

2009 - 2010
University of Michigan



International Student and Scholar
Health Insurance Plan Brochure

Underwritten by:
Aetna Life Insurance Company (ALIC)
Policy Number 711146



Dear International Students and Scholars:

Your health is your most precious possession. One serious illness or injury can mean financial disaster and can end your educational dreams. That is why we are pleased to present the University of Michigan International Student/Scholar Health Insurance Plan for the academic year 2009-2010.

A detailed description of the Student/Scholar Health Insurance Plan is outlined in the following pages. Although this protection is liberal, there are specific exclusions and limitations in coverage, which should be carefully noted as you read the provisions of the Plan.

All University of Michigan F-1 International Students whose Forms I-20 were issued by the University of Michigan, and their accompanying F-2 dependents are eligible for this Plan and must remain enrolled in the Plan throughout their stay as U-M F-1 students or F-2 dependents unless, in the judgment of the University, comparable coverage is in effect under another insurance policy. The specific criteria used to determine comparability are posted on the International Center's website at [*http://internationalcenter.umich.edu/healthins/waiver.html#standards*](http://internationalcenter.umich.edu/healthins/waiver.html#standards).

All University of Michigan J-1 International Students and Scholars whose Forms DS-2019 were issued by the University of Michigan and their accompanying J-2 dependents are eligible for this Plan and must remain enrolled in the Plan throughout their stay as J-1 students or scholars or J-2 dependents unless, in the judgment of the University, comparable coverage is in effect under another insurance policy. The specific criteria used to determine comparability are posted on the International Center's website at [*http://internationalcenter.umich.edu/healthins/waiver.html#standards*](http://internationalcenter.umich.edu/healthins/waiver.html#standards).

If you have insurance that is comparable to the U-M Health Insurance Plan, you can request a waiver of the health insurance requirement. Please consult the health insurance section of the International Center's website for more information about requirements for comparable coverage and waiver request procedures. Insurance waivers must be renewed every academic year.

We hope you enjoy your stay at the University of Michigan.

Sincerely,

The University of Michigan International Center

WHERE TO FIND HELP

In case of an emergency, call **911** or go directly to an emergency care facility.

For questions about:

- Insurance Benefits
- Claims Processing
- Pre-Certification Requirements

Please contact:

Aetna Student Health
P.O. Box 15708
Boston, MA 02215-0014
(800) 239-9697

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) 239-9697

Ann Arbor Students and Scholars - for questions about:

- Enrollment Process
- Waiver Process

Please contact:

University of Michigan International Center
603 East Madison Street
Ann Arbor, MI 48109-1370
(734) 647-2303
E-mail: ihi@umich.edu

Dearborn Students and Scholars - for questions about:

- Enrollment Process
- Waiver Process

Please contact:

International Office
2174 UC
4901 Evergreen Rd
Dearborn, MI 48128-2406
(313) 583-6600
E-mail: international@umd.umich.edu

Flint Students and Scholars - for questions about:

- Enrollment Process
- Waiver Process

Please contact:

International Center
219 UCEN
303 East Kearsley St
Flint, MI 48502-1950
(810) 762-0867

E-mail: mbarbee@umflint.edu

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) 239-9697

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 University of Michigan. If any discrepancy exists between this Brochure and the Policy, the Master Policy will govern and control the payment of benefits. The Master Policy may be viewed at the University of Michigan International Center in Ann Arbor during normal business hours.

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

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THE UNIVERSITY OF MICHIGAN INTERNATIONAL STUDENT/SCHOLAR HEALTH INSURANCE PLAN

The University of Michigan International Student/Scholar Health Insurance Plan has been developed especially for University of Michigan F-1 and J-1 International Students/Scholars and their accompanying **dependents**. The Plan, which is underwritten by Aetna Life Insurance Company (Aetna), provides coverage for illnesses and injuries that occur on and off campus (worldwide), and includes special cost-saving features to keep the coverage as affordable as possible. The University of Michigan is pleased to offer the Plan as described in this Brochure.

U.S. Government requirements for J1/J2 Visa Policyholders are satisfied under the University of Michigan International Plan.

STUDENTS/SCHOLARS ON THE ANN ARBOR CAMPUS

If you have a life-threatening emergency, call 911 or go directly to the nearest hospital emergency room.

Options for the immediate area of the Ann Arbor campus include:

- University of Michigan Medical Center, 1500 E. Medical Center Drive, Ann Arbor, MI 48109

A Deductible may apply to your visit, for details see the 'Deductible' section of the Summary of Benefits Chart on page 15.

If you need medical care, but it is not an emergency, you can avoid or reduce the Deductible by seeing the following health care providers first. For more specific information about referral requirements, please refer to the 'Deductible' section of the Summary of Benefits Chart on page 15.

- University Health Service (students, spouses, scholars, same sex domestic partners, children 10 or above)

University Health Service (UHS)
207 Fletcher Street
Ann Arbor, MI 48109
(734) 764-8320
Access to After Hours Care **(734) 662-5674**
www.uhs.umich.edu

- North Campus Family Health Service or Community Family Health Center (scholars, spouses, same sex domestic partners, children)

North Campus Family Health Service
2364 Bishop
Ann Arbor, MI 48109
(734) 647-1636
http://www.nursing.umich.edu/ncfhs/

Community Family Health Center
1230 North Maple Road
Ann Arbor, MI 48103
(734) 998-6117
http://www.nursing.umich.edu/cfhc/

- East Ann Arbor Health Center (children under age 18)

East Ann Arbor Health Center
4260 Plymouth Road
Ann Arbor, MI 48109-2700
(734) 647-5715

STUDENTS/SCHOLARS ON THE DEARBORN CAMPUS

If you have a life-threatening emergency, call 911 or go directly to the nearest hospital emergency room.

Options for the immediate area of the Dearborn campus include:

- Oakwood Hospital and Medical Center, 18101 Oakwood Blvd., Dearborn, MI 48124
- Henry Ford Medical Center-Fairlane, 19401 Hubbard Drive, Dearborn, MI 48126

A Deductible may apply to your visit; for details see the 'Deductible' section of the Summary of Benefits Chart on page 15.

If you need medical care, but it is not an emergency, you may use the following providers:

- Henry Ford Medical Center-Fairlane
19401 Hubbard Drive
Dearborn, MI 48126
(313) 982-8100

STUDENTS/SCHOLARS ON THE FLINT CAMPUS

If you have a life-threatening emergency, call 911 or go directly to the nearest hospital emergency room.

Options for the immediate area of the Flint campus include:

- Hurley Medical Center, 1 Hurley Plaza, Flint, MI 48503
- McLaren Regional Medical Center, 401 South Ballenger Hwy., Flint, MI 48532
- Genesys Health Park, One Genesys Parkway, Grand Blanc, MI 48439

A Deductible may apply to your visit; for details see the 'Deductible' section of the Summary of Benefits Chart on page 15.

If you need medical care, but it is not an emergency, you may use the following providers:

- Urban Health and Wellness Center
1153 William S. White Bldg.
Flint, MI 48502-1950
(810) 424-5259

POLICY PERIOD

1. **Students:** Coverage for all insured students enrolled for the Fall Semester, will become effective at 12:01 a.m. on **September 1, 2009**. Coverage becomes effective on that date or on the effective date printed on the "Temporary Insurance Certificate" received at the Mandatory Check-In program, whichever is later, each Policy Year. Your coverage is effective through the end date of your I-20 or DS-2019 form, or for F-1 students on post-completion Optional Practical Training (OPT), through the end of the OPT period.
2. **Insured Dependents:** Coverage will become effective on the same date the insured student's coverage becomes effective. Coverage for insured **dependents** terminates in accordance with the termination provisions described in the Master Policy. Examples include, but are not limited to: the date the **dependent** no longer meets the definition of a **dependent**.

RATES

Students and scholars will be billed once each month.

Note: Students and scholars enrolled in the Plan for part or all of a calendar month will be billed for the entire calendar month, since the monthly premium cannot be pro-rated.

Cost	Monthly Rates
Student/Scholar	\$99
Student/Scholar and One Dependent	\$411
Student/Scholar and Two or More Dependents	\$723

The rates above include both premiums for the Student Health Plan underwritten by Aetna Life Insurance Company, as well as University of Michigan's administrative fees.

DEDUCTIBLES

The following Deductibles are applied before **Covered Medical Expenses** for Preferred or Non-Preferred Care are payable:

Students: **\$50** per covered injury or sickness.
Spouse: **\$50** per covered injury or sickness.
Child: **\$50** per covered injury or sickness.

STUDENT/SCHOLAR COVERAGE

ELIGIBILITY

Eligibility for this Plan is limited to University of Michigan F-1 International Students or J-1 International Students or Scholars whose Forms I-20 or DS-2019 were issued by the University of Michigan. The accompanying **dependents** of these students and scholars are also eligible for this Plan.

University of Michigan - Ann Arbor Insurance Requirement

All University of Michigan (Ann Arbor) F-1 International Students whose Forms I-20 were issued by the University of Michigan (Ann Arbor), and their accompanying F-2 **dependents** are eligible for this Plan and must remain enrolled in the Plan throughout their stay as U-M F-1 students or F-2 **dependents** unless, in the judgment of the University, comparable coverage is in effect under another insurance policy. The specific criteria used to determine comparability are posted on the International Center's website at <http://internationalcenter.umich.edu/healthins/waiver.html#standards>.

All University of Michigan (Ann Arbor) J-1 International Students and Scholars whose Forms DS-2019 were issued by the University of Michigan (Ann Arbor) and their accompanying J-2 **dependents** are eligible for this Plan and must remain enrolled in the Plan throughout their stay as U-M J-1 students or scholars or J-2 **dependents** unless, in the judgment of the University, comparable coverage is in effect under another insurance policy. The specific criteria used to determine comparability are posted on the International Center's website at <http://internationalcenter.umich.edu/healthins/waiver.html#standards>.

University of Michigan - Dearborn Insurance Requirement

All University of Michigan (Dearborn) F-1 International Students whose Forms I-20 were issued by the University of Michigan (Dearborn), and their accompanying F-2 **dependents** are eligible for this Plan and must remain enrolled in the Plan throughout their stay as U-M/ Dearborn F-1 students or F-2 **dependents** unless, in the judgment of the University, comparable coverage is in effect under another insurance policy.

All University of Michigan (Dearborn) J-1 International Students and Scholars whose Forms DS-2019 were issued by the University of Michigan (Dearborn) and their accompanying J-2 **dependents** are eligible for this Plan and must remain enrolled in the Plan throughout their stay as U-M J-1 students or scholars or J-2 **dependents** unless, in the judgment of the University, comparable coverage is in effect under another insurance policy.

Information regarding the enrollment, billing or waiver procedures is contained within the University of Michigan Dearborn International Student Health Insurance Plan Notice. A copy of this Notice accompanies this Brochure or can be obtained from the Dearborn Counseling and Support Services at 4901 Evergreen Road, 2157 University Center. For more information visit http://www.umd.umich.edu/css_health_int_obtain_waiver/.

