injury or disease or you took prescription drugs or medicines for that injury or disease during the **12 months** prior to your first day of coverage, that injury or disease will be considered a pre-existing condition.

Limitation

Preexisting conditions are not covered during the first **12 months** that you are covered under this plan. However, there is an important exception to this general rule if you have been Continuously Insured.

Continuously Insured

You have been continuously insured if you (i) had “creditable health insurance coverage” (such as COBRA, HMO, another group or individual policy, Medicare or Medicaid) prior to enrolling in this plan; **and** (ii) the creditable coverage ended within **90 days** of the date you enrolled under this plan. If both of these tests are met, then the pre-existing limitation period under this plan will be reduced (and possibly eliminated altogether) by the number of days of your prior creditable coverage. You will be asked to provide evidence of your prior creditable coverage.

Once a break (of more than **90 days**) in your continuous coverage occurs, the definition of Pre-Existing Conditions will apply.

Pre-existing conditions limitation may not exceed 12 months, including the waiting period, if any.

DESCRIPTION OF BENEFITS

Please Note:

The Southern Maine Community College Student Health Insurance Plan may not cover all of your health care expenses. The Plan excludes coverage for certain services and contains limitations on the amounts it will pay. Please read the Southern Maine Community College Plan Brochure carefully before deciding whether this Plan is right for you. While this document will tell you about some of the important features of the Plan, other features may be important to you and some may further limit what the Plan will pay. If you want to look at the full Plan description, which is contained in the Master Policy issued to Southern Maine Community College, you may view it at the Office of the Director of Student Life or you may contact Aetna Student Health at 888-294-6058.

This Plan will never pay more than \$10,000 per condition per policy year. Additional Plan maximums may also apply. Some illnesses may cost more to treat and health care providers may bill you for what the Plan does not cover.

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

SUMMARY OF BENEFITS CHART

COINSURANCE

Covered Medical Expenses are payable at 100% up to \$2,000 per condition per policy year. Once the \$2,000 has been reached, the Covered Medical Expenses are payable at 80% of the Negotiated Charge at a Preferred Care Provider, or at 60% of the Reasonable Charge at a Non-Preferred Care Provider, to the Plan Maximum, unless otherwise noted in the policy.

All coverage is based on Reasonable Charges unless otherwise specified.

Inpatient Hospitalization Benefits	
Hospital Room and Board Expense	<p>Covered Medical Expenses are payable as follows: <u>Preferred Care:</u> 100% of the Negotiated Charge up to \$2,000, then 80% of the Negotiated Charge to the Plan Maximum. <u>Non-Preferred Care:</u> 100% of the Reasonable Charge up to \$2,000, then 60% of the Reasonable Charge to the Plan Maximum.</p>
Intensive Care Unit Expense	<p>Covered Medical Expenses are payable as follows: <u>Preferred Care:</u> 100% of the Negotiated Charge up to \$2,000, then 80% of the Negotiated Charge to the Plan Maximum. <u>Non-Preferred Care:</u> 100% of the Reasonable Charge up to \$2,000, then 60% of the Reasonable Charge to the Plan Maximum.</p>
Miscellaneous Hospital Expense	<p>Covered Medical Expenses include, but are not limited to: laboratory tests, x-rays, surgical dressings, anesthesia, supplies and equipment use, and medicines.</p> <p>Covered Medical Expenses are payable as follows: <u>Preferred Care:</u> 100% of the Negotiated Charge up to \$2,000, then 80% of the Negotiated Charge to the Plan Maximum. <u>Non-Preferred Care:</u> 100% of the Reasonable Charge up to \$2,000, then 60% of the Reasonable Charge to the Plan Maximum.</p>
Physician Hospital Visit/ Consultation Expenses	<p>Covered Medical Expenses for charges for the non-surgical services of the attending Physician, or a consulting Physician, are payable as follows: <u>Preferred Care:</u> 100% of the Negotiated Charge up to \$2,000, then 80% of the Negotiated Charge to the Plan Maximum. <u>Non-Preferred Care:</u> 100% of the Reasonable Charge up to \$2,000, then 60% of the Reasonable Charge to the Plan Maximum.</p>

Surgical Benefits (Inpatient and Outpatient)	
Surgical Expense	<p>Covered Medical Expenses for charges for surgical services, performed by a Physician, are payable as follows:</p> <p><u>Preferred Care:</u> 100% of the Negotiated Charge up to \$2,000, then 80% of the Negotiated Charge to the Plan Maximum.</p> <p><u>Non-Preferred Care:</u> 100% of the Reasonable Charge up to \$2,000, then 60% of the Reasonable Charge to the Plan Maximum.</p>
Anesthetist and Assistant Surgeon Expense	<p>Covered Medical Expenses for the charges of an anesthetist and an assistant surgeon, during a surgical procedure, are payable as follows:</p> <p><u>Preferred Care:</u> 100% of the Negotiated Charge up to \$2,000, then 80% of the Negotiated Charge to the Plan Maximum.</p> <p><u>Non-Preferred Care:</u> 100% of the Reasonable Charge up to \$2,000, then 60% of the Reasonable Charge to the Plan Maximum.</p>
Ambulatory Surgical Expense	<p>Covered Medical Expenses for outpatient surgery performed in an ambulatory surgical center are payable as follows:</p> <p><u>Preferred Care:</u> 100% of the Negotiated Charge up to \$2,000, then 80% of the Negotiated Charge to the Plan Maximum.</p> <p><u>Non-Preferred Care:</u> 100% of the Reasonable Charge up to \$2,000, then 60% of the Reasonable Charge to the Plan Maximum.</p>
Outpatient Benefits	
<p>Covered Medical Expenses include but are not limited to: Physician's office visits, hospital or outpatient department or emergency room visits, durable medical equipment, clinical lab, or radiological facility.</p>	
Hospital Outpatient Department or Walk-in Clinic Expense	<p>Covered Medical Expenses for outpatient treatment in a hospital are payable as follows:</p> <p><u>Preferred Care:</u> 100% of the Negotiated Charge up to \$2,000, then 80% of the Negotiated Charge to the Plan Maximum.</p> <p><u>Non-Preferred Care:</u> 100% of the Reasonable Charge up to \$2,000, then 60% of the Reasonable Charge to the Plan Maximum.</p>
Emergency Room Expense	<p>Covered Medical Expenses incurred for treatment of an Emergency Medical Condition are payable as follows:</p> <p><u>Preferred Care:</u> 100% of the Negotiated Charge up to \$2,000, then 80% of the Negotiated Charge to the Plan Maximum.</p> <p><u>Non-Preferred Care:</u> 100% of the Reasonable Charge up to \$2,000, then 80% of the Reasonable Charge to the Plan Maximum.</p>

<p>Urgent Care Expense</p>	<p><i>Benefits include charges for treatment by an urgent care provider.</i></p> <p>Please note: A covered person <u>should not seek medical care or treatment from an urgent care provider if their illness, injury, or condition, is an emergency condition.</u> The covered person should go directly to the emergency room of a hospital or call 911 for ambulance and medical assistance.</p> <p><u>Urgent Care</u> Benefits include charges for an urgent care provider to evaluate and treat an urgent condition.</p> <p>Covered Medical Expenses for urgent care treatment are payable as follows: <u>Preferred Care:</u> 100% of the Negotiated Charge up to \$2,000, then 80% of the Negotiated Charge to the Plan Maximum. <u>Non-Preferred Care:</u> 100% of the Reasonable Charge up to \$2,000, then 60% of the Reasonable Charge to the Plan Maximum.</p> <p><u>Non-Urgent Care</u></p> <p>Covered Medical Expenses for charges made by an urgent care provider to treat a <i>non-urgent condition</i> are payable as follows: <u>Preferred Care:</u> 100% of the Negotiated Charge up to \$2,000, then 80% of the Negotiated Charge to the Plan Maximum. <u>Non-Preferred Care:</u> 100% of the Reasonable Charge up to \$2,000, then 60% of the Reasonable Charge to the Plan Maximum.</p> <p><i>No benefit will be paid under any other part of this Plan for charges made by an urgent care provider to treat a non-urgent condition.</i></p> <p>Non-urgent care includes, but is not limited to, the following:</p> <ul style="list-style-type: none"> • Routine or preventive care (this includes immunizations), • Follow-up care, • Physical therapy, • Elective surgical procedures, and • Any lab and radiology exams which are not related to the treatment of the urgent condition.
<p>Ambulance Expense</p>	<p>Covered Medical Expenses are payable as follows: 100% of the actual charge to \$2,000, then 80% of the actual charge to the Plan Maximum.</p>
<p>Pre-Admission Testing Expense</p>	<p>Covered Medical Expenses for Pre-Admission testing charges while an outpatient before scheduled surgery are payable as follows: <u>Preferred Care:</u> 100% of the Negotiated Charge up to \$2,000, then 80% of the Negotiated Charge to the Plan Maximum. <u>Non-Preferred Care:</u> 100% of the Reasonable Charge up to \$2,000, then 60% of the Reasonable Charge to the Plan Maximum.</p> <p><i>Please see the Definition of Pre-Admission Testing on page 4 for more detailed information on this benefit.</i></p>
<p>Physician's Office Visits</p>	<p>Covered Medical Expenses are payable as follows: <u>Preferred Care:</u> 100% of the Negotiated Charge up to \$2,000, then 80% of the Negotiated Charge to the Plan Maximum. <u>Non-Preferred Care:</u> 100% of the Reasonable Charge up to \$2,000, then 60% of the Reasonable Charge to the Plan Maximum.</p>

