2013

University of Medicine and Dentistry of New Jersey Post Doctorate Student Health Insurance Plan and Rutgers University Graduate Fellows Student Health Insurance Plan

Underwritten by:
Aetna Life Insurance Company
(ALIC)

Policy Number ***812813***

Your student health insurance coverage, may not meet the minimum standards required by title XXVII of the Public Health Service Act. Specifically, the coverage will not be renewed when you are no longer enrolled as a student at the University of Medicine and Dentistry of New Jersey; and the restrictions on annual dollar limits on your benefits may not be the same as other types of coverage. For policy years beginning before September 23, 2012, if a policy for student health insurance coverage applies a dollar limit on the coverage it provides for key benefits in a year, that limit must be at least $100,000. Your student health insurance coverage put an annual limit of: $750,000 per condition per Policy Year. If you have any questions or concerns about this notice, contact Aetna Student Health at (800) 466-3185.

UMDNJ
UNIVERSITY OF MEDICINE & DENTISTRY OF NEW JERSEY

RUTGERS
THE STATE UNIVERSITY OF NEW JERSEY

aetna℠

University of Medicine and Dentistry of New Jersey (UMDNJ) Post Doctorate Student Health Insurance Plan
Rutgers University Graduate Fellows Student Health Insurance Plan

The UMDNJ Post Doctorate and Rutgers University Graduate Fellows Student Health Insurance Plan have been developed especially for UMDNJ Post Doctorates and Rutgers University Graduate Fellows.

The Plan provides coverage for illnesses and Injuries that occur on or off campus, and includes special cost saving features to keep the plan as affordable as possible.

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

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**.

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

Please contact:
Aetna Student Health
P.O. Box 981106
El Paso, TX 79998
(800) 466-3185 or **visit www.aetnastudenthealth.com**

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
(800) 466-3185

For questions about:
* Enrollment Process

Please contact:
University Health Plans, Inc.
(800) 437-6448
info@univhealthplans.com

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
(800) 466-3185

A complete list of providers can be found at the University Health Services Office, or you can use Aetna's **DocFind®** Service at either: **www.aetna.com/docfind/custom/studenthealth/index.html** or:
www.aetnastudenthealth.com

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

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

IMPORTANT NOTE

Please keep this Brochure, as it provides a general summary of your coverage. A complete description of the benefits and full terms and conditions may be found in the Master Policy issued to The University of Medicine of New Jersey (UMDNJ) Post Doctorate and Rutgers University Graduate Fellows program. 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 UMDNJ's Risk & Claims Office **(973) 972-6277** 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.

POLICY PERIOD

Annual Student Coverage: Coverage for all insured Post Doctorates and Fellows will become effective at 12:00 AM on January 1, 2013, and will terminate at 11:59 PM on August 31, 2013. Coverage for eligible Rutgers University Graduate Fellows will become effective upon receipt of the completed Enrollment Form, and will continue for the term of the fellowship.

Insured dependents: Coverage will become effective on the same date the insured student's coverage becomes effective, or the day after the postmarked date when the completed application and premium are sent, if later. Coverage for insured dependents terminates in accordance with the Termination Provisions described in the Master Policy. For more information on Termination of Covered Dependents see page 27 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

Premium Rates for the Period of January 1, 2013 through August 31, 2013

Post Doc/Fellow Only	**$274.00 Per Month**
Post Doc/Fellow and One Dependent	**$626.00 Per Month**
Post Doc/Fellow and Family *(Two or More Dependents)*	**$793.00 Per Month**

DEDUCTIBLES*

The following Deductibles are applied before Covered Medical Expenses are payable:

Preferred Care:
Students: **$100** per Policy Year
Dependents: **$100** per Policy Year
Family: **$200** per Policy Year

Non-Preferred Care:
Students: **$500** per Policy Year
Dependents: **$500** per Policy Year
Family: **$1,000** per Policy Year

*The Annual Deductible does not apply towards Lead Poisoning Testing, Newborn Hearing Screening and Childhood Immunizations, Routine Physical Exams, Routine Pap Smears, Routine Mammograms, Routine Colorectal Screenings, Routine Prostate Screenings, Routine STD Testing, Outpatient Contraceptive Drugs, Devices and Services.

University of Medicine and Dentistry of New Jersey Post Doctorate and Rutgers University Graduate Fellows Student Accident and Sickness Insurance Plan

This is a brief description of the Accident and Sickness Medical Expense benefits available for 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 UMDNJ's Risk & Claims Office **(973) 972-6277** during business hours. Please refer to your Certificate of Coverage for a complete description of the benefits available.

STUDENT COVERAGE

Eligibility: Under University Policy, all full-time UMDNJ Post Doctorate students are required to be covered by health and accident insurance. The University, in conjunction with University Health Plans, Inc. and Aetna Student Health, has developed a Post Doctorate Student Health Insurance Plan that fulfills the UMDNJ insurance requirements.

Rutgers University Graduate Fellows who have been awarded a prestigious and full competitive fellowship from external sources and will be on campus during the coming year may be eligible for single health insurance coverage. The Graduate School Dean's Office will make final determinations as to individual eligibility. Coverage for eligible Post Doctorates and Graduate Fellows will become effective upon receipt of the completed Enrollment Form, and will continue for the term of the fellowship or retention. Rutgers part-time teaching assistants and graduate assistants (TA/GAs) are also eligible under this plan which is determined by the Department of Risk Management & Insurance Office.

Student Enrollment: All full-time UMDNJ Post Doctorate students will need to complete an Enrollment Form to be submitted to the Risk & Claims Office.

All eligible Rutgers University Graduate Fellows will need to complete an Enrollment Form to be submitted to the Graduate School Dean's Office.

Eligible Rutgers Part-Time TA/GAs will need to complete an Enrollment Form to be submitted to the Rutgers University Human Resource Office.

Mid-Year Enrollment: You may enroll after the deadline date only if there has been a significant life change (i.e., marriage, birth, loss of prior coverage). If the Enrollment Form is submitted within the 31 days of the qualifying event, coverage will be backdated to the date of the qualifying event. If the Enrollment Form is submitted after the 31 days of the qualifying event, it will not be accepted. The student or dependent(s) will have to wait until the next annual open enrollment period to enroll. The completed Enrollment Form should be submitted directly to your university's office along with required documentation.

REFUND POLICY

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

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

DEPENDENT COVERAGE

ELIGIBILITY

(a) the **covered student's** spouse/**civil union partner** residing with the **covered student**, or
(b) the person identified as a domestic partner in the "Declaration of Domestic Partnership",
(c) dependent children under age 26, and
(d) the **covered student**'s child (by blood or by law) who:
- is less than 31 years of age,
- is unmarried,
- has no dependents,
- is a resident of New Jersey or is enrolled as a full-time student, and
- is not provided coverage as a named subscriber, enrollee, or covered person under any other health plan.

(e) newborn children from the moment of birth, however if payment of premium is required to provide coverage for the newborn child, Aetna may require notification of birth and payment of the required premium within 31 days after the date of birth in order to have the coverage continue beyond the 31 day period.

The term "child" also includes a **covered student**'s step-child, adopted child, children of a **civil union partner** and a child for whom a petition for adoption is pending, who is residing with the **covered student** and who is chiefly dependent on the **covered student** for their full support.

The term **dependent** does not include a person who is an eligible student.

NEWBORN INFANT AND ADOPTED CHILD COVERAGE

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

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

DEPENDENT ENROLLMENT

To enroll the dependent(s) of a covered Post Doctorate or Fellow, or Rutgers Part-Time TA/GAs, please contact University Health Plans at **(800) 437-6448**.

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 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.

You may also obtain information regarding Preferred Providers by contacting Aetna Student Health at **(800) 466-3185**, or through the Internet by accessing DocFind at **www.aetna.com/docfind/custom/studenthealth/index.html**

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

Preferred providers are independent contractors and are neither employees nor agents of 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-CERTIFICATION PROGRAM

Pre-certification simply means calling Aetna Student Health prior to treatment to obtain approval for a medical procedure or service. Pre-certification may be done by you, your doctor, a hospital administrator, or one of your relatives. All requests for certification must be obtained by contacting Aetna Student Health at **(800) 466-3185** (attention Managed Care Department).

If you do not secure pre-certification for non emergency inpatient admissions, or provide notification for emergency admissions, your Covered Medical Expenses will be subject to a penalty which is the lesser of **$200** or **50%** of the amount that would otherwise have been paid.