University of Michigan - Flint Insurance Requirement

All University of Michigan (Flint) F-1 International Students whose Forms I-20 were issued by the University of Michigan (Flint), and their accompanying F-2 **dependents** are eligible for this Plan and must remain enrolled in the Plan throughout their stay as U-M/Flint F-1 students or F-2 **dependents** unless, in the judgment of the University, comparable coverage is in effect under another insurance policy.

All University of Michigan (Flint) J-1 International Students and Scholars whose Forms DS-2019 were issued by the University of Michigan (Flint) and their accompanying J-2 **dependents** are eligible for this Plan and must remain enrolled in the Plan throughout their stay as U-M J-1 students or scholars or J-2 **dependents** unless, in the judgment of the University, comparable coverage is in effect under another insurance policy.

Information regarding the enrollment, billing or waiver procedures is contained within the University of Michigan Flint International Student Health Insurance Plan Notice. A copy of this Notice accompanies this Brochure or can be obtained from the Flint International Center at 219 UCEN 303 E. Kearsley St.

ENROLLMENT

All new University of Michigan F-1 International Students or J-1 International Students or Scholars whose Forms I-20 or DS-2019 were issued by the University of Michigan and their accompanying F-2 and J-2 **dependents** will be enrolled in the International Student/Scholar Health Insurance Plan as soon as the student or scholar has completed the mandatory check-in process, and coverage will become effective on the check-in date.

WAIVERS

University of Michigan - Ann Arbor Campus

If you are eligible for health insurance benefits administered by the University of Michigan Benefits office because you are or will be a University of Michigan employee or a U-M fellowship-holder whose fellowship includes GradCare, please enroll yourself and any eligible **dependents** in that coverage as soon as possible by following the procedures described at <http://benefits.umich.edu/enrollment/index.html>. Please also review the information available at <http://www.benefits.umich.edu/benefitgroups/index.html> carefully, or ask your department administrator for assistance, since specific procedures may be different depending on your “benefit group.” Once you and any accompanying F-2 or J-2 **dependents** are enrolled in these benefits, your International Student/Scholar Insurance Plan coverage will be cancelled and any needed adjustments (credits) will be made to your insurance account. The cancellation date will depend on the effective date of your University of Michigan benefits. No waiver request form is required since this is an automated process.

International Students and J-1 Exchange Visitors who would like to substitute private insurance or insurance provided by a sponsor for the International Student/Scholar Insurance Plan should fill out and submit the International Health Insurance Waiver Request Form, available on the International Center website, to request approval of an insurance waiver and cancellation of International Student/Scholar Insurance Plan coverage. More information about requesting a waiver and about the coverage an insurance plan must have in order for a waiver to be approved is available on the International Center website.

University of Michigan - Dearborn Campus

If you are eligible for health insurance benefits administered by the University of Michigan Benefits office because you are or will be a University of Michigan-Dearborn employee or a U-M fellowship-holder whose fellowship includes GradCare, please enroll yourself and any eligible **dependents** in that coverage as soon as possible by following the procedures given to you by your hiring department. Once the Counseling & Support Services Office is notified that you and any accompanying F-2 or J-2 **dependents** are enrolled in these benefits, your International Student/Scholar Insurance Plan coverage will be cancelled and any needed adjustments (credits) will be made to your insurance account. Since this is not an automate process you or your hiring department must inform Counseling & Support Services of your GradCare benefits otherwise you may be enrolled in both Aetna and GradCare.

Students/scholars who would like to substitute private insurance or insurance provide by a sponsor must request an insurance waiver by filling out the waiver request form and attaching information about the insurance coverage they want to substitute for the Aetna Plan. Upon approving a waiver, the Counseling & Support Services Office will update Student Accounts and any necessary adjustments (credits) will be made. More information about requesting a waiver and about the coverage an insurance plan must have in order for a waiver to be approved is available at http://www.umd.umich.edu/css_health_int_obtain_waiver/.

University of Michigan - Flint Campus

The Flint International Center will issue Waiver Request Forms and verify any non-Aetna insurance coverage of any new and continuing F-1 students. The standards used to determine comparable coverage are at <http://internationalcenter.umich.edu/healthins/waiver.html>.

International Students and J-1 Exchange Visitors who would like to substitute private insurance or insurance provided by a sponsor for the International Student/Scholar Insurance Plan should fill out and submit the International Health Insurance Waiver Request Form, available on the International Center website, to request approval of an insurance waiver and cancellation of International Student/Scholar Insurance Plan coverage. More information about requesting a waiver and about the coverage an insurance plan must have in order for a waiver to be approved is available on the International Center website.

Students can request an insurance waiver by filling out the waiver request form and attaching information about the insurance coverage they want to substitute for the Aetna Plan. Upon approving a waiver, the Flint International Center will update Student Accounts and any necessary adjustment will be made. Waiver forms can be obtained at <http://www.umflint.edu/ic/Forms/form.htm>.

COVERAGE END DATE

Your coverage under the International Student/Scholar Insurance Plan will extend through the end date of your I-20 or DS-2019, or through the end of your F-1 post-completion Optional Practical Training for students who are recommended for post-completion OPT. If the end date of your I-20 or DS-2019 changes, the end date of your health insurance coverage will also change.

AUTOMATIC RE-ENROLLMENT IN THE INTERNATIONAL STUDENT/SCHOLAR INSURANCE PLAN

University of Michigan - Ann Arbor Campus

If your alternative coverage ends before the end of your stay as an F-1 or J-1 student or scholar, you will be re-enrolled in the International Student/Scholar Insurance Plan. Also, if a waiver request form has been approved for private insurance or insurance provided by a sponsor, and the time period for which the waiver has been approved has ended, and the waiver is not renewed or is not re-approved, you will be re-enrolled in the International Student/Scholar Insurance Plan if you have not yet completed your stay as an F-1 student or J-1 student or scholar.

If you leave the University permanently before the end date of your I-20 or DS-2019, or leave the United States because you have decided not to complete your post-completion Optional Practical Training (OPT), please be sure to fill out the appropriate departure form. Forms are available at <http://internationalcenter.umich.edu/immig/forms/>. Please follow the instructions on the form that describe when and how to fill out the form and where to submit the form.

If you do not submit a departure form, the International Center will not know that you have ended your F-1 or J-1 stay, and you may be billed for health insurance, either because your enrollment in the International Student/Scholar Insurance Plan will be continued or because you will be automatically re-enrolled in the International Student/Scholar Insurance Plan if your alternative coverage and/or your insurance waiver ends before your I-20, DS-2019 or (for F-1 students on Optional Practical Training) your OPT end date.

University of Michigan - Dearborn Campus

All re-enrollment requests must be initiated and approved through the International Office, 2174 University Center.

University of Michigan - Flint Campus

All re-enrollment requests must be initiated and approved through the International Center.

REFUND POLICY

Leaving U-M or not enrolling in classes does not automatically cancel your participation in the Student/Scholar Health Insurance Plan.

UNIVERSITY OF MICHIGAN - ANN ARBOR CAMPUS

U-M F-1 or J-1 students or scholars who leave the University permanently earlier than they anticipated, should be sure to fill out the appropriate departure form so that the International Center can make appropriate adjustments to their SEVIS (Student Exchange Visitor Information System) records. Once this form is processed, the end date of your insurance coverage will also be adjusted if necessary. Departure forms are available at <http://internationalcenter.umich.edu/immig/forms/>. Please follow the instructions on the form that describe when and how to fill out the form and where to submit the form.

There are some situations in which you may need to visit the International Center Insurance Office to fill out and sign a Cancellation Form instead of or in addition to a departure form in order to change the end date of your insurance coverage. All Cancellation Forms must be approved by the Health Insurance Advisor. Please contact the Insurance Advisor at ihi@umich.edu for more information.

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.

UNIVERSITY OF MICHIGAN - DEARBORN CAMPUS

All coverage cancellation requests must be initiated and approved through the Dearborn International Office, 2174 UC.

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.

UNIVERSITY OF MICHIGAN - FLINT CAMPUS

All coverage cancellation requests must be initiated and approved through the International Center.

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

DEPENDENT COVERAGE

ELIGIBILITY

Covered students may also enroll their lawful spouse/same-sex domestic partner and unmarried **dependent** children under age 19 (23 if in school or on medical leave from school for up to **twelve months**. Proof of illness is required) who are fully supported by the student. (1) A **covered dependent** who will lose coverage due to his/her age (e.g. over 19 or 23) may stay on the Plan if the **dependent** is incapable of self support due to a mental or physical disability and is dependent on subscriber for support. Proof of dependency must be presented within **31 days** of loss of coverage. (2) A **covered dependent** who is a **covered dependent** due to full or part-time student status must be allowed to continue coverage on the Plan while taking a leave of absence from school due to an illness or injury. The coverage for the **dependent** on a leave of absence shall continue for at least **twelve months** or until the **dependent** reaches the age which he/she would normally terminate from the Plan, i.e. age 19, 23, or 25. Proof of illness or injury can be required.

ENROLLMENT

Accompanying F-2 and J-2 **dependents** of F-1/J-1 International Students and International Visiting Scholars will be enrolled in the International Student/Scholar Health Insurance Plan as soon as the student or scholar has completed the mandatory check-in process, and coverage will become effective on the check-in date.

For information or general questions on dependent enrollment, please contact:

- **Ann Arbor Campus:** University of Michigan International Center – (734) 647-2303 or ihi@umich.edu
- **Dearborn Campus:** Counseling & Support Services – (313) 593-5430 or counseling@umd.umich.edu
- **Flint Campus:** International Center – (810) 762-0867 or mbarbee@umflint.edu

NEWBORN INFANT AND ADOPTED CHILD COVERAGE

A child born to a **Covered Person** shall be covered for accident, sickness, and congenital defects, for **31 days** from the date of birth. At the end of this **31 day** period, coverage will cease under the University of Michigan International Student/Scholar 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.

For further assistance and premium information, please contact:

- **Ann Arbor Campus:** University of Michigan International Center – (734) 647-2303 or ihi@umich.edu
- **Dearborn Campus:** Counseling & Support Services – (313) 593-5430 or counseling@umd.umich.edu
- **Flint Campus:** International Center – (810) 762-0867 or mbarbee@umflint.edu

CONTINUOUSLY INSURED

Persons who have remained continuously insured under the University of Michigan International Policy, prior University of Michigan International Student/Scholar Health Insurance Policies or University of Michigan sponsored health insurance programs for Graduate Student Assistants, Fellowship-holders, or University faculty and staff will be covered for any pre-existing condition that manifests itself while continuously insured, except for expenses payable under prior policies in the absence of the Policy. Once a break in continuous coverage occurs, the definition of pre-existing conditions will apply (see page 13).

