Control No. 474949

Blanket Student Accident and Sickness Insurance Policy
a contract between

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

and

University of Nevada - Las Vegas - School of Dental Medicine
(Policyholder)

Policy Number: BP-474949
Date of issue: August 29, 2011
Policy delivered in: Nevada

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

This Policy takes effect at 12:01 A.M. standard time at the Policyholder's address on July 1, 2011. The Policy Year starts on July 1, 2011 and ends at 11:59 P.M. on June 30, 2012.

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

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

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

Mark T. Bertolini
Chairman, Chief Executive Officer and President

Aetna Life Insurance Company
(A Stock Company)

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

GR-96449
005
ED. 5-07
Rider

Attached to and made a part of Policy No. BP-474949

a contract between

Aetna Life Insurance Company

and the Policyholder

University of Nevada - Las Vegas - School of Dental Medicine

It is understood and agreed that nothing contained in this rider shall be held to alter or affect any of the terms of the policy other than as herein specifically stated.

Effective July 1, 2011, the following provision has been removed in your Policy.

1. The provision below currently appearing under SECTION 7 - EXCLUSIONS AND LIMITATIONS section of your Policy is hereby removed.

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

In Witness Whereof, the Aetna Life Insurance Company has signed this rider at Hartford, Connecticut, to become effective July 1, 2011.

Signed by the Insurance Company August 29, 2011.

Mark T. Bertolini
Chairman, Chief Executive Officer and President
2010-2011

Student Health Insurance Plan

UNLV
UNIVERSITY OF NEVADA LAS VEGAS

School of Dental Medicine

Underwritten by:
Aetna Life Insurance Company
(ALIC)

Brokered by:
Wells Fargo Insurance Services USA, Inc.
Student Insurance Division

Policy Number: 474949
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 non-emergency situations please visit or call your Student Wellness Center at (702) 895-3370.

For questions about:
* Insurance Benefits
* Claims Processing
* Pre-Certification Requirements

Please contact:
Aetna Student Health
P.O. Box 981106
El Paso, TX 79998
(877) 626-2308

For questions about:
* Eligibility
* Enrollment
* General Questions

Please contact:
Wells Fargo Insurance Services USA, Inc.
Student insurance Division
NV License No. 9191
11017 Cobblerock Drive, Suite 100
Rancho Cordova, CA 95670
(800) 853-5899
Fax: (916) 231-3398

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
(877) 626-2308

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
(877) 626-2308

A complete list of providers can be found at the University Health Services Office, or you can use Aetna’s DocFind® Service at 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.

For the insured schools
The University of Nevada Las Vegas School of Dental Medicine Student Health Insurance Plan 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.

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 University of Nevada Las Vegas School of Dental Medicine. If any discrepancy exists between this Brochure and the Policy, the Master Policy will govern and control the payment of benefits. The Master Policy may be viewed at the University’s Student Wellness Center 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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POLICY PERIOD

For coverage periods please refer to the Rate tables below.

**Insured dependents:** Coverage will become effective at 12:01 am 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 (28-29) 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

<table>
<thead>
<tr>
<th></th>
<th>Annual</th>
</tr>
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<tbody>
<tr>
<td><strong>D.M.D. Students</strong></td>
<td>$1,700</td>
</tr>
<tr>
<td><strong>Ortho, Resident, Fellowship and Pediatric Students</strong></td>
<td>$1,700</td>
</tr>
</tbody>
</table>

For dependent rate and enrollment information please contact Wells Fargo Insurance Services at (800) 853-5899.

The rates above include both premium for the student health plan underwritten by Aetna Life Insurance Company, as well as University of Nevada Las Vegas School of Dental Medicine and other third parties administrative fee.

UNIVERSITY OF NEVADA LAS VEGAS SCHOOL OF DENTAL MEDICINE
STUDENT ACCIDENT AND SICKNESS INSURANCE PLAN

This is a brief description of the Accident and Sickness Medical Expense benefits available for University of Nevada Las Vegas School of Dental Medicine students and their eligible dependents. The plan is underwritten by Aetna Life Insurance Company (called Aetna). The exact provisions governing this insurance are contained in the Master Policy issued to the University and may be viewed at the University’s Student Health Center during business hours.
STUDENT COVERAGE

ELIGIBILITY
All full-time DMD and Ortho,Fellowship, Ortho and Pediatric Program students, who are enrolled at University of Nevada Las Vegas School of Dental Medicine, 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 completed Waiver Form has been received by the University.

For enrollment contact Wells Fargo Insurance Services at (800) 853-5899.

WAIVER PROCESS/PROCEDURE
International students will be automatically enrolled in this plan, unless they qualify to submit a waiver. For qualification criteria and insurance waiver process, visit the UNLV School of Dental Medicine International Students office.

International Student Waiver submissions may be audited by University of Nevada Las Vegas School of Dental Medicine, Aetna Student Health, and/or their contractors or representatives. You may be required to provide, upon request, any coverage documents and/or other records demonstrating that you meet the school's requirements for waiving the student health insurance plan. By submitting the waiver request, you agree that your current insurance plan may be contacted for confirmation that your coverage is in force for the applicable policy year and that it meets the school's waiver requirements.

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.

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 Wells Fargo Insurance Services within 45 days of withdrawal from school.
DEPENDENT COVERAGE

ELIGIBILITY
Covered students may also enroll their lawful spouse, and dependent children under age 26.

A domestic partner/former domestic partner/surviving domestic partner has the same rights, protections and benefits, and are subject to the same responsibilities, obligations and duties under law, as a spouse/former spouse/widow(er).

ENROLLMENT
To enroll the dependent(s) of a covered student, please contact Wells Fargo Insurance Services USA, Inc at (800) 853-5899. The Fall enrollment deadline is September 30, 2010 and Spring Enrollment Deadline date is February 28, 2011. Dependent enrollment applications will not be accepted after the indicated deadline dates, 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).

NEWBORN INFANT AND ADOPTED CHILD COVERAGE
A child born to a Covered Person shall be covered for Injuries, Sickness, congenital defects and birth abnormalities for 31 days from the moment of birth. This coverage may include necessary transportation costs from place of birth to the nearest specialized treatment center. At the end of this 31 day period, coverage will cease under the University of Nevada, Las Vegas School of Dental Medicine 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.

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

For information or general questions on dependent enrollment, contact Wells Fargo Insurance Services at (800) 853-5899.

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 within 30 days from termination date of prior coverage 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 8).
PREFERRED PROVIDER NETWORK

Aetna Student Health has arranged for you to access a Preferred Provider Network in your local community. Acute care facilities and mental health networks are available nationally if you require hospitalization outside the immediate area of the University of Nevada Las Vegas School of Dental Medicine 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 University of Nevada Las Vegas School of Dental Medicine, Aetna Student Health, or Aetna. A complete listing of participating providers is available at the University of Nevada Las Vegas School of Dental Medicine Health Services.

You may also obtain information regarding Preferred Providers by contacting Aetna Student Health at (877) 626-2308, or through the Internet by accessing DocFind at www.aetnastudenthealth.com.
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 Aetna Life Insurance Company, Chickering Claims Administrators, Inc. or their affiliates. Neither Aetna Life Insurance Company, Chickering Claims Administrators, Inc. nor their affiliates provide medical care or treatment and they are not responsible for outcomes. The availability of a particular provider(s) cannot be guaranteed and network composition is subject to change.

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 treatment or services for that injury or disease or you took prescription drugs or medicines for that injury or disease during the 180 days 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 180 days 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 63 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 63 days) in your continuous coverage occurs, the definition of Pre-Existing Conditions will apply.

Pre-existing limitation will not apply to treatment of inherited metabolic diseases and pregnancy.
DESCRIPTION OF BENEFITS

Please Note:

THE UNIVERSITY OF NEVADA LAS VEGAS SCHOOL OF DENTAL MEDICINE 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 University of Nevada Las Vegas School of Dental Medicine 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 University of Nevada Las Vegas School of Dental Medicine, you may view it at Student Health Center or you may contact Aetna Student Health at (877) 626-2308.