<p>Laboratory and X-Ray Expense</p>	<p>Covered Medical Expenses are payable as follows: <u>Preferred Care:</u> 100% of the Negotiated Charge up to \$2,000, then 80% of the Negotiated Charge to the Plan Maximum. <u>Non-Preferred Care:</u> 100% of the Reasonable Charge up to \$2,000, then 60% of the Reasonable Charge to the Plan Maximum.</p>
<p>High Cost Procedures Expense</p>	<p>Covered Medical Expenses include charges incurred by a covered person are payable as follows: <u>Preferred Care:</u> 100% of the Negotiated Charge up to \$2,000, then 80% of the Negotiated Charge to the Plan Maximum. <u>Non-Preferred Care:</u> 100% of the Reasonable Charge up to \$2,000, then 60% of the Reasonable Charge to the Plan Maximum.</p> <p>For purposes of this benefit, “High Cost Procedure” means any outpatient procedure costing over \$200.</p> <p><i>Please see the Definition of High Cost Procedures on page 36 for more detailed information on this benefit.</i></p>
<p>Therapy Expense</p>	<p>Covered Medical Expenses include charges incurred by a covered person for the following types of therapy provided on an outpatient basis:</p> <ul style="list-style-type: none"> • Chiropractic Care <p>Expenses for Chiropractic Care are Covered Medical Expenses, if such care is related to neuromusculoskeletal conditions and conditions arising from: the lack of normal nerve, muscle, and/or joint function.</p> <p>Benefits must be included for the services of chiropractors to the extent that the same services would be covered by a physician. Benefits must be included for therapeutic, adjustive and manipulative services.</p> <p><u>Preferred Care:</u> 100% of the Negotiated Charge up to \$2,000, then 80% of the Negotiated Charge to the Plan Maximum. <u>Non-Preferred Care:</u> 100% of the Reasonable Charge up to \$2,000, then 60% of the Reasonable Charge to the Plan Maximum.</p>
<p>Spinal Disorder Treatment Expense</p>	<p>Covered Medical Expenses include expenses incurred for:</p> <ul style="list-style-type: none"> • Manipulative (adjustive) treatment, or • Other physical treatment, of any condition caused by or related to biomechanical or nerve conduction disorders of the spine. <p>Covered Medical Expenses will be payable as follows: <u>Preferred Care:</u> Payable as any other Condition. <u>Non-Preferred Care:</u> Payable as any other Condition.</p> <p>There is a benefit maximum of \$200 per Policy Year.</p> <p>The maximum does not apply to expenses incurred:</p> <ul style="list-style-type: none"> • While the person is a full-time inpatient in a hospital; • For treatment of scoliosis; • For fracture care; or • For surgery. This includes pre and post surgical care given or ordered by the operating physician.

<p>Chemotherapy Expense</p>	<p>Covered Medical Expenses include chemotherapy, including anti-nausea drugs used in conjunction with the chemotherapy, radiation therapy, tests and procedures, physiotherapy (for rehabilitation only after a surgery), and expenses incurred at a radiological facility. Covered medical expenses also include expenses for the administration of chemotherapy and visits by a health care professional to administer the chemotherapy.</p> <p>Benefits are payable as follows: <u>Preferred Care:</u> 100% of the Negotiated Charge up to \$2,000, then 80% of the Negotiated Charge to the Plan Maximum. <u>Non-Preferred Care:</u> 100% of the Reasonable Charge up to \$2,000, then 60% of the Reasonable Charge to the Plan Maximum.</p>
<p>Durable Medical Equipment Expense</p>	<p>Covered Medical Expenses are payable as follows: <u>Preferred Care:</u> 100% of the Negotiated Charge up to \$2,000, then 80% of the Negotiated Charge to the Plan Maximum. <u>Non-Preferred Care:</u> 100% of the Reasonable Charge up to \$2,000, then 60% of the Reasonable Charge to the Plan Maximum.</p>
<p>Prosthetic Devices Expense</p>	<p>Covered Medical Expenses include charges incurred by a covered person for: artificial limbs, or eyes, and other non-dental prosthetic devices, as a result of an accident or sickness.</p> <p>Covered Medical expenses include charges for prosthetic devices to replace, in whole or in part, an arm or leg. Coverage for repair or replacement is also included.</p> <p>Benefits are payable as follows: <u>Preferred Care:</u> 100% of the Negotiated Charge up to \$2,000, then 80% of the Negotiated Charge to the Plan Maximum. <u>Non-Preferred Care:</u> 100% of the Reasonable Charge up to \$2,000, then 60% of the Reasonable Charge to the Plan Maximum.</p>

<p>General Anesthesia and Facility Expense for Certain Dental Procedures</p>	<p>Covered Medical Expenses include expenses incurred for general anesthesia and associated hospital, ambulatory surgical center or other licensed facility charges in connection with dental care when one or more of the following criteria are met:</p> <ul style="list-style-type: none"> (a) Covered persons, including infants, exhibiting physical, intellectual, or medically compromising conditions for which dental treatment under local anesthesia cannot be expected to provide a successful result and for which dental treatment under general anesthesia can be expected to produce a superior result, (b) Covered persons exhibiting dental treatment needs for which local anesthesia is ineffective because of acute infection, anatomical variation or allergy; or (c) Covered persons who are children or adolescents who are extremely uncooperative, fearful, anxious, or uncommunicative with dental needs of such magnitude that treatment should not be postponed or deferred and for whom lack of treatment can be expected to result in dental or oral pain or infection, loss of teeth or other increased oral or dental morbidity; or (d) Covered persons who have sustained extensive orofacial and dental trauma. <p>Charges in connection with the dental procedure itself, including, but not limited to, those for the professional fees of the dentist are not covered.</p> <p>Coverage is restricted to dental care that is provided by a:</p> <ul style="list-style-type: none"> (a) Fully accredited specialist in pediatric dentistry, (b) Fully accredited specialist in oral and maxillofacial surgery, and (c) Dentist to whom hospital privileges have been granted <p>Benefits are payable as follows: <u>Preferred Care:</u> Payable as any other Condition. <u>Non-Preferred Care:</u> Payable as any other Condition.</p>
<p>Impacted Wisdom Teeth Expense</p>	<p>Covered Medical Expenses for removal of one or more impacted wisdom teeth are payable as follows:</p> <p>100% of the actual charge to \$2,000, then 80% of the actual charge to the Plan Maximum.</p> <p>Benefits are limited to \$250 per tooth.</p>
<p>Allergy Testing Expense</p>	<p>Benefits include charges incurred for diagnostic testing of allergies and immunology services.</p> <p>Covered Medical Expenses include, but are not limited to, charges for the following:</p> <ul style="list-style-type: none"> • Laboratory tests, • Physician office visits <p>Covered Medical Expenses are payable as follows: <u>Preferred Care:</u> 100% of the Negotiated Charge up to \$2,000, then 80% of the Negotiated Charge to the Plan Maximum. <u>Non-Preferred Care:</u> 100% of the Reasonable Charge up to \$2,000, then 60% of the Reasonable Charge to the Plan Maximum.</p>

<p>Diagnostic Testing for Attention Disorders and Learning Disabilities Expense</p>	<p>Covered Medical Expenses for diagnostic testing for:</p> <ul style="list-style-type: none"> • Attention deficit disorder, or • Attention deficit hyperactive disorder, or • Dyslexia. <p>are payable as follows: <u>Preferred Care</u>: 100% of the Negotiated Charge up to \$2,000, then 80% of the Negotiated Charge to the Plan Maximum. <u>Non-Preferred Care</u>: 100% of the Reasonable Charge up to \$2,000, then 60% of the Reasonable Charge to the Plan Maximum.</p> <p>Once a covered person has been diagnosed with one of these conditions, medical treatment will be payable as detailed under the outpatient Treatment of Mental and Nervous Disorders portion of this Policy.</p>
<p>Routine Physical Exam Expense</p>	<p>Benefits include expenses for a routine physical exam performed by a physician. If charges for a routine physical exam given to a child who is a covered dependent are covered under any other benefit section, those charges will not be covered under this section.</p> <p>A routine physical exam is a medical exam given by a physician, for a reason other than to diagnose or treat a suspected or identified injury or sickness. Included as a part of the exam are:</p> <ul style="list-style-type: none"> • X-rays, lab, and other tests given in connection with the exam, and • <p><u>Preferred Care</u> visits are payable at 100% of the Negotiated Charge up to \$2,000, then 80% of the Negotiated Charge to the Plan Maximum. <u>Non-Preferred Care</u> visits are payable at 100% of the Reasonable Charge up to \$2,000, then 60% of the Reasonable Charge to the Plan Maximum.</p> <p>For all exams given to a covered student or a spouse who is a covered dependent, Covered Medical Expenses will not include charges for more than:</p> <ul style="list-style-type: none"> • One exam in 24 months in a row, if the person is under age 65, and • One exam in 12 months in a row, if the person is age 65 or over.
<p>Immunizations Expense (Adult only)</p>	<p>Covered Medical Expenses include:</p> <ul style="list-style-type: none"> • charges incurred by a covered student and dependent spouse for the materials for the administration of appropriate and medically necessary immunizations, and testing for tuberculosis <p>Benefits for materials for the administration of immunizations are covered at 100% and are limited to \$200 for immunizations per Policy Year.</p> <p><u>Preferred Care</u>: 100% of the Negotiated Charge. <u>Non-Preferred Care</u>: 100% of the Reasonable Charge.</p>

<p>Consultant or Specialist Expense</p>	<p>Covered Medical Expenses include the expenses for the services of a consultant or specialist. The services must be requested by the attending physician for the purpose of confirming or determining to confirm or determine a diagnosis.</p> <p>Covered Medical Expenses are covered as follows: <u>Preferred Care:</u> 100% of the Negotiated Charge up to \$2,000, then 80% of the Negotiated Charge to the Plan Maximum. <u>Non-Preferred Care:</u> 100% of the Reasonable Charge up to \$2,000, then 60% of the Reasonable Charge to the Plan Maximum.</p>
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Mental Health Benefits	
<p>Biologically-Based Mental and Nervous Disorders Inpatient Expense</p>	<p>Covered Medical Expenses for the diagnosis and treatment of biologically based Mental and Nervous Disorders are payable on the same basis as any other sickness.</p> <p>Covered Medical Expenses also include the charges made for treatment received during partial hospitalization in a hospital or treatment facility. Prior review and approval must be obtained on a case-by-case basis by contacting Aetna Student Health. When approved, benefits will be payable in place of an inpatient admission, whereby 2 days of partial hospitalization may be exchanged for 1 day of full hospitalization.</p> <p><u>Preferred Care:</u> 100% of the Negotiated Charge up to \$2,000, then 80% of the Negotiated Charge to the Plan Maximum. <u>Non-Preferred Care:</u> 100% of the Reasonable Charge up to \$2,000, then 60% of the Reasonable Charge to the Plan Maximum.</p> <p><i>Inpatient and Partial hospitalization benefits for Treatment Of Mental And Nervous Disorders require pre-certification.</i></p> <p>Benefits for Mental and Nervous Disorders will count toward any Alcoholism and Drug Addiction Treatment maximums.</p>
<p>Biologically-Based Mental and Nervous Disorders Outpatient Expense</p>	<p>Covered Medical Expenses for the diagnosis and treatment of biologically based Mental and Nervous Disorders are payable on the same basis as any other sickness.</p> <p><u>Preferred Care:</u> 100% of the Negotiated Charge up to \$2,000, then 80% of the Negotiated Charge to the Plan Maximum. <u>Non-Preferred Care:</u> 100% of the Reasonable Charge up to \$2,000, then 60% of the Reasonable Charge to the Plan Maximum.</p> <p>Benefits for Mental and Nervous Disorders will count toward any Alcoholism and Drug Addiction Treatment maximums.</p>