PRE-EXISTING CONDITIONS/CONTINUOUSLY INSURED PROVISIONS

PRE-EXISTING CONDITION

A pre-existing condition is an injury or disease that was present before your first day of coverage under a group health insurance Plan. If you received treatment or services for that injury or disease **or** you took prescription drugs or medicines for that injury or disease during the **180 days** prior to your first day of coverage, that injury or disease will be considered a pre-existing condition.

LIMITATION

Covered Medical Expenses are payable on the same basis as any other condition for a pre-existing condition up to a maximum of **\$1,000** per accident or sickness for **Covered Persons**. This limitation will no longer apply when the **Covered Person** has been continuously insured for **180 consecutive days** under this Plan. This benefit is subject to all other Policy conditions and limitations.

However, there is an important exception to this general rule if you have been continuously insured.

CONTINUOUSLY INSURED

You have been continuously insured if you (i) had “creditable health insurance coverage” (such as COBRA, HMO, another group or individual policy, Medicare or Medicaid) prior to enrolling in this Plan, **and** (ii) the creditable coverage ended within **63 days** of the date you enrolled under this Plan. If both of these tests are met, then the pre-existing limitation period under this Plan will be reduced (and possibly eliminated altogether) by the number of days of your prior creditable coverage. You will be asked to provide evidence of your prior creditable coverage.

Once a break (of more than **63 days**) in your continuous coverage occurs, the definition of pre-existing conditions will apply.

PREFERRED PROVIDER NETWORK

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

To maximize your savings and reduce your out-of-pocket expenses, select a Preferred Provider*. It is to your advantage to use a Preferred Provider because savings may be achieved from the Negotiated Charges these providers have agreed to accept as payment for their services. Preferred Providers are independent contractors, and are neither employees nor agents of University of Michigan (with the exception of University of Michigan Medical Center providers and University Health Service), Aetna Student Health, or Aetna.

You may obtain information regarding Preferred Providers by contacting Aetna Student Health at **(800) 239-9697**, 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.***

REFERRAL REQUIREMENTS - ANN ARBOR CAMPUS ONLY

Students' health care needs can best be satisfied when an organized system of health care providers at the University of Michigan Health Service manages the treatment. If you are enrolled in the Student/Scholar Health Insurance Plan, it is to your advantage to first seek treatment at the University Health Service in order to reduce your out-of-pocket expenses. The health care providers will then refer you, if appropriate, to an outside provider. For specific information about referral requirements for students, scholars, spouses and children, please refer to the Summary of Benefits charts under "Deductible".

Please Note:

- **Covered students/scholars** and their **dependents** who continue treatment of a condition from one Policy Year to the next do not need to obtain a new referral from the University Health Service. Refer to the Summary of Benefits Chart for details.
- No referral is necessary for behavioral/mental health services. Copays still apply. Refer to the Summary of Benefits Chart for details.

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) 239-9697** (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 **\$200** per admission Deductible.
- **If you do not secure pre-certification** for partial hospitalizations, your **Covered Medical Expenses** will be subject to a **\$200** per admission Deductible.

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

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

PRE-CERTIFICATION DOES NOT GUARANTEE THE PAYMENT OF BENEFITS FOR YOUR INPATIENT ADMISSION

Each claim is subject to Medical Policy Review, in accordance with the exclusions and limitations contained in the Policy, as well as a review of eligibility, adherence to notification guidelines, and benefit coverage under the Student Accident and Sickness Plan.

PRE-CERTIFICATION OF NON-EMERGENCY INPATIENT ADMISSIONS, PARTIAL HOSPITALIZATION, IDENTIFIED OUTPATIENT SERVICES AND HOME HEALTH SERVICES

The patient, physician or hospital must telephone at least **three 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 business day** following inpatient (or partial hospitalization) admission.

DESCRIPTION OF BENEFITS

Please Note: The University of Michigan International Student/Scholar Health Insurance Plan may not cover all of your health care expenses. The Plan excludes coverage for certain services and contains limitations on the amounts it will pay. Please read the University of Michigan International Student/Scholar Health Insurance Plan Brochure carefully before deciding whether this Plan is right for you. While this document will tell you about some of the important features of the Plan, other features may be important to you and some may further limit what the Plan will pay. If you want to look at the full Plan description, which is contained in the Master Policy issued to University of Michigan, you may view it at the University of Michigan International Center in Ann Arbor during normal business hours or you may contact Aetna Student Health at (800) 239-9697.

This Plan will never pay more than \$1,000,000 any one accident, any one sickness, or any one injury per lifetime. Additional Plan maximums may also apply. Some illnesses may cost more to treat and health care providers may bill you for what the Plan does not cover.

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

SUMMARY OF BENEFITS CHART

<p>DEDUCTIBLE</p>	<p>\$50 per Covered Person, per covered injury or sickness.</p> <p><i>Applies to all services, unless otherwise noted.</i></p> <p>ANN ARBOR CAMPUS ONLY: The Deductible is waived, or reduced, if following conditions are met:</p> <ul style="list-style-type: none"> • If a student, dependent spouse, same-sex domestic partner, dependent child (age ten or older) or visiting scholar is first treated at, or referred by, the University Health Service, the Deductible will be waived; • If a dependent spouse, same-sex domestic partner or visiting scholar is first treated at, or referred by, North Campus Family Health Service or Community Family Health Center, the Deductible will be \$10 per injury or sickness; • If a dependent child is first treated at, or referred by, North Campus Family Health Service, Community Family Health Center or Pediatric Primary Care at the East Arbor Health Center (under 18 years of age), the Deductible will be \$10 per injury or sickness. <p><i>Please Note:</i> North Campus Family Health Service and Community Family Health Center are both part of the Nurse Managed Care Centers of Ann Arbor.</p>
<p>BENEFIT ALLOCATION</p>	<p>Covered Medical Expenses listed below are payable at the Negotiated/ Reasonable/ Actual Charge in accordance with the following reimbursement levels, unless specifically noted otherwise in the benefit descriptions below:</p> <ul style="list-style-type: none"> • 100% for first \$5,000 in paid benefits; • 80% for \$5,001 to \$40,000 in paid benefits; • 100% for \$40,001 in paid benefits, to the Aggregate Lifetime Maximum. <p><i>Please Note:</i> When confined in a Preferred hospital, all covered facility expenses will be covered at 100% of the Negotiated/Reasonable Charge.</p>
<p>AGGREGATE LIFETIME MAXIMUM</p>	<p>\$1,000,000 for any one accident, any one sickness, or any one injury per lifetime.</p>

All coverage is based on Reasonable Charges unless otherwise specified.

Inpatient Hospitalization Benefits	
Hospital Room and Board Expenses	<p>Covered Medical Expenses are payable as follows:</p> <p>Preferred Care: the Negotiated Charge. Non-Preferred Care: the Reasonable Charge.</p> <p><i>For more information, please refer to the Benefit Allocation shown on page 15.</i></p>
Intensive Care Unit Expenses	<p>Covered Medical Expenses are payable as follows:</p> <p>Preferred Care: the Negotiated Charge. Non-Preferred Care: the Reasonable Charge.</p> <p><i>For more information, please refer to the Benefit Allocation shown on page 15.</i></p>
Miscellaneous Hospital Expenses	<p>Covered Medical Expenses are payable as follows:</p> <p>Preferred Care: the Negotiated Charge. Non-Preferred Care: the Reasonable Charge.</p> <p><i>For more information, please refer to the Benefit Allocation shown on page 15.</i></p> <p>Covered Medical Expenses include, but are not limited to: laboratory tests, X-rays, surgical dressings, anesthesia, supplies and equipment use, and medicines.</p>
Physician Hospital Visit/ Consultation Expenses	<p>Covered Medical Expenses for charges for the non-surgical services of the attending physician, or a consulting physician, are payable as follows:</p> <p>Preferred Care: the Negotiated Charge. Non-Preferred Care: the Reasonable Charge.</p> <p><i>For more information, please refer to the Benefit Allocation shown on page 15.</i></p>
Licensed Nurse Expenses	<p>Benefits include charges incurred by a Covered Person who is confined in a hospital as a resident bed-patient, and requires the services of a registered nurse or licensed practical nurse.</p> <p>Covered Medical Expenses for a licensed nurse are as follows:</p> <p>Preferred Care: the Negotiated Charge. Non-Preferred Care: the Reasonable Charge.</p> <p><i>For more information, please refer to the Benefit Allocation shown on page 15.</i></p>

Surgical Benefits (Inpatient and Outpatient)	
Surgical Expenses	<p>Covered Medical Expenses for charges for surgical services, performed by a physician, are payable as follows:</p> <p>Preferred Care: the Negotiated Charge. Non-Preferred Care: the Reasonable Charge.</p> <p><i>For more information, please refer to the Benefit Allocation shown on page 15.</i></p>

Anesthetist and Assistant Surgeon Expenses	<p>Covered Medical Expenses for the charges of an anesthetist and an assistant surgeon, during a surgical procedure, are payable as follows:</p> <p>Preferred Care: the Negotiated Charge. Non-Preferred Care: the Reasonable Charge.</p> <p><i>For more information, please refer to the Benefit Allocation shown on page 15.</i></p>
Outpatient Hospital Services for Surgery Expenses	<p>Covered Medical Expenses are payable as follows:</p> <p>Preferred Care: the Negotiated Charge. Non-Preferred Care: the Reasonable Charge.</p> <p><i>For more information, please refer to the Benefit Allocation shown on page 15.</i></p>
Ambulatory Surgical Expenses	<p>Covered Medical Expenses for outpatient surgery performed in an ambulatory surgical center are payable as follows:</p> <p>Preferred Care: the Negotiated Charge. Non-Preferred Care: the Reasonable Charge.</p> <p><i>For more information, please refer to the Benefit Allocation shown on page 15.</i></p> <p>Covered Medical Expenses must be incurred on the day of the surgery or within 48 hours after the surgery.</p>

<p>Outpatient Benefits</p> <p>Covered Medical Expenses include but are not limited to: physician's office visits, hospital or outpatient department or emergency room visits, durable medical equipment, clinical lab, or radiological facility.</p>	
Hospital Outpatient Department or Walk-In Clinic Expenses	<p>Covered Medical Expenses for outpatient treatment in a hospital are payable as follows:</p> <p>Preferred Care: the Negotiated Charge. Non-Preferred Care: the Reasonable Charge.</p> <p><i>For more information, please refer to the Benefit Allocation shown on page 15.</i></p>
Emergency Room Expenses	<p>Covered Medical Expenses incurred for treatment of an Emergency Medical Condition are payable as follows:</p> <p>Preferred Care: the Negotiated Charge. Non-Preferred Care: the Reasonable Charge.</p> <p><i>For more information, please refer to the Benefit Allocation shown on page 15.</i></p> <p>Includes coverage for medically necessary services provided to an insured for the sudden onset of a medical condition that manifests itself by signs and symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in serious jeopardy to the individual's health or to a pregnancy in the case of a pregnant woman, serious impairment of bodily functions or serious dysfunction of any bodily organ or part.</p>

