2013 - 2014

THE NEW SCHOOL

Student Accident and Sickness Insurance Plan Brochure

Your student health insurance coverage, offered by Aetna Student Health*, may not meet the minimum standards required by the health care reform law for the restrictions on annual dollar limits. The annual dollar limits ensure that consumers have sufficient access to medical benefits throughout the annual term of the policy. Restrictions for annual dollar limits for group and individual health insurance coverage are $2 million for policy years beginning on or after September 23, 2012, but before January 1, 2014. Restrictions for annual dollar limits for student health insurance coverage are $500,000 for policy years beginning on or after September 23, 2012, but before January 1, 2014. Your student health insurance coverage includes an annual limit of $500,000 per condition on all covered services including Essential Health Benefits. Other internal maximums (on Essential Health Benefits and certain other services) are described more fully in the benefits chart included inside this Plan summary. If you have any questions or concerns about this notice, contact (800) 878-1927. Be advised that you may be eligible for coverage under a group health plan of a parent's employer or under a parent's individual health insurance policy if you are under the age of 26. Contact the plan administrator of the parent's employer plan or the parent's individual health insurance issuer for more information.

*** Fully insured Aetna Student Health Insurance Plans are underwritten by Aetna Life Insurance Company (Aetna) and administered by Chickering Claims Administrators, Inc. Aetna Student Health is the brand name for products and services provided by these companies and their applicable affiliated companies.**

Presented by:
University Health Plans, Inc.

Underwritten by:
Aetna Life Insurance Company (ALIC)

Administered by:
Aetna Student Health
Policy No. 812804

aetna®

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Dear New School Student and Family,

In order to encourage an environment where students actively seek to engage in activities that promote health and well-being, The New School offers on-campus Student Health Services, an Immunization Program, and a Student Health Insurance Plan.

Student Health Services
Student Health Services includes Medical and Counseling Services. Medical Services offers primary care to students who are ill, injured, or need routine care and preventive care services. Counseling Services offers short-term psychotherapy, psychiatric consultation, and referrals for specialized treatment needs. All services are offered by licensed professionals and are strictly confidential.

Immunizations
New York State law requires certain categories of students to provide documentation of immunizations for measles, mumps, and rubella (MMR), as well as a response to receipt of information on Meningococcal Disease (Meningitis) and vaccine by the student. Student Health Services schedules immunization clinics for students who have been unable to obtain MMR immunizations elsewhere. Meningitis information and the Immunization Form are available at Student Health Services or by accessing **www.newschool.edu/student-services/health-services/** (click on Immunization Form). Please contact Student Health Services at **SHS@newschool.edu** or call us at **(212) 229-1671**, option 5 for information on services and immunizations.

Student Health Insurance Plans
The Student Health Insurance Plan includes Plan 1 –The Student Health Services and Basic Accident Plan, and Plan 2 – The New School Accident and Sickness Plan. Any questions about Plan 1 and Plan 2 may be addressed to our health insurance administrator, University Health Plans, Inc. at **(800) 437-6448**.

All degree, diploma, online only, visiting, mobility (study abroad), Lang and Parsons consortium, graduate certificate program, ESL + Design program, ESL + Music program and both graduate and undergraduate degree program non-matriculating students are **automatically charged** a Student Health Services Fee and a Health Insurance Fee to cover the costs of the services indicated above.

The Student Health Services Fee (**$305** per semester) enables students to use Student Health Services. Plan 1 coverage is automatically provided for those who pay the Student Health Services Fee. The New School Accident and Sickness Plan Insurance Fee - Plan 2 (**$2,602**/year with **$1,055** charged in the fall and **$1,547** charged in the spring), enables students to use services outside Student Health Services. Depending on course load and status, you may be eligible to decline these services by completing an Online Waiver Form by the posted Waiver Deadline Date. Students wishing to waive may do so online at **www.universityhealthplans.com**.

Please read this Brochure carefully. It describes services, insurance coverage and limitations, waiver process, and important deadlines. It is your responsibility to understand the nature and scope of benefits and limitations as well as to abide by posted deadlines. A complete description of the benefits and full terms and conditions can be found in the Master Policy. If any discrepancy exists between this Brochure and the Policy, the Master Policy will govern and control the payment of benefits. A copy of the Master Policy can be found at The New School Student Health Services and can be seen during regular business hours.

Health care is expensive. If you plan to waive participation in the Student Health Insurance Plan, be sure your plan covers care in New York City. We strongly encourage you to consider remaining enrolled in the Student Health Insurance Plan as it offers comprehensive coverage for students.

We wish you a healthy and successful year at The New School!

Sincerely,

Tracy Robin
Tracy Robin
Assistant Vice President for Student Health and Support Services

WHERE TO FIND HELP

For Questions About:
- Enrollment Process
- Waiver Process

Please contact:
University Health Plans, Inc.
One Batterymarch Park
Quincy, MA 02169
(800) 437-6448 or visit www.universityhealthplans.com
Email address: **info@univhealthplans.com**

For Questions About:
- Insurance Benefits
- Claims Processing
- Inpatient Admission Pre-Certification
- ID Cards (including lost ID cards)

Please contact:
Aetna Student Health
P.O. Box 981106
El Paso, TX 79998
(800) 878-1927 or visit **www.aetnastudenthealth.com**
Email address: **studenthelp@aetna.com**

Got Questions? Get Answers with Aetna 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 email to Aetna Student Health Customer Service at your convenience.
- View the latest health information and news, and more!

How do I register?
- Go to **www.aetnastudenthealth.com**
- Click on Aetna Navigator
- Follow the instructions for First Time User by clicking on the "Register Now" link.
- Select a user name, password and security phrase.

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

Need help with registering onto Aetna Navigator?
Registration assistance is available toll-free, Monday through Friday, from 7 a.m. to 9 p.m. Eastern Standard Time, at **(800) 225-3375**.

For Questions About ID Cards:
Enrollees in Plan 2 – The New School Student Accident and Sickness Plan, will be issued a permanent ID card as soon as possible. Please note that ID cards will be issued only to participants in Plan 2. (No ID card will be issued for Plan 1 – Student Health Services and Basic Accident Plan.) This card is for identification only. It is not a guarantee of eligibility or benefits. If you need medical attention before your permanent 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. Prior to receiving your ID card, present the provider's office with Aetna Student Health's Customer Service number and claims address. Once you have received your ID card, present it to the provider to facilitate prompt payment of your claims. You may also print a temporary ID card from Aetna Navigator to use until your permanent card arrives.

Note: Please be advised you will receive a unique Aetna member ID number on your membership card.

For lost ID cards, contact:
Aetna Student Health
(800) 878-1927 or visit **www.aetnastudenthealth.com**
Email address: **studenthelp@aetna.com**

For Questions About:
- Status of Pharmacy Claim
- Pharmacy Claim Forms
- Excluded Drugs and Pre-Authorization

Please contact:
Aetna Pharmacy Management
(888) RX-AETNA or (888) 792-3862 (Available 24 Hours)

For Provider Listings (including Preferred Care Pharmacy locations):
Refer to the list kept at The New School Student Health Services, or visit **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.

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

IMPORTANT NOTE
Please keep this Brochure, as it provides a general summary of your coverage. A complete description of the benefits and full terms and conditions may be found in the Master Policy issued to The New School. If any discrepancy exists between this Brochure and the Policy, the Master Policy will govern and control the payment of benefits. The Master Policy may be viewed at the University's Student Health Insurance Office during business hours.

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

THE NEW SCHOOL STUDENT HEALTH SERVICES

The Student Health Services staff consists of Licensed Nurses, Physicians, Physician Assistants, Nurse Practitioners, Psychologists, Psychiatrists, Psychological Counselors, and Clinical Social Workers. This professional staff has experience and special interest in working with college students.

Student Health Services is open weekdays throughout the academic year, except for university holidays. Evening and weekend hours may be available. Summer hours are posted. Appointments are made as follows:

- A student should call in advance to make an appointment. The student will be scheduled for the next available time slot. If the student has an acute problem, they will be connected to a clinician who can assess the problem and make an appropriate appointment.
- Call 24 hours ahead to cancel an appointment. A student who is late may not be able to be seen the same day.
- A student in crisis is encouraged to walk-in and see a clinician.
- A student who is acutely ill, injured, or distressed should try to call ahead so arrangements can be made to be seen by an appropriate clinician, or an appropriate referral can be made to the nearest hospital emergency room. (It should be noted that a referral is not needed for treatment of an **Emergency Medical Condition** as defined in this Brochure.)

In addition to the Student Health Services Fee, there are nominal fees for vaccinations. These fees are billed directly to the student's university account.

In **emergency** situations, students should call **911** to be transported directly to the nearest emergency room.

Your health care is your business. Your right to privacy is protected by law and by the ethical standards of Student Health Services. Consultations and medical records are strictly confidential. No one other than the staff at Student Health Services may be given information without your prior written consent (except where required, by law, and/or in a life-threatening situation). This includes friends, relatives, parents, faculty, administration, and outside agencies.

If you wish to release your medical or counseling records to another health care provider, you should submit a written request to Student Health Services. Release forms are available.

STUDENT HEALTH FEES

The Student Health Services Fee (**$305** per semester) enables students to use Medical and Counseling Services at Student Health Services. The Student Health Insurance Fee enables students to use services outside Student Health Services. The **2013-2014** Student Health Insurance Fee is **$2,602**. You will be charged **$1,055** in the Fall Semester and **$1,547** in the Spring Semester.

All degree, diploma, online only, visiting, mobility (study abroad), Lang and Parsons consortium, graduate certificate program, ESL + Design and ESL + Music program, and both graduate and undergraduate degree program non-matriculating students are **automatically charged** the Student Health Services Fee and the Student Health Insurance Fee.

Undergraduate students who are registered for six (6) or more credits are required to pay the Student Health Services Fee at the time of registration, regardless of their place of study (e.g., online only, study abroad, etc.).

Undergraduate students who are registered for six (6) or more credits may waive participation in the Student Health Insurance Plan by demonstrating that they already have comparable health insurance.

Undergraduate students who are registered for five (5) or less credits and all Graduate students may waive participation in both Student Health Services and the Student Health Insurance Plan without demonstrating comparable health insurance.

Students who waive the Student Health Services Fee will not have access to Student Health Services.

All students who elect to pay the Student Health Insurance Fee will be required to also pay the Student Health Services Fee. Students can view their account by accessing MyNewSchool Online Services: **https://my.newschool.edu**.

WAIVER PROCESS

Students who meet the eligibility criteria, but do not want to remain enrolled in the student Plans, must submit an online waiver.

- Log on to **www.universityhealthplans.com**.
- Select "The New School" from the list of schools.
- Select "Waiver Form" from the left MENU.
- Simply follow the prompts on the screen by providing all information requested. You will receive a confirmation that your waiver form was successfully completed. A completed Online Waiver Form must be submitted by the posted Waiver Deadline Date.

Waiver Deadlines	
Fall Semester	**September 24, 2013**
Spring Semester	**February 24, 2014**

Take special note of the following:

- It is your responsibility to verify that the appropriate credit appears on your MyNewSchool online account. Any inappropriate charges must be reported before the semester Waiver Deadline.
- If you do not submit the Online Waiver Form by the semester Waiver Deadline, you will be required to pay the Student Health Insurance and Student Health Services Fees, even if you have health insurance coverage.
- Students who miss the Fall Semester Waiver Deadline and have paid the Fall Semester premium may elect to waive the remaining Spring Semester premium ONLY if the Plan is not used during the Fall Semester and proof of personal insurance is provided. Because this is an annual Plan and partial coverage is not an option, if the student or any health care provider on behalf of the student submits a claim to Aetna Student Health, or Aetna Pharmacy Management, the student is obligated to continue participation in the Plan and will be charged the remaining premium.
- You must submit a new Online Waiver Form each Fall Semester. Those who do not register in the Fall Semester must submit an Online Waiver Form in the Spring Semester, and then again the following Fall Semester.
- If you submit an Online Waiver Form in the Fall Semester, you will be automatically waived for the Spring Semester.
- If you withdraw or take a leave of absence before the semester Waiver Deadline, the Student Health Insurance Fee paid by you will be refunded in full as long as no claim against the plan has been paid.
- If you are taking a leave of absence for health reasons before the semester Waiver Deadline, you may opt to remain covered in the Student Health Insurance Plan for the remainder of that semester only by notifying Student Health Services immediately at **(212) 229-1671, option 3 or shs@newschool.edu**.
- If you withdraw or take a leave of absence after the semester Waiver Deadline, you will remain covered in the Student Health Insurance Plan for the remainder of that semester only. Absolutely no refunds will be made for Student Health Insurance or Student Health Services Fees after the semester Waiver Deadline.