The following inpatient services require pre-certification:

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

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

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

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

Aetna Student Health
Attention: Managed Care Department
P.O. Box 981106
El Paso, TX 79998
(800) 286-1144

DESCRIPTION OF BENEFITS

Please Note:

The University of Medicine of New Jersey (UMDNJ) Post Doctorate and Rutgers University Graduate Fellows programs **PLAN MAY NOT COVER ALL OF YOUR HEALTH CARE EXPENSE.**

The Plan excludes coverage for certain services and contains limitations on the amounts it will pay. Please read the University of Medicine of New Jersey (UMDNJ) Post Doctorate and Rutgers University Graduate Fellows programs **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,** The University of Medicine of New Jersey (UMDNJ) Post Doctorate and Rutgers University Graduate Fellows program **you may view it at** the UMDNJ's Risk & Claims Office **(973) 972-6277** during business hours **or you may contact Aetna Student Health at (800) 466-3185.**

This Plan will never pay more than $750,000 per condition, per policy year. Additional Plan maximums may also apply. Some illnesses may cost more to treat and health care providers may bill you for what the Plan does not cover.

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

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

SUMMARY OF BENEFITS CHART

DEDUCTIBLES
The following Deductibles are applied before Covered Medical Expenses are payable:

Preferred Care:
Students: **$100** per Policy Year
Dependents: **$100** per Policy Year
Family: **$200** per Policy Year

Non-Preferred Care:
Students: **$500** per Policy Year
Dependents: **$500** per Policy Year
Family: **$1,000** per Policy Year

COINSURANCE
Covered Medical Expenses are payable at the coinsurance percentage specified below, after any applicable deductible, up to a maximum benefit of **$750,000** per condition, per policy year.

OUT OF POCKET MAXIMUMS
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.

Preferred Care: Individual Out-of-Pocket:	**$2,500**
Preferred Care: Family Out-of-Pocket:	**$5,000**
Non-Preferred Care: Individual Out-of-Pocket:	**$10,000**
Non-Preferred Care: Family Out-of-Pocket:	**$20,000**

All coverage is based on Recognized Charges unless otherwise specified.

Inpatient Hospitalization Benefits	
Room and Board Expense	**Covered Medical Expenses** are payable as follows: Preferred Care: **100%** of the Negotiated Charge. Non-Preferred Care: **70%** of the Recognized Charge for a semi-private room.
Intensive Care Room and Board Expense	**Covered Medical Expenses** are payable as follows: Preferred Care: **100%** of the Negotiated Charge. Non-Preferred Care: **70%** of the Recognized Charge for the Intensive Care Room Rate for an overnight stay.
Miscellaneous Hospital Expense	**Covered Medical Expenses** are payable as follows: Preferred Care: **100%** of the Negotiated Charge. Non-Preferred Care: **70%** of the Recognized Charge. **Covered Medical Expenses** include, but are not limited to: laboratory tests, x-rays, surgical dressings, anesthesia, supplies and equipment use, and medicines.
Non-Surgical Physician's Expense	**Covered Medical Expenses** for charges for the non-surgical services of the attending Physician, or a consulting Physician, are payable as follows: Preferred Care: **100%** of the Negotiated Charge. Non-Preferred Care: **70%** of the Recognized Charge.

Surgical Benefits (Inpatient and Outpatient)	
Surgical Expense	**Covered Medical Expenses** for charges for surgical services, performed by a Physician, are payable as follows: Preferred Care: **100%** of the Negotiated Charge. Non-Preferred Care: **70%** of the Recognized Charge.
Anesthetist Expense	**Covered Medical Expenses** for the charges of an anesthetist, during a surgical procedure, are payable as follows: Preferred Care: **100%** of the Negotiated Charge. Non-Preferred Care: **70%** of the Recognized Charge.
Assistant Surgeon Expense	**Covered Medical Expenses** for the charges of an assistant surgeon, during a surgical procedure, are payable as follows: Preferred Care: **100%** of the Negotiated Charge. Non-Preferred Care: **70%** of the Recognized Charge.
Ambulatory Surgical Expense	**Covered Medical Expenses** for outpatient surgery performed in an ambulatory surgical center are payable as follows: Preferred Care: **100%** of the Negotiated Charge. Non-Preferred Care: **70%** of the Recognized 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.	
Hospital Outpatient Department Expense	**Covered Medical Expenses** includes treatment rendered in a Hospital Outpatient Department. **Covered Medical Expenses** do not include Emergency Room/Urgent Care Treatment, Walk-in Clinic, Therapy Expenses, Chemotherapy and Radiation, and outpatient surgical services, including physician, anesthesia and facility charges, which are covered as outlined under the individual benefit types listed in this schedule of benefits. **Covered Medical Expenses** for outpatient treatment in a hospital are payable as follows: Preferred Care: **100%** of the Negotiated Charge. Non-Preferred Care: **70%** of the Recognized Charge.
Walk-In Clinic Expense	**Covered Medical Expenses** include services rendered in a walk-in clinic. Preferred Care: After a **$20** Copay, **100%** of the Negotiated Charge. Non-Preferred Care: **70%** of the Recognized Charge.
Emergency Room Expense	**Covered Medical Expenses** incurred for treatment of an Emergency Medical Condition are payable as follows: Preferred Care: After a **$100** Copay (waived if admitted), **100%** of the Negotiated Charge. Non-Preferred Care: After a **$100** Deductible (waived if admitted), **100%** of the Recognized Charge.

Urgent Care Expense	*Benefits include charges for treatment by an urgent care provider as required by the Federal Emergency Medical Treatment and Active Labor Act.* **Please note: A covered person <u>should not seek medical care or treatment from an urgent care provider if their illness, injury, or condition, is an emergency condition.</u> The covered person should go directly to the emergency room of a hospital or call 911 for ambulance and medical assistance.** **<u>Urgent Care</u>** Benefits include charges for an urgent care provider to evaluate and treat an urgent condition. **Covered Medical Expenses** for urgent care treatment are payable as follows: <u>Preferred Care</u>: **100%** of the Negotiated Charge. <u>Non-Preferred Care</u>: **70%** of the Recognized Charge. *No benefit will be paid under any other part of this Plan for charges made by an urgent care provider to treat a non-urgent condition.*
Ambulance Expense	**Covered Medical Expenses** are payable as **100%** of the Actual Charge for the services of a professional ambulance to or from a hospital, when required due to the emergency nature of a covered Accident or Sickness.
Pre-Admission Testing Expense	**Covered Medical Expenses** for Pre-Admission testing charges while an outpatient before scheduled surgery are payable as follows: <u>Preferred Care</u>: **100%** of the Negotiated Charge. <u>Non-Preferred Care</u>: **70%** of the Recognized Charge.
Physician's Office Visit Expense	**Covered Medical Expenses** are payable as follows: <u>Preferred Care</u>: After a **$20** per visit Copay, **100%** of the Negotiated Charge. <u>Non-Preferred Care</u>: **70%** of the Recognized Charge. This benefit includes visits to specialists.
Laboratory and X-Ray Expense	**Covered Medical Expenses** are payable as follows: <u>Preferred Care</u>: **100%** of the Negotiated Charge. <u>Non-Preferred Care</u>: **70%** of the Recognized Charge.
High Cost Procedures Expense	**Covered Medical Expenses** include charges incurred by a **covered person** are payable as follows: <u>Preferred Care</u>: **100%** of the Negotiated Charge. <u>Non-Preferred Care</u>: **70%** of the Recognized Charge.
Therapy Expense	**Covered Medical Expenses** include charges incurred by a **covered person** for the following types of therapy provided on an outpatient basis: Chiropractic Care, Physical Therapy, 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**. **Covered Medical Expenses** are payable as follows: <u>Preferred Care</u>: After a **$20** Copay, **100%** of the Negotiated Charge. <u>Non-Preferred Care</u>: **70%** of the Recognized Charge.

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: **100%** of the Negotiated Charge. Non-Preferred Care: **70%** of the Recognized Charge.
Durable Medical Equipment Expense	**Covered Medical Expenses** are payable as follows: Preferred Care: **100%** of the Negotiated Charge. Non-Preferred Care: **70%** of the Recognized Charge.
Orthotic Or Prosthetic Appliances Expense	**Covered medial expenses** includes charges for orthotic or prosthetic appliances from a licensed orthotist or prosthetist or any certified pedorthist, if determined **medically necessary** by the **covered person**'s **physician**. Benefits for orthotic and prosthetic appliances are paid at the higher of the federal Medicare reimbursement schedule or the Negotiated Charge. Coverage is provided under the same terms and conditions as for any other **illness**.
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. • Non-surgical treatment of infections or diseases. This does not include those of, or related to, the teeth. Any such teeth must have been: • Free from decay, or • In good repair, and • Firmly attached to the jawbone at the time of the injury. *The treatment must be done in the calendar year of the accident or the next one*. If: • Crowns (caps), or • Dentures (false teeth), or • Bridgework, or • In-mouth appliances, are installed due to such injury, **Covered Medical Expenses** include only charges for: • The first denture or fixed bridgework to replace lost teeth, • The first crown needed to repair each damaged tooth, and • An in-mouth appliance used in the first course of orthodontic treatment after the injury. Surgery needed to: • Treat a fracture, dislocation, or wound. • Cut out cysts, tumors, or other diseased tissues. • Alter the jaw, jaw joints, or bite relationships by a cutting procedure when appliance therapy alone cannot result in functional improvement. **Covered Medical Expenses** are payable as follows: Preferred Care: **100%** of the Actual Charge. Non-Preferred Care: **100%** of the Actual Charge.