<p>Non-Biologically Based Mental and Nervous Disorders Inpatient Expense</p>	<p>Covered Medical Expenses for the treatment of a Mental and Nervous Disorders while confined as a inpatient in a hospital or facility licensed for such treatment are payable as follows:</p> <p>Covered Medical Expenses also include the charges made for treatment received during partial hospitalization in a hospital or treatment facility. Prior review and approval must be obtained on a case-by-case basis by contacting Aetna Student Health. When approved, benefits will be payable in place of an inpatient admission, whereby 2 days of partial hospitalization may be exchanged for 1 day of full hospitalization.</p> <p><u>Preferred Care:</u> 100% of the Negotiated Charge up to \$2,000, then 80% of the Negotiated Charge to the Plan Maximum.</p> <p><u>Non-Preferred Care:</u> 100% of the Reasonable Charge up to \$2,000, then 60% of the Reasonable Charge to the Plan Maximum.</p> <p><i>Inpatient and Partial hospitalization benefits for Treatment Of Mental And Nervous Disorders require pre-certification.</i></p> <p>Benefits for Mental and Nervous Disorders will count toward any Alcoholism and Drug Addiction Treatment maximums.</p>
<p>Non-Biologically Based Mental and Nervous Disorders Outpatient Expense</p>	<p>Covered Medical Expenses for outpatient treatment of a Mental and Nervous Disorders are payable as follows:</p> <p><u>Preferred Care:</u> 100% of the Negotiated Charge up to \$2,000, then 80% of the Negotiated Charge to the Plan Maximum.</p> <p><u>Non-Preferred Care:</u> 100% of the Reasonable Charge up to \$2,000, then 60% of the Reasonable Charge to the Plan Maximum.</p> <p>Benefits for Mental and Nervous Disorders will count toward any Alcoholism and Drug Addiction Treatment maximums.</p>

<p>Substance Abuse Benefits</p>	
<p>Inpatient Expense</p>	<p>Covered Medical Expenses for the treatment of a substance abuse condition while confined as a inpatient in a hospital or facility licensed for such treatment are payable as follows:</p> <p><u>Preferred Care:</u> 100% of the Negotiated Charge up to \$2,000, then 80% of the Negotiated Charge to the Plan Maximum.</p> <p><u>Non-Preferred Care:</u> 100% of the Reasonable Charge up to \$2,000, then 60% of the Reasonable Charge to the Plan Maximum.</p> <p>Covered Medical Expenses also include the charges made for treatment received during partial hospitalization in a hospital or treatment facility. Prior review and approval must be obtained on a case-by-case basis by contacting Aetna Student Health. When approved, benefits will be payable in place of an inpatient admission, whereby 2 days of partial hospitalization may be exchanged for 1 day of full hospitalization.</p> <p><i>Inpatient and partial hospitalization benefits for treatment Of Substance Abuse require pre-certification.</i></p> <p>Benefits for Alcoholism and Drug Addiction Treatment will count toward any Mental and Nervous Disorders maximums.</p>

<p>Outpatient Expense</p>	<p>Covered Medical Expenses for outpatient treatment of a substance abuse condition are payable as follows: <u>Preferred Care:</u> 100% of the Negotiated Charge up to \$2,000, then 80% of the Negotiated Charge to the Plan Maximum. <u>Non-Preferred Care:</u> 100% of the Reasonable Charge up to \$2,000, then 60% of the Reasonable Charge to the Plan Maximum.</p> <p>Benefits for Alcoholism and Drug Addiction Treatment will count toward any Mental and Nervous Disorders maximums.</p>
<p>Maternity Benefits</p>	
<p>Maternity Expense</p>	<p>Covered Medical Expenses include inpatient care of the covered person and any newborn child for a minimum of 48 hours after a vaginal delivery and for a minimum of 96 hours after a cesarean delivery.</p> <p>Any decision to shorten such minimum coverages shall be made by the attending Physician in consultation with the mother. In such cases, covered services may include: home visits, parent education, and assistance and training in breast or bottle-feeding.</p> <p>Covered Medical Expenses for pregnancy, childbirth, and complications of pregnancy (including spontaneous and non-elective abortions) are payable on the same basis as any other sickness.</p>
<p>Well Newborn Nursery Care Expense</p>	<p>Benefits include charges for routine care of a covered person's newborn child as follows:</p> <ul style="list-style-type: none"> • Hospital charges for routine nursery care during the mother's confinement, but for not more than four days [for a normal delivery], • Physician's charges for circumcision, and • Physician's charges for visits to the newborn child in the hospital and consultations, but for not more than 1 visit per day. <p>Covered Medical Expenses are payable as follows: <u>Preferred Care:</u> Payable as any other Condition. <u>Non-Preferred Care:</u> Payable as any other Condition</p>

Additional Benefits	
<p>Prescription Drug Benefit</p>	<p>Prescription Drug Benefits are payable as follows:</p> <p><u>Preferred Care Pharmacy:</u> Following a \$25 Copay for each Brand Name Prescription Drug or a \$12 Copay for each Generic Prescription Drug.</p> <p><u>Non-Preferred Care Pharmacy:</u> Following a \$25 Deductible for each Brand Name Prescription or a \$12 Deductible for each Generic Prescription Drug,</p> <p>Covered Medical Expenses are payable up to a maximum of \$500 per Policy Year.</p> <p>The cost of any prescription always will be either the Pharmacy's customary price of filling the prescription, or the copay, whichever is less.</p> <p>This Pharmacy benefit is provided to cover Medically Necessary Prescriptions associated with a covered Sickness or Accident occurring during the Policy Year. Please use your Aetna Student Health ID card when obtaining your prescriptions</p> <p>Prior Authorization is required for certain Prescription Drugs, including oral contraceptives, Imitrex, certain stimulants, growth hormones and for any Prescription quantities larger than a 30-day supply. (<i>This is only a partial list.</i>)</p> <p>Medications not covered by this benefit include, but are not limited to: allergy sera, inhalers, all acne medications, drugs whose sole purpose is to promote or to stimulate hair growth, appetite suppressants, smoking deterrents, immunization agents and vaccines, and non-self injectables. (<i>This is only a partial list.</i>)</p> <p>For assistance or for a complete list of excluded medications, or drugs requiring prior authorization, please contact Aetna Pharmacy Management at (800) 238-6279 (available 24 hours).</p> <p>Aetna Specialty Pharmacy provides specialty medications and support to members living with chronic conditions. The medications offered may be injected, infused or taken by mouth. For additional information please go to www.AetnaSpecialtyRx.com</p>
<p>Diabetic Testing Supplies and Equipment Expense</p>	<p>Benefits include charges for testing material used to detect the presence of sugar in the person's urine or blood for monitoring glycemic control.</p> <p>Diabetic Testing Supplies and Equipment include:</p> <ul style="list-style-type: none"> • Insulin • Oral hypoglycemic agents • Lancet devices • Hypodermic Needles and Syringes • Glucose Monitors, and • Test strips <p>Covered Medical Expenses are payable as follows:</p> <p><u>Preferred Care:</u> Payable as any other Condition.</p> <p><u>Non-Preferred care:</u> Payable as any other Condition.</p>

<p>Outpatient Diabetic Self-management Education Programs Expense</p>	<p>Covered Medical Expenses for outpatient diabetic self-management education programs are payable as follows: <u>Preferred Care:</u> Payable as any other Condition. <u>Non-Preferred care:</u> Payable as any other Condition.</p> <p><i>Please see the definition on page 36 of this Brochure for more specific information on Diabetic Self-Management Education Programs.</i></p>
<p>Elemental Infant Formula expense</p>	<p>Covered Medical Expenses include amino acid-based elemental infant formula for children 2 years of age and under when a physician has diagnosed and documented one of the following:</p> <ul style="list-style-type: none"> • Symptomatic allergic colitis or proctitis; • Laboratory or biopsy proven allergic eosinophilic gastroenteritis; • A history of anaphyaxis; gastroesophageal reflux disease that is nonresponsive to standard medical therapies; • Severe vomiting or diarrhea resulting in clinically significant dehydration requiring treatment by a medical provider; • Cystic fibrosis; • Or malabsorption of cow milk-based or soy milk-based formula. <p>Benefits are payable as any other Condition.</p>
<p>Non Prescription Enteral Formula Expense</p>	<p>Covered Medical Expenses include charges incurred by a covered person for non-prescription enteral formulas and special modified low-protein food products, for which a physician has issued a written order, and are for the treatment of malabsorption caused by:</p> <ul style="list-style-type: none"> • Crohn’s Disease, • Ulcerative colitis, • Gastroesophageal reflux, • Gastrointestinal motility, • Chronic intestinal pseudoobstruction, and • Inherited diseases of amino acids and organic acids. <p>Benefits are payable as follows: <u>Preferred Care:</u> Payable as any other Condition. <u>Non-Preferred care:</u> Payable as any other Condition.</p> <p>Non-Prescription Enteral Formula expenses will be paid up to \$200 per Policy Year.</p> <p>Prescribed Modified Low-Protein Food Products expenses will be paid up to \$3,000 per Policy Year.</p>