<p>Urgent Care Expenses</p>	<p><i>Benefits include charges for treatment by an urgent care provider.</i></p> <p>Please Note: A Covered Person <u>should not seek medical care or treatment from an urgent care provider if their illness, injury, or condition, is an emergency condition.</u> The Covered Person should go directly to the emergency room of a hospital or call 911 for ambulance and medical assistance.</p> <p><u>Urgent Care</u> Benefits include charges for an urgent care provider to evaluate and treat an urgent condition.</p> <p>Covered Medical Expenses for urgent care treatment are payable as follows:</p> <p>Preferred Care: the Negotiated Charge. Non-Preferred Care: the Reasonable Charge.</p> <p><i>For more information, please refer to the Benefit Allocation shown on page 15.</i></p>
<p>Ambulance Expenses</p>	<p>Covered Medical Expenses are payable at 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.</p> <p><i>For more information, please refer to the Benefit Allocation shown on page 15.</i></p> <p>Emergency medical health services include, but are not limited to, the use of emergency vehicles and emergency air transport to ensure the ability to stabilize the patient.</p>
<p>Pre-Admission Testing Expenses</p>	<p>Covered Medical Expenses for Pre-Admission testing charges while an outpatient before scheduled surgery are payable as any other condition.</p> <p><i>For more information, please refer to the Benefit Allocation shown on page 15.</i></p> <p><i>Please see the Definition of Pre-Admission Testing on page 47 for more detailed information on this benefit.</i></p>
<p>Physician's Office Visit Expenses</p>	<p>Covered Medical Expenses are payable as follows:</p> <p>Preferred Care: the Negotiated Charge. Non-Preferred Care: the Reasonable Charge.</p> <p><i>For more information, please refer to the Benefit Allocation shown on page 15.</i></p>
<p>Laboratory and X-ray Expenses</p>	<p>Covered Medical Expenses are payable as follows:</p> <p>Preferred Care: the Negotiated Charge. Non-Preferred Care: the Reasonable Charge.</p> <p><i>For more information, please refer to the Benefit Allocation shown on page 15.</i></p> <p><i>Please Note:</i> Includes routine testing for tuberculosis.</p>

Therapy Expenses	<p>Covered Medical Expenses include charges incurred by a Covered Person for the following types of therapy provided on an outpatient basis:</p> <ul style="list-style-type: none"> • Physical Therapy, • Chiropractic Care, • Speech Therapy, • Inhalation Therapy, or • Occupational Therapy. <p>Expenses for Chiropractic Care are Covered Medical Expenses, if such care is related to neuromusculoskeletal conditions and conditions arising from: the lack of normal nerve, muscle, and/or joint function.</p> <p>Expenses for Speech and Occupational Therapies are Covered Medical Expenses, only if such therapies are a result of injury or sickness.</p> <p>All therapy must be provided by a therapist who is licensed in accordance with State Law, and practicing within the scope of their license.</p> <p>Covered Medical Expenses are payable as follows:</p> <p>Preferred Care: the Negotiated Charge. Non-Preferred Care: the Reasonable Charge.</p> <p><i>For more information, please refer to the Benefit Allocation shown on page 15.</i></p> <p>After the 10th visit we may request verification of medical necessity in order to continue treatment.</p> <p>Benefits are limited to one visit per day.</p>
Chemotherapy Expenses	<p>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.</p> <p>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:</p> <p>Preferred Care: the Negotiated Charge. Non-Preferred Care: the Reasonable Charge.</p> <p><i>For more information, please refer to the Benefit Allocation shown on page 15.</i></p>
Durable Medical Equipment Expenses	<p>Covered Medical Expenses are payable as follows:</p> <p>Preferred Care: the Negotiated Charge. Non-Preferred Care: the Reasonable Charge.</p> <p><i>For more information, please refer to the Benefit Allocation shown on page 15.</i></p>

<p>Prosthetic Devices Expenses</p>	<p>Benefits include charges for: artificial limbs, or eyes, and other non-dental prosthetic devices, as a result of an accident or sickness.</p> <p>Covered Medical Expenses do not include: eye exams, eyeglasses, vision aids, hearing aids, communication aids, and orthopedic shoes.</p> <p>Covered Medical Expenses are payable as follows:</p> <p>Preferred Care: the Negotiated Charge. Non-Preferred Care: the Reasonable Charge.</p> <p><i>For more information, please refer to the Benefit Allocation shown on page 15.</i></p>
<p>Dental Injury Expenses</p>	<p>Covered Medical Expenses include dental work, surgery, and orthodontic treatment needed to remove, repair, replace, restore, or reposition:</p> <ul style="list-style-type: none"> • 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. <p>Any such teeth must have been:</p> <ul style="list-style-type: none"> • Free from decay, or • In good repair, and • Firmly attached to the jawbone at the time of the injury. <p><i>The treatment must be done in the calendar year of the accident or the next one.</i></p> <p>If:</p> <ul style="list-style-type: none"> • Crowns (caps), or • Dentures (false teeth), or • Bridgework, or • In-mouth appliances, <p>are installed due to such injury, Covered Medical Expenses include only charges for:</p> <ul style="list-style-type: none"> • 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. <p>Surgery needed to:</p> <ul style="list-style-type: none"> • 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. <p>Non-surgical treatment of infections or diseases. This does not include those of, or related to, the teeth.</p> <p>Covered Medical Expenses are payable at the Actual Charge.</p> <p><i>For more information, please refer to the Benefit Allocation shown on page 15.</i></p> <p>Benefits are limited to \$250 per Policy Year (combined with Impacted Wisdom Teeth Expense).</p>

<p>Impacted Wisdom Teeth Expenses</p>	<p>Covered Medical Expenses for removal of one or more impacted wisdom teeth are payable as follows:</p> <p>Preferred Care: the Negotiated Charge. Non-Preferred Care: the Reasonable Charge.</p> <p><i>For more information, please refer to the Benefit Allocation shown on page 15.</i></p> <p>Benefits are limited to \$250 per Policy Year (combined with Dental Injury Expense).</p>
<p>Allergy Testing Expenses</p>	<p>Benefits include charges incurred for diagnostic testing of allergies. Covered Medical Expenses include, but are not limited to, charges for the following:</p> <ul style="list-style-type: none"> • laboratory tests, • physician office visits, including visits to administer injections, • prescribed medications for testing of the allergy, including any equipment used in the administration of this prescribed medication, and • other medically necessary supplies and services. <p>Covered Medical Expenses are payable as follows:</p> <p>Preferred Care: the Negotiated Charge. Non-Preferred Care: the Reasonable Charge.</p> <p><i>For more information, please refer to the Benefit Allocation shown on page 15.</i></p>
<p>Diagnostic Testing for Attention Disorders and Learning Disabilities Expenses</p>	<p>Covered Medical Expenses for diagnostic testing for:</p> <ul style="list-style-type: none"> • Attention Deficit Disorder, or • Attention Deficit Hyperactive Disorder, or • Dyslexia, <p>are payable as follows:</p> <p>Preferred Care: the Negotiated Charge. Non-Preferred Care: the Reasonable Charge.</p> <p><i>For more information, please refer to the Benefit Allocation shown on page 15.</i></p>
<p>Well Baby Care Expenses</p>	<p>Benefits include charges for routine preventive and primary care services, rendered to a covered dependent child on an outpatient basis.</p> <p>Routine preventive and primary care services are services rendered to a covered dependent child, from the date of birth through five 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.</p> <p>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.</p> <p>Covered Medical Expenses are payable as follows:</p> <p>Preferred Care: the Negotiated Charge. Non-Preferred Care: the Reasonable Charge.</p>

	<p><i>For more information, please refer to the Benefit Allocation shown on page 15.</i></p> <p>Benefits are payable for scheduled visits in accordance with the prevailing clinical standards of the American Academy of Pediatrics.</p>
Immunizations Expenses	<p>Covered Medical Expenses include charges incurred by a covered student and/or dependent spouse for administration of vaccination for Human Papillomavirus (HPV), only.</p> <p>Covered Medical Expenses are payable as follows:</p> <p>Preferred Care: the Negotiated Charge. Non-Preferred Care: the Reasonable Charge.</p> <p><i>For more information, please refer to the Benefit Allocation shown on page 15.</i></p>
Consultant or Specialist Expenses	<p>Covered Medical Expenses include the expenses for the services of a consultant or specialist. The services must be requested by the attending physician for the purpose of confirming or determining to confirm or determine a diagnosis.</p> <p>Covered Medical Expenses are payable as follows:</p> <p>Preferred Care: the Negotiated Charge. Non-Preferred Care: the Reasonable Charge.</p> <p><i>For more information, please refer to the Benefit Allocation shown on page 15.</i></p>

Mental Health Benefits	
Mental and Nervous Disorders Inpatient Expenses	<p>Covered Medical Expenses for the treatment of a mental and nervous disorders while confined as a inpatient in a hospital or facility licensed for such treatment are payable as follows:</p> <p>Preferred Care: the Negotiated Charge. Non-Preferred Care: the Reasonable Charge.</p> <p><i>For more information, please refer to the Benefit Allocation shown on page 15.</i></p> <p>Partial hospitalization, inpatient, and outpatient benefits for Treatment of Mental and Nervous Disorders require pre-certification.</p> <p>Inpatient mental health treatment is limited to a maximum of 30 days per Policy Year for any one or related mental health condition.</p> <p>Covered Medical Expenses also include the charges made for treatment received during partial hospitalization in a hospital or treatment facility. Prior review and approval must be obtained on a case-by-case basis by contacting Aetna Student Health. When approved, benefits will be payable in place of an inpatient admission, whereby two days of partial hospitalization may be exchanged for one day of full hospitalization.</p>
Mental and Nervous Disorders Outpatient Expenses	<p>Covered Medical Expenses for outpatient treatment of a mental and nervous disorders are payable as follows:</p> <p><u>Preferred Care:</u> After a \$25 Copay, 100% of the Negotiated Charge. <u>Non-Preferred Care:</u> After a \$50 per visit Deductible, 100% of the Reasonable Charge.</p> <p>Benefits are limited to 25 visits per Policy Year.</p>

Substance Abuse Benefits	
Inpatient Expenses	<p>Covered Medical Expenses for the treatment of a substance abuse condition while confined as an inpatient in a hospital or facility licensed for such treatment are payable as follows:</p> <p>Preferred Care: the Negotiated Charge. Non-Preferred Care: the Reasonable Charge.</p> <p><i>For more information, please refer to the Benefit Allocation shown on page 15.</i></p> <p>Partial hospitalization and inpatient Treatment of Alcohol and Drug Addiction require pre-certification.</p> <p>Covered Medical Expenses also include the charges made for treatment received during partial hospitalization in a hospital or treatment facility. Prior review and approval must be obtained on a case-by-case basis by contacting Aetna Student Health. When approved, benefits will be payable in place of an inpatient admission, whereby two days of partial hospitalization may be exchanged for one day of full hospitalization.</p> <p>Inpatient substance abuse treatment is limited to a maximum of 30 days per Policy Year.</p>
Outpatient Expenses	<p>Covered Medical Expenses for outpatient treatment of a substance abuse condition are payable as follows:</p> <p><u>Preferred Care:</u> After a \$25 Copay, 100% of the Negotiated Charge. <u>Non-Preferred Care:</u> After a \$50 per visit Deductible, 100% of the Reasonable Charge.</p> <p>The maximum benefit is \$3,919 per Policy Year.</p>