Allergy Testing Expense	Benefits include charges incurred for **diagnostic testing** 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, • Other medically necessary supplies and services **Covered Medical Expenses** are payable as follows: Preferred Care: **100%** of the Negotiated Charge. Non-Preferred Care: **70%** of the Recognized Charge.
Routine Physical Exam Expense	**Covered Medical Expenses** include the expenses incurred by a **covered student** or a **covered dependent** for a routine physical exam performed by a **physician**. If charges made by a **physician** in connection with a routine physical exam given to a child' who is a **covered dependent,** are **Covered Medical Expenses** under any other benefit section, no charges in connection with that physical exam will be considered **Covered Medical Expenses** 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. • For all persons age 20 and older: • Annual testes to determine blood hemoglobin blood pressure, blood glucose level, and blood cholesterol level or, alternatively, low density kliportein (LDL) level and blood high-density lipoprotein (HDL) level, and • An annual consultation with a health care provider to discuss lifestyle behaviors and promote health and well being including, but not limited to: smoking control, nutrition and diet recommendations, exercise plans, lower back protection, weight control, immunization practices, breast self-examination, testicular self-examination and seat belt usage in motor vehicles. • For all persons age 35 and older, a glaucoma eye test every five years. • For all persons age 40 and older, an annual stool exam for the presence of blood. • For all persons age 45 or older, a left-sided colon exam of 35 to 60 centimeters every five years. • For all women age 20 and older, pap smears. • For all women age 40 and older, mammograms. For all exams given to **covered dependent** under age 2, **Covered Medical Expenses** will not include charges for the following: • More than 6 exams performed during the first year of the child's life, • More than 2 exams performed during the second year of the child's life. For 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 2 up and over, **Covered Medical Expenses** will not include charges for more than one exam in 12 months in a row. **Covered medical expenses** include all childhood immunizations as recommended by the Advisory Committee on Immunizations Practices of the United States Public Health Service and the Department of Health and Senior Services. Aetna shall notify its Policyholders, in writing, of any change in coverage with respect to childhood immunizations.

	For all exams given to a **covered student** or a spouse who is a **covered dependent**, **Covered Medical Expenses** will not include charges for more than one exam in 12 months in a row. Also included as **Covered Medical Expenses** are: • Charges made by a **physician** for one annual routine gynecological exam, and • An annual consultation with a physician to discuss lifestyle behaviors that promote health and well being including but not limited to: smoking control, nutrition and diet recommendations, exercise plans lower back protection, weight control, immunization practices, breast self-exams, testicular self exams, and proper seat belt usage. Not covered are charges for: • Services which are for diagnosis or treatment of a suspected or identified **injury** or **sickness**. • Exams given while the **covered person** is confined in a **hospital** or other facility for medical care. • Services which are not given by a **physician** or under his or her direct supervision. • Appliances, equipment, or supplies. • Psychiatric, psychological, personality, or emotional testing or exams. • Exams in any way related to employment. • Premarital exams. • Vision, hearing, or dental exams. • A **physician's** office visit in connection with immunizations or testing for tuberculosis. **Covered Medical Expenses** are payable as follows: Preferred Care: **100%** of the Negotiated Charge. Non-Preferred Care: **100%** of the Recognized Charge. Screenings for Sexually Transmitted Diseases are not covered under this benefit.
Consultant Expense	**Covered Medical Expenses** include the expenses for the services of a consultant. The services must be requested by the attending physician for the purpose of confirming or determining a diagnosis. **Covered Medical Expenses** are covered as follows: Preferred Care: After a **$20** per visit Copay**, 100%** of the Negotiated Charge. Non-Preferred Care: **70%** of the Recognized Charge.

Mental Health Benefits	
Biologically-Based Mental Illness Inpatient Expense	**Covered Medical Expenses** for the diagnosis and treatment of biologically based mental illnesses are payable on the same basis as any other sickness. Covered Medical Expenses also include the charges made for treatment received during partial hospitalization in a hospital or treatment facility. Prior review and approval must be obtained on a case-by-case basis by contacting Aetna Student Health. When approved, benefits will be payable in place of an inpatient admission, whereby 2 days of partial hospitalization may be exchanged for 1 day of full hospitalization.
Biologically-Based Mental Illness Outpatient Expense	**Covered Medical Expenses** for the diagnosis and treatment of biologically based mental illnesses are payable on the same basis as any other sickness.
Non-Biologically Based Mental and Emotional Disorders Inpatient Expense	**Covered Medical Expenses** for the treatment of a mental health condition while confined as a inpatient in a hospital or facility licensed for such treatment are payable on the same basis as any other sickness. **Covered Medical Expenses** also include the charges made for treatment received during partial hospitalization in a hospital or treatment facility. Prior review and approval must be obtained on a case-by-case basis by contacting Aetna Student Health. When approved, benefits will be payable in place of an inpatient admission, whereby 2 days of partial hospitalization may be exchanged for 1 day of full hospitalization.
Non-Biologically Based Mental and Emotional Disorders Outpatient Expense	**Covered Medical Expenses** for outpatient treatment of a mental health condition are payable on the same basis as any other sickness
Autism Disorders Expense	**Covered Medical Expenses** include: Coverage for the screening and diagnosing of autism or other developmental disabilities, coverage, as prescribed through a treatment plan, for medically necessary occupational therapy, physical therapy and speech therapy when the covered person's primary diagnosis is autism or another developmental disability, and Coverage, as prescribed through a treatment plan, for medically necessary behavioral interventions, based on principles of applied behavioral analysis, when the covered person is under age 21 and their primary diagnosis is autism. The maximum benefit per calendar year shall be **$36,000**. Benefits are payable on the same basis as any other condition.
Diagnostic Testing For Learning Disabilities Expense	**Covered Medical Expenses** are covered as follows: Preferred Care: **100%** of the Negotiated Charge. Non-Preferred Care: **70%** of the Recognized Charge.

Alcoholism Treatment Benefits	
Inpatient Expense	**Covered Medical Expenses** for the treatment of alcoholism while confined as an inpatient in a hospital or facility licensed for such treatment are payable on the same basis as any sickness. Covered Medical Expenses also include the charges made for treatment received during partial hospitalization in a hospital or treatment facility. Prior review and approval must be obtained on a case-by-case basis by contacting Aetna Student Health. When approved, benefits will be payable in place of an inpatient admission, whereby 2 days of partial hospitalization may be exchanged for 1 day of full hospitalization.
Outpatient Expense	**Covered Medical Expenses** for outpatient treatment of alcoholism condition are payable as any sickness.
Maternity Benefits	
Maternity Expense	**Covered Medical Expenses** include inpatient care of the covered person and any newborn child for a minimum of 48 hours after a vaginal delivery and for a minimum of 96 hours after a cesarean delivery. Any decision to shorten such minimum coverages shall be made by the attending Physician in consultation with the mother. In such cases, covered services may include: home visits, parent education, and assistance and training in breast or bottle-feeding. **Covered Medical Expenses** for pregnancy, childbirth, and complications of pregnancy are payable on the same basis as any other sickness.
Well Newborn Nursery Care Expense	Benefits include charges for routine care of a covered person's newborn child as follows: • hospital charges for routine nursery care during the mother's confinement, but for not more than four days for a normal delivery, • physician's charges for circumcision, and • physician's charges for visits to the newborn child in the hospital and consultations, but for not more than 1 visit per day. **Covered Medical Expenses** are payable as follows: Preferred Care: **100%** of the Negotiated Charge. Non-Preferred Care: **70%** of the Recognized Charge.
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 **eighteen (18)** 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. **Benefits for materials for the administration of immunizations** are covered at **100%**. 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: **100%** 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: **100%** of the Recognized Charge. Benefits are payable for scheduled visits in accordance with the prevailing clinical standards of the American Academy of Pediatrics.
Additional Benefits	
Prescribed Medicines Expense	Prescription Drug Benefits are payable as follows: Preferred Care Pharmacy: **100%** of the Negotiated Charge, following: **$10** Copay for each Generic Prescription Drug. **$20** Copay for each Preferred Brand Prescription Drug. **$30** Copay for each Non-Preferred Prescription Drug. Non-Preferred Care Pharmacy: **100%** of the Recognized Charge, following: **$10** Deductible for each Generic Prescription Drug. **$20** Deductible for each Preferred Brand Prescription Drug. **$30** Deductible for each Non-Preferred Prescription Drug. You must pay out of pocket for Prescriptions at a Non-Preferred Pharmacy and then submit the receipt with a Prescription Claim Form for reimbursement. 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. Benefits are paid under this section for prescription female contraceptives for any drug or device used for contraception by a female, which: • Is approved by the federal Food and Drug Administration for that purpose, • That can only be purchased with a prescription written by a health care professional licensed or authorized to write prescriptions, and • Includes, but is not limited to birth control pills and diaphragms. These contraceptives are payable at **100%** of the Negotiated or Recognized Charge, with waiver of the Annual Deductible. Prior Authorization is required for certain Prescription Drugs, including 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, 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**