Under certain circumstances, students may appeal the Waiver Deadline. Students should contact University Health Plans, Inc., at **(800) 437-6448**. The deadline to submit a formal appeal is:

Waiver Appeal Deadlines	
Fall Semester	**November 5, 2013**
Spring Semester	**April 7, 2014**

MEDICAL SERVICES

Eligibility

All students who have paid the **$305** per semester Student Health Services Fee are able to access care at no additional charge. However, insurance may be used to cover the costs of diagnostic tests, x-rays, lab tests and other outside services. In those instances, deductibles and copayments may apply.

Medical Consultation and Treatment

Medical Services provides primary care for students, including diagnosis and treatment of illnesses and injuries. When a consultation with a specialist is needed, referrals are made to appropriate physicians. Our medical service providers will follow up with the student as well as the specialists, hospitals and other agencies to ensure proper communication and continuity of care.

Routine and Preventive Health Care Services

Preventing an illness is preferable to treating one. To this end, Student Health Services offers certain routine preventive care services, these include: physical examinations, women's health care, travel health, LGBTQI GNC healthcare, immunizations, cholesterol screening, blood pressure monitoring, tuberculosis skin testing (PPD), vision screening, nutritional guidance, smoking cessation, and dental referrals.

Nutrition

Through Medical Services, students can schedule nutrition appointments with a registered dietician or dietary intern, for general nutritional counseling or to discuss a particular nutritional concern.

Women's Health

Gynecological examinations and treatment including routine care, reproductive health counseling, and diagnosis of disease are available. Pap smears and other laboratory tests may be performed.

Birth Control

Condoms are available in our waiting area and upon request. After reproductive health counseling, prescriptions can be written for other contraceptive methods, including birth control pills, to be filled at an outside pharmacy. Emergency contraception (Plan B) is also available at no cost, with no appointment needed.

Safer Sex and Sexuality Counseling

Both medical, counseling, and health promotion staff are available to help students with any questions or concerns, including questions or concerns about sexually transmitted infections (Chlamydia, Herpes, Syphilis, HPV, etc.), sexual functioning, social and emotional issues, and birth control. In addition, therapists are available to speak with students who are concerned about sexual relationships, gender issues or body image.

Lesbian, Gay, Bisexual, Transgender, Queer, Intersex or Gender Non Conforming (LGBTQIGNC)

Students who identify as LGBTQI GNC may have health questions and concerns specific to their sexual orientation, sexual identity or gender identity that they want to bring up with their medical provider. Staff welcome any health concerns or questions, and strives to create an inclusive and responsive health and wellness service for all students.

Student Health Services coordinates the Safe Zone program, a voluntary network of New School community members that includes LGBTQI GNC advocates and straight allies.

Travel Health

Our medical staff is prepared to provide you with the latest health information and immunization services for travel. If we do not have the vaccines available, our staff will refer you to a local health center that has the immunizations required for travel. The earlier you prepare for your trip abroad, the better. Please contact Student Health Services as soon as you know that you are traveling to determine your travel health needs. We advise you to schedule an appointment 4-6 weeks in advance of your trip if possible. If you are planning a long trip, i.e. Study Abroad, 8-12 weeks in advance is advisable. Please check with your insurance carrier regarding coverage. Also, bring records of prior immunizations with you to your appointment if possible. Additional information about how to stay healthy while you are traveling can be obtained at the Center for Disease Control (CDC) Travel Health Site at **www.cdc.gov/travel**.

Immunizations
As part of our focus on prevention we offer vaccinations on site. The following immunizations are commonly available: Hepatitis A, Hepatitis B, Meningitis, Measles-Mumps-Rubella (MMR), Tetanus, and HPV. Flu shots are available in the fall/winter season. The costs of vaccines are charged to your student account. Please call ahead to make an appointment and to ensure the vaccine is available at that time, or to discuss any questions you may have about immunizations. Additional information about immunizations can be obtained at the Center for Disease Control (CDC) at **www.cdc.gov/vaccines/spec-grps/college.htm**.

Laboratory Tests
Some routine laboratory tests are performed on site at no cost to you. Other tests are sent to an outside laboratory that will bill you or your health insurance provider.

HIV/AIDS Testing
HIV testing is provided in Medical Services by appointment. If testing is performed by Medical Services, insurance copayments and deductibles may apply.

Free, confidential HIV testing is also offered at Student Health Services through a partnership with the Lower East Side Harm Reduction Center. Please call ahead to confirm testing days and times at **212-229-1671**, option 1.

Medication and Prescriptions
Certain medications can be dispensed by our staff following consultation. If you need to renew a prescription or a new prescription is written, you will need to use your insurance coverage or pay at an outside pharmacy.

Referrals
Any concerns or issues can be discussed with the medical staff. Although the vast majority of concerns can be managed at Medical Services, in some instances a referral is needed. If you are provided a referral your Medical Services provider will communicate with the specialist to ensure continuity of care.

Wellness and Health Promotion
There are a variety of health related workshops, training and outreach programs offered throughout the year by the health promotion staff. Examples include individual counseling in sex and body positivity, nutrition, and time management, as well as group processes like meditation, auricular acupuncture and acupressure, and alcohol and other drugs harm reduction programming.

Peer Health Advocates are an integral part of the Wellness and Health Promotion team. Peer Health Advocates are students trained in health education, communication skills, and program facilitation to support and implement the services provided by the program.

After Hours Nurse Advice Line
There is a Nurse Response services available to students whenever Student Health Services is closed. Experienced nurses will provide you with medical guidance, health information, decision-making assistance, and referrals.

COUNSELING SERVICES

Short Term Therapy
Counseling offers the opportunity to talk to someone who will listen in a supportive and non-judgmental manner. Counselors will help you clarify issues, explore feelings and discuss problem solving strategies. We offer short-term individual treatment (a maximum of 12 sessions per academic year) but the duration of the treatment is decided on an individual basis. During the initial visit, you and the counselor will decide on a treatment plan. Sometimes long term or specialized treatment is indicated and your counselor will help you find appropriate referrals in the community.

Crisis Intervention
Students in crisis will be seen regardless of session limit. Walk-in hours are Monday through Friday, 1:45pm-2:45pm.

Psychiatric Services
The psychiatrist and psychiatric nurse practitioner are available to students who are being seen for short term counseling. Psychiatric services include: psychiatric consultation, evaluation, and medication treatment.

Creative Arts Therapy
Art therapy is offered on an individual, group and community basis. Student can have up to 12 art therapy sessions in which they can use a combination of talk therapy and the creative process to transform feelings and thoughts into tangible objects to be reflected upon as a way to gain insight, heal and self-expression. Individual art therapy can be done on an adjunctive basis by referral from student's primary counselor. Art therapy is also offered in the form of an elective 8-week closed art therapy group focused on gaining self-knowledge through artistic expression. Additionally weekly drop-in Open Art Therapy Studios are offered on Friday afternoons throughout the year. These are open to all New School community members as unstructured time to make personal artworks for stress relief and self-expression. Throughout the year there are other opportunities to participate in art therapy around campus during events or in residence halls.

Group Therapy
Counseling Services offers a variety of groups during the academic year. Some target specific issues or themes; others are general psychotherapy groups. The kinds of groups offered depend on student interest and the interests and specialties of the staff.

Biofeedback
Biofeedback is about understanding the messages are body is sending us. A biofeedback training session is 30-minute process, where an ear sensor picks up your pulse, autonomic nervous system response, and heart rate variability data. The training is guided on a computer screen, handheld device, where you learn exactly how your mind and body can relax together.

Meditation and Stress Reduction
Guided meditation can help you cultivate happiness, relax, gain greater awareness, and support your creativity and academic performance. A weekly guided mindfulness meditation is offered; come once, come twice, come every week — no commitment is required.

Low Fee Psychological and Educational Testing
Psychological and educational testing consists of the administration of several tests widely used in the field of psychology. Its purpose is to understand more about your cognitive functioning (such as memory, information processing and problem solving ability) as well as clarify emotional and personality issues that may interfere with your ability to reach your full potential as a student.

BASICS
BASICS is a two-session brief alcohol screening and intervention for college students. The program is for those who want to learn more about how their alcohol and substance use may be impacting them. BASICS counselors work from a harm reduction model, which means you will not be forced to stop drinking or using substances. Our philosophy holds that any change in the direction of healthier living in positive and worthwhile.

Safe Zone Program
The aim of the New School Safe Zone program is to assemble a voluntary network of faculty, staff, and student allies and advocates to LGBTQIGNC people to increase safety and create a more supportive campus environment for the lesbian, gay, bisexual, transgender, queer/questioning, intersex, and gender nonconforming (LGBTQIGNC) community at The New School. Any time you see a Safe Zone sticker or card posted in an office or work area, it represents a safe place to approach, ask questions, and find resources. Students, staff and faculty can train to become Safe Zone allies or LGBTQIGNC advocates.

THE NEW SCHOOL MMR IMMUNIZATION INFORMATION

Due to past outbreaks of mumps, rubella, and especially measles on college campuses, New York State Law requires students to provide the university with documentation of their immunizations. These highly contagious diseases can cause severe health problems.

The MMR vaccine provides protection against measles, mumps, and rubella in one dose. It is advisable to have the MMR for both measles vaccines to enhance protection against all three vaccine-preventable diseases. Students who are unsure whether or not they have been previously vaccinated will not be harmed by repeating the MMR.

Any degree-seeking student enrolled for six (6) or more credits and born on or after January 1, 1957, must submit documentation in English. Proof of immunization against measles, mumps, and rubella may be supplied in one of the following ways:

- A record of vaccination on or after the first birthday, with live virus vaccine, including one dose for mumps, one dose for rubella, and two doses for measles. The dates of the live mumps and rubella vaccines must be 1969 or later. Both measles vaccines must be given in 1968 or later, with the first measles vaccine given on or after the first birthday. The second measles vaccine must be given on or at least 30 days later than the first.
- For measles or mumps, a record of medically diagnosed disease from a Physician or health care provider that specifies dates of disease. Any record of measles or mumps disease will satisfy the requirement for that one disease. For rubella, a record of medically diagnosed disease is not sufficient to prove immunity. The only acceptable proofs of immunity to rubella are either a blood test as described below, or a vaccination given on or after the first birthday.
- A report of the positive antibody results and dates of titers to one or more of the diseases. (A titer is a laboratory test of an antibody performed on blood.)

For students who attended elementary or secondary school in the United States, documentation of such attendance may suffice as proof of receiving one dose of live measles virus vaccine. In addition to proof of such school attendance, proof of an additional recent measles, mumps, and rubella immunization or proof of disease or titers for each of the three diseases must be supplied.

Be sure to keep immunization documentation in a safe place. Never hand in the original document. Keep it for future school admissions and travel. Make copies to give out to others, if necessary. Submit immunization documentation as soon as possible to Student Health Services via email to **shs@newschool.edu** or fax to **212-614-7484**. Documentation should be completed by a Physician or health care provider.

Students may obtain the required immunizations from a medical provider. For a list of immunization walk-in clinics in New York City, visit **www.nyc.gov/html/doh/html/living/immun-clinics.shtm/**. During the fall and spring registration periods, Immunization Clinics will be scheduled at convenient times and places to provide required measles, mumps, and rubella immunizations to students who have been unable to obtain them elsewhere. There is a nominal fee for these immunizations. The fee will be billed to your student account.

International students should be advised that their country of citizenship may not require the same immunizations as mandated by New York State. Students must, however, comply with the New York State requirement in order to register for classes. Documentation must be submitted in English. Student Health Services staff cannot make translations nor accept verbal translations. International students will most likely be receiving their immunizations in their home countries. If a student is unable to do this, the first shot should be obtained immediately upon arrival in the United States.

THE NEW SCHOOL MENINGOCOCCAL DISEASE (MENINGITIS) INFORMATION

Effective August 15, 2003, New York State Public Health Law requires institutions, including colleges and universities, to distribute information about Meningococcal Disease and vaccination to all students meeting the enrollment criteria, whether they live on or off campus.

Students are not required to have the vaccination; however, all degree-seeking students enrolled for six (6) or more credits must submit an Immunization Form to The New School Student Health Services indicating receipt of information on Meningococcal Disease and vaccine. Information and Immunization Forms are available from Student Health Services or by accessing www.newschool.edu/student-services/healthservices.