Maternity Benefits	
Maternity Expenses	<p>Covered Medical Expenses include inpatient care of the Covered Person and any newborn child for a minimum of 48 hours after a vaginal delivery and for a minimum of 96 hours after a cesarean delivery.</p> <p>Any decision to shorten such minimum coverages shall be made by the attending physician in consultation with the mother. In such cases, covered services may include: home visits, parent education, and assistance and training in breast or bottle-feeding.</p> <p>Covered Medical Expenses for pregnancy, childbirth, and complications of pregnancy are payable on the same basis as any other sickness.</p> <p>A referral is not required for this benefit.</p>
Well Newborn Nursery Care Expenses	<p>Benefits include charges for routine care of a Covered Person's newborn child as follows:</p> <ul style="list-style-type: none"> • hospital charges for routine nursery care during the mother's confinement, but for not more than four days (for a normal delivery), • physician's charges for circumcision, and • physician's charges for visits to the newborn child in the hospital and consultations, but for not more than one visit per day. <p>Covered Medical Expenses are payable on the same basis as any other condition.</p>

Additional Benefits	
<p>Prescription Drug Benefit Expenses</p> <p><i>(The Deductible shown on page 15 does not apply.)</i></p>	<p>Prescription drug benefits are payable as follows: <u>Preferred Care Pharmacy: 90% of Negotiated Charge.</u> <u>Non-Preferred Care Pharmacy: 90% of the Reasonable Charge.</u></p> <p><i>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.</i></p> <p>This pharmacy benefit is provided to cover medically necessary prescriptions associated with a covered sickness or accident occurring during the Policy Year. Please use your Aetna Student Health ID card when obtaining your prescriptions.</p> <p>Prior authorization is required for certain prescription drugs, including Imitrex, certain stimulants, growth hormones and for any prescription quantities larger than a 30-day supply. <i>(This is only a partial list.)</i></p> <p>Medications not covered by this benefit include, but are not limited to: allergy sera, oral contraceptives, all acne medications, drugs whose sole purpose is to promote or to stimulate hair growth, appetite suppressants, smoking deterrents, immunization agents and vaccines, and non-self injectables. <i>(This is only a partial list.)</i></p> <p>For assistance or for a complete list of excluded medications, or drugs requiring prior authorization, please contact Aetna Pharmacy Management at (800) 238-6279 (available 24 hours).</p> <p>Aetna Specialty Pharmacy provides specialty medications and support to members living with chronic conditions. The medications offered may be injected, infused or taken by mouth. For additional information please go to www.AetnaSpecialtyRx.com.</p> <p>Benefits include coverage for off-label use of FDA approved prescription drugs, drugs used in antineoplastic therapy and the reasonable cost of administration of the drugs.</p>
<p>Diabetic Testing Supplies Expenses</p>	<p>Benefits include charges for testing material used to detect the presence of sugar in the person's urine or blood for monitoring glycemic control.</p> <p>Diabetic Testing Supplies are limited to:</p> <ul style="list-style-type: none"> • Lancet devices, including spring-powered lancet devices, • glucose monitors, and blood glucose monitors for the legally blind, • test strips, visual readings and urine testing strips, • syringes, and • insulin pumps and medical supplies required for the use of an insulin pump. <p>Other items, used in the treatment of Diabetes, are not Covered Medical Expenses.</p> <p>Covered Medical Expenses are payable on the same basis as any other sickness.</p> <p>Coverage includes insulin, non-experimental medication for controlling blood sugar, and medications used in the treatment of foot ailments, infections, and other medical conditions of the foot, ankle, or nails, associated with Diabetes, if prescribed by allopathic or osteopathic physician.</p> <p><i>Please Note: Insulin, syringes, and Diabetic testing supplies are covered under the Prescription Drug Benefit portion of the Plan.</i></p>

<p>Outpatient Diabetic Self-Management Education Programs Expenses</p>	<p>Covered Medical Expenses for outpatient Diabetic self-management education programs are payable as follows:</p> <p>Preferred Care: the Negotiated Charge. Non-Preferred Care: the Reasonable Charge.</p> <p><i>For more information, please refer to the Benefit Allocation shown on page 15.</i></p> <p>Please see the definition on page 47 of this Brochure for more information on Outpatient Diabetic Self-Management Education Courses.</p>
<p>Non-Prescription Enteral Formula Expenses</p>	<p>Benefits include charges incurred by a Covered Person for non-prescription enteral formulas, for which a physician has issued a written order, and are for the treatment of malabsorption caused by:</p> <ul style="list-style-type: none"> • Crohn’s Disease, • ulcerative colitis, • gastroesophageal reflux, • gastrointestinal motility, • chronic intestinal pseudoobstruction, and • inherited diseases of amino acids and organic acids. <p>Covered Medical Expenses for inherited diseases of amino acids and organic acids, will also include food products modified to be low protein.</p> <p>Covered Medical Expenses are payable as follows:</p> <p>Preferred Care: the Negotiated Charge. Non-Preferred Care: the Reasonable Charge.</p> <p><i>For more information, please refer to the Benefit Allocation shown on page 15.</i></p>
<p>Intractable Pain Evaluation and Treatment Expenses</p>	<p>Covered Medical Expenses include charges incurred by a Covered Person for the evaluation and treatment of intractable pain, when it is determined to be medically necessary and otherwise eligible by Aetna.</p> <p>Covered Medical Expenses are payable as follows:</p> <p>Preferred Care: the Negotiated Charge. Non-Preferred Care: the Reasonable Charge.</p> <p><i>For more information, please refer to the Benefit Allocation shown on page 15.</i></p>
<p>Pap Smear Expenses</p>	<p>Covered Medical Expenses include one annual routine Pap smear screening for women age 18 and older.</p> <p>Covered Medical Expenses are payable as follows:</p> <p>Preferred Care: the Negotiated Charge. Non-Preferred Care: the Reasonable Charge.</p> <p><i>For more information, please refer to the Benefit Allocation shown on page 15.</i></p> <p>A referral is not required for this benefit.</p>

<p>Mammography Expenses</p>	<p>Benefits are payable for charges for mammograms. The charges must be incurred while a Covered Person is insured for these benefits.</p> <p>Benefits will be paid for Expenses incurred for the following:</p> <ul style="list-style-type: none"> • A baseline mammogram for women between the ages of 35 to 40, and • A mammogram every year, or more frequently based on the recommendation of the woman’s physician, for women 40 years of age and older. <p>Covered Medical Expenses also include breast cancer diagnostic services, breast cancer rehabilitative services, and breast cancer outpatient treatment services.</p> <p>Covered Medical Expenses are payable as follows:</p> <p>Preferred Care: the Negotiated Charge. Non-Preferred Care: the Reasonable Charge.</p> <p><i>For more information, please refer to the Benefit Allocation shown on page 15.</i></p> <p>A referral is not required for this benefit.</p>
<p>Mastectomy and Prosthetic Devices Expenses</p>	<p>Covered Medical Expenses include charges incurred by a Covered Person for prosthetic devices to maintain or replace body parts of a Covered Person who has undergone a mastectomy.</p> <p>Covered Medical Expenses include charges for the cost and fitting of a prosthetic device.</p> <p>Covered Medical Expenses are payable as follows:</p> <p>Preferred Care: the Negotiated Charge. Non-Preferred Care: the Reasonable Charge.</p> <p><i>For more information, please refer to the Benefit Allocation shown on page 15.</i></p>
<p>Elective Abortion Expenses</p>	<p>If, as a result of pregnancy, a Covered Person incurs expenses in connection with an elective abortion, a benefit is payable.</p> <p>Covered Medical Expenses for Elective Abortion Expenses are covered as follows: <u>Preferred Care:</u> 100% of the Negotiated Charge. <u>Non-Preferred Care:</u> 100% of the Reasonable Charge.</p> <p>This benefit is in lieu of any other Policy benefits.</p> <p>Benefits are limited to \$350 per Policy Year.</p>

<p>Chlamydia Screening Test Expenses</p>	<p>Benefits include charges incurred for an annual Chlamydia screening test.</p> <p>Benefits will be paid for Chlamydia screening expenses incurred for:</p> <ul style="list-style-type: none"> • Women who are: <ul style="list-style-type: none"> ○ 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. <p>Covered Medical Expenses are payable as follows:</p> <p>Preferred Care: the Negotiated Charge. Non-Preferred Care: the Reasonable Charge.</p> <p><i>For more information, please refer to the Benefit Allocation shown on page 15.</i></p> <p><i>Please see definition on page 41 for more information on this benefit.</i></p>
<p>Routine Screening for Sexually Transmitted Disease Expenses</p>	<p>Covered Medical Expenses include charges for Covered Persons who are at sexually active for annual routine screening for the following sexually transmitted diseases:</p> <ul style="list-style-type: none"> • Gonorrhea. <p>Benefits are payable as follows:</p> <p>Preferred Care: the Negotiated Charge. Non-Preferred Care: the Reasonable Charge.</p> <p><i>For more information, please refer to the Benefit Allocation shown on page 15.</i></p> <p><i>Please see definition on page 50 for more information on this benefit.</i></p>
<p>Acupuncture in Lieu of Anesthesia Expenses</p>	<p>Covered Medical Expenses include acupuncture therapy, when acupuncture is used in lieu of other anesthesia, for a surgical or dental procedure covered under this Plan.</p> <p>The acupuncture must be administered by a health care provider who is a legally qualified physician, practicing within the scope of their license.</p> <p>Covered Medical Expenses are payable as follows:</p> <p>Preferred Care: the Negotiated Charge. Non-Preferred Care: the Reasonable Charge.</p> <p><i>For more information, please refer to the Benefit Allocation shown on page 15.</i></p>
<p>Dermatological Expenses</p>	<p>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.</p> <p>Benefits are payable as follows:</p> <p>Preferred Care: the Negotiated Charge. Non-Preferred Care: the Reasonable Charge.</p> <p><i>For more information, please refer to the Benefit Allocation shown on page 15.</i></p> <p><i>Covered Medical Expenses do not include treatment for acne, or cosmetic treatment and procedures.</i></p>