This Plan will never pay more than $250,000.00 per condition in a 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 coverages 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

<table>
<thead>
<tr>
<th>COINSURANCE</th>
<th>Covered Medical Expenses are payable at the coinsurance percentage specified below, after any applicable deductible, up to a maximum benefit of $250,000 per condition per Lifetime for students and $50,000 per condition per Lifetime for dependents.</th>
</tr>
</thead>
<tbody>
<tr>
<td>OUT OF POCKET MAXIMUMS</td>
<td>Once the Individual or Family Out-of-Pocket Limit has been satisfied, Covered Medical Expenses will be payable at 100% for the remainder of the Policy Year, up to any benefit maximum that may apply. Coinsurance applies to the Out-of-Pocket Limit.</td>
</tr>
<tr>
<td>Preferred Care Individual Out-of-Pocket: $1,250</td>
<td>Non-Preferred Care Individual Out-of-Pocket: $2,500</td>
</tr>
</tbody>
</table>

All coverage is based on Reasonable Charges unless otherwise specified.
<table>
<thead>
<tr>
<th><strong>Inpatient Hospitalization Benefits</strong></th>
<th></th>
</tr>
</thead>
</table>
| **Hospital Room and Board Expense** | **Covered Medical Expenses** are payable as follows:  
Preferred Care: **80%** of the **Negotiated Charge**.  
Non-Preferred Care: **60%** of the **Reasonable Charge** for a semi-private room. |
| **Intensive Care Unit Expense** | **Covered Medical Expenses** are payable as follows:  
Preferred Care: **80%** of the **Negotiated Charge**.  
Non-Preferred Care: **60%** of the **Reasonable Charge** for the **Intensive Care Room Rate** for an overnight stay. |
| **Miscellaneous Hospital Expense** | **Covered Medical Expenses** include, but are not limited to: laboratory tests, x-rays, surgical dressings, anesthesia, supplies and equipment use, and medicines.  
Benefits are payable as follows:  
Preferred Care: **80%** of the **Negotiated Charge**.  
Non-Preferred Care: **60%** of the **Reasonable Charge**. |
| **Physician Hospital Visit/Consultation Expenses** | **Covered Medical Expenses** for charges for the non-surgical services of the attending **Physician**, or a consulting **Physician**, are payable as follows:  
Preferred Care: **80%** of the **Negotiated Charge**.  
Non-Preferred Care: **60%** of the **Reasonable Charge**.  
Benefits are limited to 1 visit per day. |
| **Surgical Benefits (Inpatient and Outpatient)** |  |
| **Surgical Expense** | **Covered Medical Expenses** for charges for surgical services, performed by a **Physician**, are payable as follows:  
**Inpatient**  
Preferred Care: **80%** of the **Negotiated Charge**.  
Non-Preferred Care: **60%** of the **Reasonable Charge**.  
**Outpatient**  
Preferred Care: After a **$25 Copay** per Surgery, **80%** of the **Negotiated Charge**.  
Non-Preferred Care: After a **$25 Deductible** per Surgery, **60%** of the **Reasonable Charge**. |
| **Anesthetist Expense** | **Covered Medical Expenses** for the charges of an anesthetist, during a surgical procedure, are payable as follows:  
Preferred Care: **80%** of the **Negotiated Charge**.  
Non-Preferred Care: **60%** of the **Reasonable Charge**. |
| **Assistant Surgeon Expense** | **Covered Medical Expenses** for the charges of an assistant surgeon, during a surgical procedure, are payable as follows:  
Preferred Care: **80%** of the **Negotiated Charge**.  
Non-Preferred Care: **60%** of the **Reasonable Charge**. |
Ambulatory Surgical Expense

Covered Medical Expenses for outpatient surgery performed in an ambulatory surgical center are payable as follows:

Preferred Care: 80% of the Negotiated Charge.
Non-Preferred Care: 60% of the Reasonable Charge.

Covered Medical Expenses must be incurred on the day of the surgery or within 48 hours after the surgery.

Outpatient Benefits

Covered Medical Expenses include but are not limited to: Physician’s office visits, hospital or outpatient department or emergency room visits, durable medical equipment, clinical lab, or radiological facility.

<table>
<thead>
<tr>
<th>Hospital Outpatient Department</th>
<th>Covered Medical Expenses for outpatient treatment in a hospital are payable as follows:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Preferred Care: After a $25 Copay per visit, 80% of the Negotiated Charge.</td>
</tr>
<tr>
<td></td>
<td>Non-Preferred Care: After a $25 Deductible per visit, 60% of the Reasonable Charge.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Hospital Outpatient Department</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Medical Expenses for outpatient treatment in a hospital are payable as follows:</td>
</tr>
<tr>
<td>Preferred Care: 80% of the Negotiated Charge.</td>
</tr>
<tr>
<td>Non-Preferred Care: 60% of the Reasonable Charge.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Emergency Room Expense</th>
<th>Covered Medical Expenses incurred for treatment of an Emergency Medical Condition are payable as follows:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Preferred Care: After a $100 Copay per visit (waived if admitted), 80% of the Negotiated Charge.</td>
</tr>
<tr>
<td></td>
<td>Non-Preferred Care: After a $100 Deductible per visit (waived if admitted), 80% of the Reasonable Charge.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Urgent Care Expense</th>
<th>Benefits include charges for treatment by an urgent care provider.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Please note: A covered person should not seek medical care or treatment from an urgent care provider if their illness, injury, or condition, is an emergency condition. The covered person should go directly to the emergency room of a hospital or call 911 for ambulance and medical assistance.</td>
</tr>
<tr>
<td></td>
<td>Urgent Care Benefits include charges for an urgent care provider to evaluate and treat an urgent condition.</td>
</tr>
<tr>
<td></td>
<td>Covered Medical Expenses for urgent care treatment are payable as follows:</td>
</tr>
<tr>
<td></td>
<td>Preferred Care: After a $100 Copay per visit, 80% of the Negotiated Charge.</td>
</tr>
<tr>
<td></td>
<td>Non-Preferred Care: After a $100 Deductible per visit, 60% of the Reasonable Charge.</td>
</tr>
<tr>
<td></td>
<td>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.</td>
</tr>
</tbody>
</table>

| Ambulance Expense | Covered Medical Expenses are payable as follows 80% of the Actual Charge to a maximum of $150 per Policy Year for the services of a professional ground ambulance to or from a hospital, when required due to the emergency nature of a covered Accident or Sickness and $400 per Policy Year for the services of a professional air ambulance to or from a hospital, when required due to the emergency nature of a covered Accident or Sickness. |