After carefully reviewing the information offered by The New School, and if you are considering having the vaccination, your personal physician is a good source of information on Meningococcal Disease, and is an individual who can give you the vaccine. The New School Student Health Services will be able to administer the vaccine after the start of the Semester, as supply allows. There will be a nominal charge for the vaccine which is billed to your student account.

THE NEW SCHOOL BASIC ACCIDENT AND STUDENT ACCIDENT AND SICKNESS HEALTH INSURANCE PLANS

The New School Plan 1 – Student Health Services and Basic Accident Plan, and **Plan 2 – the New School Student Accident and Sickness Plan** have been developed especially for New School students. The Plans provide coverage for Illnesses and Injuries that occur on and off campus, and include special cost-saving features to keep the coverage as affordable as possible. The New School is pleased to offer the Plans as described in this Brochure.

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. If any discrepancy exists between this Brochure and the Policy, the Master Policy will govern and control the payment of benefits. A copy of the Master Policy can be found at the New School and can be seen during normal business hours.

POLICY PERIOD

Coverage for all insured students enrolled for the Fall Semester will become effective at **12:01 a.m. on August 20, 2013**, and will terminate at **11:59 p.m. on August 19, 2014**. Coverage for all newly-enrolled insured students for the Spring Semester will become effective at **12:01 a.m. on January 15, 2014,** and will terminate at **11:59 p.m. on August 19, 2014**.

PREMIUM RATES (BILLED BY SEMESTER)

Please note, if you are not enrolled for the Spring Semester, coverage will end at midnight on **January 14, 2014**.

Student	**Annual* 8/20/13-8/19/14**	**Spring 1/15/14-8/19/14**
Plan 1 – Student Health Services and Basic Accident Plan	Included in Per Semester Student Health Services Fee	Included in Per Semester Student Health Services Fee
Plan 2 – The New School Student Accident and Sickness Plan	**$2,602**	**$1,547**

** Student Fall Installment is **$1,055***

STUDENT COVERAGE

Your method of enrollment in these Plans will depend on your course load and class status as follows:

PLEASE NOTE*: All degree, diploma, online only, visiting, mobility (study abroad), Lang and Parsons consortium, graduate certificate program, and both graduate and undergraduate degree program non-matriculating students are* ***automatically charged*** *for health insurance.*

Enrollment Class	Description	Plan 1	Plan 2*
Compulsory Students	All undergraduate students taking six (6) or more credit hours, including ESL + Design and ESL + Music.	Student Health Services per semester charge (**$305**) is mandatory and cannot be declined.	**$2,602** Annual Charge may be waived by submitting proof of other coverage with a completed Online Waiver Form submitted by the Waiver Deadline Date.
Optional Students	All undergraduate students who are taking five (5) or less credits and all graduate students.	Student Health Services per semester charge (**$305**) may be declined by submitting a completed Online Waiver Form by the Waiver Deadline Date.	**$2,602** Annual Charge may be declined by submitting a completed Online Waiver Form by the Waiver Deadline Date.

** Note that you must be covered under Plan 1 in order to purchase Plan 2.*

ELIGIBILITY

Plan 1 – Student Health Services and Basic Accident Plan
Students who pay the Student Health Services Fee will have access to Student Health Services (SHS) and will be covered by Plan 1 – Basic Accident Plan. Coverage begins at **12:01 a.m. on August 20, 2013,** and continues until **11:59 p.m. on August 19, 2014**. Coverage under Plan 1 ends at **11:59 p.m. on January 14, 2014,** for students not returning for the Spring Semester.

Plan 2 – The New School Student Accident and Sickness Plan
Students who pay the Student Health Insurance Fee will be covered by Plan 2 – Student Accident and Sickness Plan (**$2**,**602** Annual, to be billed in two installments; **$1,055** for Fall Semester and **$1,547** for Spring Semester). Coverage begins at **12:01 a.m. on August 20, 2013,** and continues until **11:59 p.m. on August 19, 2014**.

ELIGIBILITY AND HOW TO WAIVE

Compulsory Students: All degree, diploma online only, visiting, mobility (study abroad), Lang and Parsons consortium, graduate certificate program, ESL + Design, ESL + Music, and both graduate and undergraduate degree program non-matriculating students are **automatically charged** the Student Health Services Fee and the Student Health Insurance Fee. Undergraduate students who are registered for six (6) or more credits, including ESL + Design and ESL + Music, are required to pay the Student Health Services Fee regardless of their place of study (e.g., online only, study abroad, etc.). Any undergraduate student may waive participation in the Student Health Insurance Plan 2 by demonstrating that they already have comparable health insurance.

Compulsory Students who have comparable coverage under other insurance may waive participation in Plan 2 by waiving online. In order to have the Student Health Insurance Fee for Plan 2 removed from your MyNewSchool online account, you must submit an Online Waiver Form by the posted Waiver Deadline Date.

Optional Students: Undergraduate students who are registered for five (5) or less credits and all graduate students may waive participation in both Plan 1 and Plan 2. However, if you participate in Plan 2, you will be required to participate in Plan 1. In order to have the fee(s) waived from your MyNewSchool online account, you must submit an Online Waiver Form by the posted Waiver Deadline Date.

Late Enrollment: Under certain circumstances, coverage for late enrollees may be possible. For the Fall Semester, any enrollment occurring after **September 24, 2013,** is considered a late enrollment. For the Spring Semester, any enrollment occurring after **February 24, 2014,** is considered a late enrollment. Contact University Health Plans, Inc., at **(800) 437-6448** for late enrollment. If the student experiences a significant life change that directly affects his or her insurance coverage, the deadline to enroll is **30** days after the significant life changing event. A life changing event may include a loss of coverage from a prior plan, marriage, divorce, and other reasons beyond a person's control. Coverage for dependents will begin on **August 20, 2013**, if they are enrolled prior to the **September 24, 2013** deadline.

ENROLLMENT UPDATE PERIODS

IMPORTANT NOTICE: **Students may experience a slight disruption in use of their insurance coverage at the beginning of each semester**. This disruption occurs because enrollment updates are done at the beginning of every semester. This is the period when the university notifies the Insurance Company of all students enrolled in the Student Health Insurance Plan. While we understand this interruption may be unpleasant for some students, semester updates are extremely important for many reasons. The most important reason is to ensure only eligible students remain enrolled from semester to semester. Only students who are enrolled in and registered for classes are eligible to be enrolled in The New School Student Health Insurance Plan. During these update periods, all students' coverage will appear as "terminated" within Aetna Student Health/Aetna files as of the last day of the most recent coverage period. Once the update is complete, the student status will reflect no lapse in coverage. Updates may take up to 4-6 weeks, but we assure you this process is completed as quickly and efficiently as possible.

Example: The Fall **2013** Semester period of coverage is **August 20, 2013,** through **January 14, 2014.** The Spring **2014** semester coverage period is **January 15, 2014,** through **August 19, 2014**. A student enrolled during the Fall **2013** semester will show as "terminated coverage" as of **January 14, 2014**. The student receives a prescription **January 15, 2014**. He/she attempts to fill the prescription and is told he/she no longer is covered. A couple of weeks later (this is the update period), the Insurance Company is notified by the university the student has registered for classes before the Waiver Deadline Date and is eligible for the Spring period insurance. The student's coverage is updated to reflect effective dates **August 20, 2013,** through **August 19, 2014,** and will no longer have a disruption in using his/her insurance.

There is **NO LAPSE IN COVERAGE**. Any covered medical expenses or prescriptions that would normally be paid by the Insurance Company (but paid by the student during the update period) will be reimbursed to the student once the update is completed.

Medical Care: Any covered medical expenses you incur during the update period can be submitted to Aetna Student Health for processing/payment once the update is completed. Students can submit their receipt and itemized billing statement for reimbursement, or students can request their provider (hospital, doctor, etc.) to wait 30 days before billing the Insurance Company.

Prescriptions: To have a prescription filled you must pay for it, then submit the receipt, prescription stub, and a Prescription Drug claim form for reimbursement.

Please be aware that every student enrolled in the Student Health Insurance Plan will be affected by these update periods. Students should plan ahead to make payment arrangements for services needed during these update periods.

Claim Forms/Requesting Reimbursement: Bills for Medical Services do not require a claim form, however, you should indicate on the bill that you are a New School student, and include your Student ID Number. To request reimbursement for prescriptions for which you paid, you will need to complete a Prescription Drug claim form and submit with receipt and prescription stub. Prescription Drug claim forms can be obtained at The New School Student Health Services office, or downloaded and printed from the Student Connection section of Aetna Student Health's website: **www.aetnastudenthealth.com** (Policy Number **812804**). Please note any request for reimbursement will be denied during the update period; please wait until enrollment is updated to mail your reimbursement request.

Please note that the university does not notify the Insurance Company of a student's enrollment in the Student Insurance Plan until **after** the student has registered for classes for that semester and eligibility is confirmed.

PREMIUM REFUND POLICY

Except for a leave of absence for health reasons, any student who has not incurred any claims and who withdraws from school prior to the Waiver Deadline Date **September 24, 2013,** for Fall Semester, and **February 24, 2014,** for Spring Semester) during the period for which coverage is purchased shall not be covered under the Plan and a full refund of the premium will be made. Students withdrawing after such Waiver Deadline Date will remain covered under this Plan for the full period for which the premium has been paid. No refund will be allowed.

A **Covered Person** entering the armed forces of any country will not be covered under the Policy as of the date of such entry. A pro-rata refund of premium will be made for such person 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, domestic partner, and dependent children under age 26.

Annual Coverage 08/20/13 – 08/19/14	**Spring Coverage 01/15/14 – 08/19/14**
Spouse/DP - **$6,506**	Spouse/DP - **$3,867**
Child(ren) - **$5,074**	Child(ren) - **$3,016**

ENROLLMENT

To enroll the dependent(s) of a covered student, please complete the Enrollment Application provided by University Health Plans at **www.universityhealthplans.com** or you may contact them directly at **(800) 437-6448**. The Fall enrollment deadline is **September 24, 2013** and the Spring enrollment deadline is **February 24, 2014** Dependent enrollment applications will not be accepted after these dates, unless there is a significant life change that directly affects their insurance coverage. If the student's dependent(s) experiences a significant life change that directly affects his or her insurance coverage, the deadline to enroll is **30** days after the significant life changing event. (An example of a significant life change would be loss of health coverage under another health plan.)

NEWBORN INFANT AND ADOPTED CHILD COVERAGE

A child born to a Covered Person shall be covered for 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 New School Student Health Insurance Plan. To extend coverage for a newborn past the 31 days, the Covered Student must: 1) enroll the child within 31 days of birth, and 2) pay the additional premium, starting from the date of birth.

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

For information or general questions on dependent enrollment, contact University Health Plans at **(800) 437-6448.**

PREFERRED PROVIDER NETWORK

Aetna 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 New School 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 significant savings may be achieved from the substantially lower rates these providers have agreed to accept as payment for their services.

You may also obtain information regarding Preferred Providers by contacting Aetna Student Health at **(800) 878-1927** or through the Internet by accessing DocFind at **www.aetnastudenthealth.com**.

Preferred providers are independent contractors and are neither employees nor agents of Aetna Life Insurance Company, Chickering Claims Administrators, Inc. or their affiliates. Neither Aetna Life Insurance Company, Chickering Claims Administrators, Inc. nor their affiliates provide medical care or treatment and they are not responsible for outcomes. The availability of a particular provider(s) cannot be guaranteed and network composition is subject to change.

PRE-CERTIFICATION PROGRAM

Pre-certification simply means calling Aetna Student Health prior to treatment to obtain approval for a medical procedure or service. Pre-certification may be done by you, your doctor, a hospital administrator, or one of your relatives. All requests for certification must be obtained by contacting Aetna Student Health at **(800) 878-1927** (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** benefit penalty.

The following inpatient services require pre-certification:

- All inpatient admissions, including length of stay, to a hospital, 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 and Partial Hospitalization:
The patient, Physician or hospital must telephone at least **three (3) business days** prior to the planned admission or prior to the date the services are scheduled to begin.

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

DESCRIPTION OF BENEFITS*

Please Note:

THE NEW SCHOOL 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 New School Plan Brochure carefully before deciding whether This Plan is right for you. While this document will tell you about some of the important features of the Plan, other features may be important to you and some may further limit what the Plan will pay. If you want to look at the full Plan description, which is contained in the Master Policy issued to The New School, you may view it at The New School Student Health Services or you may contact Aetna Student Health at (800) 878-1927.