Diabetic Equipment And Self-Management Education Expense	Certain expenses incurred in connection with the treatment of diabetes are Covered Medical Expenses. Benefits are payable for **Covered Medical Expenses** on the same basis as any other **sickness**. If a **physician**, nurse practitioner, or clinical nurse specialist: **(a)** diagnoses diabetes, or **(b)** diagnoses a significant change in the person's diabetic symptoms or condition that requires a change in the person's self -management of the disease, or **(c)** determines that a person who is a diabetic needs reeducation or refresher education, charges for the following will be included as Other Medical Expenses, to the extent they are not already covered under any part of this Plan: Equipment - Charges for: **(d)** blood glucose monitors, including monitors for the legally blind, and **(e)** test strips for glucose monitors, and **(f)** visual reading and urine testing strips, and **(g)** insulin, injection aids, cartridges for the legally blind, syringes, insulin pumps and **(h)** appurtenances, insulin infusion devices, and oral agents for controlling blood sugar, and Self Management Education - Charges made by: **(i)** a **physician**, nurse practitioner, clinical nurse specialist, or **(j)** a pharmacist or dietitian who is legally qualified by the State of New Jersey to provide diabetic management education, for diabetic self-management education. "Diabetic self-management education" is training designed to instruct a person in the self-management of diabetes. It may include training in self care or diet. Charges incurred for the following are not included: **(k)** a diabetic education program whose only purpose is weight control, or which is available to the public at no cost, or **(l)** a general program not just for diabetics, or **(m)** a program made up of services not generally accepted as necessary for the management of diabetes.
Specialized Infant Formula Benefit	**Covered Medical Expenses** include specialized non-standard infant formulas when the covered infant's physician has diagnosed the infant (birth through 12 months) as having multiple food protein intolerance and formula is medically necessary. Coverage may be subject to medical review. Benefits are payable same as any other sickness.
Pap Smear Expense	**Covered Medical Expenses** include one annual routine pap smear screening and exam for women age 18 and older. Benefits are payable as follows: Preferred Care: **100%** of the Negotiated Charge. Non-Preferred Care: **100%** of the Recognized Charge.
Mammogram Expense	Benefits are payable for charges for mammograms. The charges must be incurred while a **covered person** is insured for these benefits. Benefits will be paid for Expenses incurred for the following: A baseline mammogram for women between the ages of 35 to 40, and A mammogram on an annual basis for women 40 years of age and older. Mammograms at such age and intervals as deemed necessary by the Physician for a person age 40 and under with a family history of breast cancer or other breast cancer risk factors.

	Benefits are payable as follows: Preferred Care: **100%** of the Negotiated Charge. Non-Preferred Care: **100%** of the Recognized Charge.
Elective Abortion Expenses	If, as a result of pregnancy having its inception during the Policy Year, a covered person incurs expenses in connection with an elective abortion, a benefit is payable. **Covered Medical Expenses** for Elective Abortion Expense are covered as follows: Preferred Care: **100%** of the Negotiated Charge. Non-preferred Care: **70%** of the Recognized Charge. This benefit is in lieu of any other Policy benefits.
Chlamydia Screening Test Expense	Benefits include charges incurred for an annual Chlamydia screening test. Benefits will be paid for Chlamydia screening expenses incurred for: • Women who are: - under the age of 20 if they are sexually active, and - at least 20 years old if they have multiple risk factors. • Men who have multiple risk factors. **Covered Medical Expenses** are payable as follows: Preferred Care: **100%** of the Negotiated Charge. Non-Preferred Care: **100%** of the Recognized Charge.
Routine Screening for Sexually Transmitted Disease Expense	**Covered Medical Expenses** include charges for covered persons who are at least 18 years old and who are sexually active for an annual routine screening for sexually transmitted diseases. Benefits are payable as follows: Preferred Care: **100%** of the Negotiated Charge. Non-Preferred Care: **100%** of the Recognized Charge.
Routine Colorectal Cancer Screening Expense	**Covered Medical Expenses** include charges incurred by a **covered person** for colorectal cancer examination and laboratory tests, for any person age 50 or more, or any person under age 50 who is considered to be a high risk for colorectal cancer, for the following: • A screening fecal occult blood test, • A flexible Sigmoidoscopy, • A barium enema, • A colonoscopy, • A Virtual colonoscopy • Stool DNA, or • Any combination of the above, or • The most reliable, medically recognized screening test available. The method and frequency of the screening to be utilized shall be in accordance with American Cancer Society guidelines. Benefits are payable as follows: Preferred Care: **100%** of the Negotiated Charge. Non-Preferred Care: **100%** of the Recognized Charge.

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: **100%** of the Negotiated Charge. Non-Preferred Care: **100%** of the Recognized Charge.
Second Surgical Opinion Expense	**Covered Medical Expense**s will include expenses incurred for a second opinion consultation by a specialist on the need for surgery which has been recommended by the covered person's physician. The specialist must be board certified in the medical field relating to the surgical procedure being proposed. Coverage will also be provided for any expenses incurred for required X-rays and diagnostic tests done in connection with that consultation. Aetna must receive a written report on the second opinion consultation. Benefits are payable as follows: Preferred Care: After a **$20** per visit Copay, **100%** of the Negotiated Charge. Non-Preferred Care: **70%** of the Recognized 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 **$20** per visit Copay **100%** of the Negotiated Charge. Non-Preferred Care: **70%** of the Recognized 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: **100%** of the Negotiated Charge. Non-Preferred Care: **70%** of the Recognized Charge.
Dermatological Expense	**Covered Medical Expenses** include charges for the diagnosis and treatment of skin disorders, excluding laboratory fees. Related laboratory expenses are covered under the Outpatient Expense Benefit. Benefits are payable same as any Sickness. *Covered Medical Expenses do not include cosmetic treatment and procedures.*
Podiatric Expense	**Covered Medical Expenses** include charges for podiatric services, provided on an outpatient basis following an injury. Benefits are payable as follows: Preferred Care: **100%** of the Negotiated Charge. Non-Preferred Care: **70%** of the Recognized Charge. Expenses for routine foot care, such as trimming of corns, calluses, and nails, are **not Covered Medical Expenses**.

Home Health Care Expenses	**Covered Medical Expenses** include charges incurred by a covered person for home health care services made by a home health agency pursuant to a home health care plan, but only if: (a) The services are furnished by, or under arrangements made by, a licensed home health agency (b) The services are given under a home care plan. This plan must be established pursuant to the written order of a physician, and the physician must renew that plan every 60 days. Such physician must certify that the proper treatment of the condition would require inpatient confinement in a hospital or skilled nursing facility if the services and supplies were not provided under the home health care plan. The physician must examine the covered person at least once a month (c) Except as specifically provided in the home health care services, the services are delivered in the patient's place of residence on a part-time, intermittent visiting basis while the patient is confined (d) The care starts within 7 days after discharge from a hospital as an inpatient, and (e) The care is for the same condition that caused the hospital confinement, or one related to it. Benefits are payable on the same basis as any other condition.
Transfusion or Dialysis of Blood Expense	**Covered Medical Expenses** include charges for the transfusion or dialysis of blood, including the cost of: whole blood, blood components, and the administration thereof. Benefits are payable as follows: Preferred Care: **100%** of the Negotiated Charge. Non-Preferred Care: **70%** of the Recognized Charge.
Hospice Expense	**Covered Medical Expenses** include charges for hospice care provided for a terminally ill covered person during a hospice benefit period. Benefits are payable as follows: Preferred Care: **100%** of the Negotiated Charge. Non-Preferred care: **70%** of the Recognized Charge. Benefits for Hospice expenses require pre-certification.
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: **100%** of the Negotiated Charge. Non-Preferred Care: **70%** of the Recognized Charge.
Skilled Nursing Facility Expense	**Covered Medical Expenses** include charges incurred by a covered person for confinement in a skilled nursing facility for treatment rendered: (a) In lieu of confinement in a hospital as a full time inpatient, or (b) 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: **100%** of the Negotiated Charge for the semi-private room rate. Non-Preferred Care: **70%** of the Recognized Charge for the semi-private room rate. ***Benefits for Skilled Nursing require pre-certification.***