<p>Podiatric Expenses</p>	<p>Covered Medical Expenses include charges for podiatric services, provided on an outpatient basis following an injury.</p> <p>Benefits are payable as follows:</p> <p>Preferred Care: the Negotiated Charge. Non-Preferred Care: the Reasonable Charge.</p> <p><i>For more information, please refer to the Benefit Allocation shown on page 15.</i></p> <p>Expenses for routine foot care, such as trimming of corns, calluses, and nails, are not Covered Medical Expenses.</p>
<p>Home Health Care Expenses</p>	<p>Covered Medical Expenses include charges incurred by a Covered Person for home health care services made by a home health agency pursuant to a home health care plan, but only if:</p> <ul style="list-style-type: none"> (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 seven 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. <p><u>Home Health Care Services</u></p> <ul style="list-style-type: none"> • Part-time or intermittent nursing care by: a registered nurse (R.N.), a licensed practical nurse (L.P.N.), or under the supervision on a R.N. if the services of a R.N. are not available, • Part time or intermittent home health aide services, that consist primarily of care of a medical or therapeutic nature by other than a R.N., • Physical, occupational speech therapy, or respiratory therapy, • Medical supplies, drugs and medicines, and laboratory services. However, these items are covered only to the extent they would be covered if the patient was confined to a hospital, • Medical social services by licensed or trained social workers, • Nutritional counseling. <p>Covered Medical Expenses will not include: 1) services by a person who resides in the Covered Person's home, or is a member of the Covered Person's immediate family, 2) homemaker or housekeeper services, 3) maintenance therapy, 4) dialysis treatment, 5) purchase or rental of dialysis equipment, or 6) food or home delivered services.</p> <p>Covered Medical Expenses are payable as follows:</p> <p>Preferred Care: the Negotiated Charge. Non-Preferred Care: the Reasonable Charge.</p> <p><i>For more information, please refer to the Benefit Allocation shown on page 15.</i></p>

<p>Transfusion or Dialysis of Blood Expenses</p>	<p>Covered Medical Expenses include charges for the transfusion or dialysis of blood, including the cost of: whole blood, blood components, and the administration thereof.</p> <p>Benefits are payable as follows:</p> <p>Preferred Care: the Negotiated Charge. Non-Preferred Care: the Reasonable Charge.</p> <p><i>For more information, please refer to the Benefit Allocation shown on page 15.</i></p>
<p>Hospice Benefit Expenses</p>	<p>Covered Medical Expenses include charges for hospice care provided for a terminally ill Covered Person during a hospice benefit period.</p> <p>Benefits are payable as follows:</p> <p>Preferred Care: the Negotiated Charge. Non-Preferred Care: the Reasonable Charge.</p> <p><i>For more information, please refer to the Benefit Allocation shown on page 15.</i></p> <p><i>Please see definition on page 45 for more information on Hospice Care Expenses.</i></p> <p>Benefits for Hospice expenses require pre-certification.</p>
<p>Skilled Nursing Facility Expenses</p>	<p>Covered Medical Expenses include charges incurred by a Covered Person for confinement in a skilled nursing facility for treatment rendered:</p> <ul style="list-style-type: none"> • in lieu of confinement in a hospital as a full time inpatient, or • within 24 hours following a hospital confinement and for the same or related cause(s) as such hospital confinement. <p>Covered Medical Expenses are payable as follows:</p> <p>Preferred Care: the Negotiated Charge. Non-Preferred Care: the Reasonable Charge.</p> <p><i>For more information, please refer to the Benefit Allocation shown on page 15.</i></p> <p>Benefits for Skilled Nursing require pre-certification.</p>
<p>Rehabilitation Facility Expenses</p>	<p>Covered Medical Expenses include charges incurred by a Covered Person for confinement as a full time inpatient in a rehabilitation facility. Confinement in the rehabilitation facility must follow within 24 hours of, and be for the same or related cause(s) as, a period of hospital or skilled nursing facility confinement.</p> <p>Covered Medical Expenses for Rehabilitation Facility Expense are payable as follows:</p> <p>Preferred Care: the Negotiated Charge. Non-Preferred Care: the Reasonable Charge.</p> <p><i>For more information, please refer to the Benefit Allocation shown on page 15.</i></p> <p>Benefits for Rehabilitation Facility expenses require pre-certification.</p>

INTERNATIONAL STUDENT/SCHOLAR HEALTH INSURANCE VISION PLAN

University Health Service (UHS) will manage the vision benefit for those insured by the International Student/Scholar Health Insurance Plan. This service is not underwritten by Aetna.

The UHS Eye Care Clinic will provide **one routine eye exam** per Policy Year/per enrollee with a **\$15** Copay per exam as long as the individual is enrolled in the International Student/Scholar Health Insurance Plan at the time of service.

The routine eye exam will include:

- Refraction and dilation of the eyes
- Health history
- Check of the interior and exterior eye as well as surrounding area for defects, disease, and clarity of vision
- Eye coordination
- Color vision
- Depth perception
- Refractive error and field of vision

Not Included: Contact Lenses evaluation or fitting. Additional fees will be charged if these services are performed and will be the patient's financial responsibility.

VISION CARE PROVIDER OF YOUR CHOICE

In some instances you may need to use a Vision Care Provider other than UHS. UHS will reimburse the Policyholder when a routine eye exam is received outside of UHS at a Vision Care Provider of your choice. UHS will reimburse for **one routine eye exam** per Policy Year/per enrollee not to exceed a benefit maximum of **\$30**, after applying the **\$15** Copay per exam, and subject to UHS guidelines.

The reimbursement option is limited to:

- Infant/toddlers under three years of age
- Students/Scholars studying out of the Ann Arbor area

The University Health Service Eye Care Clinic is located at:

207 Fletcher Street
Ann Arbor, MI 48109-1050
<http://www.uhs.umich.edu/eyecare>

For an appointment call: **(734) 764-8325** or toll free **(866) 386-0002**.

For eligible reimbursement of eligible services provided by a Vision Care Provider of your choice, send your original paid receipt to:

University of Michigan/University Health Service
Managed Care/Student Insurance Office
207 Fletcher Street
Ann Arbor, MI 48109-1050
www.uhs.umich.edu
mancare-stuins@umich.edu

Please remember to make a copy of your receipt for your own records.

ADDITIONAL SERVICES AND DISCOUNTS

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

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

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

**Offered by WellCall, Inc. through GlobalFit.*

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

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

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

Find a meal plan that works for you at eDiets[®]: Get a personalized plan for healthy eating that fits your lifestyle, and save 25% on weekly eDiets dues. You'll have access to customized weekly menus, recipes, support boards, chats, nutrition tools and fitness tips.

Use Zagat[®] reviews as a guide for your night out: Planning a night on the town? Or, want to visit a city where you've never been? Subscribe to Zagat online and get a 30% discount on their members-only services. You can sign up for access to restaurant reviews only, or choose full access and get ratings and reviews on hotels, restaurants, movies and other attractions. You can even order printed guides at a discount!

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

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

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

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

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

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

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

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

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

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

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

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

Vital SavingsSM on Dental* is a dental Discount Program helping you (and your dependents) save an average of 15% to 50% on a wide array of dental services – with one low annual fee of \$25 per student. Enroll online at www.aetnastudenthealth.com.

Student Only **\$25**; Student and One Dependent **\$44**; Student and Two or More Dependents **\$63**.

**Actual costs and savings vary by provider and geographic area.*

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

All of the above services, programs or benefits may be offered by vendors who are independent contractors and not employees or agents of Aetna.

Discount Programs provide access to discounted prices and are NOT insured benefits. The member is responsible for the full cost of the discounted services. Discounts are subject to change without notice. Discount Programs may not be available in all states. Discount Programs may be offered by vendors who are independent contractors and not employees or agents of Aetna.

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

GENERAL PROVISIONS

STATE MANDATED BENEFITS

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

SUBROGATION/REIMBURSEMENT RIGHT OF RECOVERY PROVISION

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

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

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

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

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

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

NON-DUPLICATION OF BENEFITS

This provision applies if a **covered student**:

- (a) Is covered by any other group or blanket health care plan, and
- (b) Would, as a result, receive medical expense or service benefits in excess of the actual expenses incurred.

In this case, the medical expense benefits the Plan will pay will be reduced by such excess.

EXTENSION OF BENEFITS

If a **Covered Person** is confined to a hospital on the date his/her insurance terminates, expenses incurred after the termination date and during the continuance of that hospital confinement, shall be payable in accordance with the policy, but only while they are incurred during the **31 day period**, following such termination of insurance.

TERMINATION OF INSURANCE

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

TERMINATION OF STUDENT COVERAGE

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

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

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

TERMINATION OF DEPENDENT COVERAGE

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

- (a) For a child, on the first premium due date following the first to occur of:
 1. the date the child is no longer chiefly dependent upon the student for support and maintenance,
 2. the date of the child's marriage, and
 3. the child's 19th birthday (23rd birthday if a student).
- (b) The date the **covered student** fails to pay any required premium.
- (c) For the spouse, the date the marriage ends in divorce or annulment.
- (d) The date **dependent** coverage is deleted from this Policy.
- (e) For a domestic partner, the earlier to occur of:
 1. the date this Policy no longer allows coverage for domestic partners, and
 2. the date of termination of the domestic partnership. In that event, a completed and signed declaration of termination of domestic partnership must be provided to the Policyholder.
- (f) The date the **dependent** ceases to be in an eligible class.

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

INCAPACITATED DEPENDENT CHILDREN

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

Due proof of the child's incapacity and dependency must be furnished to Aetna by the **covered student** within **31 days** 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 each year, that the child remains physically or mentally unable to earn his/her own living. The premium due for the child's insurance will be the same as for a child who is not so incapacitated.

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

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

CONTINUATION OF COVERAGE

Once an International Student or International Visiting Scholar's status as a University of Michigan F-1 or J-1 visa holder ends, the International Student or International Visiting Scholar may be eligible to continue coverage in this Plan up to **nine months**. The cost of this continuation Plan will be two times that of the current (active) Plan. Questions relating to this provision should be directed to Aetna Student Health at **(800) 239-9697**.

Note: Coverage under this provision ceases on the date this Policy terminates.

EXCLUSIONS

This Policy does not cover nor provide benefits for:

1. Expenses incurred as a result of dental treatment, except for treatment resulting from **injury to sound natural teeth** or for extraction of impacted wisdom teeth as provided elsewhere in this Policy.
2. Expenses incurred for services normally provided without charge by the Policyholder's Health Service, Infirmary or **Hospital**, or by health care providers employed by the Policyholder.
3. Expenses incurred for 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** (does not apply to the UHS Vision Plan, which is not underwritten by Aetna Life Insurance company).
4. Expenses incurred as a result of **injury** due to participation in a riot. "Participation in a riot" means taking part in a riot in any way, including inciting the riot or conspiring to incite it. It does not include actions taken in self-defense, so long as they are not taken against persons who are trying to restore law and order.
5. Expenses incurred as a result of an **accident** occurring in consequence of riding as a passenger or otherwise in any vehicle or device for aerial navigation, except as a fare-paying passenger in an aircraft operated by a scheduled airline maintaining regular published schedules on a regularly established route.
6. Expenses incurred as a result of an **injury** or **sickness** due to working for wage or profit or for which benefits are payable under any Workers' Compensation or Occupational Disease Law.
7. Expenses 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.
8. Expenses incurred for treatment provided in a governmental **hospital** unless there is a legal obligation to pay such charges in the absence of insurance.
9. Expenses incurred for **elective treatment** or elective surgery except as specifically provided elsewhere in this Policy and performed while this Policy is in effect.
10. Expenses incurred for cosmetic surgery, reconstructive surgery, or other services and supplies which improve, alter, or enhance appearance, whether or not for psychological or emotional reasons, except to the extent needed to:
 - Improve the function of a part of the body that:
 - is not a tooth or structure that supports the teeth, and
 - is malformed:
 - as a result of a severe birth defect, including harelip, webbed fingers, or toes, or
 - as direct result of:
 - disease, or
 - surgery performed to treat a disease or **injury**.