This Plan will never pay more than $10,000 per Accident per lifetime for students under Plan 1 or more than $500,000 per condition per policy year for students or $500,000 per condition per policy year for dependents under Plan 2. 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.

*Benefit descriptions have been added to this brochure to help illustrate new Health Care Reform (HCR) requirements. HCR requirements are currently being filed for support in individual states and will appear in policy contracts and certificates of coverage once approved.

SUMMARY OF BENEFITS CHART

The following benefits are subject to the Policy limits and exclusions. All coverage is based on Recognized Charges unless otherwise specified. Benefits are subject to a **$100** Policy Year Deductible. This annual Deductible applies to both Plan 1 (Student Health Services and Basic Accident Plan) and Plan 2 (The New School Student Accident and Sickness Plan). The Pharmacy benefit is not subject to the deductible. This Plan always pays benefits in accordance with any applicable New York State Insurance Law(s).

Plan 1 – Student Health Services and Basic Accident Plan

Payment will be made as allocated herein for **Covered Medical Expenses** incurred for any one **Accident** while covered under the Plan, not to exceed an **Aggregate Maximum** while continuously insured of **$10,000** per condition, per lifetime. The following benefits are subject to a **$100 Policy Year Deductible**.

In addition to the Plan's **Aggregate Maximum** the **Policy** may contain benefit level maximums. Please review the Summary of Benefits section of this brochure for any additional benefit level maximums.

The payment of any **Copays**, **Deductibles**, the balance above any Coinsurance amount, and any medical expenses not covered are the responsibility of the **Covered Person**.

Covered Medical Expenses include (a) hospital room and board, (b) miscellaneous hospital expenses, (c) inpatient and outpatient surgery, (d) inpatient and outpatient Anesthesia, (e) inpatient and outpatient doctor visits, (f) consultant, (g) licensed nurse, (h) hospital outpatient department, (i) emergency room, (j) diagnostic X-ray and lab tests, (k) outpatient Prescription Drug, (l) ambulance, and (m) other expenses incurred for the treatment of an Injury.

Please note that coverage includes treatment of Injury to sound, natural teeth.

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

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

Inpatient Hospitalization Benefits	
Room and Board Expense	**Covered Medical Expenses** are payable as follows: Preferred Care: **90%** of the Negotiated Charge. Non-Preferred Care: **60%** of the Recognized Charge for a semi-private room.
Intensive Care Room and Board Expense	**Covered Medical Expenses** are payable as follows: Preferred Care: **90%** of the Negotiated Charge. Non-Preferred Care: **60%** of the Recognized Charge for the Intensive Care Room Rate for an overnight stay.
Miscellaneous Hospital Expense	**Covered Medical Expenses** include, among others, expenses incurred during a hospital confinement for: • Anesthesia and operating room; • Laboratory tests and X rays; • Oxygen tent; and • Drugs, medicines, dressings. Benefits are payable as follows: Preferred Care: **90%** of the Negotiated Charge. Non-Preferred Care: **60%** of the Recognized Charge.
Non-Surgical Physicians Expense	**Covered Medical Expenses** for charges for the non-surgical services of the attending Physician or a consulting Physician are payable as follows: Preferred Care: **90%** of the Negotiated Charge. Non-Preferred Care: **60%** of the Recognized Charge.
Surgical Expense - Inpatient	
Surgical Expense	**Covered Medical Expenses** for charges for surgical services performed by a Physician are payable as follows: Preferred Care: **90%** of the Negotiated Charge. Non-Preferred Care: **60%** of the Recognized Charge.
Anesthesia Expense	**Covered Medical Expenses** for the charges of anesthesia during a surgical procedure are payable as follows: Preferred Care: **90%** of the Negotiated Charge. Non-Preferred Care: **60%** of the Recognized Charge.
Assistant Surgeon Expense	**Covered Medical Expenses** for the charges of an assistant surgeon during a surgical procedure are payable as follows: Preferred Care: **90%** of the Negotiated Charge. Non-Preferred Care: **60%** of the Recognized Charge.

Surgical Expense - Outpatient	
Surgical Expense	**Covered Medical Expenses** for charges for surgical services performed by a Physician are payable as follows: Preferred Care: **90%** of the Negotiated Charge. Non-Preferred Care: **60%** of the Recognized Charge.
Anesthesia Expense	**Covered Medical Expenses** for the charges of anesthesia during a surgical procedure are payable as follows: Preferred Care: **90%** of the Negotiated Charge. Non-Preferred Care: **60%** of the Recognized Charge.
Assistant Surgeon Expense	**Covered Medical Expenses** for the charges of an assistant surgeon during a surgical procedure are payable as follows: Preferred Care: **90%** of the Negotiated Charge. Non-Preferred Care: **60%** of the Recognized Charge.
Ambulatory Surgical Expense	Benefits are payable for **Covered Medical Expenses** incurred by a covered person for expenses incurred for outpatient surgery performed in a hospital outpatient surgery department or in an ambulatory surgical center. **Covered Medical Expenses** must be incurred on the day of the surgery or within 48 hours after the surgery. Preferred Care: **90%** of the Negotiated Charge. Non-Preferred Care: **60%** of the Recognized Charge.
Outpatient Benefits **Covered Medical Expenses** include but are not limited to: Physician's office visits, hospital or outpatient department or emergency room visits, durable medical equipment, clinical lab, or radiological facility.	
Hospital Outpatient Department Expense	**Covered Medical Expenses** includes treatment rendered in a Hospital Outpatient Department. **Covered Medical Expenses** do not include Emergency Room/Urgent Care Treatment, Walk-in Clinic, Therapy Expenses, Chemotherapy and Radiation, and outpatient surgical services, including physician, anesthesia and facility charges, which are covered as outlined under the individual benefit types listed in this schedule of benefits. Benefits are payable as follows: Preferred Care: **90%** of the Negotiated Charge. Non-Preferred Care: **60%** of the Recognized Charge.
Walk-in Clinic Visit Expense	**Covered Medical Expenses** include services rendered in a walk-in clinic. Benefits are payable as follows: Preferred Care: **90%** of the Negotiated Charge. Non-Preferred Care: After a **$25** per visit deductible, **60%** of the Recognized Charge.
Emergency Room Expense	**Covered Medical Expenses** incurred for treatment of an Emergency Medical Condition are payable as follows: Preferred Care: **90%** of the Negotiated Charge. Non-Preferred Care: **90%** of the Recognized Charge.

Emergency Room Expense (continued)	**Important Note:** Please note that as **Non-Preferred Care Providers** do not have a contract with **Aetna**, the provider may not accept payment of your cost share (your **deductible** and **coinsurance)** as payment in full. You may receive a bill for the difference between the amount billed by the provider and the amount paid by this Plan. If the provider bills you for an amount above your cost share, you are not responsible for paying that amount. Please send **Aetna** the bill at the address listed on the back of your member ID card and **Aetna** will resolve any payment dispute with the provider over that amount. Make sure your member ID number is on the bill.
Urgent Care Expense	Benefits include charges for treatment by an urgent care provider. **Please note: A covered person should not seek medical care or treatment from an urgent care provider if their illness, injury, or condition, is an emergency condition. The covered person should go directly to the emergency room of a hospital or call 911 (or the local equivalent) for ambulance and medical assistance.** **Urgent Care** Benefits include charges for an urgent care provider to evaluate and treat an urgent condition. **Covered Medical Expenses** for urgent care treatment are payable as follows: Preferred Care: **90%** of the Negotiated Charge. Non-Preferred Care: After a **$25** per visit deductible, **60%** of the Recognized Charge. No benefit will be paid under any other part of This Plan for charges made by an urgent care provider to treat a non-urgent condition.
Ambulance Expense	**Covered Medical Expenses** are payable for the services of a professional ambulance to or from a hospital, when required due to the emergency nature of a covered Accident. **Covered Medical Expenses** are payable as follows: Preferred Care: **90%** of the Negotiated Charge. Non-Preferred Care: **90%** of the Recognized Charge.
Pre-Admission Testing Expense	**Covered Medical Expenses** for Pre-Admission testing charges while an outpatient before scheduled surgery are payable same basis as any other Sickness.
Physician's Office Visit Expense	**Covered Medical Expenses** are payable as follows: Preferred Care: **90%** of the Negotiated Charge Non-Preferred Care: After a **$25** per visit deductible, **60%** of the Recognized Charge. This benefit includes visits to specialists.
Laboratory and X-ray Expense	**Covered Medical Expenses** are payable as follows: Preferred Care: **90%** of the Negotiated Charge. Non-Preferred Care: **60%** of the Recognized Charge.
High Cost Procedures Expense	**Covered Medical Expenses** include charges incurred by a covered person for High Cost Procedures that are required as a result of injury or sickness. **Covered Medical Expenses** for High Cost Procedures must be provided on an outpatient basis and are payable on the same basis as any other sickness. Expenses for High Cost Procedures may be incurred in the following: • A physician's office, or • Hospital outpatient department or emergency room, or • Clinical laboratory, or • Radiological facility or other similar facility licensed by the applicable state or the state in which the facility is located.

High Cost Procedures Expense (continued)	**Covered Medical Expenses** for High Cost Procedures include charges for the following procedures and services: • C.A.T. Scan; • Magnetic Resonance Imaging; **Covered Medical Expenses** are payable as follows: Preferred Care: **90%** of the Negotiated Charge. Non-Preferred Care: **60%** of the Recognized Charge.
Therapy Expense	**Covered Medical Expenses** include charges incurred by a **covered person** for the following types of therapy provided on an outpatient basis: • Physical Therapy, • Chiropractic Care, • Speech Therapy, • Inhalation Therapy, or • Occupational Therapy. Expenses for Speech and Occupational Therapies are **Covered Medical Expenses** only if such therapies are a result of **injury**. **Covered Medical Expenses** are payable as follows: Preferred Care: **90%** of the Negotiated Charge. Non-Preferred Care: **60%** of the Recognized Charge.
Chemotherapy Expense	**Covered Medical Expenses** for chemotherapy, including oral chemotherapy and anti-nausea drugs used in conjunction with the chemotherapy, radiation therapy, tests and procedures, physiotherapy (for rehabilitation only after a surgery), and expenses incurred at a radiological facility. **Covered medical expenses** also include expenses for the administration of chemotherapy and visits by a health care professional to administer the chemotherapy. Such expenses are payable as follows: Preferred Care: **90%** of the Negotiated Charge. Non-Preferred Care: **60%** of the Recognized Charge.
Durable Medical and Surgical Equipment Expense	**Covered Medical Expenses** are payable as follows: Preferred Care: **90%** of the Negotiated Charge. Non-Preferred Care: **60%** of the Recognized Charge.
Prosthetic Devices Expense	Benefits include charges for: artificial limbs, or eyes, and other non-dental prosthetic devices, as a result of an accident, and wigs required as a result of chemo or radiation therapy. **Covered Medical Expenses** do **not** include: eye exams, eyeglasses, vision aids, hearing aids, communication aids, and orthopedic shoes, foot orthotics, or other devices to support the feet. **Covered Medical expenses** are payable as follows: Preferred Care: **90%** of the Negotiated Charge. Non-Preferred Care: **60%** of the Recognized Charge.

Physical Therapy Expense	**Covered Medical Expenses** for physical therapy are payable as follows when provided by a licensed physical therapist: Preferred Care: **90%** of the Negotiated Charge. Non-Preferred Care: **60%** of the Recognized Charge.
Dental Injury Expense	**Covered Medical Expenses** include dental work, surgery, and orthodontic treatment needed to remove, repair, replace, restore, or reposition: • Natural teeth damaged, lost, or removed, or • Other body tissues of the mouth fractured or cut due to injury. The accident causing the injury must occur while the person is covered under This Plan. Any such teeth must have been: • Free from decay, or • In good repair, and • Firmly attached to the jawbone at the time of the injury. ***The treatment must be done in the calendar year of the accident or the next one***. If: • Crowns (caps), or • Dentures (false teeth), or • Bridgework, or • In-mouth appliances, are installed due to such injury, **Covered Medical Expenses** include only charges for: • The first denture or fixed bridgework to replace lost teeth, • The first crown needed to repair each damaged tooth, and • An in-mouth appliance used in the first course of orthodontic treatment after the injury. Surgery needed to: • Treat a fracture, dislocation, or wound. • Cut out cysts, tumors, or other diseased tissues. • Alter the jaw, jaw joints, or bite relationships by a cutting procedure when appliance therapy alone cannot result in functional improvement. • Non-surgical treatment of infections or diseases. This does not include those of, or related to, the teeth. **Covered Medical Expenses** are payable as follows: **90%** of the Actual Charge.
Musculoskeletal/ Chiropractic Therapy Expense	**Covered Medical Expenses** include charges for Musculoskeletal Therapy provided on an outpatient basis. For purposes of this benefit, "Musculoskeletal Therapy" means the diagnosis, and treatment, by manual or mechanical means, of the musculoskeletal structure, due to lack of normal nerve, muscle, and /or joint function. Benefits for chiropractic care will be paid on the same basis as those payable for care or services provided by other health professionals in the diagnosis, treatment and management of the same or similar conditions, injuries, complaints, disorders or ailments.