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: After a **100%** of the Negotiated Charge for the rehabilitation facility's daily room and board maximum for semi-private accommodations. Non-Preferred Care: **70%** of the Recognized Charge for the rehabilitation facility's daily room and board maximum for semi-private accommodations. ***Benefits for Rehabilitation Facility expenses require pre-certification.***
Hearing Aids for Children	**Covered Medical Expenses** include coverage for medically necessary expenses (including fittings, examinations and hearing tests, dispensing fees, modifications and repairs, ear molds, and headbands for bone-anchored hearing implants) incurred in the purchase of hearing aids for a covered person 15 years of age and younger. **Covered Medical Expenses** are payable on the same basis as any other sickness, and will include one hearing aid (as medically necessary) for each ear. **This benefit is limited to $1,000 per hearing aid every 24 months. This limit applies only to the purchase of hearing aids.**
Lead Poisoning Screening Expense	**Covered Medical Expenses** include charges incurred by a **covered person,** for screening by lead measurement for lead poisoning in children, including confirmatory blood lead poisoning as specified in New Jersey law. Benefits are payable for **Covered Medical Expenses** on the same basis as any other **sickness**.
Cancer Treatment Expense	**Covered Medical Expenses** include benefits for the treatment of cancer by dose-intensive chemotherapy/autologous bone marrow transplants and peripheral blood stem cell transplants. Benefits will be payable same as any other illness.
Wilm's Tumor Treatment Expense	**Covered Medical Expenses** include expenses incurred in the treatment of Wilm's tumor, including autologous bone marrow transplants when standard chemotherapy treatment is unsuccessful, notwithstanding that any such treatment may be deemed experimental or investigational. Benefits are payable on the same basis as any other **sickness.**
Infertility Treatment Expense	Covered Medical Expenses include expenses incurred by a covered person for services and supplies for the diagnosis and treatment of infertility. Benefits are payable as any other Sickness. **Infertility** means: A recognized disease or condition that results in the abnormal functioning of the reproductive system, such that: A person is not able to impregnate another person, A person is not able to conceive after two years of unprotected intercourse, if the female partner is less than 35 years of age, or conceive after one year of unprotected intercourse if the female partner is 35 or more years of age, One of the partners is determined to be medically sterile, or A person is not able to carry a pregnancy to live birth. Infertility must not be caused by a voluntary sterilization or a hysterectomy. **Covered Medical Expenses** include, but are not limited to, the following: Expenses for the Diagnosis and Treatment of Infertility. These include: Physicians' services,

	Diagnosis and diagnostic tests, Prescription drugs, Surgery, Expenses for Artificial Insemination, including prescription drugs. Expenses for the following services, including prescription drugs: In-vitro fertilization (IVF), Gamete intra fallopian transfers (GIFT), Ovulation induction, Zygote intra fallopian transfers (ZIFT), Intracytoplasmic sperm injection (ICSI), Fresh and cryopreserved embryo transfers, Assisted hatching, Microsurgical sperm aspiration, Obtaining the sperm of a covered female's partner. and Care of: (a) a covered female who is participating in a donor IVF program, including fertilization and culture, the transfer of the embryo, and synchronization of the covered female's cycle with the donor's cycle, and (b) the donor until the donor is released from care by the reproductive endocrinologist. **Expenses will be covered on the same basis as for disease.** Services must be performed at medical facilities that meet standards established by: the American Society for Reproductive Medicine, or the American College of Obstetricians and Gynecologists. **Limitations:** Procedures involving in-vitro fertilization (IVF), gamete intra fallopian transfers (GIFT) or zygote intra fallopian transfers (ZIFT) are subject to the following limitations: These procedures are covered only if a successful pregnancy cannot be attained through less costly and medically appropriate treatments available under this Plan. Not more than the total number of eggs harvested during the first four complete egg retrievals will be covered during a covered female's lifetime. Egg retrievals where the cost is not covered by any plan or program will not count in determining this limitation. "Egg retrieval" is a procedure to collect eggs contained in the ovarian follicles.
Dental Anesthesia Expenses	Coverage is provided if you are severely disabled or to a child age five or under for expenses for: - General anesthesia and **hospitalization** for dental services, or - A medical condition covered by this Booklet-Certificate which requires **hospitalization** or general anesthesia for dental services rendered by a **dentist** regardless of where the dental services are provided. Benefits are payable on the same basis as any other **sickness.**
Treatment Of Hemophilia	**Covered Medical Expenses** include expenses incurred in connection with the treatment of routine bleeding episodes associated with hemophilia which includes: - Purchase of blood products, - Blood infusion equipment required for home treatment of routine bleeding episodes, when such home treatment program is under the supervision of a State approved hemophilia treatment center, - Blood products includes Factor VIII, Factor IX and cryoprecipitate, and blood infusion equipment including syringes and needles. The benefit shall be provided to the same extent as for any **sickness**.

Newborn Hearing Testing And Monitoring Expenses	**Covered medical expense**s include charges incurred for screening for newborn hearing loss by appropriate electrophysiological screening measures and periodic monitoring of infants for delayed onset hearing loss. Benefits are payable for **covered medical expenses** on the same basis as any other **sickness**.
Off-Label Prescription Drugs	FDA approved prescription drugs may be covered when the off-label use of the drug has not been approved by the FDA for that indication. The drug must be recognized for treatment of the indication in one of the standard compendia (the United States Pharmacopoeia Drug Information or the American Hospital Formulary Service Drug Information) or, the safety and effectiveness of use for this indication has been adequately demonstrated by at least one study published in a nationally recognized peer review journal. When covered, prescription drugs approved for off-label use are subject to the same terms, conditions, limitations, and exclusions as other prescription drug**s** covered under the Plan.
Inherited Metabolic Disease Expense	Coverage is provided for expenses incurred in the therapeutic treatment of inherited metabolic diseases, including the purchase of medical foods and low protein modified food products, when diagnosed and determined to be **medically necessary** by your **physician.** Inherited metabolic disease is a disease by an inherited abnormality of body chemistry for which testing is mandated by law. Low protein modified food product are food products that are specially formulated to have less than one gram of protein per serving and are intended to be used under the direction of a **physician** for the dietary treatment of an inherited metabolic disease, but does not include natural food that is naturally low in protein. Medical foods are foods that are intended for the dietary treatment of a disease or condition for which nutritional requirements are established by medical evaluation and are formulated to be consumed or administered internally under the direction of a **physician.** Coverage is provided under the same terms and conditions as for any other **sickness.**
Hypodermic Needles Expense	**Covered Medical Expenses** include expenses incurred by a covered person for hypodermic needles used in the treatment of diabetes. **Covered Medical Expenses** are payable on the same basis 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. Please note that these programs are subject to change. To learn more about these additional services and search for providers visit, **www.aetnastudenthealth.com**.

Aetna Book[SM] discount program: Access to discounts on books and other items from the American Cancer Society Bookstore, the **MayoClinic.com** Bookstore and Pranamaya.

Aetna Blood Pressure Monitor discount program: Access to discounts on the Deluxe Blood Pressure Monitor from Omron Health Care.

Aetna Specialty Pharmacy provides specialty medications and support to members living with chronic conditions and illnesses. These medications are usually injected or infused, or some may be taken by mouth. Custom compounded doses and forms are also available. For additional information please go to **www.AetnaSpecialtyRx.com**.

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.

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.

Aetna Health Connections℠ 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 **1-866-269-4500**.

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 Company 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 may receive a percentage of the fee you pay to the discount vendor.

Aetna's Informed Health® Line*:
Call toll free **1-800-556-1555** 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.

** While only your doctor can diagnose, prescribe or give medical advice, the Informed Health Line nurses can provide information on more than 5,000 health topics. Contact your doctor first with any questions or concerns regarding your health care needs.*

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 **www.aetnastudenthealth.com**.

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**
• Using the dropdown menu to the right, find your school and click on "Go".
• Click on "For Members".

• Click on “Aetna Navigator Member Website”.
• 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**.

GENERAL PROVISIONS

STATE MANDATED BENEFITS

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

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 who has been insured for at least 3 months 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**, until the policy terminates or premium is not paid.

TERMINATION OF INSURANCE

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

TERMINATION OF STUDENT COVERAGE

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

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

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

TERMINATION OF DEPENDENT COVERAGE

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

- For a child, on the last day of the Policy Period following the child's 26th birthday.
- For a child, on the last day of the policy period following the child's 31st birthday for children who are unmarried, have no dependents, are residence of New Jersey, or is enrolled as a full-time student, and is not provided coverage as a named subscriber, enrollee, or covered person under any other health plan.
  (a) The date the **covered student** fails to pay any required premium.
  (b) For the spouse, the date the marriage ends in divorce or annulment.
  (c) The date **dependent** coverage is deleted from This Plan.
  (d) For a domestic partner, the earlier to occur of:
    - The date This Plan no longer allows coverage for domestic partners, and
    - The date of termination of the domestic partnership. In that event, a completed and signed declaration of Termination of Domestic Partnership must be provided to the Policyholder.
  (e) The date the **dependent** ceases to be in an eligible class.

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

INCAPACITATED DEPENDENT CHILDREN

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

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

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

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

CONTINUATION OF COVERAGE

Under certain circumstances, a Covered Student and their Covered Dependents may be eligible for Continuation of Coverage under this Plan. Students presently enrolled in the UMDNJ Post Doc Rutgers Fellows Student Health Insurance Plan who loses their eligibility for the Plan through graduation or otherwise leaving school are eligible to continue their coverage by enrolling in the UMDNJ Post Doc Rutgers Fellows Continuation Plan. This Plan will be available to terminating students and eligible dependents as long as they were enrolled in the UMDNJ Post Doc Rutgers Fellows Student Health Insurance Plan for the previous academic term.