<p>Prescription Contraceptive Devices</p>	<p>Covered Medical Expenses include:</p> <ul style="list-style-type: none"> • Charges incurred for contraceptive drugs and devices that by law need a physician's prescription, and that have been approved by the FDA. • Related outpatient contraceptive services such as: • Consultations, • Exams, • Procedures, and • Other medical services and supplies • Benefits for contraceptive drugs are payable as follows: <u>Preferred Care:</u> Payable as any other Condition. <u>Non-Preferred care:</u> Payable as any other Condition. <p>Benefits for contraceptive devices and outpatient contraceptive services are payable as follows: <u>Preferred Care:</u> Payable as any other Condition. <u>Non-Preferred care:</u> Payable as any other Condition.</p>
<p>Pap Smear Expense</p>	<p>Covered Medical Expenses include one annual routine pap smear screening for women age 18 and older.</p> <p>Benefits are payable as follows: <u>Preferred Care:</u> 100% of the Negotiated Charge up to \$2,000, then 80% of the Negotiated Charge to the Plan Maximum. <u>Non-Preferred Care:</u> 100% of the Reasonable Charge up to \$2,000, then 60% of the Reasonable Charge to the Plan Maximum.</p>
<p>Mammography Expense</p>	<p>Covered Medical Expenses include one baseline mammogram for women between age 35 and 40. Coverage is also provided for one routine annual mammogram for women age 40 and older, as well as when medically indicated for women with risk factors who are under age 40. Risk factors for women under 40 are:</p> <ul style="list-style-type: none"> • Prior personal history of breast cancer • Positive Genetic Testings • Family history of breast cancer; or • Other risk factors <p>Mammogram screenings coverage will also include comprehensive ultrasound screening for the entire breast or breasts if a mammogram demonstrates heterogenous or dense breast tissue and when determined to be medically necessary by a licensed physician.</p> <p>Benefits are payable as follows: <u>Preferred Care:</u> 100% of the Negotiated Charge up to \$2,000, then 80% of the Negotiated Charge to the Plan Maximum. <u>Non-Preferred Care:</u> 100% of the Reasonable Charge up to \$2,000, then 60% of the Reasonable Charge to the Plan Maximum.</p>

<p>Mastectomy and Breast Reconstruction Expense Benefit</p>	<p>Mastectomy Reconstruction Expense Benefits are payable for charges incurred by a covered person incident to a mastectomy for reconstructive surgery.</p> <p>Covered Medical Expenses will include expenses incurred for:</p> <p>(a) All stages of reconstruction of the breast on which the mastectomy has been performed, and</p> <p>(b) Surgery and reconstruction of the other breast to produce a symmetrical appearance.</p> <p>Benefits are payable on the same basis as any other sickness.</p>
<p>Elective Abortion Expenses</p>	<p>If, as a result of pregnancy having its inception during the Policy Year, a covered person incurs expenses in connection with an elective abortion, a benefit is payable.</p> <p>Covered Medical Expenses for Elective Abortion Expense are covered as follows:</p> <p><u>Preferred Care</u>: 100% of the Negotiated Charge up to \$2,000, then 80% of the Negotiated Charge to the Plan Maximum.</p> <p><u>Non-Preferred Care</u>: 100% of the Reasonable Charge up to \$2,000, then 60% of the Reasonable Charge to the Plan Maximum.</p> <p>This benefit is in lieu of any other Policy benefits.</p>
<p>Routine Screening for Sexually Transmitted Disease Expense</p>	<p>Covered Medical Expenses include charges for covered persons who are at least 18 years old and who are sexually active for annual routine screening for sexually transmitted diseases.</p> <p>Benefits are payable as follows:</p> <p><u>Preferred Care</u>: 100% of the Negotiated Charge up to \$2,000, then 80% of the Negotiated Charge to the Plan Maximum.</p> <p><u>Non-Preferred Care</u>: 100% of the Reasonable Charge up to \$2,000, then 60% of the Reasonable Charge to the Plan Maximum.</p> <p><i>Please see definition on page 44 for more information on this benefit.</i></p> <p>Benefits are limited to \$150 per Policy Year.</p>
<p>Routine Colorectal Cancer Screening Expense</p>	<p>Covered Medical Expenses include charges for colorectal cancer examination and laboratory tests, for any nonsymptomatic person age 50 or more, or a symptomatic person under age 50, for the following:</p> <ul style="list-style-type: none"> • One fecal occult blood test every 12 months in a row • A Sigmoidoscopy at age 50 and every 3 years thereafter • One digital rectal exam every 12 months in a row • A double contrast barium enema, once every 5 years • A colonoscopy, once every 10 years • Virtual colonoscopy • Stool DNA. <p>Benefits are payable as follows:</p> <p><u>Preferred Care</u>: Payable as any other Condition.</p> <p><u>Non-Preferred care</u>: Payable as any other Condition.</p>

<p>Routine Prostate Cancer Screening Expense</p>	<p>Covered Medical Expenses include charges incurred by a covered person for the screening of cancer as follows:</p> <ul style="list-style-type: none"> • For a male age 50 or over, one digital rectal exam and one prostate specific antigen test each Policy Year. <p>Benefits are payable as follows: <u>Preferred Care:</u> Payable as any other Condition. <u>Non-Preferred care:</u> Payable as any other Condition.</p>
<p>Surgical Second Opinion Expense</p>	<p>Covered Medical Expenses will include a second opinion consultation by a specialist on the need for surgery which has been recommended by the covered person's physician. The specialist must be board certified in the medical field relating to the surgical procedure being proposed. Coverage will also be provided for any expenses incurred for required X-rays and diagnostic tests done in connection with that consultation. Aetna must receive a written report on the second opinion consultation.</p> <p>Benefits are payable as follows: <u>Preferred Care:</u> 100% of the Negotiated Charge up to \$2,000, then 80% of the Negotiated Charge to the Plan Maximum. <u>Non-Preferred Care:</u> 100% of the Reasonable Charge up to \$2,000, then 60% of the Reasonable Charge to the Plan Maximum.</p>
<p>Elective Surgical Second Opinion Expense</p>	<p>Covered Medical Expenses will include a second opinion consultation by a specialist on the need for non-emergency 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.</p> <p>Benefits are payable as follows: <u>Preferred Care:</u> 100% of the Negotiated Charge up to \$2,000, then 80% of the Negotiated Charge to the Plan Maximum. <u>Non-Preferred Care:</u> 100% of the Reasonable Charge up to \$2,000, then 60% of the Reasonable Charge to the Plan Maximum.</p>
<p>Acupuncture in Lieu of Anesthesia Expense</p>	<p>Covered Medical Expenses include acupuncture therapy, when acupuncture is used in lieu of other anesthesia, for a surgical or dental procedure covered under this Plan.</p> <p>The acupuncture must be administered by an acupuncturist who is a legally qualified physician, practicing within the scope of their license.</p> <p><u>Preferred Care:</u> 100% of the Negotiated Charge up to \$2,000, then 80% of the Negotiated Charge to the Plan Maximum. <u>Non-Preferred Care:</u> 100% of the Reasonable Charge up to \$2,000, then 60% of the Reasonable Charge to the Plan Maximum</p>

<p>Home Health Care Expenses</p>	<p>Covered Medical Expenses include charges incurred by a covered person for home health care services rendered in the patient’s place of residence on a part-time basis only if:</p> <ul style="list-style-type: none"> • Confinement in a hospital or skilled nursing facility would be required in the absence of the home health care services; and • The plan covering the home health services is established as prescribed in writing by a physician. <p>Prior hospitalization is not required for Home Health Care benefits.</p> <p><u>Preferred Care:</u> 100% of the Negotiated Charge up to \$2,000, then 80% of the Negotiated Charge to the Plan Maximum.</p> <p><u>Non-Preferred Care:</u> 100% of the Reasonable Charge up to \$2,000, then 60% of the Reasonable Charge to the Plan Maximum</p> <p>Home Health Care Services will only be Covered Medical Expenses if they are rendered by a Home Health Care Provider. Please see definition on page 38 for the definition of a Home Health Care Provider.</p>
<p>Transfusion or Dialysis of Blood Expense</p>	<p>Covered Medical Expenses include charges for the transfusion or dialysis of blood, including the cost of: whole blood, blood components, and the administration thereof.</p> <p>Benefits are payable as follows:</p> <p><u>Preferred Care:</u> 100% of the Negotiated Charge up to \$2,000, then 80% of the Negotiated Charge to the Plan Maximum.</p> <p><u>Non-Preferred Care:</u> 100% of the Reasonable Charge up to \$2,000, then 60% of the Reasonable Charge to the Plan Maximum</p>
<p>Hospice Benefit</p>	<p>Covered Medical Expenses include charges for hospice care provided for a terminally ill covered person during a hospice benefit period.</p> <p>Benefits include services provided in a home setting or an inpatient setting.</p> <p>Benefits are payable as follows:</p> <p><u>Preferred Care:</u> 100% of the Negotiated Charge up to \$2,000, then 80% of the Negotiated Charge to the Plan Maximum.</p> <p><u>Non-Preferred Care:</u> 100% of the Reasonable Charge up to \$2,000, then 60% of the Reasonable Charge to the Plan Maximum</p> <p><i>Please see definition on page 38 for more information on Hospice Benefit Period.</i></p>
<p>Licensed Nurse Expense</p>	<p>Benefits include charges incurred by a covered person who is confined in a hospital as a resident bed-patient, and requires the services of a registered nurse or licensed practical nurse.</p> <p>Benefits are payable as follows:</p> <p><u>Preferred Care:</u> 100% of the Negotiated Charge up to \$2,000, then 80% of the Negotiated Charge to the Plan Maximum.</p> <p><u>Non-Preferred Care:</u> 100% of the Reasonable Charge up to \$2,000, then 60% of the Reasonable Charge to the Plan Maximum</p>