| Pre-Admission Testing Expense | **Covered Medical Expenses** for Pre-Admission testing charges while an outpatient before scheduled surgery are payable as follows:  
Preferred Care: Payable as any other condition.  
Non-Preferred Care: Payable as any other condition. |
|-----------------------------|--------------------------------------------------------------------------------------------------|
| Physician’s Office Visits   | **Covered Medical Expenses** are payable as follows:  
Preferred Care: After a $25 Copay per visit, 80% of the Negotiated Charge.  
Non-Preferred Care: After a $25 Deductible per visit, 60% of the Reasonable Charge. |
| Laboratory and X-Ray Expense| **Covered Medical Expenses** are payable as follows:  
Preferred Care: 80% of the Negotiated Charge.  
Non-Preferred Care: 60% of the Reasonable Charge. |
| High Cost Procedures Expense| **Covered Medical Expenses** include charges incurred by a covered person are payable as follows:  
Preferred Care: 80% of the Negotiated Charge.  
Non-Preferred Care: 60% of the Reasonable Charge.  
For purposes of this benefit, “High Cost Procedure” means any outpatient procedure costing over $200. |
| Therapy Expense             | **Covered Medical Expenses** include charges incurred by a covered person for the following types of therapy provided on an outpatient basis:  
- Physical Therapy,  
- Chiropractic Care,  
- Speech Therapy,  
- Inhalation Therapy, or  
- Occupational Therapy.  
Expenses for Chiropractic Care are **Covered Medical Expenses**, if such care is related to neuromusculoskeletal conditions and conditions arising from: the lack of normal nerve, muscle, and/or joint function.  
Expenses for Speech and Occupational Therapies are **Covered Medical Expenses**, only if such therapies are a result of injury or sickness.  
Preferred Care: 80% of the Negotiated Charge.  
Non-Preferred Care: 60% of the Reasonable Charge.  
Benefits for Outpatient Therapies are limited to 1 visit per day. |
| Chemotherapy Expense        | **Covered Medical Expenses** for 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. Such expenses are payable as follows:  
Preferred Care: 80% of the Negotiated Charge.  
Non-Preferred Care: 60% of the Reasonable Charge. |
| Durable Medical Equipment Expense | Covered Medical Expenses are payable as follows:  
Preferred Care: 80% of the Negotiated Charge.  
Non-Preferred Care: 60% of the Reasonable Charge. |
|----------------------------------|-------------------------------------------------------------------------------------------------------|
| Prosthetic Devices Expense       | Benefits include charges for: artificial limbs, or eyes, and other non-dental prosthetic devices, as a result of an accident or sickness.  
Covered Medical Expenses do not include: eye exams, eyeglasses, vision aids, hearing aids, communication aids, and orthopedic shoes, foot orthotics, or other devices to support the feet.  
Covered Medical expenses are payable as follows:  
Preferred Care: 80% of the Negotiated Charge.  
Non-Preferred Care: 60% of the Reasonable Charge. |
| Dental Injury Expense            | Covered Medical Expenses include dental work, surgery, and orthodontic treatment needed to remove, repair, replace, restore, or reposition:  
• Natural teeth damaged, lost, or removed, or  
• Other body tissues of the mouth fractured or cut due to injury. The accident causing the injury must occur while the person is covered under this Plan.  
Any such teeth must have been:  
• Free from decay, or  
• In good repair, and  
• Firmly attached to the jawbone at the time of the injury.  
If:  
• Crowns (caps), or  
• Dentures (false teeth), or  
• Bridgework, or  
• In-mouth appliances,  
are installed due to such injury; Covered Medical Expenses include only charges for:  
• The first denture or fixed bridgework to replace lost teeth,  
• The first crown needed to repair each damaged tooth, and  
• An in-mouth appliance used in the first course of orthodontic treatment after the injury.  
Surgery needed to:  
• Treat a fracture, dislocation, or wound.  
• Cut out cysts, tumors, or other diseased tissues.  
• Alter the jaw, jaw joints, or bite relationships by a cutting procedure when appliance therapy alone cannot result in functional improvement.  
Non-surgical treatment of infections or diseases. This does not include those of, or related to, the teeth.  
Covered Medical Expenses are payable as follows:  
80% of the Actual Charge. |
| **Allergy Testing and Treatment Expense** | Benefits include charges incurred for diagnostic testing and treatment of allergies and immunology services.  

**Covered Medical Expenses** include, but are not limited to, charges for the following:  
- Laboratory tests,  
- **Physician** office visits, including visits to administer injections,  
- Prescribed medications for testing and treatment of the allergy, including any equipment used in the administration of prescribed medication, and  
- Other medically necessary supplies and services,  

**Covered Medical Expenses** are payable as follows:  
Preferred Care: Payable as any other condition.  
Non-Preferred Care: Payable as any other condition. |
| **Routine Physical Exam Expense** | Benefits include expenses for a routine physical exam performed by a **physician**. If charges for a routine physical exam given to a child who is a **covered dependent** are covered under any other benefit section, those charges will not be covered under this section.  

A routine physical exam is a medical exam given by a **physician**, for a reason other than to diagnose or treat a suspected or identified **injury** or **sickness**. Included as a part of the exam are:  
- X-rays, lab, and other tests given in connection with the exam, and  
- Materials for the administration of immunizations for infectious disease and testing for tuberculosis.  

**Preferred Care visits** are payable at 80% of the **Negotiated Charge** after a per visit **Copay** of $25.  
**Preferred care immunizations** are payable at 80% **Negotiated Charge**.  

**Non-Preferred Care visits** are payable at 60% of the **Reasonable Charge** after a per visit **Deductible** of $25.  
**Non-Preferred Care immunizations** are payable at 60% of the **Reasonable Charge**.  

Benefits are limited to a combined maximum of $500 per **Policy Year** for **Routine Physical Exam and Immunization Expenses**.  

For a **child** who is a covered dependent:  
- The physical exam must include at least:  
  - A review and written record of the patient's complete medical history,  
  - A check of all body systems, and  
  - A review and discussion of the exam results with the patient or with the parent or guardian.  

For all exams given to a covered dependent from **age 19 and over**, **Covered Medical Expenses** will **not include** charges for **more than** one exam in 24 months in a row.  

For all exams given to a **covered student** or a spouse who is a **covered dependent**, **Covered Medical Expenses** will **not include** charges for **more than**:  
- One exam in 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.  

Also included as **Covered Medical Expenses** are charges made by a **physician** for one annual routine gynecological exam. |
| Well Baby Care Expense | Benefits include charges for routine preventive and primary care services, rendered to a covered dependent child on an outpatient basis.  

**Routine preventive and primary care** services are services rendered to a **covered dependent** child, from the date of birth through the attainment of **three (3)** years of age. Services include: initial hospital check-ups, other hospital visits, physical examinations, including routine hearing and vision examinations, medical history, developmental assessments, and materials for the administration of appropriate and necessary immunizations and laboratory tests, when given in accordance with the prevailing clinical standards of the American Academy of Pediatrics.  

Coverage for such services shall be provided only to the extent that such services are provided by, or under the supervision of a **physician**, or other licensed professional.  

**Covered Medical Expenses** are payable as follows:  

**Preferred Care**: **80%** of the **Negotiated Charge**.  

Benefits are payable for scheduled visits in accordance with the prevailing clinical standards of the American Academy of Pediatrics.  

**Non-Preferred Care**: **60%** of the **Reasonable Charge**.  

Benefits are payable for scheduled visits in accordance with the prevailing clinical standards of the American Academy of Pediatrics.  

| Consultant or Specialist Expense | **Covered Medical Expenses** include the expenses for the services of a consultant or specialist, when referred by the School Health Services. The services must be requested by the attending **physician** for the purpose of confirming or determining to confirm or determine a diagnosis.  

**Covered Medical Expenses** are covered as follows:  

**Preferred Care**: After a **$25 Copay** per visit, **80%** of the **Negotiated Charge**.  

**Non-Preferred Care**: After a **$25 Deductible** per visit, **60%** of the **Reasonable Charge**.  

|
### Mental Health Benefits

<table>
<thead>
<tr>
<th>Mental and Nervous Disorders (other than severe) Expense</th>
<th>Covered Medical Expenses for the diagnosis and treatment of mental and nervous disorders (other than severe) are payable as follows:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Preferred Care</strong>: 80% of the Negotiated Charge.</td>
</tr>
<tr>
<td></td>
<td><strong>Non-Preferred Care</strong>: 60% of the Reasonable charge.</td>
</tr>
<tr>
<td></td>
<td>Benefits are limited to 40 days per Policy Year for Inpatient Expenses.</td>
</tr>
<tr>
<td></td>
<td>Benefits are limited to 40 visits per Policy Year for Outpatient Expenses.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Autism Expense</th>
<th>Covered Medical Expenses include coverage for screening and diagnosis of autism spectrum disorders and for treatment of autism spectrum disorders for persons covered by the policy under the age of 18 (up to age 22 if in enrolled in high school).</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Treatment of autism spectrum disorders must be identified in a treatment plan and may include medically necessary habilitative or rehabilitative care, prescription care, psychiatric care, psychological care, behavior therapy or therapeutic care that is:</td>
</tr>
<tr>
<td></td>
<td>(a) Prescribed for a person diagnosed with an autism spectrum disorder by a licensed <strong>physician</strong> or licensed psychologist, and</td>
</tr>
<tr>
<td></td>
<td>(b) Provided for a person diagnosed with an autism spectrum disorder by a licensed <strong>physician</strong>, licensed psychologist, licensed behavior analyst or other provider that is supervised by the licensed <strong>physician</strong>, psychologist or behavior analyst.</td>
</tr>
<tr>
<td></td>
<td><strong>Covered Medical Expenses</strong> are payable on the same basis as any other condition.</td>
</tr>
<tr>
<td></td>
<td><strong>Applied Behavior Analysis Treatment</strong> is limited to $36,000 per policy year.</td>
</tr>
</tbody>
</table>

For the purposes of Behavioral Health Parity in the state of Nevada, serious mental illnesses include the following diagnoses:
- Schizophrenia;
- Schizoaffective disorder;
- Bipolar disorder;
- Major depressive disorder;
- Panic disorder; and
- Obsessive-compulsive disorder.