Consultant Expense	**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 a diagnosis. Benefits are payable as follows: Preferred Care: **90%** of the Negotiated Charge. Non-Preferred Care: After a **$25** per visit deductible, **60%** of the Recognized Charge.
Additional Benefits	
Prescribed Medicines Expense	**Covered Medical Expenses** for outpatient **Prescription Drugs** associated with a covered Accident which occurs during the Policy Year are payable as follows: **90%** of the **Actual Charge**. Benefits are limited to a maximum of **$800 per Policy Year.** You must pay out of pocket for **Prescriptions** and then submit the receipt with a Prescription Claim Form for reimbursement. This **Pharmacy** benefit is provided to cover **Medically Necessary Prescriptions** associated with a covered **Accident** occurring during the **Policy Year**.
Second Surgical Opinion Expense	**Covered Medical Expenses** will include expenses incurred for a second opinion consultation by a specialist on the need for surgery which has been recommended by the covered person's physician. The specialist must be board certified in the medical field relating to the surgical procedure being proposed. Coverage will also be provided for any expenses incurred for required X-rays and diagnostic tests done in connection with that consultation. Aetna must receive a written report on the second opinion consultation. **Covered Medical Expenses** are payable on the same basis as any other condition.
Acupuncture In Lieu Of Anesthesia Expense	**Covered Medical Expenses** include acupuncture therapy when acupuncture is used in lieu of other anesthesia for a surgical or dental procedure covered under This Plan. The acupuncture must be administered by a health care provider who is a legally qualified physician practicing within the scope of their license. **Covered Medical Expenses** are payable as follows: Preferred Care: **90%** of the Negotiated Charge. Non-Preferred Care: **60%** of the Recognized Charge.
Dermatological Expense	**Covered Medical Expenses** include charges for the diagnosis and treatment of skin disorders, excluding laboratory fees. Related laboratory expenses are covered under the Outpatient Expense Benefit. **Covered Medical Expenses** are payable same basis as any other condition. **Covered Medical Expenses** do not include treatment for acne or cosmetic treatments and procedures and must be for treatment due to an accident.
Podiatric Expense	**Covered Medical Expenses** include charges for podiatric services, provided on an outpatient basis following an injury. **Covered Medical Expenses** are payable same basis as any other Sickness. Expenses for routine foot care, such as trimming of corns, calluses, and nails, are **not Covered Medical Expenses**.

Home Health Care Expense	**Covered Medical Expenses** include charges incurred by a covered person for home health care services made by a home health agency pursuant to a home health care plan. Preferred Care: **90%** of the Negotiated Charge. Non-Preferred Care: **60%** of the Recognized Charge. Benefits are limited to a maximum of **40** visits per policy year.
Transfusion or Dialysis of Blood Expense	**Covered Medical Expenses** include charges for the transfusion or dialysis of blood, including the cost of: whole blood, blood components, and the administration thereof. **Covered Medical Expenses** are payable same basis as any other Sickness.
Licensed Nurse Expense	Benefits include charges incurred by a covered person who is confined in a hospital as a resident bed-patient, and requires the services of a registered nurse or licensed practical nurse. **Covered Expenses** for a Licensed Nurse are covered as follows: Preferred Care: **90%** of the Negotiated Charge. Non-Preferred Care: **60%** of the Recognized Charge.
Skilled Nursing Facility Expense	**Covered Medical Expenses** include charges incurred by a covered person for confinement in a skilled nursing facility for treatment rendered: • in lieu of confinement in a hospital as a full time inpatient, or • within 24 hours following a hospital confinement and for the same or related cause(s) as such hospital confinement. **Covered Medical Expenses** are payable as follows: Preferred Care: **90%** of the Negotiated Charge for the semi-private room rate. Non-Preferred Care: **60%** of the Recognized Charge for the semi-private room rate.
Rehabilitation Facility Expense	**Covered Medical Expenses** include charges incurred by a covered person for confinement as a full time inpatient in a rehabilitation facility. Confinement in the rehabilitation facility must follow within 24 hours of, and be for the same or related cause(s) as, a period of hospital or skilled nursing facility confinement. **Covered Medical Expenses** for Rehabilitation Facility Expense are covered as follows: Preferred Care: **90%** of the Negotiated Charge for the rehabilitation facility's daily room and board maximum for semi-private accommodations Non-Preferred Care: **60%** of the Recognized Charge for the rehabilitation facility's daily room and board maximum for semi-private accommodations.

Plan 2 – The New School Student Accident and Sickness Plan

Payment will be made as allocated herein for **Covered Medical Expenses** incurred for any one **Accident** or any one **Sickness** while covered under the Plan, not to exceed an **Aggregate Maximum** while continuously insured of **$500,000** per condition, per policy year, for any one covered **Accident** or any one covered **Sickness**. The following benefits are subject to a **$100 Policy Year Deductible** (waived if already met under Plan 1) for students and a **$100 Policy Year Deductible** for dependents. The **Pharmacy** benefit is not subject to the deductible. Per visit or admission **deductibles** do not apply towards satisfying the plan **Deductible**.

Waiver of Annual Deductible
In compliance with Federal Health Care Reform legislation, the Annual Deductible is waived for Preferred Care **Covered Medical Expenses** (refer to specific benefit types for list of services) rendered as part of the following benefit types:

Routine Physical Exam Expense (Office Visits), Pap Smear Screening Expense, Mammogram Expense, Routine Screening for Sexually Transmitted Disease Expense, Routine Colorectal Cancer Screening, Routine Prostate Cancer Screening Expense, Preventive Care Immunizations (Facility or Office Visits), Well Woman Preventive Visits *(Office Visits)*, Screening & Counseling Services *(Office Visits)* as illustrated under the Routine Physical Exam benefit type, Routine Cancer Screenings *(Outpatient)*, Prenatal Care *(Office Visits)*, Comprehensive Lactation Support and Counseling Services *(Facility or Office Visits)*, Breast Pumps & Supplies, Family Contraceptive Counseling Services *(Office Visits)*, Female Voluntary Sterilization *(Inpatient and Outpatient)*, Female Contraceptive Generic Prescription Drugs, Female Contraceptive Generic Devices, and FDA-Approved Female Generic Emergency Contraceptives.

STUDENTS: For **Accident Expense**, the first **$10,000** of **Covered Medical Expenses** will be paid under Plan 1. Expenses in excess of **$10,000** will be paid under Plan 2.

In addition to the Plan's **Aggregate Maximum** the **Policy** may contain benefit level maximums. Please review the Summary of Benefits section of this brochure for any additional benefit level maximums.

The payment of any **Copays**, **Deductibles**, the balance above any Coinsurance amount, and any medical expenses not covered are the responsibility of the **Covered Person**.

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

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

All coverage is based on Recognized charges unless otherwise specified.

Inpatient Hospitalization Benefits	
Room and Board Expense	**Covered Medical Expenses** are payable as follows: Preferred Care: **90%** of the Negotiated Charge. Non-Preferred Care: **60%** of the Recognized Charge for a semi-private room.
Intensive Care Room and Board Expense	**Covered Medical Expenses** are payable as follows: Preferred Care: **90%** of the Negotiated Charge. Non-Preferred Care: **60%** of the Recognized Charge for the Intensive Care Room Rate for an overnight stay.
Miscellaneous Hospital Expense	**Covered Medical Expenses** include, among others, expenses incurred during a hospital confinement for: • Anesthesia and operating room; • Laboratory tests and X rays; • Oxygen tent; and • Drugs, medicines, dressings. Benefits are payable as follows: Preferred Care: **90%** of the Negotiated Charge. Non-Preferred Care: **60%** of the Recognized Charge.
Non-Surgical Physicians Expense	**Covered Medical Expenses** for charges for the non-surgical services of the attending Physician, or a consulting Physician, are payable as follows: Preferred Care: **90%** of the Negotiated Charge. Non-Preferred Care: **60%** of the Recognized Charge.

Surgical Expense - Inpatient	
Surgical Expense	**Covered Medical Expenses** for charges for surgical services, performed by a Physician, are payable as follows: Preferred Care: **90%** of the Negotiated Charge. Non-Preferred Care: **60%** of the Recognized Charge.
Anesthesia Expense	**Covered Medical Expenses** for the charges of anesthesia during a surgical procedure are payable as follows: Preferred Care: **90%** of the Negotiated Charge. Non-Preferred Care: **60%** of the Recognized Charge.
Assistant Surgeon Expense	**Covered Medical Expenses** for the charges of an assistant surgeon during a surgical procedure are payable as follows: Preferred Care: **90%** of the Negotiated Charge. Non-Preferred Care: **60%** of the Recognized Charge.
Surgical Expense - Outpatient	
Surgical Expense	**Covered Medical Expenses** for charges for surgical services performed by a Physician are payable as follows: Preferred Care: **90%** of the Negotiated Charge. Non-Preferred Care: **60%** of the Recognized Charge.
Anesthesia Expense	**Covered Medical Expenses** for the charges of anesthesia, during a surgical procedure, are payable as follows: Preferred Care: **90%** of the Negotiated Charge. Non-Preferred Care: **60%** of the Recognized Charge.
Assistant Surgeon Expense	**Covered Medical Expenses** for the charges of an assistant surgeon during a surgical procedure are payable as follows: Preferred Care: **90%** of the Negotiated Charge. Non-Preferred Care: **60%** of the Recognized Charge.
Ambulatory Surgical Expense	Benefits are payable for **Covered Medical Expenses** incurred by a covered person for expenses incurred for outpatient surgery performed in a hospital outpatient surgery department or in an ambulatory surgical center. **Covered Medical Expenses** must be incurred on the day of the surgery or within 48 hours after the surgery. Preferred Care: **90%** of the Negotiated Charge. Non-Preferred Care: **60%** of the Recognized Charge.
Outpatient Benefits **Covered Medical Expenses** include but are not limited to: Physician's office visits, hospital or outpatient department or emergency room visits, durable medical equipment, clinical lab, or radiological facility.	
Hospital Outpatient Department Expense	**Covered Medical Expenses** includes treatment rendered in a Hospital Outpatient Department. **Covered Medical Expenses** do not include Emergency Room/Urgent Care Treatment, Walk-in Clinic, Therapy Expenses, Chemotherapy and Radiation, and outpatient surgical services, including physician, anesthesia and facility charges, which are covered as outlined under the individual benefit types listed in this schedule of benefits. Benefits are payable as follows: Preferred Care: **90%** of the Negotiated Charge. Non-Preferred Care: **60%** of the Recognized Charge.