The UMDNJ Post Doc Rutgers Fellows Continuation Plan coverage is the same as the 2013 UMDNJ Post Doc Rutgers Fellows Student Health Insurance Plan. Please see the brochure on-line at **www.aetnastudenthealth.com**. Coverage may be purchased for a sixty (60) day Period of Coverage. Initial selection is non-renewable and non-refundable. To enroll, a Continuation Enrollment Form must be completed and payment must be made within 31 days after the termination of eligibility under the active Student Health Insurance Plan. Please contact University Health Plans, Inc. at **(800) 437-6448** for information on the Continuation Plan.

Continuation of Coverage	
Post Doc/Fellow Only	**$1,309.00**
Post Doc/Fellow and One Dependent	**$2,994.00**
Post Doc/Fellow and Family (Two or More Dependents)	**$3,805.00**

If a covered student dies, covered dependents must be allowed to continue coverage under the policy for up to 180 days providing appropriate premium is paid.

EXCLUSIONS

This Policy does not cover nor provide benefits for:

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

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

3. Expense incurred as a result of **injury** due to participation in a riot. "Participation in a riot" means taking part in an illegal 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 which is not necessitated by a pathological change in the function or structure in any part of the body. 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;
   - treatment for learning disabilities;
   - temporomandibular joint dysfunction (TMJ);
   - immunizations; unless otherwise covered under the Policy;
   - vaccines; unless otherwise covered under the Policy.

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 finger or toes; or
     - as direct result of:
       - disease; or
       - surgery performed to treat a disease or **injury**.

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

- in the calendar year of the accident which causes the injury; or
- in the next calendar year.

This exclusion does not apply when reconstructive surgery is needed, as specifically described under the Breast Reconstruction Expense Benefit provision of this Booklet-Certificate or to treat a congenital deformity or birth defect in persons who have been covered under the policy from the moment of birth.

10. Expense incurred as a result of commission of a felony when the commission contributes to the loss.

11. Expense incurred for voluntary or elective abortions unless otherwise stated in this policy.

12. Expense incurred for the treatment of drug addiction.

13. Expense for allergy serums and injections.

14. Expense incurred for experimental or investigative procedures; except for the treatment of Wilm's tumor.

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

16. Expenses incurred for gastric bypass; and any restrictive procedures; for weight loss.

17. Expenses incurred for breast reduction/mamoplasty.

18. Expenses incurred for gynecomastia (male breasts).

19. Expenses incurred for any sinus surgery; except for acute purulent sinusitis.

20. 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.

21. Expense incurred for treatment of temporomandibular joint (TMJ) dysfunction and associated myofascial pain.

22. Expense incurred for acupuncture; unless services are rendered for anesthetic purposes.

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

24. 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.

25. 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;
    - by whom they are recommended; or
    - by whom or by which they are performed.

26. Expense incurred as a result of **dental** treatment; including extraction of wisdom teeth; except for treatment resulting from **injury** to **sound natural teeth** as provided elsewhere in the Policy.

27. Expense incurred for injury resulting from the play or practice of intercollegiate sports; (participating in sports clubs; or intramural athletic activities; is not excluded).

28. Expenses incurred for or in connection with, speech therapy; except for **medically necessary** non-restorative speech therapy for the treatment of biologically based mental illness so long as such service are not experimental or investigational. This exclusion does not apply for charges for speech therapy that is expected to restore speech to a person who has lost existing function (the ability to express thoughts, speak words and form sentences) as a result of an **accident** or **sickness.**

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

30. 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.

31. 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.

32. 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.

Ambulatory Surgical Center
A freestanding ambulatory surgical facility that:

Meets licensing standards.
Is set up, equipped and run to provide general surgery.
Makes charges.
Is directed by a staff of **physicians**. At least one of them must be on the premises when surgery is performed and during the recovery period.
Has at least one certified anesthesiologist at the site when surgery which requires general or spinal anesthesia is performed and during the recovery period.
Extends surgical staff privileges to:
- physicians who practice surgery in an area **hospital**, and
- **dentist**s who perform oral surgery.

Have at least 2 operating rooms and one recovery room.
Provides, or arranges with a medical facility in the area for, diagnostic x-ray and lab services needed in connection with surgery.
Does not have a place for patients to stay overnight.
Provides, in the operating and recovery rooms, full-time skilled nursing services directed by a R.N.
Is equipped and has trained staff to handle medical emergencies.
It must have:
- a physician trained in cardiopulmonary resuscitation, and
- a defibrillator, and
- a tracheotomy set, and
- a blood volume expander.

Has a written agreement with a **hospital** in the area for immediate emergency transfer of patients. Written procedures for such a transfer must be displayed and the staff must be aware of them.
Provides an ongoing quality assurance program. The program must include reviews by physicians who do not own or direct the facility.
Keeps a medical record on each patient.

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

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

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

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.)

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

Covered Dental Expenses
Those charges for any treatment, service, or supplies, covered by this Policy which are:
not in excess of the **recognized and customary** charges, or
not in excess of the charges that would have been made in the absence of this coverage,
and incurred while this Policy is in force as to the **covered person.**

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

Covered Medical Expense
Those charges for any treatment, service or supplies covered by this Policy which are:
not in excess of the **recognized 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.

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/**civil union partner** residing with the **covered student**, or
(b) The person identified as a domestic partner in the "Declaration of Domestic Partnership",
(c) Dependent children under age 26, and
(d) T he **covered student**'s child (by blood or by law) who:
is less than 31 years of age,
is unmarried,
has no dependents,
is a resident of New Jersey or is enrolled as a full-time student, and
is not provided coverage as a named subscriber, enrollee, or covered person under any other health plan.
(e) Newborn children from the moment of birth, however if payment of premium is required to provide coverage for the newborn child, Aetna may require notification of birth and payment of the required premium within 31 days after the date of birth in order to have the coverage continue beyond the 31 day period.

The term "child" also includes a **covered student**'s step-child, adopted child, children of a **civil union partner** and a child for whom a petition for adoption is pending, who is residing with the **covered student** and who is chiefly dependent on the **covered student** for their full support.

The term **dependent** does not include a person who is an eligible student.

Diagnostic Testing for Attention Disorders and Learning Disabilities
Covered Medical Expenses for diagnostic testing for:
attention deficit disorder,
attention deficit hyperactive disorder, or
Dyslexia

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,
temporamandibular 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 Care
This means the first treatment given in a **hospital's** emergency room right after the sudden and, at that time, unexpected onset of a change in a person's physical or mental condition which:
requires **hospital** level care because:
the care could not safely and adequately have been provided other than in a **hospital**, or
adequate care was not available elsewhere in the area at the time and place it was needed, and
if the **hospital** level care was not given could, as determined by Aetna, reasonably be expected to result in:
loss of life or limb, or
significant impairment to bodily function, or
permanent dysfunction of a body part.

Emergency care also means the dispensing by any **Non-Preferred Pharmacy** of **Prescription Drugs** which are needed immediately because of an injury or illness when the time required to reach a **Preferred Pharmacy** would have meant serious deterioration of, or permanent damage to, the person's health. **Emergency care** includes benefits for the coverage of trauma services at any designated Level I or Level II trauma center as medically necessary, which shall be continued at least until, in the judgment of the attending physician, the covered person is medically stable, no longer requires critical care, and can be transferred safely to another facility. It also includes benefits for the coverage of a medical screening examination provided upon a covered person’s arrival in a hospital, as required to be performed by the hospital in accordance with federal and state legislation, but only as necessary to determine whether an emergency medical condition exists.

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.

Home Health Agency

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

Home health aide

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

Home Health Care

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

Home Health Care Plan

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

Hospice

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

Hospice Benefit Period

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

Hospital

A facility which meets all of these tests:

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

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

Hospital Confinement

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

Injury

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

Intensive Care Unit

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

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

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

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

Be care or treatment which is likely to produce as significant positive outcome as any alternative service or supply, both as to the sickness or injury involved and the person's overall health condition. It must be no more likely to produce a negative outcome than any alternative service or supply, both as to the sickness or injury involved and the person's overall health condition.

Be a diagnostic procedure which is indicated by the health status of the person. It must be as likely to result in information that could affect the course of treatment as any alternative service or supply, both as to the sickness or injury involved and the person's overall health condition. It must be no more likely to produce a negative outcome than any alternative service or supply, both as to the sickness or injury involved and the person's overall health condition, and

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.

Mental Illness: Biologically Based
A Mental or nervous condition that is caused by a biological disorder of the brain and results in a clinically significant or psychological syndrome or pattern that substantially limits the functioning of the person with the illness, including but not limited to:

Schizoprhenia
Schizoaffective disorder
Major depressive disorder
Bipolar disorder, paranoia and other psychotic disorders
Obsessive-compulsive disorder
Panic disorder
Pervasive developmental disorder
Autism

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.**

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**.