Benefits include 40 days of hospitalization as an inpatient and 40 visits for treatment as an outpatient per Policy Year, excluding visits for the management of medication. Two visits for partial or respite care, or a combination thereof, may be substituted for each one day of hospitalization not used by the insured.

Benefits are payable as follows:
- **Preferred Care**: 80% of the Negotiated Charge.
- **Non-Preferred Care**: 60% of the Reasonable charge.

Benefits are limited to 40 days per Policy Year for Inpatient Expenses.
Benefits are limited to 40 visits per Policy Year for Outpatient Expenses.
<table>
<thead>
<tr>
<th>Substance Abuse Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Inpatient Expense</strong></td>
</tr>
<tr>
<td><strong>Covered Medical Expenses</strong></td>
</tr>
<tr>
<td><strong>Covered Medical Expenses</strong> 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.</td>
</tr>
<tr>
<td>Benefits are payable as follows:</td>
</tr>
<tr>
<td>Preferred Care: 80% of the Negotiated Charge.</td>
</tr>
<tr>
<td>Non-Preferred Care: 60% of the Reasonable charge.</td>
</tr>
<tr>
<td>Benefits for withdrawal from the physiological effects of alcohol or drugs are payable up to $1,500 per Policy Year.</td>
</tr>
<tr>
<td>Benefits for treatment for a patient admitted to a facility are payable up to $9,000 or 40 days per Policy Year, whichever is greater.</td>
</tr>
<tr>
<td><strong>Outpatient Expense</strong></td>
</tr>
<tr>
<td><strong>Covered Medical Expenses</strong> include outpatient treatment received in any (a) facility for the treatment of abuse of alcohol or drugs which is certified by the Department of Health and Human Services and (b) hospital or other medical facility which is licensed by the Department of Health and Human Services, accredited by the Joint Commission on Accreditation of Healthcare Organizations and provides treatment of abuse of alcohol or drugs. Outpatient Treatment includes Drug or Alcohol Abuse counseling for any person, group or family who is not admitted to a facility.</td>
</tr>
<tr>
<td>Benefits are payable as follows:</td>
</tr>
<tr>
<td>Preferred Care: 80% of the Negotiated Charge.</td>
</tr>
<tr>
<td>Non-Preferred Care: 60% of the Reasonable charge.</td>
</tr>
<tr>
<td>Benefits for outpatient treatment are payable up to $4,000 or 40 visits per Policy year, whichever is greater.</td>
</tr>
<tr>
<td>Maternity Benefits</td>
</tr>
<tr>
<td>--------------------</td>
</tr>
<tr>
<td><strong>Maternity Expense</strong></td>
</tr>
</tbody>
</table>
| **Well Newborn Nursery Care Expense** | Benefits include charges for routine care of a covered person’s newborn child as follows:  
- Hospital charges for routine nursery care during the mother’s confinement, but for not more than four days,  
- Physician’s charges for circumcision, and  
- Physician’s charges for visits to the newborn child in the hospital and consultations, but for not more than 1 visit per day.  
Covered Medical Expenses are payable as follows:  
Preferred Care: Payable as any other condition.  
Non-Preferred Care: Payable as any other condition. |

<table>
<thead>
<tr>
<th>Additional Benefits</th>
</tr>
</thead>
</table>
| **Prescription Drug Benefit** | The University of Nevada Las Vegas School of Dental Medicine plan uses a prescription drug formulary. This is a list of prescription drugs, both generic and brand name, that are available through your health plan. Your health plan may only pay for medications that are on the formulary. For information regarding how medications are reviewed and selected for the preferred drug list, please refer to Aetna’s website at www.aetna.com or the Aetna Preferred Drug (Formulary) Guide. Printed Preferred Drug Guide information will be provided upon request. Additional information can be obtained by calling Member Services at the toll-free number listed on your ID card. The medications listed on the preferred drug list are subject to change in accordance with applicable state law.  
Prescription Drug Benefits are payable as follows:  
Preferred Care Pharmacy: 100% of the Negotiated Charge, following a $20 Copay for each Brand Name Prescription Drug or a $10 Copay for each Generic Prescription Drug.  
Non-Preferred Care Pharmacy: 100% of the Reasonable Charge, following a $20 Deductible for each Brand Name Prescription or a $10 Deductible for each Generic Prescription Drug.  
Covered Medical Expenses are payable up to a maximum of $10,000 per Policy Year.  
This Pharmacy benefit is provided to cover Medically Necessary Prescriptions associated with a covered Sickness or Accident occurring during the Policy Year. Please use your Aetna Student Health ID card when obtaining your prescriptions  
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. (This is only a partial list.)  
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. *(This is only a partial list).*

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).

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](http://www.AetnaSpecialtyRx.com).