<p>Skilled Nursing Facility Expense</p>	<p>Covered Medical Expenses include charges incurred by a covered person for confinement in a skilled nursing facility for treatment rendered:</p> <ul style="list-style-type: none"> • In lieu of confinement in a hospital as a full time inpatient, or • Within 24 hours following a hospital confinement and for the same or related cause(s) as such hospital confinement. <p>Covered Medical Expenses are payable as follows: <u>Preferred Care:</u> 100% of the Negotiated Charge up to \$2,000, then 80% of the Negotiated Charge to the Plan Maximum. <u>Non-Preferred Care:</u> 100% of the Reasonable Charge up to \$2,000, then 60% of the Reasonable Charge to the Plan Maximum.</p>
<p>Rehabilitation Facility Expense</p>	<p>Covered Medical Expenses include charges incurred by a covered person for confinement as a full time inpatient in a rehabilitation facility. Confinement in the rehabilitation facility must follow within 24 hours of, and be for the same or related cause(s) as, a period of hospital or skilled nursing facility confinement.</p> <p>Covered Medical Expenses for Rehabilitation Facility Expense are covered as follows:</p> <p><u>Preferred Care:</u> 100% of the Negotiated Charge up to \$2,000, then 80% of the Negotiated Charge to the Plan Maximum. <u>Non-Preferred Care:</u> 100% of the Reasonable Charge up to \$2,000, then 60% of the Reasonable Charge to the Plan Maximum.</p> <p>Covered Medical Expenses incurred for mental and nervous disorders will be payable on the same basis as any other illness.</p>
<p>Children's Hearing Aids Expense</p>	<p>Covered Medical Expenses include the purchase of a hearing aid for each hearing-impaired ear for individuals up to age 19, subject to the following requirements:</p> <ul style="list-style-type: none"> • The hearing loss must be documented by a physician or licensed audiologist • The hearing aid must be purchased from a licensed audiologist or licensed hearing aid dealer <p>Benefits are payable as follows: <u>Preferred Care:</u> 80% of the Negotiated Charge. <u>Non-Preferred Care:</u> 60% of the Reasonable Charge.</p> <p>Benefits are limited to \$1,400 per hearing aid for each hearing-impaired ear, every 36 months.</p>

Supplemental Medical Coverage
The Maximum benefit under the Student Accident and Sickness Insurance described above is **\$10,000** per condition, per policy year. If you have purchased the Student Health Insurance Plan at Southern Maine Community College, you are eligible to purchase this Supplemental Plan (Annual cost \$120, Spring Semester \$82) to extend a combined maximum of **\$50,000** per condition per policy year. This Supplemental Coverage must be purchased at the time of enrollment in the Annual basic medical plan, or at the time of enrollment in the Spring Semester basic medical plan if you are a student newly eligible in the Spring.

ADDITIONAL SERVICES AND DISCOUNTS

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

Aetna VisionSM Discount Program: The Aetna Vision discount program helps you save on vision exams and many eye care products, including sunglasses, contact lenses, non-prescription sunglasses, contact lens solutions and other eye care accessories. Plus, you can receive up to a 15% discount on LASIK surgery (the laser vision correction procedure).

Aetna FitnessSM Discount Program: Aetna's Fitness discount program provides members with access to preferred membership rates at nearly 10,000 fitness clubs nationwide and in Canada in the GlobalFitTM network. Members can also save on GlobalFit's other programs and services, such as at-home weight loss programs, home fitness equipment and videos and even one-on-one health coaching services* to help them quit smoking, reduce stress, lose weight, or meet any other health goal.

**Offered by WellCall, Inc. through GlobalFit*

Aetna Weight ManagementSM Discount Program: Helps you achieve your weight loss goals and develop a balanced approach to your active lifestyle. This program provides members and their eligible family members access to discounts on Jenny Craig[®] weight loss programs and products. Start with a FREE 30-day trial membership* then choose either a 6* -or 12* -month program** that's right for you. You also receive individual weight loss consultations, personalized menu planning, tailored activity planning, motivational materials and much more.

** Offers good at participating centers in the United States, Canada and Puerto Rico and through Jenny Direct at-home. Additional cost for all food purchases and shipping where applicable.*

***Additional weekly food discounts will grow throughout the year, based on active participation.*

Find a meal plan that works for you at eDiets[®]:

Get a personalized plan for healthy eating that fits your lifestyle, and save 25 percent on weekly eDiets dues. You'll have access to customized weekly menus, recipes, support boards, chats, nutrition tools and fitness tips.

Use Zagat[®] reviews as a guide for your night out:

Planning a night on the town? Or, want to visit a city where you've never been? Subscribe to Zagat online and get a 30 percent discount on their members-only services. You can sign up for access to restaurant reviews only, or choose full access and get ratings and reviews on hotels, restaurants, movies and other attractions.

You can even order printed guides at a discount!

Give the gift of relaxation to yourself or a friend through SpaWish:

Get a 10 percent discount when you buy a gift certificate of at least \$100, good for services at any of over 1,000 spas across the U.S. Choose a spa close to home or near your favorite place to visit!

Get trusted health information from the MayoClinic.com Bookstore:

Choose from newsletters and books — with recipes for healthy living, advice on staying in shape, guides on living with certain health conditions and more. It's all at your fingertips — and at a discount! The size of the discount will depend on the item price and other available discounts.

Aetna's Informed Health[®] Line:

Get answers from a registered nurse at any time — just call our toll-free Informed Health Line. With one simple call, you can:

- Learn more about health conditions that you or your family members have.
- Find out more about a medical test or procedure.
- Come up with questions to ask your doctor.

Talk to a registered nurse:

Our nurses can discuss more than 5,000 health and wellness topics. Call them anytime you have a health question.

Listen to our Audio Health Library:*

Call and learn about a topic that interests you. Choose from thousands of health conditions. Listen in English or Spanish. You can also transfer to a registered nurse at any time during your call.

**Not all topics discussed within the Audio Health Library are covered expenses under your health insurance plan.*

Go online for even more health information

If you like to go online for health information, check out the Healthwise® Knowledgebase. You can learn more about a health condition you have, medications you take, and more. Link to it through your secure Aetna Navigator® website at www.aetnanavigator.com.

Health and Wellness Portal: This dynamic, interactive website will give you health care and assessment tools to calculate body mass index, financial health, risk activities and health and wellness indicators. The site provides resources for wellness programs and activities.

Beginning RightSM Maternity Program: Give your baby a healthy start. Our Beginning Right Maternity Program comes with your health insurance plan. Use it throughout your pregnancy and after your baby is born. If you have health conditions or risk factors that may need special attention, we can help. Our nurses can give you personal case management to help you find ways to lower your risks. The more you know the better chance you have for good health ... for you and your baby.

Aetna Natural Products and ServicesSM Discount Program: Offers members access to reduced rates on services from natural therapy professionals, including acupuncturists, chiropractors, massage therapists and dietetic counselors, and access to discounts on over-the-counter vitamins, herbal and nutritional supplements and health-related products, such as foot care and natural body care products.

Quit Tobacco Cessation Program – Say good-bye to tobacco and hello to a healthier future! The one-year Quit Tobacco program is provided by Healthyroads, a leading provider of tobacco cessation programs. You'll get personal attention from health professionals that can help find what works for you.

Aetna Health ConnectionsSM Disease Management Program – This program offers support for over 35 conditions with smart technology and supportive services to ensure a healthier you. Our goal is to make it easier to manage your health and live your life well. Our CareEngine® system continuously scans your health data to identify safety risks and solutions. Using technology to look for opportunities for better care and programs and services helps to meet your individual needs. You may also receive a call or letter from the Aetna Health Connections Disease Management nurse. Call us at 1-866-269-4500 to get started.

GENERAL PROVISIONS

STATE MANDATED BENEFITS

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

SUBROGATION/REIMBURSEMENT

RIGHT OF RECOVERY PROVISION

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

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

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

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

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.

Non-Duplication of Benefits

This provision applies if a Covered Student:

- (a) Is covered by any other group, individual, or blanket health care plan, and
- (b) Would, as a result, receive medical expense or service benefits in excess of the actual expenses incurred.
In this case, the medical expense benefits the Plan will pay will be reduced by such excess.

EXTENSION OF BENEFITS

If Basic Sickness Expense, Supplemental Sickness Expense coverage for a **covered person** ends while he is **totally disabled**, benefits will continue to be available for expenses incurred for that person for covered expenses directly relating to the condition causing total disability, only while the **covered person** continues to be **totally disabled**. Benefits will end six months from the date coverage ends.

If a Covered Person is confined to a hospital on the date his or her insurance terminates, expenses incurred after the termination date and during the continuance of that hospital confinement, shall be payable in accordance with the policy, but only while they are incurred during the six month period, following such termination of insurance.

TERMINATION OF INSURANCE

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

TERMINATION OF STUDENT COVERAGE

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

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

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

TERMINATION OF DEPENDENT COVERAGE

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

- (a) For a child, on the first premium due date following the first to occur of:
 - (1) The date the child is no longer chiefly dependent upon the student for support and maintenance,
 - (2) The date of the child's marriage, and
 - (3) The child's 25th birthday,
- (b) The date the **covered student** fails to pay any required premium.
- (c) For the spouse, the date the marriage ends in divorce or annulment.
- (d) The date **dependent** coverage is deleted from this Policy.
- (e) For a domestic partner, the earlier to occur of:
 - 1) The date this Policy no longer allows coverage for domestic partners, and
 - 2) The date of termination of the domestic partnership. In that event, a completed and signed declaration of Termination of Domestic Partnership must be provided to the Policyholder.
- (f) The date the **dependent** ceases to be in an eligible class.

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

INCAPACITATED DEPENDENT CHILDREN

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

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

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

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

EXCLUSIONS

This Policy does not cover nor provide benefits for:

1. Expense incurred as a result of dental treatment, except for treatment for extraction of impacted wisdom teeth as provided elsewhere in this Policy.
2. Expense incurred for eye refractions, vision therapy, radial keratotomy, eyeglasses, contact lenses (except when required after cataract surgery), or other vision or hearing aids, or **prescriptions** or examinations except as required for repair caused by a covered **injury and except as specifically provided elsewhere in this Policy**.
3. Expense incurred as a result of **injury** due to participation in a riot. "Participation in a riot" means taking part in a riot in any way, including inciting the riot or conspiring to incite it. It does not include actions taken in self-defense, so long as they are not taken against persons who are trying to restore law and order.
4. Expense incurred as a result of an **accident** occurring in consequence of riding as a passenger or otherwise in any vehicle or device for aerial navigation, except as a fare-paying passenger in an aircraft operated by a scheduled airline maintaining regular published schedules on a regularly established route.
5. Expense incurred as a result of an **injury** or **sickness** due to working for wage or profit or for which benefits are payable under any Workers' Compensation or Occupational Disease Law.
6. Expense incurred as a result of an **injury** sustained or **sickness** contracted while in the service of the Armed Forces of any country. Upon the **covered person** entering the Armed Forces of any country, the unearned pro-rata premium will be refunded to the Policyholder.
7. Expense incurred for treatment provided in a governmental **hospital** unless there is a legal obligation to pay such charges in the absence of insurance.
8. Expense incurred for **elective treatment** or elective surgery except as specifically provided elsewhere in this Policy and performed while this Policy is in effect.