- Repair an **injury** (including reconstructive surgery for prosthetic device for a **Covered Person** who has undergone a mastectomy) which occurs while the **Covered Person** is covered under this Policy. Surgery must be performed:
 - in the **Policy Year** of the **accident** which causes the **injury**, or
 - in the next **Policy Year**.
11. Expenses covered by any other valid and collectible medical, health or **accident** insurance to the extent that benefits are payable under other valid and collectible insurance whether or not a claim is made for such benefits.
 12. Expense for **injuries** sustained as the result of a motor vehicle **accident** to the extent that benefits are payable under other valid and collectible insurance whether or not claim is made for such benefits.
 13. Expenses incurred as a result of preventive medicines, serums, vaccines or oral contraceptives, unless otherwise provided for in this Policy.
 14. Expenses incurred as a result of commission of a felony.
 15. Expenses incurred after the date insurance terminates for a **Covered Person** except as may be specifically provided in the Extension of Benefits Provision.
 16. Expenses incurred for services normally provided without charge by the school and covered by the school fee for services.
 17. Expenses incurred for any services rendered by a member of the **Covered Person's** immediate family or a person who lives in the **Covered Person's** home.
 18. Expenses incurred for **injury** resulting from the play or practice of collegiate or intercollegiate sports, injury resulting from club sports and intramural athletic activities are not excluded from coverage.
 19. Expenses incurred for treatment of temporomandibular joint dysfunction and associated myofascial pain.
 20. Treatment for **injury** to the extent benefits are payable under any state No-fault automobile coverage, first party medical benefits payable under any other mandatory No-fault law.
 21. Expenses incurred for **custodial care**. **Custodial care** means services and supplies furnished to a person mainly to help him/her in the activities of daily life. This includes **room and board** and other institutional care. The person does not have to be disabled. Such services and supplies are **custodial care** without regard to:
 - by whom they are prescribed, or
 - by whom they are recommended, or
 - by whom or by which they are performed.
 22. Expenses incurred for blood or blood plasma, except charges by a **hospital** for the processing or administration of blood.
 23. Expenses incurred for the repair or replacement of existing artificial limbs, orthopedic braces, or orthotic devices.
 24. Expenses incurred for or in connection with: procedures, services, or supplies that are, as determined by Aetna, to be experimental or investigational. A drug, a device, a procedure, or treatment will be determined to be experimental or investigational if:
 - There are insufficient outcomes data available from controlled clinical trials published in the peer reviewed literature, to substantiate its safety and effectiveness, for the disease or **injury** involved, or
 - If required by the FDA, approval has not been granted for marketing, or

- A recognized national medical or dental society or regulatory agency has determined, in writing, that it is experimental, investigational, or for research purposes, or
- The written protocol or protocols used by the treating facility, or the protocol or protocols of any other facility studying substantially the same drug, device, procedure, or treatment, or the written informed consent used by the treating facility, or by another facility studying the same drug, device, procedure, or treatment, states that it is experimental, investigational, or for research purposes.

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

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

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

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

25. Expenses incurred for gastric bypass, and any restrictive procedures, for weight loss.
26. Expenses incurred for breast reduction/mammoplasty unless specifically provided for in this Policy.
27. Expenses incurred for gynecomastia (male breasts) unless specifically provided for in this Policy.
28. Expenses incurred for any sinus surgery, except for acute purulent sinusitis.
29. Expenses incurred by a **Covered Person**, not a United States citizen, for services performed within the **Covered Person's** home country, if the **Covered Person's** home country has a socialized medicine program.
30. Expenses incurred for, or related to, services, treatment, or training for Attention Deficit Disorder, Attention Deficit Hyperactive Disorder, or learning disabilities, or other developmental delays.
31. Expenses incurred for acupuncture, unless services are rendered for anesthetic purposes.
32. Expenses incurred for alternative, holistic medicine, and/or therapy, including but not limited to, yoga and hypnotherapy.
33. Expenses for: (a) care of flat feet, (b) supportive devices for the foot, (c) care of corns, bunions, or calluses, (d) care of toenails, and (e) care of fallen arches, weak feet, or chronic foot strain, except that (c) and (d) are not excluded when **medically necessary**, because the **Covered Person** is Diabetic, or suffers from circulatory problems.
34. Expenses incurred when the person or individual is acting beyond the scope of his/her/its legal authority.
35. Expenses incurred for hearing aids, the fitting, or **prescription** of hearing aids.
36. Expenses incurred for hearing exams.
37. Expenses for care or services to the extent the charge would have been covered under Medicare Part A or Part B, even though the **Covered Person** is eligible, but did not enroll in Part B.

38. Expenses for telephone consultations, charges for failure to keep a scheduled visit, or charges for completion of a claim form.
39. Expenses for personal hygiene and convenience items, such as air conditioners, humidifiers, hot tubs, whirlpools, or physical exercise equipment, even if such items are prescribed by a **physician**.
40. Expenses for services or supplies provided for the treatment of obesity and/or weight control.
41. Expenses for incidental surgeries, and standby charges of a **physician**.
42. Expenses for treatment and supplies for programs involving cessation of tobacco use.
43. Expenses for contraceptive methods, devices or aids, and charges for services and supplies for or related to gamete intrafallopian transfer, artificial insemination, in-vitro fertilization (except as required by the State Law), or embryo transfer procedures, elective sterilization or its reversal, or elective abortion, unless specifically provided for in this Policy.
44. Expenses incurred for massage therapy.
45. Expenses incurred for, or in connection with, speech therapy. This exclusion does not apply for charges for speech therapy that is expected to restore speech to a person who has lost existing function (the ability to express thoughts, speak words, and form sentences), as a result of an **accident** or **sickness**.
46. Expenses incurred for, or related to, sex change surgery, or to any treatment of gender identity disorder.
47. Expenses for charges that are not **Reasonable Charges**, as determined by Aetna.
48. Expenses for treatment of **covered students** who specialize in the mental health care field, and who receive treatment as a part of their training in that field.
49. Expenses for treatment of **injury** or **sickness** to the extent payment is made, as a judgment or settlement, by any person deemed responsible for the **injury** or **sickness** (or their Insurers).
50. Expenses arising from a **pre-existing condition** in excess of **\$1,000**.
51. Expenses for routine physical exams, including expenses in connection with well newborn care, routine vision exams, routine dental exams, routine hearing exams, immunizations, or other preventive services and supplies, except to the extent coverage of such exams, immunizations, services, or supplies is specifically provided in the Policy.
52. Expenses incurred for a treatment, service, or supply, which is not **medically necessary**, as determined by Aetna, for the diagnosis care or treatment of the **sickness** or **injury** involved. This applies even if they are prescribed, recommended, or approved, by the person's attending **physician**, or **dentist**.

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

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

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

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

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

53. Expenses incurred for the treatment of acne.

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

DEFINITIONS

Accident

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

Actual Charge

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

Aggregate Lifetime Maximum

The maximum benefit that will be paid under this Policy for all **Covered Medical Expenses** incurred by a **Covered Person** for any one **accident**, any one **sickness**, or any one **injury** that accumulate in a lifetime.

Ambulatory Surgical Center

A freestanding ambulatory surgical facility that:

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

Breast Cancer Diagnostic Services

A procedure intended to aid in the diagnosis of breast cancer, delivered on an inpatient or outpatient basis, including but not limited to mammogram, mammography, surgical breast biopsy, and pathologic examination and interpretation.

Breast Cancer Outpatient Treatment Services

A procedure intended to treat cancer of the human breast, delivered on an outpatient basis, including but not limited to surgery, radiation therapy, chemotherapy, hormonal therapy, and related medical follow-up services.

Breast Cancer Rehabilitative Services

A procedure intended to improve the result of, or ameliorate the debilitating consequences of, treatment of breast cancer, delivered on an inpatient or outpatient basis, including by not limited to reconstructive plastic surgery, physical therapy, and psychological and social support services.

Chlamydia Screening Test

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

Coinsurance

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

Complications of Pregnancy

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

- acute nephritis or nephrosis, or
- cardiac decompensation or missed abortion, or
- similar conditions as severe as these.

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

Complications of Pregnancy also include:

- non-elective cesarean section, and
- termination of an ectopic pregnancy, and
- spontaneous termination when a live birth is not possible. (This does not include voluntary abortion.)

Convalescent Facility

This is an institution that:

- Is licensed to provide, and does provide, the following on an inpatient basis for persons convalescing from disease or **injury**:
 - professional nursing care by a R.N., or by a L.P.N. directed by a full-time R.N., and
 - physical restoration services to help patients to meet a goal of self-care in daily living activities.
- Provides **24 hour** a day nursing care by licensed nurses directed by a full-time R.N.
- Is supervised full-time by a **physician** or R.N.
- Keeps a complete medical record on each patient.
- Has a utilization review plan.
- Is not mainly a place for rest, for the aged, for drug addicts, for alcoholics, for mental retardates, for custodial or educational care, or for care of mental disorders.
- Makes charges.

Copay

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

Covered Dependent

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

Covered Medical Expenses

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

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

Covered 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** before benefits are paid.

Dental Consultant

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

Dental Provider

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

Dentist

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

Dependent

(a) the **covered student's** spouse residing with the **covered student**, or (b) the person identified as a domestic partner in the "Declaration of Domestic Partnership" which is completed and signed by the **covered student**, and (c) the **covered student's** unmarried child under the age of 19 years (or 23 if a student). The child must be fully supported by the **covered student**. The term "child" includes a **covered student's** step-child, adopted child, and a child for whom a petition for adoption is pending, and who is chiefly dependent on the **covered student** for his/her full support.

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

Diabetic Self-Management Education Course

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

The following are not considered Diabetic Self-Management Education Courses for the purposes of this Plan:

- A Diabetic Education program whose only purpose is weight control, or which is available to the public at no cost, or
- A general program not just for Diabetics, or
- A program made up of services not generally accepted as necessary for the management of Diabetes.