<table>
<thead>
<tr>
<th><strong>Diabetic Medication, Equipment, Supplies and Appliances Expense</strong></th>
<th><strong>Benefits</strong> include coverage for medication, equipment, supplies and appliances that are medically necessary for the treatment of diabetes.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Covered Medical Expenses</strong></td>
<td>Payable as follows:</td>
</tr>
<tr>
<td>Preferred Care:</td>
<td>Payable as any other condition.</td>
</tr>
<tr>
<td>Non-Preferred Care:</td>
<td>Payable as any other condition.</td>
</tr>
<tr>
<td>“Diabetes” includes type I, type II and Gestational Diabetes.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Diabetic Self-Management Training Expense</strong></th>
<th><strong>Covered Medical Expenses</strong> for diabetic self-management training, education and nutritional counseling are payable as follows:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preferred Care:</td>
<td>Payable as any other condition.</td>
</tr>
<tr>
<td>Non-Preferred Care:</td>
<td>Payable as any other condition.</td>
</tr>
<tr>
<td>“Diabetes” includes type I, type II and Gestational Diabetes.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Enteral Formula Expense</strong></th>
<th><strong>Covered Medical Expenses</strong> include:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Enteral formulas for use at home that are prescribed or ordered by a physician as medically necessary for the treatment of inherited metabolic diseases characterized by deficient metabolism, or malabsorption originating from congenital defects or defects arising shortly after birth, of amino acid, organic acid, carbohydrate or fat; and</td>
<td></td>
</tr>
<tr>
<td>• Special food products which are prescribed or ordered by a physician as medically necessary for the treatment of a person described above.</td>
<td></td>
</tr>
<tr>
<td>Benefits are payable as follows:</td>
<td></td>
</tr>
<tr>
<td>Preferred Care:</td>
<td>Payable as any other condition.</td>
</tr>
<tr>
<td>Non-Preferred Care:</td>
<td>Payable as any other condition.</td>
</tr>
<tr>
<td><strong>Benefits for special food products will be payable up to $2,500 per Policy Year.</strong></td>
<td></td>
</tr>
<tr>
<td>Coverage for this benefit will be provided whether or not the condition existed when the policy was purchased.</td>
<td></td>
</tr>
<tr>
<td>Covered Medical Expenses</td>
<td>Covered Medical Expenses include charges incurred by a covered person for medically necessary treatment of Temporomandibular Joint (TMJ) Dysfunction.</td>
</tr>
<tr>
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</tr>
<tr>
<td></td>
<td>Benefits are payable as follows:</td>
</tr>
<tr>
<td></td>
<td>Preferred Care: Payable as any other condition.</td>
</tr>
<tr>
<td></td>
<td>Non-Preferred Care: Payable as any other condition.</td>
</tr>
<tr>
<td>Prescription Contraceptive Drugs and Devices and Hormone Replacement Therapy Expense</td>
<td>Covered Medical Expenses include:</td>
</tr>
<tr>
<td></td>
<td>Charges incurred for contraceptive drugs and devices and hormone replacement therapy that by law need a physician's prescription, and that have been approved by the FDA.</td>
</tr>
</tbody>
</table>
|                          | Related outpatient services such as: Consultations,  
|                          | • Exams,  
|                          | • Procedures, and  
|                          | • Other medical services and supplies                                                                                                                                                    |
|                          | Benefits for contraceptive and hormone replacement therapy drugs are payable as follows:  
|                          | Preferred Care: Payable as any other condition.  
|                          | Non-Preferred Care: Payable as any other condition.                                                                                                                                  |
|                          | Benefits for contraceptive devices and outpatient hormone replacement therapy or contraceptive services are payable as follows:  
|                          | Preferred Care: Payable as any other condition.  
|                          | Non-Preferred Care: Payable as any other condition.                                                                                                                                  |
| Pap Smear Expense | Covered Medical Expenses include one annual routine pap smear or other cytologic screening for women age 18 and older. |
|                          | Benefits are payable as follows:                                                                                                                                                      |
|                          | Preferred Care: 80% of the Negotiated Charge.  
|                          | Non-Preferred Care: 60% of the Reasonable charge.                                                                                                                                 |
| Human Papillomavirus (HPV) Vaccine | Covered Medical Expenses include administration of the human papillomavirus vaccine (HPV) to girls ages 11 and older.                                                             |
|                          | Benefits are payable as follows:                                                                                                                                                      |
|                          | Preferred Care: Payable as any other condition.  
|                          | Non-Preferred Care: Payable as any other condition.                                                                                                                                  |
| Mammography Expense | **Covered Medical Expenses** include the following:  
  - A baseline mammogram for women between the ages of 35 and 40,  
  - A mammogram on an annual basis for women 40 years of age and older.  
Benefits are payable as follows:  
  **Preferred Care:** 80% of the **Negotiated Charge**.  
  **Non-Preferred Care:** 60% of the **Reasonable charge**. |
| Mastectomy and Breast Reconstruction Expense Benefit | Coverage will be provided to a **covered person** who is receiving benefits for a necessary mastectomy and who elects breast reconstruction after the mastectomy for:  
  - Reconstruction of the breast on which a mastectomy has been performed,  
  - Surgery and reconstruction of the other breast to produce a symmetrical appearance,  
  - Prostheses,  
  - Treatment of physical complications of all stages of mastectomy, including lymphedemas, and  
  - Reconstruction of the nipple/areolar complex following a mastectomy is covered without regard to the lapse of time between the mastectomy and the reconstruction. This is subject to the approval of the attending **physician**.  
**Covered Medical Expenses** are payable as follows:  
  **Preferred Care:** Payable as any other condition.  
  **Non-Preferred Care:** Payable as any other condition.  
This coverage will be provided in consultation with the attending physician and the patient. It will be subject to the same annual **deductibles** and coinsurance provisions that apply to the mastectomy. |
| Routine Screening for Sexually Transmitted Disease Expense | **Covered Medical Expenses** include charges for **covered persons** who are at least 18 years old and who are sexually active for annual routine screening for sexually transmitted diseases.  
Benefits are payable on the same basis as any other condition. |
| Routine Colorectal Cancer Screening Expense | **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:  
  - 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.  
**Covered Medical Expenses** are payable as follows:  
  **Preferred Care:** Payable as any other condition.  
  **Non-Preferred Care:** Payable as any other condition. |
<table>
<thead>
<tr>
<th>Section</th>
<th>Description</th>
</tr>
</thead>
</table>
| **Routine Prostate Cancer Screening Expense** | Covered Medical Expenses include charges incurred by a covered person for one digital rectal exam and one prostate specific antigen test each Policy Year for the screening of cancer as follows:  
- For a male age 50 or over or;  
- A male age 40 and over with a family history  

Benefits are payable as follows:  
Preferred Care: Payable as any other condition.  
Non-Preferred Care: Payable as any other condition. |
| **Surgical Second Opinion Expense** | Covered Medical Expenses will include expenses incurred for a second opinion consultation by a specialist on the need for surgery which has been recommended by the covered person's physician. The specialist must be board certified in the medical field relating to the surgical procedure being proposed. Coverage will also be provided for any expenses incurred for required X-rays and diagnostic tests done in connection with that consultation. Aetna must receive a written report on the second opinion consultation.  

Benefits are payable as follows:  
Preferred Care: After a $25 Copay per visit, 80% of the Negotiated Charge.  
Non-Preferred Care: After a $25 Deductible per visit, 60% of the Reasonable Charge. |
| **Elective Surgical Second Opinion Expense** | Covered Medical Expenses will include expenses incurred for 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.  

Benefits are payable as follows:  
Preferred Care: After a $25 Copay per visit, 80% of the Negotiated Charge.  
Non-Preferred Care: After a $25 Deductible per visit, 60% of the Reasonable Charge. |
| **Acupuncture in Lieu of Anesthesia Expense** | Covered Medical Expenses include acupuncture therapy, when acupuncture is used in lieu of other anesthesia, for a surgical or dental procedure covered under this Plan.  
The acupuncture must be administered by a health care provider who is a legally qualified physician, practicing within the scope of their license.  

Preferred Care: Payable as any other condition.  
Non-Preferred Care: Payable as any other condition. |
<table>
<thead>
<tr>
<th>Service</th>
<th>Covered Medical Expenses</th>
<th>Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Dermatological Expense</strong></td>
<td><strong>Covered Medical Expenses</strong> include charges for the diagnosis and treatment of skin disorders, excluding laboratory fees. Related laboratory expenses are covered under the Outpatient Expense Benefit.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Benefits are payable as follows:</td>
<td>Preferred Care: Payable as any other condition. Non-Preferred Care: Payable as any other condition.</td>
</tr>
<tr>
<td></td>
<td><strong>Covered Medical Expenses</strong> do not include cosmetic treatment and procedures.</td>
<td></td>
</tr>
<tr>
<td><strong>Podiatric Expense</strong></td>
<td><strong>Covered Medical Expenses</strong> include charges for podiatric services, provided on an outpatient basis.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Benefits are payable as follows:</td>
<td>Preferred Care: Payable as any other condition. Non-Preferred Care: Payable as any other condition.</td>
</tr>
<tr>
<td></td>
<td>Expenses for routine foot care, such as trimming of corns, calluses, and nails, are <strong>not Covered Medical Expenses</strong>.</td>
<td></td>
</tr>
<tr>
<td><strong>Home Health Care Expenses</strong></td>
<td><strong>Covered Medical Expenses</strong> include charges incurred from care at home or health supportive services if the care or service was prescribed by a physician and would have been covered by the policy if performed in a medical facility.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Benefits are payable as follows: Preferred Care: 80% of the Negotiated Charge. Non-Preferred Care: 60% of the Reasonable Charge.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Benefits are limited to 100 visits per <strong>Policy Year</strong>.</td>
<td></td>
</tr>
<tr>
<td><strong>Transfusion or Dialysis of Blood Expense</strong></td>
<td><strong>Covered Medical Expenses</strong> include charges for the transfusion or dialysis of blood, including the cost of: whole blood, blood components, and the administration thereof.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Benefits are payable as follows: Preferred Care: Payable as any other condition. Non-Preferred Care: Payable as any other condition.</td>
<td></td>
</tr>
<tr>
<td><strong>Hospice Benefit</strong></td>
<td><strong>Covered Medical Expenses</strong> include charges for hospice care. A hospice care program includes the provision of <strong>physical</strong>, psychological, custodial and spiritual care for persons who are terminally ill and their families.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Benefits are payable as follows: Preferred Care: 80% of the Negotiated Charge. Non-Preferred Care: 60% of the Reasonable charge.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>The maximum benefit is <strong>$4,000</strong> per Lifetime.</td>
<td></td>
</tr>
</tbody>
</table>
| Licensed Nurse Expense | Benefits include charges incurred by a **covered person** who is confined in a hospital as a resident bed-patient, and requires the services of a registered nurse or licensed practical nurse.  

**Covered Expenses** for a Licensed Nurse are covered as follows:  

**Preferred Care:** 80% of the **Negotiated Charge**.  
**Non-Preferred Care:** 60% of the **Reasonable Charge**. |
|---|---|
| Skilled Nursing Facility Expense | **Covered Medical Expenses** include charges incurred by a **covered person** for confinement in a skilled nursing facility for treatment rendered:  

- In lieu of confinement in a hospital as a full time inpatient, or  
- Within 24 hours following a hospital confinement and for the same or related cause(s) as such hospital confinement.  