9. Expense incurred for cosmetic surgery, reconstructive surgery, or other services and supplies which improve, alter, or enhance appearance, whether or not for psychological or emotional reasons, except to the extent needed to:

Improve the function of a part of the body that:

- Is not a tooth or structure that supports the teeth, and
- Is malformed:
 - As a result of a severe birth defect, including harelip, webbed fingers, or toes, or
 - As direct result of:
 - Disease, or
 - Surgery performed to treat a disease or **injury**.

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

- In the calendar year of the accident which causes the **injury**, or
- In the next calendar year.

10. Expense covered by any other valid and collectible medical, health or accident insurance to the extent that benefits are payable under other valid and collectible insurance whether or not a claim is made for such benefits.
11. Expense for **injuries** sustained as the result of a motor vehicle accident to the extent that benefits are payable under other valid and collectible insurance whether or not claim is made for such benefits.
12. Expense incurred as a result of commission of a felony.
13. Expense incurred after the date insurance terminates for a **covered person** except as may be specifically provided in the Extension of Benefits Provision.
14. Expense incurred for any services rendered by a member of the **covered person's** immediate family or a person who lives in the **covered person's** home.
15. Expense incurred for treatment of temporomandibular joint dysfunction and associated myofascial pain.
16. Treatment for **injury** to the extent benefits are payable under any state no-fault automobile coverage, first party medical benefits payable under any other mandatory No-fault law.
17. 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).
18. Expense incurred for which no member of the **covered person's** immediate family has any legal obligation for payment.
19. Expense incurred for **custodial care**. **Custodial care** means services and supplies furnished to a person mainly to help him or her in the activities of daily life. This includes **room and board** and other institutional care. The person does not have to be disabled. Such services and supplies are custodial care without regard to:
- By whom they are prescribed, or
 - By whom they are recommended, or
 - By whom or by which they are performed.
20. Expenses incurred for blood or blood plasma, except charges by a hospital for the processing or administration of blood.
21. Expenses incurred for the repair or replacement of existing artificial limbs, orthopedic braces, or orthotic devices.

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

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

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

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

- Have been granted treatment investigational new drug (IND), or Group c/treatment IND status, or
- Are being studied at the Phase III level in a national clinical trial, sponsored by the National Cancer Institute,

If Aetna determines that available, scientific evidence demonstrates that the drug is effective, or shows promise of being effective, for the disease.

These sections describe requirements for health plans offered in Maine. The requirements include, but are not limited to: access to clinical trials, access to prescription drugs, utilization review standards, and independent external review.

23. 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.
24. Expense incurred for alternative, holistic medicine, and/or therapy, including but not limited to, yoga and hypnotherapy.
25. 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.
26. Expense incurred when the person or individual is acting beyond the scope of his/her/its legal authority.
27. Expense incurred for hearing aids, the fitting, or prescription of hearing aids, unless specifically provided for in this policy.
28. Expenses incurred for hearing exams.
29. Expense for care or services to the extent the charge would have been covered under Medicare Part A or Part B, even though the **covered person** is eligible, but did not enroll in Part B.

30. Expense for telephone consultations, charges for failure to keep a scheduled visit, or charges for completion of a claim form.
31. 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**.
32. Expense for incidental surgeries, and standby charges of a **physician**.
33. Expense for treatment and supplies for programs involving cessation of tobacco use.
34. Expense incurred for **injury** resulting from the play or practice of intercollegiate sports, in excess of \$1,000 (participating in sports clubs, or intramural athletic activities, is not excluded).
35. Expense for charges for services and supplies for or related to gamete intrafallopian transfer, artificial insemination, in-vitro fertilization (except as required by the state law), or embryo transfer procedures, elective sterilization or its reversal, or elective abortion, unless specifically provided for in this Policy.
36. Expense incurred for, or related to, sex change surgery, or to any treatment of gender identity disorder.
37. Expense for charges that are not **reasonable charges**.
38. Expense for charges that are not **recognized charges** except that this will not apply if the charge for a service, or supply, does not exceed the **recognized charge** for that service or supply, by more than the amount or percentage, specified as the Allowable Variation.
39. 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.
40. Expenses for treatment of **injury** or **sickness** to the extent payment is made, as a judgement or settlement, by any person deemed responsible for the **injury** or **sickness** (or their Insurers).
41. Expenses arising from a **pre-existing condition**.
42. Expenses for routine physical exams, including expenses in connection with well newborn care, routine vision exams, routine dental exams, routine hearing exams, immunizations, or other preventive services and supplies, except to the extent coverage of such exams, immunizations, services, or supplies is specifically provided in the Policy.
43. Expense incurred for a treatment, service, or supply, which is not **medically necessary** for the diagnosis care or treatment of the **sickness** or **injury** involved. This applies even if they are prescribed, recommended, or approved, by the person's attending **physician**, or **dentist**. **Medically Necessary** means health care services or products provided to a **covered person** for the purpose of preventing, diagnosing or treating an illness, injury or disease or the symptoms of an illness, injury or disease in a manner that is:
 - (a) Consistent with generally accepted standards of medical practice,
 - (b) Clinically appropriate in terms of type, frequency, extent, site and duration,
 - (c) Demonstrated through scientific evidence to be effective in improving health outcomes,
 - (d) Representative of "best practices" in the medical profession, and
 - (e) Not primarily for the convenience of the **covered person** or **physician** or other health care practitioner.

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

In no event will the following services or supplies be considered to be **medically necessary**:

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

44. Expense incurred for acupuncture, unless services are rendered for anesthetic purposes.

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

DEFINITIONS

Accident

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

Actual Charge

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

Aggregate Maximum

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

Ambulatory Surgical Center

A freestanding ambulatory surgical facility that:

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

Birth Center

A freestanding facility that:

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

Brand Name Prescription Drug or Medicine

A **prescription drug** which is protected by trademark registration.

Cardiac Rehabilitation

A multidisciplinary, **medically necessary** treatment of persons with documented cardiovascular disease, which shall be provided in either a **hospital**, or other setting.

Chlamydia Screening Test

This is any laboratory test of the urogenital tract that specifically detects for infection by one or more agents of Chlamydia trachomatis, and which test is approved for such purposes by the FDA.

Coinsurance

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

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

This is a fee charged to a person for **Covered Medical Expenses**.

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

Covered Dental Expenses

Those charges for any treatment, service, or supplies, covered by this Policy which are:

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

Covered dependent

A **covered student's dependent** who is insured under this Policy.

Covered Medical Expense

Those charges for any treatment, service or supplies covered by this Policy which are:

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

Covered person

A **covered student** and any **covered dependent** while coverage under this Policy is in effect.

Covered student

A student of the Policyholder who is insured under this Policy.

Deductible

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

Dental consultant

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

Dental provider

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

Dentist

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

Dependent

(a) the **covered student's** spouse residing with the **covered student**, or (b) the person identified as a domestic partner in the "Declaration of Domestic Partnership" which is completed and signed by the **covered student**, and (c) the **covered student's** unmarried child under the age of 25 years.

The term "child" includes: step-children; and adopted children. Adopted children include those who are placed for adoption with the **covered student**. "Placed for adoption" means the existence of a legal obligation for the total or partial support of a child in anticipation of adoption.

The term **dependent** does not include a person who is: (a) an eligible student, or (b) a member of the armed forces.

Designated Care

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

Designated Care Provider

A health care provider [or **pharmacy**,] that is affiliated with, and has an agreement with, the **School Health Services** to furnish services and supplies at a **negotiated charge**.

Diabetic Self-Management Education Course

The diabetes out-patient self-management training and educational services covered by this plan are provided through ambulatory diabetes education facilities authorized by the State's Diabetes Control Project within the Bureau of Health.

Directory

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

Durable Medical and Surgical Equipment

No more than one item of equipment for the same or similar purpose, and the accessories needed to operate it, that is:

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

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

Elective Treatment

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

- Tubal ligation,
- Vasectomy,
- Breast reduction,
- Sexual reassignment surgery,
- Submucous resection and/or other surgical correction for deviated nasal septum, other than necessary treatment of covered acute purulent sinusitis,
- Treatment for weight reduction,
- Learning disabilities,
- Temporomandibular joint dysfunction (TMJ),
- Immunization,
- Treatment of infertility, and
- Routine physical examinations.

Emergency Admission

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

- If immediate inpatient care was not given could, 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 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.

Generic Prescription Drug or Medicine

A **prescription drug** which is not protected by trademark registration, but is produced and sold under the chemical formulation name.

High Cost Procedure

High Cost Procedures include the following procedures and services:

- C.A.T. Scan,
- Magnetic Resonance Imaging,
- Laser treatment, which must be provided on an outpatient basis, and may be incurred in the following:
 - (a) A **physician's** office, or
 - (b) **Hospital** outpatient department, or emergency room, or
 - (c) Clinical laboratory, or
 - (d) Radiological facility, or other similar facility, licensed by the applicable state, or the state in which the facility is located.

Home Health Provider

A home health care agency which is certified under Title XVIII of the Social Security Act of 1965, as amended, which:

1. Is primarily engaged in and licensed or certified to provide skilled nursing and other therapeutic services;
2. Has standards, policies and rules established by a professional group, associated with the agency or organization, which professional group must include at least one physician and one registered nurse;
3. Is available to provide the care needed in the home 7 days a week and has telephone answering service available 24 hours per day;
4. Has the ability to and does provide, either directly or through contract, the services of a coordinator responsible for case discovery and planning and assuring that the covered person receives the services ordered by the physician;
5. Has under contract the services of a physician-advisor licensed by the State or a physician;
6. Conducts periodic case conferences for the purpose of individualized patient care planning and utilization review; and
7. Maintains a complete medical record on each patient.

Hospice

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

Hospice benefit period

A period that begins on the date the attending **physician** certifies that the **covered person** is a terminally ill patient who has less than 12 months to live. It ends after 12 months (or such later period for which treatment is certified) or on the death of the patient, if sooner.