Walk-in Clinic Visit Expense	**Covered Medical Expenses** include services rendered in a walk-in clinic. Benefits are payable as follows: Preferred Care: **90%** of the Negotiated Charge. Non-Preferred Care: After a **$25** per visit Deductible, **60%** of the Recognized Charge.
Emergency Room Expense	**Covered Medical Expenses** incurred for treatment of an Emergency Medical Condition are payable as follows: Preferred Care: **90%** of the Negotiated Charge. Non-Preferred Care: **90%** of the Recognized Charge. **Important Note:** Please note that as **Non-Preferred Care Providers** do not have a contract with **Aetna**, the provider may not accept payment of your cost share (your **deductible** and **coinsurance)** as payment in full. You may receive a bill for the difference between the amount billed by the provider and the amount paid by this Plan. If the provider bills you for an amount above your cost share, you are not responsible for paying that amount. Please send **Aetna** the bill at the address listed on the back of your member ID card and **Aetna** will resolve any payment dispute with the provider over that amount. Make sure your member ID number is on the bill.
Urgent Care Expense	Benefits include charges for treatment by an urgent care provider. **Please note: A covered person should not seek medical care or treatment from an urgent care provider if their illness, injury, or condition, is an emergency condition. The covered person should go directly to the emergency room of a hospital or call 911 (or the local equivalent) for ambulance and medical assistance.** **Urgent Care** Benefits include charges for an urgent care provider to evaluate and treat an urgent condition. **Covered Medical Expenses** for urgent care treatment are payable as follows: Preferred Care: **90%** of the Negotiated Charge. Non-Preferred Care: After a **$25** per visit Deductible, **60%** of the Recognized Charge. No benefit will be paid under any other part of This Plan for charges made by an urgent care provider to treat a non-urgent condition.
Ambulance Expense	**Covered Medical Expenses** are payable 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. **Covered Medical Expenses** are payable as follows: Preferred Care: **90%** of the Negotiated Charge. Non-Preferred Care: **90%** of the Recognized Charge.
Pre-Admission Testing Expense	**Covered Medical Expenses** for Pre-Admission testing charges while an outpatient before scheduled surgery are payable same basis as any other Sickness.
Physician's Office Visit Expense	**Covered Medical Expenses** are payable as follows: Preferred Care: **90%** of the Negotiated Charge Non-Preferred Care: After a **$25** per visit Deductible, **60%** of the Recognized Charge. This benefit includes visits to specialists.

Laboratory and X-ray Expense	**Covered Medical Expenses** are payable as follows: Preferred Care: **90%** of the Negotiated Charge. Non-Preferred Care: **60%** of the Recognized Charge.
High Cost Procedures Expense	**Covered Medical Expenses** include charges incurred by a covered person for High Cost Procedures that are required as a result of injury or sickness. **Covered Medical Expenses** for High Cost Procedures must be provided on an outpatient basis and are payable on the same basis as any other sickness. Expenses for High Cost Procedures may be incurred in the following: • A physician's office, or • Hospital outpatient department or emergency room, or • Clinical laboratory, or • Radiological facility or other similar facility licensed by the applicable state or the state in which the facility is located. **Covered Medical Expenses** for High Cost Procedures include charges for the following procedures and services: • C.A.T. Scan; • Magnetic Resonance Imaging; **Covered Medical Expenses** are payable as follows: Preferred Care: **90%** of the Negotiated Charge. Non-Preferred Care: **60%** of the Recognized Charge.
Therapy Expense	**Covered Medical Expenses** include charges incurred by a **covered person** for the following types of therapy provided on an outpatient basis: • Physical Therapy, • Chiropractic Care, • Speech Therapy, • Inhalation Therapy, or • Occupational Therapy. Expenses for Speech and Occupational Therapies are **Covered Medical Expenses,** only if such therapies are a result of **injury** or **sickness**. **Covered Medical Expenses** are payable as follows: Preferred Care: **90%** of the Negotiated Charge. Non-Preferred Care: **60%** of the Recognized Charge.
Chemotherapy Expense	**Covered Medical Expenses** for chemotherapy, including oral chemotherapy and anti-nausea drugs used in conjunction with the chemotherapy, radiation therapy, tests and procedures, physiotherapy (for rehabilitation only after a surgery), and expenses incurred at a radiological facility. **Covered medical expenses** also include expenses for the administration of chemotherapy and visits by a health care professional to administer the chemotherapy. Such expenses are payable as follows: Preferred Care: **90%** of the Negotiated Charge. Non-Preferred Care: **60%** of the Recognized Charge.

Durable Medical and Surgical Equipment Expense	**Covered Medical Expenses** are payable as follows: Preferred Care: **90%** of the Negotiated Charge. Non-Preferred Care: **60%** of the Recognized Charge. **Breast Feeding Durable Medical Equipment** Coverage includes the rental or purchase of breast feeding **durable medical equipment** for the purpose of lactation support (pumping and storage of breast milk) as follows. Preferred Care: **100%** of the Negotiated Charge. Non-Preferred Care: **70%** of the Recognized Charge. *Breast Pump* C**overed expenses** include the following: • The rental of a hospital-grade electric pump for a newborn child when the newborn child is confined in a **hospital**. • The purchase of: • an electric breast pump (non-hospital grade), if requested within 60 days from the date of the birth of the child. A purchase will be covered once every five years following the date of the birth; or • a manual breast pump, if requested within 6-12 months from the date of the birth of the child. A purchase will be covered once every five years following the date of the birth. • If an electric breast pump was purchased within the previous one period, the purchase of an electric or manual breast pump will not be covered until a five year period has elapsed from the last purchase of an electric pump. *Breast Pump Supplies* Coverage is limited to only one purchase per pregnancy in any year where a covered female would not qualify for the purchase of a new pump. Coverage for the purchase of breast pump equipment is limited to one item of equipment, for the same or similar purpose, and the accessories and supplies needed to operate the item. The covered person is responsible for the entire cost of any additional pieces of the same or similar equipment that he or she purchases or rents for personal convenience or mobility. **Aetna** reserves the right to limit the payment of charges up to the most cost efficient and least restrictive level of service or item which can be safely and effectively provided. The decision to rent or purchase is at the discretion of **Aetna**. **Limitations:** Unless specified above, not covered under this benefit are charges incurred for: • Services which are covered to any extent under any other part of this Plan.
Prosthetic Devices Expense	Benefits include charges for: artificial limbs, or eyes, and other non-dental prosthetic devices, as a result of an accident or sickness, and wigs required as a result of chemo or radiation therapy. **Covered Medical Expenses** do **not** include: eye exams, eyeglasses, vision aids, hearing aids, communication aids, and orthopedic shoes, foot orthotics, or other devices to support the feet. **Covered Medical expenses** are payable as follows: Preferred Care: **90%** of the Negotiated Charge. Non-Preferred Care: **60%** of the Recognized Charge.

Physical Therapy Expense	**Covered Medical Expenses** for physical therapy are payable as follows when provided by a licensed physical therapist. Preferred Care: **90%** of the Negotiated Charge. Non-Preferred care: **60%** of the Recognized Charge.
Dental Injury Expense	**Covered Medical Expenses** include dental work, surgery, and orthodontic treatment needed to remove, repair, replace, restore, or reposition: • Natural teeth damaged, lost, or removed, or • Other body tissues of the mouth fractured or cut due to injury. The accident causing the injury must occur while the person is covered under This Plan. Any such teeth must have been: • Free from decay, or • In good repair, and • Firmly attached to the jawbone at the time of the injury. ***The treatment must be done in the calendar year of the accident or the next one***. If: • Crowns (caps), or • Dentures (false teeth), or • Bridgework, or • In-mouth appliances, are installed due to such injury, **Covered Medical Expenses** include only charges for: • The first denture or fixed bridgework to replace lost teeth, • The first crown needed to repair each damaged tooth, and • An in-mouth appliance used in the first course of orthodontic treatment after the injury. Surgery needed to: • Treat a fracture, dislocation, or wound. • Cut out cysts, tumors, or other diseased tissues. • Alter the jaw, jaw joints, or bite relationships by a cutting procedure when appliance therapy alone cannot result in functional improvement. • Non-surgical treatment of infections or diseases. This does not include those of, or related to, the teeth. **Covered Medical Expenses** are payable as follows: **90%** of the Actual Charge.
Allergy Testing and Treatment Expense	Benefits include charges incurred for diagnostic testing and treatment of allergies and immunology services. **Covered Medical Expenses** include, but are not limited to, charges for the following: • laboratory tests, • physician office visits, including visits to administer injections, • prescribed medications for testing and treatment of the allergy, including any equipment used in the administration of prescribed medication, and • other medically necessary supplies and services. **Covered Medical Expenses** are payable same basis as any other condition.

Diagnostic Testing For Learning Disabilities Expense	**Covered Medical Expenses** for diagnostic testing for: • attention deficit disorder, or • attention deficit hyperactive disorder. Benefits are payable as follows: Preferred Care: **90%** of the Negotiated Charge. Non-Preferred Care: **60%** of the Recognized Charge. Once a covered person has been diagnosed with one of these conditions, medical treatment will be payable as detailed under the outpatient Treatment of Mental and Nervous Disorders portion of This Plan.
Musculoskeletal/ Chiropractic Therapy Expense	**Covered Medical Expenses** include charges for Musculoskeletal Therapy provided on an outpatient basis. For purposes of this benefit, "Musculoskeletal Therapy" means the diagnosis, and treatment, by manual or mechanical means, of the musculoskeletal structure, due to lack of normal nerve, muscle, and /or joint function. Benefits for chiropractic care will be paid on the same basis as those payable for care or services provided by other health professionals in the diagnosis, treatment and management of the same or similar conditions, injuries, complaints, disorders or ailments.

Routine Physical Exam Expense	Benefits include expenses for a routine physical exam performed by a physician. If charges for a routine physical exam given to a child who is a covered dependent are covered under any other benefit section, those charges will not be covered under this section.
	
	A routine physical exam is a medical exam given by a physician, for a reason other than to diagnose or treat a suspected or identified injury or sickness. Included as a part of the exam are:
	• Routine vision and hearing screenings given as part of the routine physical exam.
	• X-rays, lab, and other tests given in connection with the exam, and
	• Materials for the administration of immunizations for infectious disease and testing for tuberculosis.
	
	Preferred Care **visits** are payable at **100%** of the Negotiated Charge.
	Preferred Care **immunizations** are payable at **100%** of the Negotiated Charge.
	
	Non-Preferred Care **visits** are payable as follows: After a **$25** per visit Deductible, **70%** of the Recognized Charge.
	Non-Preferred Care **immunizations** are payable at **70%** of the Recognized Charge.
	
	In addition to any state regulations or guidelines regarding mandated Routine Physical Exam services, **Covered Medical Expenses** include services rendered in conjunction with,
	• Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force.
	• For females, screenings and counseling services as provided for in the comprehensive guidelines recommended by the Health Resources and Services Administration. These services may include but are not limited to:
	  • Screening and counseling services, such as:
	  o Interpersonal and domestic violence;
	  o Sexually transmitted diseases; and
	  o Human Immune Deficiency Virus (HIV) infections.
	  o Screening for gestational diabetes.
	High risk Human Papillomavirus (HPV) DNA testing for women age 18 and older and limited to once every three years.
	*Sexually transmitted disease counseling expense is limited to two counseling visits per Policy Year.

Routine Physical Exam Expense (continued)	• X-rays, lab and other tests given in connection with the exam. • Immunizations for infectious diseases and the materials for administration of immunizations that have been recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. • If the plan includes dependent coverage, for covered newborns, an initial **hospital** check up. **Important Note:** ***For details on the frequency and age limits that apply to Routine Physical Exams and Routine Cancer Screenings, a covered person may contact his or her physician or Member Services by logging onto the Aetna website www.aetna.com or calling the toll-free number on the back of the ID card.*** For a **child** who is a covered dependent: The physical exam must include at least: • A review and written record of the patient's complete medical history, • A check of all body systems, and • A review and discussion of the exam results with the patient or with the parent or guardian. For all exams given to covered dependent **under age 2, Covered Medical Expenses** will **not include** charges for the following: • **More than** 6 exams performed during the first year of the child's life, • **More than** 2 exams performed during the second year of the child's life. For all exams given to a covered dependent from **age 2 and over**, **Covered Medical Expenses** will **not include** charges for **more than** one exam in 12 months in a row. For all exams given to a covered student or a spouse who is a covered dependent, **Covered Medical Expenses** will **not include** charges for **more than**: • One exam in 12 months in a row. **Covered Medical Expenses** incurred by a woman, are charges made by a physician for, one annual routine gynecological exam. **Screening and Counseling Services:** **Covered Medical Expenses** include charges made by a **physician** in an individual or group setting for the following: **Depression Screening** This service is limited to once per year. **Obesity** Screening and counseling services to aid in weight reduction due to obesity. Coverage includes: • Preventive counseling visits and/or risk factor reduction intervention; • Medical nutrition therapy; • Nutritional counseling; and • Healthy diet counseling visits provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease. Services in this category are subject to a combined limit of 26 individual or group visits by any recognized provider per Policy Year. The 10 Healthy Diet Counseling visits will be counted toward the total number of visits allowed for Obesity counseling.