**Covered Medical Expenses** are payable as follows:  

**Preferred Care:** 80% of the **Negotiated Charge** for the semi-private room rate.  
**Non-Preferred Care:** 60% of the **Reasonable Charge** for the semi-private room rate. |
| Rehabilitation Facility Expense | **Covered Medical Expenses** include charges incurred by a **covered person** for confinement as a full time inpatient in a rehabilitation facility. Confinement in the rehabilitation facility must follow within 24 hours of, and be for the same or related cause(s) as, a period of hospital or skilled nursing facility confinement.  

**Covered Medical Expenses** for Rehabilitation Facility Expense are covered as follows:  

**Preferred Care:** 80% of the **Negotiated Charge** for the rehabilitation facility’s daily room and board maximum for semi-private accommodations.  
**Non-Preferred Care:** 60% of the **Reasonable Charge** for the rehabilitation facility’s daily room and board maximum for semi-private accommodations. |
| Medical Treatment Pursuant to a Clinical Trial Expense | **Covered Medical Expenses** include medical treatment which an insured receives as part of a clinical trial or study if: (a) the medical treatment is provided in a Phase II, Phase III or Phase IV study or clinical trial for the treatment of cancer or chronic fatigue syndrome.  

**Covered Medical Expenses** for treatment described above is limited to: (a) coverage for any drug or device that is approved for sale by the FDA without regard to whether the approved drug or device has been approved for use in the medical treatment of the insured; (b) the cost of any reasonably necessary health care services that are required as a result of the medical treatment provided in the clinical trial or study or as a result of any complication arising out of the medical treatment provided in the clinical trial or study, to the extent that such health care services would otherwise be covered under group health policy; (c) the initial consultation to determine whether the insured is eligible to participate in the clinical trial or study; (d) health care services required for the clinically appropriate monitoring of the insured during the clinical trial or study.  

Benefits are payable as follows:  

**Preferred Care:** Payable as any other condition.  
**Non-Preferred Care:** Payable as any other condition. |
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 and are not insurance. To learn more about these additional services and search for providers visit, www.aetnastudenthealth.com.

Aetna Book Discount Program: Access to a 10% discount on any book or DVD purchase from the MayoClinic.com Bookstore.

Aetna Fitness Discount Program: Access to preferred rates on gym memberships and discounts on at-home weight loss programs, home fitness options and one-on-one health coaching services through GlobalFit™.

Aetna Hearing Discount Program: Access to discounts on hearing devices and hearing exams from HearPO®. Average savings on hearing aids is 25%.

Aetna Natural Products and Services Discount Program: Access to reduced rates on services from participating providers for acupuncture, chiropractic care, massage therapy and dietetic counseling. Also, access to discounts on over-the-counter vitamins, herbal and nutritional supplements and natural products.

All products and services are provided through American Specialty Health Incorporated (ASH) and its subsidiaries.

Aetna Vision Discount Program: Access to discounts on vision exams, lenses and frames when a member utilizes a provider participating in the EyeMed Select Network.

Aetna Weight Management Discount Program: Access to discounts on Jenny Craig® weight loss programs and products. Also, access to a 30% discount on monthly eDiet membership dues. eDiets is an online diet, fitness and healthy living website.

Oral Health Care Discount Program: Access to discounts on oral health care products. Save on xylitol mints, mouth rinses, gum, candies and toothpaste from Epic. Additionally, receive exclusive savings on Waterpik® dental water jets and sonic toothbrushes.

Zagat Discounts: Access to a 30% discount on a one-year online subscription fee to Zagat.com. The Zagat website provides access to over 40,000 restaurants, nightspots, hotels and attractions around the world.

These services, programs or benefits are offered by vendors who are independent contractors and not employees or agents of Chickering Claims Administrators, Inc., Aetna Life Insurance or their affiliates.

Discount programs and other programs above provide access to discounted prices and are NOT insured benefits. The member is responsible for the full cost of the discounted services. Discount programs may be offered by vendors who are independent contractors and not employees or agents of Aetna.
Aetna’s Informed Health® Line:
Call toll free (800) 556-1555 24 hours a day, 7 days a week.
Get health answers 24/7. When you have an Aetna health benefits and health insurance plan, you have instant access to the
information you need. Our tools and resources can help you:
• Make more informed decisions about your care
• Communicate better with your doctors
• Save time and money, by showing you how to get the right care at the right time

When you call our Informed Health Line, you can talk directly to a registered nurse. Our nurses can discuss a wide variety
of health and wellness topics.

Listen to the Audio Health Library:
It explains thousands of health conditions in English and Spanish. Transfer easily to a registered nurse at any time during
the call.

* Not all topics in the audio health service are covered expenses under your plan.

Use the Healthwise® Knowledgebase to find out more about a health condition you have or medications you take.
It explains things in terms that are easy to understand. Get to it through your secure Aetna Navigator® member website, at

Health and Wellness Portal: This dynamic, interactive website at www.aetnastudenthealth.com 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 Right® Maternity Program: Make healthy choices for you and your baby. Learn what decisions are good ones
for you and your baby. Our Beginning Right maternity program helps prepare you for the exciting changes pregnancy
brings.

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 addresses over 35 health conditions, using
smart technology and supportive services to personalize your experience. The program helps you learn ways to improve
your health. Our CareEngine® system compares your health data with over 1,000 current evidence-based guidelines of care.
It runs constantly to identify safety risks and solutions, opportunities for better care and program services that can help you
reach your health goals. You may receive a call or letter, depending on the situation. Or, to get started right away, call us
at (866) 269-4500.

With our Aetna Dental® PPO insurance plan, participating dentists have agreed to provide services at a negotiated rate for
covered services, as well as reduced fees for certain *non-covered services such as cosmetic tooth whitening, so you
generally pay less out of pocket. Enroll and search dentists online at www.aetnastudenthealth.com.

Price:
• $354.00 Annual Student only
• $372.00 Annual Spouse
• $450.00 Annual Per Child

In Texas, the Preferred Provider Organization (PPO) plan is known as the Participating Dental Network (PDN).*Discounts
for non-covered services may not be available in all states. The Aetna Dental PPO insurance plan is underwritten by Aetna
Life Insurance Company.

Health/Dental information programs provide general health/dental information and are not a substitute for diagnosis or
treatment by a physician or other health/dental care professional.
GENERAL PROVISIONS

STATE MANDATED BENEFITS
The Plan will pay benefits in accordance with any applicable Nevada State Insurance Law(s).

Continuity of Care
If an insured is receiving medical treatment for a medical condition from a provider whose contract with Aetna is terminated during the course of the medical treatment, this Policy will provide that the insured may continue to obtain medical treatment for the medical condition if: (1) the insured is actively undergoing a medically necessary course of treatment; and (2) the provider and the insured agree that they continuity of care is desirable.

Such coverage will be provided until the later of: (a) the 120th day after the date the contract is terminated; or (b) If the medical condition is pregnancy, the 45th day after: (1) The date of delivery; or (2) If the pregnancy does not end in delivery, the date of the end of the pregnancy.

SUBROGATION/REIMBURSEMENTRIGHT 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.

The Covered Person acknowledges that this Plan's subrogation and reimbursement rights are a first priority claim against all potential responsible parties, and are to be paid to Aetna before any other claim for the Covered Person's damages. This Plan shall be entitled to full reimbursement first from any potential responsible party payments, even if such payment to the Plan will result in a recovery to the Covered Person, which is insufficient to make the Covered Person whole, or to compensate the Covered Person in part or in whole for the damages sustained. This Plan is not required to participate in or pay attorney fees to the attorney hired by the Covered Person to pursue the Covered Person's damage claim. In addition, this Plan shall be responsible for the payment of attorney fees for any attorney hired or retained by this Plan. The Covered Person shall be responsible for the payment of all attorney fees for any attorney hired or retained by the Covered Person or for the benefit of the Covered Person.
The terms of this entire subrogation and reimbursement provision shall apply. This Plan is entitled to full recovery regardless of whether any liability for payment is admitted by any potentially responsible party, and regardless of whether the settlement or judgment received by the Covered Person identifies the medical benefits this Plan provided. This Plan is entitled to recover from any and all settlements or judgments, even those designated as "pain and suffering" or "non-economic damages" only.