Directory

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

Durable Medical and Surgical Equipment

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

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

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

Elective Treatment

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

- tubal ligation,
- vasectomy,
- breast reduction,
- sexual reassignment surgery,
- submucous resection and/or other surgical correction for deviated nasal septum, other than necessary treatment of covered acute purulent sinusitis,
- treatment for weight reduction,
- learning disabilities,
- temporomandibular joint dysfunction (TMJ),
- immunization,
- treatment of infertility, and
- routine physical examinations.

Emergency Admission

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

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

Emergency Condition

This is any traumatic **injury** or condition which:

- occurs unexpectedly,
- requires immediate diagnosis and treatment, in order to stabilize the condition, and
- is characterized by symptoms such as severe pain and bleeding.

Emergency Medical Condition

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

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

Generic Prescription Drug or Medicine

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

High Cost Procedure

High Cost Procedures include the following procedures and services:

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

Home Health 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 a R.N., L.P.N., or L.V.N., 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 **six months** to live. It ends after **six months** (or such later period for which treatment is certified) or on the death of the patient, if sooner.

Hospice Care Expenses

The **reasonable and customary** charges made by a **hospice** for the following services or supplies: charges for inpatient care, charges for drugs and medicines, charges for part-time nursing by a R.N., L.P.N., or L.V.N., charges for physical and respiratory therapy in the home, charges for the use of medical equipment, charges for visits by licensed or trained social workers, psychologists or counselors, charges for bereavement counseling of the **Covered Person's** immediate family prior to, and within **three months** after, the **Covered Person's** death, and charges for **respite care** for up to **five days** in any **30 day period**.

Hospital

A facility which meets all of these tests:

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

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

Hospital Confinement

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

Injury

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

Intensive Care Unit

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

Jaw Joint Disorder

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

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/her, or any person who is part of his/her family, any health care provider, or health care facility, or
- Those furnished solely because the person is an inpatient on any day on which the person's **sickness or injury** could safely and adequately be diagnosed or treated while not confined, or
- Those furnished solely because of the setting if the service or supply could safely and adequately be furnished, in a **physician's** or a **dentist's** office, or other less costly setting.

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**.

Outpatient Diabetic Self-Management Education Program

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

Partial Hospitalization

Continuous treatment consisting of not less than **four hours** and not more than **twelve hours** in any **24 hour period** under a program based in a **hospital**.

Pervasive Developmental Disorder

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

Pharmacy

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

Physician

(a) legally qualified **physician** licensed by the state in which he/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.

Pre-Admission Testing

Tests done by a **hospital, surgery center**, licensed diagnostic lab facility, or **physician**, in its own behalf, to test a person while an outpatient before scheduled surgery if:

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

If the person cancels the scheduled surgery, benefits are paid at the covered percentage that would have applied in the absence of this benefit.

Pre-Existing Condition

Any **injury, sickness**, or condition for which medical advice, diagnosis, care, or treatment was recommended or received within **six months** prior to the **Covered Person's** enrollment in the Plan, or up to **six months** after the effective date of the Policy.

Preferred Care

Care provided by a **Covered Person's Primary Care Physician**, or a **Preferred Care Provider** on the referral of the **Primary Care Physician**.

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**.

Prescriber

Any person, while acting within the scope of his/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.
- Non-experimental medication for controlling blood sugar, if prescribed by a **physician**, and
- Medications used in the treatment of foot ailments, infections, and other medical conditions of the foot, ankle, or nails associated with Diabetes, if prescribed by a **physician**.

Reasonable and Customary

The charge which is the smallest of:

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

Reasonable Charge

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

- The provider's usual charge for furnishing it, and
- The charge Aetna determines to be appropriate, based on factors such as the cost of providing the same or a

- similar service or supply and the manner in which charges for the service or supply are made, and
- The charge Aetna determines to be the prevailing charge level made for it in the geographic area where it is furnished.

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

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

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

Aetna may take into account factors, such as:

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

Recognized Charge

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

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

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

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

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

Aetna may take into account factors, such as:

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

Residential Treatment Facility

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

Respite Care

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

Room and Board

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

Routine Screening for Sexually Transmitted Disease

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

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

School Health Services

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

Semi-Private Rate

The charge for **room and board** which an institution applies to the most beds in its semi-private rooms with two 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 R.N.'s,
- a capacity of six or more beds,
- a daily medical records for each patient, and
- a **physician** available at all times.

Sound Natural Teeth

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

Surgery Center

A free standing ambulatory surgical facility that:

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

- Has at least two 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 Expenses

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 **two 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 **eight 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

HOW TO FILE A CLAIM

In the event of an accident or sickness, the student should report to the University Health Service or a qualified provider or hospital health care provider to secure treatment. As described in the Preferred Provider Network section of the Brochure, it is to your advantage to utilize participating Preferred Providers because of the savings for services and reduced out-of-pocket expenses.

Most providers of service will file a claim for you. In the event your provider of service does not file a claim on your behalf, it is your responsibility to initiate a claim in order to obtain reimbursement.

Please send all itemized medical bills within **90 days** after treatment is rendered to Aetna Student Health. Your name, eight-digit UMID number, name of the country where treatment was provided (if not in the U.S.), and University of Michigan International Plan should be written clearly and attached to your medical bills.

All information should be mailed to:

Aetna Student Health

P.O. Box 15708

Boston, MA 02215-0014

(800) 239-9697

(617) 218-8400 (outside the United States)

Subsequent itemized medical bills should also be mailed promptly to the above address. Payment for covered expenses will be made directly to the hospital or physician unless you submit paid receipts attached to the itemized bills.

For assistance in filing a claim, or inquiring about the status of a claim, please contact the Customer Service Department at Aetna Student Health directly at **(800) 239-9697** between the hours of 8:30 a.m. and 8:30 p.m. Eastern Standard Time, Monday through Friday.

General coverage questions and claims questions should also be directed to the Customer Service Department at Aetna Student Health at **(800) 239-9697**.

You will receive an "Explanation of Benefits" form after your claims are processed. The Explanation of Benefits will explain how your claim was processed according to the benefits of your Student Health Insurance Plan. If you have any questions regarding the Explanation of Benefits, please contact the Customer Service Department at Aetna Student Health at **(800) 239-9697**.

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

GRIEVANCE AND APPEALS

Aetna has established a procedure for resolving grievances and appeals by **Covered Persons**. If a **Covered Person's** claim is denied in whole or in part, the **Covered Person** will receive a written notice of the denial from Aetna. The notice will explain the reason for the denial, and the procedures to follow for filing a grievance or appeal. To file a grievance or appeal, the **Covered Person**, or health care provider on behalf of the **Covered Person**, may request a review of any coverage decision by contacting:

Aetna Student Health

P.O. Box 15717

Boston, MA 02215-0014

If, after exhausting the internal appeals procedures, the **Covered Person**, the **Covered Person's** physician, or the hospital is still dissatisfied with Aetna's response, the **Covered Person** may be eligible to file a request for an External Review with the Michigan Insurance Commissioner.

Information about filing a request for an External Review may be obtained by contacting:

Michigan Insurance Commissioner
(877) 999-6442

When filing a request for an External Review, the **Covered Person** will be required to authorize the release of any medical records that may be required to be reviewed for the purpose of reaching a decision on the External Review.

PRESCRIPTION DRUG CLAIM PROCEDURE

PREFERRED CARE

When obtaining a covered prescription, please present your Aetna ID card to an Aetna Preferred Pharmacy along with your applicable coinsurance. The pharmacy will submit a claim to Aetna for the drug.

When you need to fill a prescription and do not have your ID card with you, you may obtain your prescription from an Aetna Preferred Pharmacy and be reimbursed by submitting a completed Aetna Prescription Drug claim form. A claim form is available at by calling Aetna Pharmacy Management at **(800) 238-6279**. You will be reimbursed for covered medications directly by Aetna. Please note, in addition to your coinsurance, 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 the pharmacy had billed Aetna directly. Information regarding Preferred Care pharmacy locations is available by accessing the Internet at www.aetna.com/docfind.

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 Reasonable Charge allowance, less any applicable coinsurance, directly by Aetna. You will be responsible for any amount in excess of the Reasonable 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 attend The University of Michigan and include your name, address, and student identification number.

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 \$10,000.

NOTE: For most school plans, ADD benefits are provided by Aetna Life Insurance Company (ALIC). However, in some states, ADD benefits may be provided through a contractual relationship between Chickering Claims Administrators, Inc. (CCA) and On Call International (On Call). ADD coverage provided through On Call is underwritten by United States Fire Insurance Company (USFIC). Please refer to your school's policy to determine whether ALIC or USFIC underwrites ADD benefits for your specific Plan. Should you have questions or need to file a claim please contact (800) 239-9697.

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 (or crossing an international border), anywhere in the world:

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

WORLDWIDE EMERGENCY TRAVEL ASSISTANCE (WETA) SERVICES

On Call provides the following travel assistance services:

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

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

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

Supplemental repatriation and medical evacuation insurance is available for purchase by the International Students and Scholars who have prior qualifying coverage for medical care as outlined in this Brochure and require only coverage for the medical evacuation and repatriation benefits. Coverage may be purchased for the student/scholar or for the student/scholar and all dependents. The cost of this stand-alone medical evacuation and repatriation coverage is \$30 per Policy Year per insured and cannot be pro-rated.

AETNA NAVIGATOR®

GOT QUESTIONS? GET ANSWERS WITH AETNA'S NAVIGATOR®

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

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

HOW DO I REGISTER?

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

NEED HELP WITH REGISTERING ONTO AETNA NAVIGATOR?

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

UNIVERSITY OF MICHIGAN NON-DISCRIMINATION POLICY NOTICE

The University of Michigan, as an equal opportunity/affirmative action employer, complies with all applicable Federal and State Laws regarding non-discrimination and affirmative action, including Title IX of the Education Amendments of 1972 and Section 504 of the Rehabilitation Act of 1973. The University of Michigan is committed to a Policy of nondiscrimination and equal opportunity for all persons regardless of race, sex, color, religion, creed, national origin or ancestry, age, marital status, sexual orientation, gender identity, gender expression, disability, or Vietnam-era veteran status in employment, educational programs and activities, and admissions. Inquiries or

complaints may be addressed to the Senior Director for Institutional Equity and Title IX/Section 504 Coordinator, Office of Institutional Equity, 2072 Administrative Services Building, Ann Arbor, Michigan 48109-1432, (734) 763-0235, TTY (734) 647-1388. For other University of Michigan information call (734) 764-1817.

NOTICE

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

Administered by:

Aetna Student Health
P.O. Box 15708
Boston, MA 02215-0014
(800) 239-9697
www.aetnastudenthealth.com

Underwritten by:

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

Policy No. **711146**

The University of Michigan International Student Health Insurance Plan is underwritten by Aetna Life Insurance Company (ALIC) and administered by Chickering Claims Administrators, Inc. Aetna Student HealthSM is the brand name for products and services provided by these companies and their applicable affiliated companies.

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