Routine Physical Exam Expense (continued)	**Misuse of Alcohol and/or Drugs** Screening and counseling services to aid in the prevention or reduction of the use of an alcohol agent or controlled substance. Coverage includes preventive counseling visits, risk factor reduction intervention and a structured assessment. Services in this category are subject to a combined limit of 5 individual or group visits by any recognized provider per Policy Year. **Use of Tobacco Products** Screening and counseling services to aid a covered person to stop the use of tobacco products. Coverage includes: • Preventive counseling visits; • Treatment visits; and • Class visits; to aid a covered person to stop the use of tobacco products. Tobacco product means a substance containing tobacco or nicotine including: • cigarettes; • cigars; • smoking tobacco; • snuff; • smokeless tobacco; and • candy-like products that contain tobacco. Services in this category are subject to a combined limit of 8 individual or group visits by any recognized provider per Policy Year. **Limitations:** Unless specified above, not covered under this Screening and Counseling Services benefit are charges incurred for: • Services which are covered to any extent under any other part of this Plan Screening and Counseling Services are payable as follows: Preferred Care: **100%** of the Negotiated Charge. Non-Preferred Care: **70%** of the Recognized Charge.
Immunizations Expense	**Covered Medical Expenses** include: • charges incurred by a covered student and dependent spouse for the materials for the administration of appropriate and **medically necessary** immunizations, and testing for tuberculosis, and • charges incurred by a covered dependent up to age 19, for the materials for the administration of appropriate and **medically necessary** immunizations, when given in accordance with the prevailing clinical standards of the American Academy of Pediatrics. Preferred Care: **100%** of the Negotiated Charge. Non-Preferred Care: **70%** of the Recognized Charge. **Covered Medical Expenses do not include** a physician's office visit in connection with immunization or testing for tuberculosis.

Consultant Expense	**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 a diagnosis. Benefits are payable as follows: Preferred Care: **90%** of the Negotiated Charge. Non-Preferred Care: After a **$25** per visit Deductible, **60%** of the Recognized Charge.
Treatment of Mental and Nervous Disorders	
Biologically based Mental Illness and for Children with Serious Emotional Disturbances	"Biologically Based Mental Illness" means a mental, nervous or emotional condition that is caused by a biological disorder of the brain and results in a clinically significant, psychological syndrome or pattern that substantially limits the functioning of the person with the illness. Such biologically based mental illnesses are defined as schizophrenia/psychotic disorders, major depression, bipolar disorder, delusional disorders, panic disorder, obsessive-compulsive disorder, bulimia and anorexia. "Children with Serious Emotional Disturbances" means: persons under the age of eighteen years who have diagnoses of attention deficit disorders, disruptive behavior disorders, or pervasive development disorders, and where there are one or more of the following: • Serious suicidal symptoms or other life-threatening self-destructive behaviors, • Significant psychotic symptoms (hallucinations, delusion, bizarre behaviors), • Behavior caused by emotional disturbances that placed the child at risk of causing personal injury or significant property damage, or • Behavior caused by emotional disturbances that placed the child at substantial risk of removal from the household. **Inpatient** **Covered Medical Expenses** include expenses incurred by a **covered person** while confined as a full-time inpatient in a **hospital** or **residential treatment facility** for the treatment of Biologically based Mental Illness or Children with Serious Emotional Disturbances. These expenses are covered on the same basis as inpatient treatment for any **sickness**. Preferred Care: **90%** of the Negotiated Charge. Non-Preferred Care: **60%** of the Recognized Charge. Includes the charges made for treatment received during partial hospitalization or intensive outpatient in a hospital or treatment facility. Prior review and approval must be obtained on a case-by-case basis. **Outpatient** **Covered Medical Expenses** include expenses while a **covered person** is not confined as a full-time inpatient in a **hospital,** for the treatment of Biologically based Mental Illness or Children with Serious Emotional Disturbances. These expenses are covered on the same basis as outpatient treatment for any **sickness**. Preferred Care: **90%** of the Negotiated Charge. Non-Preferred Care: After a **$25** per visit Deductible, **60%** of the Recognized Charge. ***Not Covered are Charges for Services*:** • While incarcerated, confined or committed to a local correctional facility or a prison, or a custodial facility for youth. • Provided solely because such services are ordered by a court. • Deemed to be cosmetic in nature.

Other than Biologically based Mental Illness and Children with Serious Emotional Disturbances	**Inpatient Benefits** **Covered Medical Expenses** include expenses incurred by a **covered person** while confined as a full-time inpatient in a **hospital** or **residential treatment facility** for the treatment of Mental Illness other than Biologically based Mental Illness or Children with Serious Emotional Disturbances. Preferred Care: **90%** of the Negotiated Charge. Non-Preferred Care: **60%** of the Recognized Charge. Inpatient benefits are payable up to a maximum of a maximum of **30** days per policy year. Includes the charges made for treatment received during partial hospitalization or intensive outpatient in a hospital or treatment facility. Prior review and approval must be obtained on a case-by-case basis. When approved, benefits will be payable in place of an inpatient admission, whereby 2 days of partial hospitalization or intensive outpatient treatment may be exchanged for 1 day of full hospitalization **Outpatient Treatment** **Covered Medical Expenses** include expenses while a **covered person** is not confined as a full-time inpatient in a **hospital,** for the treatment of Mental Illness other than Biologically based Mental Illness or Children with Serious Emotional Disturbances. Preferred Care: **90%** of the Negotiated Charge. Non-Preferred Care: After a **$25** per visit Deductible, **60%** of the Recognized Charge. Outpatient treatment is covered up to a maximum of a maximum of **20** visits per policy year. ***Not Covered are Charges for Services*:** • While incarcerated, confined or committed to a local correctional facility or a prison, or a custodial facility for youth. • Provided solely because such services are ordered by a court. • Deemed to be cosmetic in nature.
Alcoholism And Drug Addiction Treatment Expense	
Inpatient Expense	**Covered Medical Expenses** include the treatment of a substance abuse condition while confined as a inpatient in a hospital or facility licensed for such treatment. **Covered Medical Expenses** also include the charges made for treatment received during partial hospitalization in a hospital or treatment facility. Prior review and approval must be obtained on a case-by-case basis by contacting Aetna Student Health. When approved, benefits will be payable in place of an inpatient admission, whereby 2 days of partial hospitalization may be exchanged for 1 day of full hospitalization. Benefits are payable as follows: Preferred Care: **90%** of the Negotiated Charge. Non-Preferred Care: **60%** of the Recognized Charge. Benefits will include **7** inpatient days for detoxification in any policy year and **30** inpatient days for rehabilitation in any policy year.

Outpatient Expense	**Covered Medical Expenses** for outpatient diagnosis and treatment of a substance abuse condition are payable as follows: Preferred Care: **90%** of the Negotiated Charge. Non-Preferred Care: After a **$25** per visit Deductible, **60%** of the Recognized Charge. Benefits are limited to **60** visits per Policy Year, **20** of which may be used for family counseling.
Maternity Benefits	
Maternity Expense	**Covered Medical Expenses** include inpatient care of the covered person and any newborn child for a minimum of 48 hours after a vaginal delivery and for a minimum of 96 hours after a cesarean delivery. During the initial 48 or 96 hours, no pre-certification is required for the mother, or her newly born child. Pre-certification is required, after the 48 or 96 hours. Any decision to shorten such minimum coverages shall be made by the attending Physician**,** in consultation with the mother. In such cases, **covered medical expenses** may include at least one home care visit. This home care visit may be requested at any time within 48 hours of the time of a vaginal delivery, or within 96 hours of a delivery, and shall be delivered within 24 hours after discharge, or 24 hours of the mother's request, whichever is later. The home care visit will not be subject to any deductible, copay or insurance. **Covered Medical Expenses** for maternity care also include: • Parent education, • Blood lead testing, • Services provided by a licensed midwife unless those services duplicate the services already provided by the covered person's physician, • Assistance and training in breast or bottle feeding, and • The performance of any necessary maternal and newborn clinical assessments. **Covered Medical Expenses** for pregnancy, childbirth, and complications of pregnancy are payable on the same basis as any other Sickness. **Prenatal Care** Prenatal care will be covered for services received by a pregnant female in a **physician's**, obstetrician's, or gynecologist's office but only to the extent described below. Coverage for prenatal care under this benefit is limited to pregnancy-related **physician** office visits including the initial and subsequent history and physical exams of the pregnant woman (maternal weight, blood pressure and fetal heart rate check). **Comprehensive Lactation Support and Counseling Services** **Covered Medical Expenses** will include comprehensive lactation support (assistance and training in breast feeding) and counseling services provided to females during pregnancy and in the post partum period by a certified lactation support provider. The "post partum period" means the 60 day period directly following the child's date of birth. **Covered expenses** incurred during the post partum period also include the rental or purchase of breast feeding equipment as described below. Lactation support and lactation counseling services are **covered expenses** when provided in either a group or individual setting. **Covered Medical Expenses** for Prenatal Care and Comprehensive Lactation Support and Counseling Services are payable as follows: Preferred Care: **100%** of the Negotiated Charge. Non-Preferred Care: After a **$25** per visit Deductible, **70%** of the Recognized Charge.

Well Newborn Nursery Care Expense	Benefits include charges for routine care of a covered person's newborn child as follows: • hospital charges for routine nursery care during the mother's confinement, but for not more than four days, • physician's charges for circumcision, and • physician's charges for visits to the newborn child in the hospital and consultations, but for not more than 1 visit per day. **Covered Medical Expenses** are payable as follows: Preferred Care: **90%** of the Negotiated Charge. Non-Preferred Care: **60%** of the Recognized Charge.
Additional Benefits	
Prescribed Medicines Expense	Prescription Drug Benefits* are payable as follows: Preferred Care Pharmacy: **100%** of the Negotiated Charge, following a **$40 Copay** for each Preferred Brand Name Prescription Drug, a **$50 Copay** for each Non-Preferred Brand Name Prescription Drug, or a **$25** Copay for each Generic Prescription Drug. Non-Preferred Care Pharmacy: **70%** of the Recognized charge, following a **$40 Copay** for each Preferred Brand Name Prescription Drug, a **$50 Copay** for each Non-Preferred Brand Name Prescription Drug, or a **$25 Copay** for each Generic Prescription Drug. You must pay out of pocket for Prescriptions at a Non-Preferred Pharmacy and then submit the receipt with a Prescription Claim Form for reimbursement. **Covered Medical Expenses** are payable up to a maximum of **$500,000** per Policy Year. This Pharmacy benefit is provided to cover Medically Necessary Prescriptions associated with a covered Sickness or Accident occurring during the Policy Year. Covered Medical Expenses also include prescription smoking cessations aids. Please use your Aetna Student Health ID card when obtaining your prescriptions. Prior Authorization may be required for certain Prescription Drugs and some medications may not be covered under this Plan. For assistance and a complete list of excluded medications, or drugs requiring prior authorization, please contact Aetna Pharmacy Management at **(888) RX-AETNA** or **(888) 792-3862** (available 24 hours). Aetna Specialty Pharmacy provides specialty medications and support to members living with chronic conditions. The medications offered may be injected, infused or taken by mouth. For additional information please go to **www.AetnaSpecialtyRx.com**. *Contraceptive Drugs and Device benefits are illustrated under the Family Planning Benefit of this Policy. **Please Note: Covered Medical Expenses** for prescribed supplies for the treatment of diabetes will not be subject to the listed per Policy Year Prescription Drug limit.
Diabetic Treatment and Supplies Expenses	**Covered Medical Expenses** include expenses incurred in connection with the treatment of diabetes, including diabetic testing supplies and equipment, including: Blood glucose monitors (including monitors for the legally blind), data management systems, test strips, insulin injecting aids, cartridges for the legally blind, syringes, insulin pumps and appurtenances, insulin infusion devices and oral agents for controlling blood sugar. **Covered Medical Expenses** are payable on the same basis as any other Sickness.