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

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

EXTENSION OF BENEFITS

If Basic Sickness Expense, 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, only while the covered person continues to be totally disabled. Benefits will end three 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 30 day period, following such termination of insurance.

TERMINATION OF INSURANCE

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

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 26th 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.

Continuation of Coverage
A covered student who has graduated or is otherwise ineligible for coverage under this Policy, and has been continuously insured under the plan offered by the Policyholder (regular student plan), may be covered for up to 9 months provided that:
(1) a written request for continuation has been forwarded to Aetna 31 days prior to the termination of coverage, and (2) premium payment has been made. Coverage under this provision ceases on the date this Policy terminates.

Continuation while on Medical Leave of Absence
This Plan will continue coverage for a covered student and his dependents who are otherwise covered by the Policy while the student is on a Medical Leave of Absence as a result of a total disability. The coverage must be for any injury or illness suffered by the student which is not related to the total disability or for any injury or illness suffered by his dependent. The coverage will be equal to the coverage otherwise provided by the Policy, and will continue until (a) the date on which the student obtains another policy of health insurance; (b) the date on which this Policy terminates, or; (c) after a period of 12 months in which benefits under such coverage are provided to the member, whichever occurs first.
EXCLUSIONS

This Policy does not cover nor provide benefits for:

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

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

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

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

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

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

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

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

9. Expense incurred for cosmetic surgery, reconstructive surgery, or other services and supplies which improve, alter, or enhance appearance, whether or not for psychological or emotional reasons, except to the extend needed to:
   • 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 incurred as a result of preventive medicines, serums or vaccines unless otherwise provided in the policy.

12. Expense incurred as a result of commission of a felony.
13. Expense incurred for voluntary or elective abortions unless otherwise provided in this Policy.

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

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

16. 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.

17. Expense incurred for injury resulting from the play or practice of collegiate or intercollegiate sports, including collegiate or intercollegiate club sports and intermurals.

18. Expense for the contraceptive methods, devices or aids, and charges for or related to artificial insemination, in-vitro fertilization, or embryo transfer procedures, elective sterilization or its reversal or elective abortion unless specifically provided for in this Policy.

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

20. 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.

21. Expense incurred for the removal of an organ from a covered person for the purpose of donating or selling the organ to any person or organization. This limitation does not apply to a donation by a covered person to a spouse, child, brother, sister, or parent.

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

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

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

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

- Also, this exclusion will not apply with respect to drugs that:
  - Have been granted treatment investigational new drug (IND), or Group c/treatment IND status, or
  - Are being studied at the Phase III level in a national clinical trial, sponsored by the National Cancer Institute,
  - If Aetna determines that available, scientific evidence demonstrates that the drug is effective, or shows promise of being effective, for the disease.

24. Expenses incurred for gastric bypass, and any restrictive procedures, for weight loss except for **medically necessary** surgical treatment of morbid obesity.

25. Expenses incurred for breast reduction/mammoplasty.

26. Expenses incurred for gynecomastia (male breasts).

27. 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.

28. Expense incurred for, or related to, services, treatment, testing, educational testing or, training, or medication for Attention Deficit Disorder, Attention Deficit Hyperactive Disorder, or Learning Disabilities, or other developmental delays except for Diagnostic Testing For Learning Disabilities.

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

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

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

32. 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.

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

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

35. Expenses incurred for hearing exams.

36. Expense for transplants, other than cornea and kidney.

37. 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.

38. Expense for telephone consultations, charges for failure to keep a scheduled visit, or charges for completion of a claim form.
39. 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.

40. Expense for services or supplies provided for the treatment of obesity and/or weight control except for medically necessary surgical treatment of morbid obesity.

41. Expense for incidental surgeries, and standby charges of a physician.

42. Expense for treatment and supplies for programs involving cessation of tobacco use, unless specifically provided for in this Policy.

43. Expense for contraceptive methods, devices or aids, and 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.

44. Expenses incurred for massage therapy.

45. Expense incurred for, or related to, sex change surgery, or to any treatment of gender identity disorder.

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

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

48. 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.

49. Expenses arising from a pre-existing condition.

50. 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.
51. Expense incurred for a treatment, service, or supply, which is not medically necessary, as determined by Aetna, for the diagnosis care or treatment of the sickness or injury involved. This applies even if they are prescribed, recommended, or approved, by the person’s attending physician, or dentist.

In order for a treatment, service, or supply, to be considered medically necessary, the service or supply must:

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

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

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

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

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

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 from one Policy year to the next.

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.
**Birthing Center**
A freestanding facility that:

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

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

**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.

**Clinical Trial Medical Treatment**
Medical treatment which an insured receives as part of a clinical trial or study if: (a) the medical treatment is provided in a Phase II, Phase III or Phase IV study or clinical trial for the treatment of cancer or chronic fatigue syndrome; (b) the clinical trial or study is approved by: (1) an agency of the National Institutes of Health; (2) a cooperative group; (3) the FDA as an application for a new investigational drug; (4) the U.S. Department of Veterans Affairs; or (5) the U.S. Department of Defense; (c) the medical treatment is provided by a provider of health care and the facility and personnel have the experience and training to provide the treatment in a capable manner; (d) there is no medical treatment available which is considered a more appropriate alternative medical treatment than the medical treatment provided in the clinical trial or study; (e) there is a reasonable expectation based on clinical data that the medical treatment provided in the clinical trial or study will be at least as effective as any other medical treatment; (f) the clinical trial or study is conducted in this state; and (g) the insured has signed, before his participation in the clinical trial or study, a statement of consent indicating that he has been informed of, without limitation: (1) the procedure to be undertaken; (2) alternative methods of treatment; and (3) the risks associated with participation in the clinical trial or study, including, without limitation, the general nature and extent of such risks.
2. The coverage for medical treatment described above is limited to: (a) coverage for any drug or device that is approved for sale by the FDA without regard to whether the approved drug or device has been approved for use in the medical treatment of the insured; (b) the cost of any reasonably necessary health care services that are required as a result of the medical treatment provided in the clinical trial or study or as a result of any complication arising out of the medical treatment provided in the clinical trial or study, to the extent that such health care services would otherwise be covered under group health policy; (c) the initial consultation to determine whether the insured is eligible to participate in the clinical trial or study; (d) health care services required for the clinically appropriate monitoring of the insured during the clinical trial or study. The services provided pursuant to this paragraph 2(b) and (d) must be covered only if the services are provided by a provider with whom the insurer has contracted for such services. If the insurer has not contracted for the provision of such services, the insurer shall pay the provider the rate of reimbursement that is paid to other providers with whom the insurer has contracted for similar services and the provider shall accept that rate of reimbursement as payment in full.

3. Particular medical treatment described above and provided to an insured is not required to be covered if that particular medical treatment is provided by the sponsor of the clinical trial or study free of charge to the person insured under the group health policy.

4. The coverage for medical treatment required by this section does not include: (a) any portion of the clinical trial or study that is customarily paid for by a government or a biotechnical, pharmaceutical or medical industry; (b) coverage for a drug or device described in 2(a) above which is paid for by the manufacturer, distributor or provider of the drug or device; (c) health care services that are specifically excluded from coverage under the insured's policy of group health insurance, regardless of whether such services are provided under the clinical trial or study; (d) health care services that are customarily provided by the sponsors of the clinical trial or study free of charge to the participants in the trial or study; (e) extraneous expenses related to participation in the clinical trial or study including, without limitation, travel, housing and other expenses that a participant may incur; (f) any expenses incurred by a person who accompanies the insured during the clinical trial or study; (g) any item or service that is provided solely to satisfy a need or desire for data collection or analysis that is not directly related to the clinical management of the insured; (h) any costs for the management of research relating to the clinical trial or study.

5. Coverage required by this section shall be subject to the same deductible, copayment, coinsurance and other such conditions for coverage that are required under the policy.