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** which are payable at a rate greater than 50%.

The following expenses do not apply toward meeting the **Out-of-Pocket Limit:**
expenses that are not **Covered Medical Expenses,**
penalties,
expenses for prescription drugs, and
other expenses not covered by this Policy.

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

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

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

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

Preferred Care
Care provided by

a **covered person's** primary care **physician**, or a **preferred care provider** 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** of a person's **Primary Care Physician**, or
- a **dentist** who is a **Non-Preferred Care Provider**, but only one who is not of a type that falls into one or more of the categories of providers listed in the **directory** of **Preferred Care Providers**.

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

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

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

Primary Care Physician
This is the **Preferred Care Provider** who is:
selected by a person from the list of **Primary Care Physician**s in the **directory**,
responsible for the person's on-going health care, and
shown on Aetna's records as the person's **Primary Care Physician**.

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

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.

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

In some circumstances, Aetna may have an agreement, either directly or indirectly, through a third party, with a provider which sets the rate that Aetna will pay for a service or supply. In these instances, in spite of the methodology described above, the **recognized charge** is the rate established in such agreement.
In determining the **recognized charge** for a service or supply that is:
- Unusual, or
- Not often provided in the area, or
- Provided by only a small number of providers in the area.

Aetna may take into account factors, such as:
- The complexity,
- The degree of skill needed,
- The type of specialty of the provider,
- The range of services or supplies provided by a facility, and
- The **recognized charge** in other areas.

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

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

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

School Health Services

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

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
- **dentist**s who perform oral surgery.

Has at least 2 operating rooms and one recovery room.
Provides, or arranges with a medical facility in the area for, diagnostic x-ray and lab services needed in connection with surgery.
Does not have a place for patients to stay overnight.
Provides, in the operating and recovery rooms, full-time skilled nursing services directed by a registered nurse.
Is equipped and has trained staff to handle medical emergencies.
It must have:
- a **physician** trained in cardiopulmonary resuscitation, and
- a defibrillator, and
- a tracheotomy set, and
- a blood volume expander.

Has a written agreement with a hospital in the area for immediate emergency transfer of patients. Written procedures for such a transfer must be displayed, and the staff must be aware of them.
Provides an ongoing quality assurance program. The program must include reviews by **physicians** who do not

own or direct the facility.
Keeps a medical record on each patient.

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

Surgical expense
Charges by a **physician** for,
a surgical procedure,
a necessary preoperative treatment during a **hospital** stay in connection with such procedure, and
usual postoperative treatment.

Surgical procedure
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 Student Health
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.

PRESCRIPTION DRUG CLAIM PROCEDURE

Preferred Care: When obtaining a covered Prescription, please present your Aetna Student Health ID card to an Aetna Preferred Pharmacy along with your applicable Coinsurance payment. The Pharmacy will submit a claim to Aetna for the drug. Information regarding Preferred Care Pharmacy locations is available by accessing the internet at: **www.aetnastudenthealth.com**, then click on DocFind® and follow prompts.

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 for covered medications by submitting a completed Aetna Prescription Drug claim form. A claim form is available at **www.universityhealthplans.com** or by calling **(800) 238-6279**. You will be reimbursed for covered medications directly by Aetna. Please note, in addition to your Copay, you may be required to pay the difference between the retail price you paid for the prescription drug and the amount Aetna would have paid if you had presented your ID card and Pharmacy had billed Aetna directly.

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

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

Claim forms, Pharmacy locations, and claims status information can be obtained by contacting Aetna Pharmacy Management at **(800) 238-6279**. When submitting a claim, please include all Prescription receipts; indicate that you are a UMDNJ Post Doctorate or Rutgers University Graduate Fellow, and include your name, address, and student identification number.

APPEALS PROCEDURE

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

Aetna Student Health
P.O. Box 14464
Lexington, KY 40512

DEFINITIONS

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

Such Adverse Benefit Determination may be based on, among other things:
The **covered person**'s eligibility for coverage,
The results of any Utilization Review activities,
A determination that the service or supply is experimental or investigational, or
A determination that the service or supply is not **medically necessary**.

Appeal: An oral or written request to Aetna to reconsider an Adverse Benefit Determination.

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

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

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

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

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

Urgent or **Emergency Care** Claim: Any claim for medical care or treatment including, but not limited to, severe paid which would lead a prudent layperson possessing an average knowledge of medicine and health, to believe that their condition, illness or injury is of such a nature that failure to get immediate medical care would 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. With respect to a pregnant woman who is having contractions, an emergency condition exists where there is inadequate time to effect a safe transfer to another **hospital** before delivery or the transfer may pose a threat to the health or safety of the woman or the unborn child.

CLAIM DETERMINATIONS

Urgent or Emergency Care Claims

Aetna will make notification of an Urgent or **Emergency Care** Claim determination as soon as possible but not more than 72 hours after the claim is made. If more information is needed to make an urgent claim determination, Aetna will notify the claimant within 24 hours of receipt of the claim. The claimant has 48 hours after receiving such notice to provide Aetna with the additional information. Aetna will notify the claimant within 48 hours of the earlier of the receipt of the additional information or the end of the 48 hour period given the **physician** to provide Aetna with the information. If the claimant fails to follow plan procedures for filing a claim, Aetna will notify the claimant within 24 hours following the failure to comply.

Pre-Service Claims

Aetna will provide written notification of a pre-service determination not later than 5 business days or sooner if the medical exigencies dictate, upon request, of any determination to deny coverage or authorization of services or payment of benefits therefore otherwise covered under the Plan and shall include an explanation of the Appeal process.

Post-service Claims

Aetna will make notification of a claim determination as soon as possible but not later than 30 calendar days or the time limit established by Medicare, if earlier, after the Post-Service Claim is made if the claim is submitted electronically or 40 days if submitted by a means other than electronic.

If all or a portion of the claim is not paid within the time frames indicated above because:

a) the claim submission is incomplete because the required documentation has not been submitted to Aetna:
b) the diagnosis coding, procedure coding or any other required information to be submitted with the claim is incorrect:
c) Aetna disputes the amount claimed, or
d) there is strong evidence of fraud by the provider and Aetna has initiated an investigation into the suspected fraud

Aetna will notify the health care provider, by electronic means and the **covered person** in writing within 30 days of receiving an electronic claim, or notify the **covered person** and health care provider in writing within 40 days of receiving a claim submitted by other than electronic means, that:

i. the claim is incomplete with a statement as to what documentation is required,
ii. the claim contains incorrect information with a statement as to what information must be corrected,
iii. Aetna disputes the amount claimed in whole or in part with a statement as to the basis of that dispute, or
iv. Aetna finds there is strong evidence of fraud and has initiated an investigation into the suspected fraud in accordance with its fraud prevention plan.

Concurrent Care Claim Extension

Following a request for a Concurrent Care Claim Extension, Aetna will make notification of a claim determination for inpatient hospital services and emergency or urgent care as soon as possible but not later than 24 hours following the time the request was made. If the request for an extension is not made at least 24 hours prior to the expiration of the approved course of treatment, Aetna will make a determination within the time frame applicable to (1) an Urgent or **Emergency Care** Claim (if the care is urgent) or (2) a Pre-Servic**e** or Post-Service Claim (if the care is not urgent or has been completed).

Concurrent Care Claim Reduction or Termination

If Aetna makes notification of a claim determination to reduce or terminate a previously approved course of treatment while the treatment or services are ongoing, you (or a provider on your behalf) may request an expedited Appeal, and Aetna will handle such a request as a level one Appeal of an Urgent or **Emergency Care** Claim (see Appeals of Adverse Benefit Determinations. Aetna will not deny coverage based on **medical necessity** for previously approved services unless the approval was based on material misrepresentation or fraudulent information submitted by you or the provider.

COMPLAINTS

If you are dissatisfied with the service you receive from the Plan or want to complain about a **preferred care** provider you must call or write Aetna Customer Service within 30 calendar days of the incident. You must include a detailed

description of the matter and include copies of any records or documents that you think are relevant to the matter. Aetna will review the information and provide you with a written response within 30 calendar days of the receipt of the Complaint, unless additional information is needed and it cannot be obtained within this period. The notice of the decision will tell you what you need to do to seek an additional review.

APPEALS OF ADVERSE BENEFIT DETERMINATIONS

You may submit an Appeal if Aetna gives notice of an Adverse Benefit Determination. This Plan provides for two levels of Appeal. It will also provide an option to request an external review of the Adverse Benefit Determination.

You have 180 calendar days following the receipt of notice of an Adverse Benefit Determination to request your level one Appeal. Your Appeal should include:

Your name,
Your school's name,
A copy of Aetna's notice of an Adverse Benefit Determination,
Your reasons for making the Appeal, and
Any other information you would like to have considered. You have the option to provide Aetna with additional information about your Appeal, however you are not required to provide additional information in order to have your claim decisions reviewed.