Hospice Care Expenses

The reasonable and customary charges made by a hospice for the following services or supplies: charges for inpatient care, charges for drugs and medicines, charges for part-time nursing by an RN, LPN, or LVN, charges for physical and respiratory therapy in the home, charges for the use of medical equipment, charges for visits by licensed or trained social workers, psychologists or counselors, charges for bereavement counseling of the covered person's immediate family prior to, and within 3 months after, the covered person's death, and charges for respite care for up to 5 days in any 30 day period.

Hospital

A facility which meets all of these tests:

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

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

Hospital Confinement

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

Injury

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

Intensive Care Unit

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

Jaw Joint Disorder

This is a Temporomandibular Joint Dysfunction or any similar disorder in the relationship between the jaws or jaw joint, and the muscles, and nerves.

Mail Order Pharmacy

An establishment where **prescription drugs** are legally dispensed by mail.

Medically Necessary

Health care services or products provided to a **covered person** for the purpose of preventing, diagnosing or treating an illness, injury or disease or the symptoms of an illness, injury or disease in a manner that is:

- (a) Consistent with generally accepted standards of medical practice;
- (b) Clinically appropriate in terms of type, frequency, extent, site and duration;
- (c) Demonstrated through scientific evidence to be effective in improving health outcomes;
- (d) Representative of "best practices" in the medical profession; and
- (e) Not primarily for the convenience of the **covered person** or **physician** or other health care practitioner.

Medication Formulary

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

Member Dental Provider

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.

Member Dental Provider Service Area

The area within a 50 mile radius of the **covered student's member dental provider**.

Negotiated Charge

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

Non-Occupational Disease

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

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

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

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

Non-Occupational Injury

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

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

Non-Preferred Care

A health care service or supply furnished by a health care provider that is not a **Designated Care Provider**, or that is not a **Preferred Care Provider**, if:

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

Non-Preferred Care Provider

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

Non-Preferred Pharmacy

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

Non-Preferred Prescription Drug Expense

An expense incurred for a **prescription drug** that is not a **preferred prescription drug expense**.

Non-Serious Mental and Nervous Disorder

A mental health condition which manifests symptoms which are primarily mental or nervous for which the primary treatment is psychotherapy or psychotropic medication and is not included as a **Serious Mental Disorder**.

One Sickness

A **sickness** and all recurrences and related conditions which are sustained by a **covered person**.

Orthodontic treatment

Any

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

Out-of-Area Emergency Dental Care

Medically necessary care or treatment for an **emergency medical condition**, that is rendered outside a 50 mile radius of the **covered student's member dental provider**. Such care is subject to specific limitations set forth in this Policy.

Out-of-Pocket Limit

The amount that must be paid, by the **covered student**, or the **covered student** and their **covered dependents**, before **Covered Medical Expenses** will be payable at [100%-50%], for the remainder of the **Policy Year**. The **Out-of-Pocket Limit** applies only to **Covered Medical Expenses** for **preferred care**, which are payable at a rate greater than 50%.

The following expenses do not apply toward meeting the **Out-of-Pocket Limit**:

- **Deductibles**,
- **Copays**,
- Expenses that are not **Covered Medical Expenses**,
- Expenses for **designated care** or **non-preferred care**,
- Penalties,
- Expenses for prescription drugs, and
- Other expenses not covered by this Policy.

Outpatient Diabetic Self-Management Education Program

A scheduled program on a regular basis, which is designed to instruct a covered person in the self-management of diabetes. It is a day care program of educational services and self-care training, (including medical nutritional therapy). The program must be under the supervision of an appropriately licensed, registered, or certified health care professional whose scope of practice includes diabetic education or management.

Partial hospitalization

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

Pervasive Developmental Disorder

A neurological condition, including Asperger's syndrome and autism, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

Pharmacy

An establishment where **prescription drugs** are legally dispensed.

Physician

(a) legally qualified **physician** licensed by the state in which he or she practices, and (b) any other practitioner that must by law be recognized as a doctor legally qualified to render treatment. This includes psychologists, optometrists, dentists, licensed social workers and counseling professionals, chiropractors, and acupuncturists, to the extent that the services they provide would be covered if they were performed by a physician.

Covered Medical Expenses also include charges for services rendered by a nurse practitioner, licensed midwife, or registered nurse first assistant.

Policy Year

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

Pre-Admission Testing:

Tests done 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 Covered Percentage that would have applied in the absence of this benefit.

Pre-Existing Condition

Any **injury, sickness**, or condition that was diagnosed or treated, or would have caused a prudent person to seek diagnosis or treatment, within [six-twelve] months prior to the **covered person's** effective date of insurance.

Preferred Care

Care provided by

- A **covered person's primary care physician**, or a **preferred care provider** 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**, is not feasible, or
- A **Non-Preferred Urgent Care Provider** when travel to a **Preferred Urgent Care Provider** for treatment is not feasible, and if authorized by Aetna.

Preferred Care Provider

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

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

Preferred Pharmacy

A **pharmacy**, including a **mail order pharmacy**, which is party to a contract with Aetna to dispense drugs to persons covered under this Policy, but only:

- While the contract remains in effect, and
- While such a **pharmacy** dispenses a **prescription drug**, under the terms of its contract with Aetna.

Preferred Prescription Drug Expense

An expense incurred for a **prescription drug** that:

- Is dispensed by a **Preferred Pharmacy**, or for an **emergency medical condition** only, by a **non-preferred pharmacy**, and
- Is dispensed upon the **Prescription** of a **Prescriber** who is:
 - A **Designated Care Provider**, or
 - A **Preferred Care Provider**, or
 - A **Non-Preferred Care Provider**, but only for an **emergency condition**, or of a person's **Primary Care Physician**, or
 - A **dentist** who is a **Non-Preferred Care Provider**, but only one who is not of a type that falls into one or more of the categories of providers listed in the **directory** of **Preferred Care Providers**.

Prescriber

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

Prescription

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

Prescription Drugs

Any of the following:

- A drug, biological, or compounded **prescription**, which, by Federal law, may be dispensed only by **prescription** and which is required to be labeled "Caution: Federal Law prohibits dispensing without **prescription**",
- Injectable insulin, disposable needles, and syringes, when prescribed and purchased at the same time as insulin, and disposable diabetic supplies.

Primary Care Physician

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

- Selected by a person from the list of **Primary Care Physicians** in the **directory**,
- Responsible for the person's on-going health care, and
- Shown on Aetna's records as the person's **Primary Care Physician**.

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

Reasonable and customary

The charge which is the smallest of:

- The **actual charge**,
- The charge usually made for a covered service by the provider who furnishes it, and
- The prevailing charge made for a covered service in the geographic area by those of similar professional standing.

Reasonable Charge

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

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

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

In determining the **reasonable charge** for a service or supply that is:

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

Aetna may take into account factors, such as:

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

Recognized Charge

Only that part of a charge which is recognized is covered. The **recognized charge** for a service or supply is the lowest of:

- The provider's usual charge for furnishing it, and
- The charge Aetna determines to be appropriate, based on factors such as the cost of providing the same or a similar service or supply, and the manner in which charges for the service or supply are made, and
- The charge Aetna determines to be the **recognized charge** percentage made for that service or supply.

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

In determining the **recognized charge** for a service or supply that is:

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

Aetna may take into account factors, such as:

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

Rehabilitation Facility

This means a comprehensive free-standing facility which provides rehabilitative services. Rehabilitative services are the combined and coordinated use of medical; social; educational and vocational measures for training or retraining covered persons disabled by disease or injury.

Residential treatment facility

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

Respite care

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

Room and Board

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

Routine Screening for Sexually Transmitted Disease

This is any laboratory test approved for such purposes by the FDA that specifically detects for infection by one or more agents of:

- Gonorrhea,
- Syphilis,
- Hepatitis,
- HIV, and
- Genital Herpes

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.

Serious Mental Disorders

are:

- (1) Psychotic disorders, including schizophrenia;
- (2) Dissociative disorders;
- (3) Mood disorders;
- (4) Anxiety disorders;
- (5) Personality disorders;
- (6) Paraphilias;
- (7) Attention Deficit and disruptive behavior disorders;
- (8) Pervasive developmental disorders;
- (9) Tic Disorders
- (10) Eating disorders, including bulimia and anorexia; and
- (11) Substance abuse related disorders.

Service Area

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

Sickness

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

Skilled Nursing Facility

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

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

Sound Natural Teeth

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

Surgery Center

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

Surgical assistant

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

Surgical expense

Charges by a **physician** for,

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

Surgical procedure

- 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.

Totally Disabled

Due to disease or **injury**, the **covered person** is not able to engage in most of the normal activities of a person of like age and sex in good health.

Urgent Admission

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

- The onset of or change in a disease, or
- The diagnosis of a disease, or
- An **injury** caused by an **accident**,

which, while not needing an **emergency admission**, is severe enough to require confinement as an inpatient in a **hospital** within 2 weeks from the date the need for the confinement becomes apparent.

Urgent Condition

This means a sudden illness, **injury**, or condition, that:

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

Urgent Care Provider

This is:

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

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

Walk-in Clinic

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

CLAIM PROCEDURE

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

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

1. Bills must be submitted within 15 months from the date of treatment.
2. Payment for Covered Medical Expenses will be made directly to the hospital or physician concerned, unless bill receipts and proof of payment are submitted.
3. If itemized medical bills are available at the time the claim form is submitted, attach them to the claim form. Subsequent medical bills should be mailed promptly to the above address.
4. In the event of a disagreement over the payment of a claim, a written request to review the claim must be mailed to Aetna, within one year from the date appearing on the Explanation of Benefits.
5. You will receive an "Explanation of Benefits" when your claims are processed. The Explanation of Benefits will explain how your claim was processed, according to the benefits of your Student Accident and Sickness Insurance Plan.

HOW TO APPEAL A CLAIM

In the event a Covered Person disagrees with how a claim was processed, he/she may request a review of the decision. The Covered Person's requests must be made in writing within one hundred eighty (180) days of receipt of the Explanation of Benefits (EOB). The Covered Person's request must include why he/she disagrees with the way the claim was processed. The request must also include any additional information that supports the claim (e.g., medical records, Physician's office notes, operative reports, Physician's letter of medical necessity, etc.). Please submit all requests to:

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

Aetna has established the following procedure for resolving complaints by covered persons.