6. An insurer who issues group health insurance specified in subsection 1 is immune from liability for: (a) any injury to the insured caused by: (1) any medical treatment provided to the insured in connection with his participation in a clinical trial or study described in this section; or (2) an act or omission by a provider of health care who provides medical treatment or supervises the provision of medical treatment to the insured in connection with his participation in a clinical trial or study described in this section; (b) any adverse or unanticipated outcome arising out of an insured's participation in a clinical trial or study described in this section.

**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 except with respect to any expenses payable under the Extension of Benefit Provisions.

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 child under the age of 26. The child must reside with, and be fully supported by, the **covered student**.

The term “child” includes a **covered student**’s step-child, adopted child whose coverage is effective upon the earlier of the date of placement for the purpose of adoption, or the date of the entry of an order granting the adoptive parent custody of the child for purposes of adoption and who is residing with the covered student, and who is chiefly dependent on the **covered student** for his or her full support.

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 Training, Education and Counseling Benefit**
Training and education provided to the member (1) After an initial diagnosis of diabetes which is medically necessary for the care and management of diabetes, including, without limitation, counseling in nutrition and the proper use of equipment and supplies for the treatment of diabetes; (2) Training and Education which is medically necessary as a result of a subsequent diagnosis that indicates a significant change in the symptoms of condition of the member; and (3) Training and Education which is medically necessary because of the development of new techniques and treatment for diabetes.

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

Emergency 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 Care

“Agency to provide nursing in the home” means any person or governmental organization which provides in the home, through its employees or by contractual arrangement with other persons, skilled nursing and assistance and training in health and housekeeping skills. The term does not include a provider of supported living arrangement services during any period in which the provider of supported living arrangement services is engaged in providing supported living arrangement services.

“Agency to provide personal care services in the home” means any person, other than a natural person, which provides in the home, through its employees or by contractual arrangement with other persons, nonmedical services related to personal care to elderly persons or persons with disabilities to assist those persons with activities of daily living, including, without limitation:

(a) The elimination of wastes from the body;
(b) Dressing and undressing;
(c) Bathing;
(d) Grooming;
(e) The preparation and eating of meals;
(f) Laundry;
(g) Shopping;
(h) Cleaning;
(i) Transportation; and
(j) Any other minor needs related to the maintenance of personal hygiene.

2. The term does not include:

(a) An independent contractor who provides nonmedical services specified by subsection 1 without the assistance of employees;
(b) An organized group of persons composed of the family or friends of a person needing personal care services that employs or contracts with persons to provide services specified by subsection 1 for the person if:
   (1) The organization of the group of persons is set forth in a written document that is made available for review by the Health Division upon request; and
   (2) The personal care services are provided to only one person or one family who resides in the same residence; or
(c) An intermediary service organization.

Hospice

1. “Hospice care” means a centrally administered program of palliative services and supportive services provided by an interdisciplinary team directed by a physician. The program includes the provision of physical, psychological, custodial and spiritual care for persons who are terminally ill and their families. The care may be provided in the home, at a residential facility or at a medical facility at any time of the day or night. The term includes the supportive care and services provided to the family after the patient dies.

2. As used in this section:

(a) “Family” includes the immediate family, the person who primarily cared for the patient and other persons with significant personal ties to the patient, whether or not related by blood.
(b) “Interdisciplinary team” means a group of persons who work collectively to meet the special needs of terminally ill patients and their families and includes such persons as a physician, registered nurse, social worker, clergyman and trained volunteer.

Hospital

A facility which meets all of these tests:

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

Hospital does not include a place run mainly: (a) for alcoholics or drug addicts, (b) as a convalescent home, or (c) as a nursing or rest home. The term “hospital” includes an alcohol and drug addiction treatment facility during any period in which it provides effective treatment of alcohol and drug addiction to the covered person.
Hospital Confinement
A stay of 18 or more hours in a row as a resident bed patient in a hospital.

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

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

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

In no event will the following services or supplies be considered to be medically necessary:
• Those that do not require the technical skills of a medical, a mental health, or a dental professional, or
• Those furnished mainly for: the personal comfort, or convenience, of the person, any person who cares for him or her, or any person who is part of his or her family, any healthcare provider, or healthcare facility, or
• Those furnished solely because the person is an inpatient on any day on which the person's sickness or injury could safely and adequately be diagnosed or treated while not confined, or
• Those furnished solely because of the setting if the service or supply could safely and adequately be furnished, in a physician's or a dentist's office, or other less costly setting.
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 into 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, as determined by Aetna:
• The service or supply could have been provided by a Preferred Care Provider, and
• The provider is of a type that falls into one or more of the categories of providers listed in the directory.

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

Non-Preferred Pharmacy
A pharmacy not party to a contract with Aetna, or a pharmacy who is party to such a contract but who does not dispense prescription drugs in accordance with its terms.
Non-Preferred Prescription Drug Expense
An expense incurred for a prescription drug that is not a preferred prescription drug expense.

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

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

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% for the remainder of the Policy Year. The Out-of-Pocket Limit applies only to Covered Medical Expenses for preferred care and non-preferred, 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, including chiropractors, that must by law be recognized as a doctor legally qualified to render treatment.

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

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 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 on the referral of the primary care physician, or
- A health care provider that is not a Preferred Care Provider for an emergency medical condition when travel to a Preferred Care Provider 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 on referral of a person's Primary Care Physician, or
  - A dentist who is a Non-Preferred Care Provider, but only one who is not of a type that falls into one or more of the categories of providers listed in the 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.
- Enteral formulas for the treatment of inherited metabolic diseases characterized by deficient metabolism or malabsorption originating from congenital defects or defects arising shortly after birth, of amino acid, organic acid, carbohydrate or fat.

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.

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

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

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

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

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

Skilled Nursing Facility
A lawfully operating institution engaged mainly in providing treatment for people convalescing from injury or sickness. It must have:
- organized facilities for medical services,
- 24 hours nursing service by RNs,
- a capacity of six or more beds,
- a daily medical records for each patient, and
- a physician available at all times.

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

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

1. Bills must be submitted within 90 days from the date of treatment.
2. Payment for Covered Medical Expenses will be made directly to the hospital or physician concerned, unless bill receipts and proof of payment are submitted.
3. If itemized medical bills are available at the time the claim form is submitted, attach them to the claim form. Subsequent medical bills should be mailed promptly to the above address.
4. 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
P.O. Box 14464
Lexington, KY 40512

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.
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 (877) 626-2308.

**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)
- $2,500 Joining of Ill Family Member Accommodations
- Return of Traveling Companion
- $2,500 EMERGENCY RETURN TO

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

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

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

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

Need help 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.

CLAIMS ADMINISTERED BY:

Claims and Coverage Questions
Aetna Student Health
PO Box 981106
El Paso, TX 79998
(877) 626-2308 (Toll-Free)
www.aetnastudenthealth.com

EMERGENCY TRAVEL ASSISTANCE:
(Provide this information to your Emergency Contact)
On Call International 24/7 Emergency Travel Assistance Services
(866) 525-1956 (within U.S.).
If outside the U.S., call collect by dialing the U.S. access code plus (603) 328-1956.
www.aetnastudenthealth.com

PREFERRED PROVIDER:
To Find a Doctor or Provider
Aetna Preferred Provider Network
(877) 626-2308 (Toll-Free)
www.aetna.com/docfind/custom/studenthealth

PRESCRIPTIONS: Aetna Pharmacy Management
(800) 238-6279
www.aetna.com/docfind/custom/studenthealth

24-HOUR NURSE ADVICE: Aetna Informed Health® Line
(800) 556-1555

THE PLAN ADMINISTERED BY:
Eligibility, Enrollment and General Questions
Wells Fargo of California Insurance Services, Inc.
Student Insurance Division
NV License No. 9191
11017 Cobblerock Drive, Suite 100
Rancho Cordova, CA 95670

www.aetnastudenthealth.com
The University of Nevada Las Vegas School of Dental Medicine Student Health Insurance Plan is underwritten by Aetna Life Insurance Company (ALIC) and administered by Chickering Claims Administrators, Inc. Aetna Student Health℠ is the brand name for products and services provided by these companies and their applicable affiliated companies.