Send in your Appeal to Customer Service at the address shown on your ID Card or Call in your Appeal to Customer Service using the toll-free telephone number shown on your ID Card.

Send your Appeal to the address shown on the notice of Adverse Benefit Determination, or you may call in your Appeal using the toll-free telephone number listed on such notice.

You may also choose to have another person (an authorized representative) make the Appeal on your behalf by providing written consent to Aetna.

LEVEL ONE APPEAL

A level one Appeal of an Adverse Benefit Determination shall be provided by Aetna personnel not involved in making the Adverse Benefit Determination.

Urgent or Emergency Care Claims (May Include Concurrent Care Claim Reduction or Termination)

Aetna shall issue a decision within 36 hours of receipt of the request for an Appeal.

Pre-Service Claims (May Include Concurrent Care Claim Reduction or Termination)

Aetna shall issue a decision within 5 business days of receipt of the request for an Appeal.

Post-Service Claims

Aetna shall issue an utilization management decision within 5 business days of receipt of the request for an Appeal.

Aetna shall issue a non-utilization management decision within 30 calendar days of receipt of the request for an Appeal.

LEVEL TWO APPEAL

If Aetna upholds an Adverse Benefit Determination at the first level of Appeal, and the reason for the adverse determination was based on **medical necessity** or experimental or investigational reasons or in situations where the

denial is based on characterizing the service as dental or as cosmetic, you or your authorized representative have the right to file a level two Appeal. The Appeal must be submitted within 60 calendar days following the receipt of notice of a level one Appeal.

A level two Appeal of an Adverse Benefit Determination of an Urgent or **Emergency Care** Claim shall be provided by Aetna personnel not involved in making the Adverse Benefit Determination. A level two Appeal of an Adverse Benefit Determination of a Pre-Service Claim or a Post-Service claim will be reviewed by the Aetna Appeals Committee.

Urgent or Emergency Care Claims (May Include Concurrent Care Claim Reduction or Termination)
Aetna shall issue a decision within 24 hours of receipt of the request for a level two Appeal.

Pre-Service Claims (May Include Concurrent Care Claim Reduction or Termination)
Aetna shall issue a decision within 5 business days of receipt of the request for level two Appeal.

Post-Service Claims
Aetna shall issue an utilization management decision within 20 business days of receipt of the request for a level two Appeal.

Aetna shall issue a non-utilization management decision within 30 calendar days of receipt of the request for a level two Appeal.

EXHAUSTION OF PROCESS

The level one Appeal and level two Appeal process above and the External Review process below are mandatory and must be exhausted prior to the establishing of any litigation regarding **medical necessity** issues, except where serious or significant harm to the **covered person** has occurred or will imminently occur.

EXTERNAL REVIEW

You or any provider acting on behalf of you, with your consent, who is dissatisfied with the result of the Level One appeal and Level Two Appeal process, shall have the right to pursue their appeal to an independent utilization review organization (IURO) in accordance with the procedures set forth below. The appeal review shall not include any decision regarding benefits not covered by your health benefits plan. The right to an external appeal under this section shall be contingent upon your exhaustion of both stages of the Level One and Level Two Appeal process, except that you and any provider acting on your behalf with your consent shall be relieved of the Aetna's internal Appeal process and may pursue an appeal by an independent utilization review organization (IURO) through the Independent Health Care Appeals program if:

A determination on any appeal regarding urgent or **emergency care** is not forthcoming from Aetna within 72 hours of receipt by Aetna of notice (in the manner required under the plan) of the appeal,

A determination on an initial appeal, other than one regarding urgent or **emergency care**, is not forthcoming from Aetna within five business days of the date that Aetna received notice (in manner required under the plan) of the appeal, or

A determination of a subsequent level of appeal, other than one regarding urgent or **emergency care**, is not forthcoming from Aetna within 20 business days of the date that Aetna received notice (in the manner required under the plan) of the appeal.

1. Within 60 calendar days from receipt of the written determination of the Level Two appeal panel, you, or a provider acting on behalf of you with your consent, shall file a written request with the New Jersey Department of Banking and Insurance. The request shall be filed on forms, if applicable, provided to you by Aetna and include both a filing fee and a general release executed by you for all medical records pertinent to the appeal. The request shall be mailed to

Consumer Protection Services
Department of Banking and Insurance
20 West State Street, 9th Floor

Trenton, New Jersey 08625-0329
Main Phone: **(609) 292-5316**
Fax: **(609) 292-5865**

Appeals may also be submitted on-line to the New Jersey Department of Banking and Insurance by selecting the current on-line complaint form at: **www.state.nj.us/dobi/enfcon**.

2. The fee for filing an appeal shall be **$25.00**, payable by check or money order to the New Jersey Department of Banking and Insurance. The filing fee is payable by you. Upon a determination of financial hardship, the fee may be reduced to **$2.00**. Financial hardship may be demonstrated by you through evidence of eligibility for either the Pharmaceutical Assistance to the Aged and Disabled, Medicaid, NJ Family Care, General Assistance, SSI, or New Jersey Unemployment Assistance.

3. Upon receipt of the appeal, together with the executed release and the appropriate fee, the New Jersey Department of Banking and Insurance shall immediately assign the appeal to an IURO.

4. Upon receipt of the request for appeal from the New Jersey Department of Banking and Insurance, the IURO shall conduct a preliminary review of the appeal and accept it for processing if it determines that:
   i. the individual was or is covered by Aetna,
   ii. the service which is the subject of the complaint or appeal reasonably appears to be a **covered medical expense** under the plan,
   iii. you have fully complied with both the Level One and Level Two Appeal processes except as provided above,
   iv. you have provided all information required by the IURO and the New Jersey Department of Banking and Insurance to make the preliminary determination including the appeal form and a copy of any information provided by Aetna regarding its decision to deny, reduce, or terminate the **covered medical expense**, and a fully executed release to obtain any necessary medical records from Aetna and any other relevant health care provider.
   v. you have remitted the required fee to the New Jersey Department of Banking and Insurance.

5. Upon completion of the preliminary review, the IURO shall immediately notify you and/or the provider in writing as to whether the appeal has been accepted for processing and if not so accepted, the reasons therefore.

6. Upon acceptance of the appeal for processing, the IURO shall conduct a full review to determine whether you were deprived of **medically necessary covered medical expense**. In reaching this determination, the IURO shall take into consideration all pertinent medical records, consulting **physician** reports, and other documents submitted by the parties, any applicable, generally accepted practice guidelines developed by the Federal government, national or professional medical societies, boards and associations, and any applicable clinical protocols and/or practice guidelines developed by Aetna.

7. The full review referenced above shall initially be conducted by a registered, professional nurse or **physician** licensed to practice in New Jersey. When necessary, the IURO shall refer all cases for review to a consultant **physician** in the same specialty or area of practice who would generally manage the type of treatment that is the subject of the appeal. All final recommendations of the IURO shall be approved by the medical director of the IURO.

8. The IURO shall complete its review and issue its recommended decision as soon as possible in accordance with the medical exigencies of the case which, except as provided for in this subsection, in no event shall exceed 30 business days from receipt of all documentation necessary to complete the review. The IURO may, however, extend its review for a reasonable period of time as may be necessary due to circumstances beyond its control. In such an event, the IURO shall, prior to the conclusion of the preliminary review, provide written notice to you, to the New Jersey Department of Banking and Insurance, and to Aetna setting forth the status of its review and the specific reasons for the delay.

9. If the IURO determines that you were deprived of **medically necessary covered medical expense**, the IURO shall recommend to you, Aetna, and the New Jersey Department of Banking and Insurance, the appropriate covered health care services you should receive.

10. Once the review is complete, Aetna will abide by the decision of the IURO.

For more information about the External Review process, call the toll-free **covered person** services telephone number shown on your ID card.

On Call International

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

Accidental Death and Dismemberment (ADD) Benefits

Benefits are payable for the Accidental Death and Dismemberment of Covered Persons, up to a maximum of Thirty Thousand Dollars ($30,000).

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 (800) 466-3185.

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

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

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

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

Natural Disaster and Political Evacuation Services
The following benefits are underwritten by an insurer contracted with On Call, with medical and travel assistance services provided by On Call. If a **Covered Person** requires emergency evacuation due to governmental or social upheaval, which places him/her in imminent bodily harm (as determined by On Call security personnel in accordance with local and U.S. authorities), On Call will arrange and pay for his/her transportation to the nearest safe location, and then to the his/her home country. If a **Covered Person** requires emergency evacuation due to a natural disaster, which makes his/her location uninhabitable, On Call will arrange and pay for his/her evacuation from a safe departure point. Benefits are payable up to **$100,000** per event per person.

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

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

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

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

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

NOTICE

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

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The University of Medicine of New Jersey (UMDNJ) Post Doctorate and Rutgers University Graduate Fellows programs 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.