Appeal Review

First Level Appeal Review Procedure.

- An Appeal must be submitted to Aetna within 60 days of the date Aetna provides notice of denial. The Aetna address is on the covered person's ID card.
- An acknowledgment letter will be sent to the covered person within 3 business days of Aetna's receipt of the Appeal. This letter will contain the name, address, and telephone number, of the Appeal Coordinator (Coordinator) assigned to review the Appeal. If the Appeal concerns an adverse determination, the Coordinator will be a clinical peer health care professional. This letter may request additional information. If so, it must be submitted to Aetna within 15 days of the date of the letter.
- If Aetna is in receipt of all needed information, a final response will be sent to the covered person within 20 business days of Aetna's receipt of the Appeal. The response will be based on the information provided with, or right after, the Appeal. The Coordinator deciding the Appeal shall not be: a person who made the initial decision regarding the claim, or be a person with previous involvement with the Appeal.
- If the Appeal concerns an eligibility issue, and if additional information is not given to Aetna after receipt of Aetna's response, the decision is deemed 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 done within 15 days of the date of Aetna's response letter.

- Additional time may be needed to resolve the Appeal if Aetna is unable to get needed information from a person, or entity, not affiliated with or under contract with Aetna. If so, Aetna will send the covered person a written letter advising that more time is needed. The letter will explain the reasons and set a new date for a response. The additional time will not be extended beyond another 20 business days after Aetna's receipt of all needed information.
- In an urgent or emergency situation, an Expedited First Level Appeal procedure may be initiated by a telephone call to Aetna's Member Services. The telephone number is on the covered person's ID card. Expedited First Level Appeals will be reviewed by a clinical peer health care professional(s). A verbal response to the Appeal will be given to the covered person within 72 hours, provided that all needed information is made available to Aetna. Written notice of the decision will be sent within 2 business days of Aetna's verbal response.
- If Aetna's final written response is an adverse decision, it will contain:
 - The names, titles, and qualifying credentials, of the person(s) involved in the First Level Appeal Review,
 - A statement of the Coordinator's understanding of the Appeal and all pertinent facts,
 - The Coordinator's basis for the decision in clear terms,
 - A reference to the evidence, or documentation, used as the basis for the decision and instructions for requesting copies of such materials,
 - A notice of the covered person's right to contact the Maine Bureau of Insurance including the address and telephone number of the Bureau, and
 - A description of the process to obtain a Second Level Appeal Review (including the rights, procedures, and time frames that govern such a review).

Second Level Appeal Review Procedure.

If not satisfied with the First Level Appeal Review decision, the covered person may request a Second Level Appeal Review by employing the follow procedures.

- A written appeal must be submitted to the Appeal Committee (Committee).
- For a Second Level Appeal Review concerning an adverse determination, the majority of the members of the Committee will be made up of clinical peer health care professionals. In cases where coverage of services has been denied, the reviewing health care professionals shall not have a financial interest in the outcome of the review. A majority of the Committee members will be made up of persons who were not previously involved with the Appeal. However, a person who was previously involved with the Appeal may be a member of the Committee or appear before the Committee to present information or answer questions. The Committee must include at least one clinical peer health care professional who was not previously involved with the Appeal.
- For a Second Level Appeal Review concerning all other Appeals, the majority of the members of the Committee will be made up of employees or representatives of Aetna who were not previously involved with the Appeal. However, a person who was previously involved with the Appeal may be a member of the Committee or appear before the Committee to present information or answer questions.
- If the covered person asks to appear in person before the Committee, the Committee will schedule and hold a Second Level Appeal Review hearing within 45 business days of receiving the request for a Second Level Appeal Review. The covered person will be notified in writing at least 15 business days in advance of the hearing date. This notice will advise the covered person if an attorney will be present to argue Aetna's case. Aetna will advise the covered person of his or her right to obtain legal representation. The hearing will be held during regular business hours. If the covered person can not attend the hearing, he or she may participate by conference call or other available technology at Aetna's expense. The covered person may also request that Aetna consider a postponement and re-scheduling of the hearing.
- The covered person may request Aetna to provide him or her with all relevant information that is not confidential or privileged.
- The covered person may be helped or represented at the hearing by a person of his or her choice.
- The covered person may submit supporting material. This may be done both before and during the hearing.
- The covered person may ask questions of any representative of Aetna.

The Appeal Committee shall render a written decision within 5 business days of the conclusion of the Second Level Appeal Hearing. If the decision is an adverse decision, it will contain:

- The names, titles, and qualifying credentials, of the person(s) involved in the First Level Appeal Review,
- A statement of the Committee's understanding of the Appeal and all pertinent facts,
- The Committee's basis for the decision in clear terms,
- A reference to the evidence, or documentation, used as the basis for the decision and instructions for requesting copies of such materials, and
- A notice of your right to contact the Maine Bureau of Insurance including the address and telephone number of the Bureau.

Aetna will keep the records of your complaint for 3 years.

NOTICE:

You may contact the Maine Bureau of Insurance for help at any time during the Appeal Process outlined above. The address is:

Maine Bureau of Insurance
Consumer Health Care Division
#34 State House Station
Augusta, Maine 04333
Telephone Number: 1-800-300-5000
Web: www.state.me.us/pfr/ins/inslhbro.htm

External Review Process

If, after exhausting the internal Appeals Procedure the **covered person**, the **covered person's physician** or the **hospital** is still dissatisfied with Aetna's response, the **covered person** may request an External Review. An external review is a review by an independent **physician**, selected by an External Review Organization, who has expertise in the problem or question involved. A request for an External Review must be submitted in writing within 60 calendar days from the date the **covered person** received their final determination letter. Aetna will abide by the decision of the External Review Organization, except where Aetna can show conflict of interest, bias or fraud.

The final determination letter will provide instructions on how to submit a request for an External Review.

For more information on the External Review Process, the **covered person** may call Chickering Claims Administrators at the toll-free number shown on their ID Card.

PRESCRIPTION DRUG CLAIM PROCEDURE

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

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

On Call International

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

A brief description of these benefits is outlined below.

Accidental Death and Dismemberment (ADD) Benefits

Benefits are payable for the Accidental Death and Dismemberment of Covered Persons, up to a maximum of Ten Thousand Dollars (\$10,000).

NOTE: For most school plans, ADD benefits are provided by Aetna Life Insurance Company (ALIC). However, in some states, ADD benefits may be provided through a contractual relationship between Chickering Claims Administrators, Inc. (CCA) and On Call International (On Call). ADD coverage provided through On Call is underwritten by United States Fire Insurance Company (USFIC). Please refer to your school's policy to determine whether ALIC or USFIC underwrites ADD benefits for your specific Plan. Should you have questions or need to file a claim please contact (888) 294-6058.

MEDICAL EVACUATION AND REPATRIATION (MER) AND WORLDWIDE EMERGENCY TRAVEL ASSISTANCE (WETA) SERVICES PROVIDED THROUGH ON CALL INTERNATIONAL, INC.

Chickering Claims Administrators, Inc. (CCA) has contracted with On Call International, Inc. (On Call) to provide Covered Persons with access to certain Medical Evacuation and Repatriation (MER) and Worldwide Emergency Travel Assistance (WETA) benefits and/or services.

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

- Unlimited Emergency Medical Evacuation
- Unlimited Medically Supervised Repatriation (while traveling or on campus)
- Unlimited Return of Mortal Remains (while traveling or on campus)
- Return of Traveling Companion
- \$2,500 Emergency Return Home in the event of death or life-threatening illness of a parent or sibling

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

- 24/7 Emergency Travel Arrangements
- Translation Assistance
- Emergency Travel Funds Assistance
- Lost Luggage and Travel Documents Assistance
- Assistance with Replacement of Credit Card/Travelers Checks
- 24/7 U.S. Nurse Help Line
- Medical/Dental/Pharmacy Referral Service
- Hospital Deposit Arrangements
- Dispatch of Physician
- Emergency Medical Record Assistance

NOTE: In order to obtain coverage, all MER and WETA services must be provided and arranged through On Call. Reimbursement will NOT be provided for any such services not provided and arranged through On Call. Although certain medical services may be covered under the terms of the Covered Person's student health insurance plan (the "Plan"), On Call does not provide coverage for medical treatment rendered by doctors, hospitals, pharmacies or other health care providers. Coverage for such services will be provided in accordance with the terms of the Plan and exclusions and limitations may apply.

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

CCA and On Call are independent contractors and not employees or agents of the other. CCA provides access to certain ADD, MER and WETA benefits/services through a contractual arrangement with On Call. However, neither CCA nor any of its affiliates underwrites or administers any MER or WETA benefits/services. Neither CCA nor any of its affiliates underwrites or administers any ADD benefits that are provided through On Call. Neither CCA nor any of its affiliates is responsible in any way for the benefits/services provided by or through On Call, USFIC or VSC. Premiums/fees for benefits/services provided through On Call, USFIC and VSC are included in the Rates outlined in this brochure.

Got Questions? Get Answers with Aetna’s Navigator®

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

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

How do I register?

- Go to **www.aetnastudenthealth.com**
- Find your school in the School Directory
- Click on Aetna Navigator® Member Website and then the “Register for Aetna Navigator” link.
- Follow the instructions for the registration process, including selecting a user name, password and security phrase.

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

Need help with registering onto Aetna Navigator?

Registration assistance is available toll free, Monday through Friday, from 7 a.m. to 9 p.m. Eastern Time at **(800) 225-3375**.

NOTICE

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

Administered by:

Aetna Student Health.
P.O. Box 15708
Boston, MA 02215-0014
(888) 294-6058
www.aetnastudenthealth.com

Presented by:

Cross Insurance
217 Main Street, P.O. Box 3028
Lewiston, ME 04243-3028
(800) 537-6444
www.crossagency.com/usmint



Underwritten by:

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

Policy No. 474923

The Southern Maine Community College is underwritten by Aetna Life Insurance Company (ALIC) and administered by Chickering Claims Administrators, Inc. Aetna Student HealthSM is the brand name for products and services provided by these companies and their applicable affiliated companies.