Outpatient Diabetic Self-Management Education Program Expense	**Covered Medical Expenses** will include training designed to instruct a person in the self-management of diabetes. It may include training in self-care or diet. Such education may be provided in a group setting, and when medically necessary, diabetic self-management education shall also include home visits. Benefits for Self-Management Education and Home Health Care are payable on the same basis as any other Sickness.
Non-Prescription Enteral Formula Expense	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: • Crohn's Disease, • ulcerative colitis, • gastroesophageal reflux, • gastrointestinal motility, • chronic intestinal pseudoobstruction, and • inherited diseases of amino acids and organic acids. **Covered Medical Expenses** for inherited diseases of amino acids and organic acids, will also include food products modified to be low protein. **Covered Medical Expenses** are payable as follows: Preferred Care: **90%** of the Negotiated Charge. Non-Preferred Care: **60%** of the Recognized Charge.
Temporomandibular Joint Dysfunction Expense	**Covered Medical Expenses** include charges incurred, by a **covered person,** for non-surgical treatment of Temporomandibular Joint (TMJ) Dysfunction, when the TMJ disorder is medical in origin. **Covered Medical Expenses** are payable on the same basis as any other Sickness.
Pap Smear Screening Expense	**Covered Medical Expenses** include one annual routine for an annual cervical cytology screening for cervical cancer and its precursor states for women aged 18 and older, the cervical cytology screening shall include an annual pelvic exam, collection and preparation of pap smear, and laboratory and diagnostic services provided in connection with examining and evaluating the pap smear. Preferred Care: **100%** of the Negotiated Charge. Non-Preferred Care: **70%** of the Recognized Charge.
Mammogram Expense	**Covered Medical Expenses** include one baseline mammogram for women between age 35 and 40. Coverage is also provided for one routine annual mammogram for women age 40 and older, as well as when medically indicated for women with risk factors who are under age 40. Risk factors for women under 40 are: • Prior personal history of breast cancer • Positive Genetic Testings • Family history of breast cancer, or • Other risk factors Mammogram screenings coverage must also include comprehensive ultrasound screening for the entire breast or breasts if a mammogram demonstrates heterogenous or dense breast tissue and when determined to be medically necessary by a licensed physician. Preferred Care: **100%** of the Negotiated Charge. Non-Preferred Care: **70%** of the Recognized Charge.

Cancer Treatment Expense	**Covered Medical Expenses** include inpatient hospital care for lymph node dissection or lumpectomy for the treatment of breast cancer, or a mastectomy covered by the policy. **Covered Medical Expenses** are payable on the same basis as any other Sickness.
Reconstructive Surgery As Result of Mastectomy Expense	**Covered Medical Expenses** will include expenses incurred for: • all stages of reconstruction of the breast on which a partial or complete mastectomy has been performed; and • surgery and reconstruction of the other breast to produce a symmetrical appearance. **Covered Medical Expenses** are payable on the same basis as any other Sickness.
Elective Abortion Expense	If, as a result of pregnancy having its inception during the Policy Year, a covered person incurs expenses in connection with an elective abortion, a benefit is payable. **Covered Medical Expenses** for Elective Abortion Expense are covered as follows: Preferred Care: **90%** of the Negotiated Charge. Non-preferred Care: **60%** of the Recognized Charge. This benefit is in lieu of any other Policy benefits.
Family Planning Expense	For females with reproductive capacity, **Covered Medical Expenses** include those charges incurred for services and supplies that are provided to prevent pregnancy. All contraceptive methods, services and supplies covered under this benefit must be approved by the Food and Drug Administration (FDA). Coverage includes counseling services on contraceptive methods provided by a **physician**, obstetrician or gynecologist. Such counseling services are **Covered Medical Expenses** when provided in either a group or individual setting. The following contraceptive methods are **covered expenses** under this benefit: *Voluntary Sterilization* **Covered expenses** include charges billed separately by the provider for female voluntary sterilization procedures and related services and supplies including, but not limited to, tubal ligation and sterilization implants. **Covered expenses** under this *Preventive Care* benefit would not include charges for a voluntary sterilization procedure to the extent that the procedure was not billed separately by the provider or because it was not the primary purpose of a confinement. *Contraceptives* **Covered expenses** include charges made by a **physician** or **pharmacy** for: • female contraceptives that are **generic prescription drugs**. The prescription must be submitted to the pharmacist for processing. *This contraceptives benefit covers only **generic prescription drugs**.* • female contraceptive devices and related services and supplies that are generic prescription devices when prescribed in writing by a **physician**. *This contraceptives benefit covers only those devices that are generic prescription devices.* • FDA-approved female over-the-counter contraceptive methods that are prescribed by your **physician**. The **prescription** must be submitted to the pharmacist for processing. These items are limited to one per day and a 30 day supply per **prescription**.

Family Planning Expense (continued)	**Limitations:** Unless specified above, not covered under this benefit are charges for: • Services which are covered to any extent under any other part of this Plan; • Services and supplies incurred for an abortion; • Services provided as a result of complications resulting from a voluntary sterilization procedure and related follow-up care; • Services which are for the treatment of an identified **illness** or **injury**; • Services that are not given by a **physician** or under his or her direction; • Psychiatric, psychological, personality or emotional testing or exams; • Any contraceptive methods that are only "reviewed" by the FDA and not "approved" by the FDA; • Male contraceptive methods, sterilization procedures or devices; • The reversal of voluntary sterilization procedures, including any related follow-up care. **Covered Medical Expenses** are payable as follows: Preferred Care: **100%** of the Negotiated Charge. Non-Preferred Care: **70%** of the Recognized Charge. **Important note:** Brand-Name Prescription Drug or Devices will be covered at **100%** of the Negotiated Charge, including waiver of Annual Deductible if a Generic Prescription Drug or Device is not available in the same therapeutic drug class or the prescriber specifies Dispense as Written
Chlamydia Screening Test Expense	**Covered Medical Expenses** include charges incurred for an annual Chlamydia screening test. Benefits will be paid for Chlamydia screening expenses incurred for: • Women who are: • under the age of 20 if they are sexually active, and • at least 20 years old if they have multiple risk factors. • Men who have multiple risk factors. Benefits are payable as follows: Preferred Care: **100%** of the Negotiated Charge. Non-Preferred Care: **70%** of the Recognized Charge.
Routine Screening For Sexually Transmitted Disease Expense	**Covered Medical Expenses** include charges incurred by a covered person for annual routine screening for sexually transmitted diseases. As used above; “routine screening for sexually transmitted disease” means any laboratory test that specifically detects for infection by one or more agents of: • gonorrhea, • syphilis, • hepatitis, • HIV, and • genital herpes, and • which test is approved for such purposes by the FDA. Benefits will be paid; for routine screening for sexually transmitted disease expenses incurred by covered persons who are at least 18 years old and who are sexually active. Benefits are payable as follows: Preferred Care: **90%** of the Negotiated Charge. Non-Preferred Care: **60%** of the Recognized Charge.

Routine Colorectal Cancer Screening Expense	**Covered Medical Expenses** include charges for colorectal cancer examination and laboratory tests, for any nonsymptomatic person age 50 or more, or a symptomatic person under age 50, for the following: • One fecal occult blood test every 12 months in a row • A Sigmoidoscopy at age 50 and every 3 years thereafter • One digital rectal exam every 12 months in a row • A double contrast barium enema, once every 5 years • A colonoscopy, once every 10 years • Virtual colonoscopy • Stool DNA. Benefits are payable as follows: Preferred Care: **100%** of the Negotiated Charge. Non-Preferred Care: **70%** of the Recognized Charge.
Routine Prostate Cancer Screening Expense	Although not incurred in connection with a **sickness** or **injury**; **Covered Medical Expenses** include charges incurred by a **covered person** for the screening of cancer as follows: • For a male age 50 or over; one digital rectal exam and one prostate specific antigen test each **Policy Year**. • For a male age 40 and over, with a family history of prostate cancer or other prostate cancer risk factors, one digital rectal exam and one prostate specific antigen test each **Policy Year**. • For a male, at any age, with a prior history of prostate cancer, one digital rectal exam and one prostate specific antigen test each **Policy Year**. Preferred Care: **100%** of the Negotiated Charge. Non-Preferred Care: **70%** of the Recognized Charge.
Second Opinion For Cancer Treatment Expense	**Covered Medical Expenses** include a second opinion consultation by a specialist for the diagnosis or recommended treatment of cancer. The specialist must be board certified in the medical field relating to the diagnosis. Coverage will also be provided for any expenses incurred for required X-rays and diagnostic tests done in connection with that consultation. Aetna must receive a written report on the second opinion consultation. If the covered person does not **obtain a referral** from a Preferred Care provider for Non-Preferred Care, the level of coinsurance for Non-Preferred Care may be reduced. With a referral, benefits will be payable at the same level for a Non-Preferred Care as it would be for Preferred Care. **Covered Medical Expenses** are payable on the same basis as any other Sickness.
Second Surgical Opinion Expense	**Covered Medical Expenses** will include expenses incurred for a second opinion consultation by a specialist on the need for surgery which has been recommended by the covered person's physician. The specialist must be board certified in the medical field relating to the surgical procedure being proposed. Coverage will also be provided for any expenses incurred for required X-rays and diagnostic tests done in connection with that consultation. Aetna must receive a written report on the second opinion consultation. **Covered Medical Expenses** are payable on the same basis as any other Sickness.

Acupuncture In Lieu Of Anesthesia Expense	**Covered Medical Expenses** include acupuncture therapy when acupuncture is used in lieu of other anesthesia for a surgical or dental procedure covered under This Plan. The acupuncture must be administered by a health care provider who is a legally qualified physician practicing within the scope of their license. **Covered Medical Expenses** are payable as follows: Preferred Care: **90%** of the Negotiated Charge. Non-Preferred Care: **60%** of the Recognized Charge.
Dermatological Expense	**Covered Medical Expenses** include charges for the diagnosis and treatment of skin disorders, excluding laboratory fees. Related laboratory expenses are covered under the Outpatient Expense Benefit. **Covered Medical Expenses** are payable same basis as any other Sickness. **Covered Medical Expenses** do not include cosmetic treatment and procedures.
Podiatric Expense	**Covered Medical Expenses** include charges for podiatric services, provided on an outpatient basis following an injury. **Covered Medical Expenses** are payable same basis as any other Sickness. Expenses for routine foot care, such as trimming of corns, calluses, and nails, are **not Covered Medical Expenses**.
Hypodermic Needles Expense	**Covered Medical Expenses** for hypodermic needles and syringes used in the treatment of diabetes are payable same basis as any Sickness.
Home Health Care Expense	**Covered Medical Expenses** include charges incurred by a covered person for home health care services made by a home health agency pursuant to a home health care plan. Preferred Care: **90%** of the Negotiated Charge. Non-Preferred Care: **60%** of the Recognized Charge. Benefits are limited to a maximum of **40** visits per policy year.
Transfusion or Dialysis of Blood Expense	**Covered Medical Expenses** include charges for the transfusion or dialysis of blood, including the cost of: whole blood, blood components, and the administration thereof. **Covered Medical Expenses** are payable same basis as any other Sickness.
Hospice Expense	**Covered Medical Expenses** include charges incurred by a **covered person** for **hospice** care provided for a terminally ill **covered person** during a **hospice benefit period**. Hospice Care Expenses are the **recognized charges** made by a **hospice** for the following services or supplies: charges for inpatient care; charges for drugs and medicines; charges for part-time nursing by an **RN; LPN;** or **LVN**; charges for physical and respiratory therapy in the home; charges for the use of medical equipment; and charges for visits by licensed or trained social workers; psychologists or counselors. Benefits are payable as follows: Preferred Care: **100%** of the Negotiated Charge. Non-Preferred Care: **100%** of the Recognized Charge.

Licensed Nurse Expense	Benefits include charges incurred by a covered person who is confined in a hospital as a resident bed-patient, and requires the services of a registered nurse or licensed practical nurse. **Covered Expenses** for a Licensed Nurse are covered as follows: Preferred Care: **90%** of the Negotiated Charge. Non-Preferred Care: **60%** of the Recognized Charge.
Skilled Nursing Facility Expense	**Covered Medical Expenses** include charges incurred by a covered person for confinement in a skilled nursing facility for treatment rendered: • in lieu of confinement in a hospital as a full time inpatient, or • within 24 hours following a hospital confinement and for the same or related cause(s) as such hospital confinement. **Covered Medical Expenses** are payable as follows: Preferred Care: **90%** of the Negotiated Charge for the semi-private room rate. Non-Preferred Care: **60%** of the Recognized Charge for the semi-private room rate.
Rehabilitation Facility Expense	**Covered Medical Expenses** include charges incurred by a covered person for confinement as a full time inpatient in a rehabilitation facility. Confinement in the rehabilitation facility must follow within 24 hours of, and be for the same or related cause(s) as, a period of hospital or skilled nursing facility confinement. **Covered Medical Expenses** for Rehabilitation Facility Expense are covered as follows: Preferred Care: **90%** of the Negotiated Charge for the rehabilitation facility's daily room and board maximum for semi-private accommodations Non-Preferred Care: **60%** of the Recognized Charge for the rehabilitation facility's daily room and board maximum for semi-private accommodations.
Bone Density Screening Expense	**Covered Medical Expenses** include bone mineral density measurements or tests. Benefits will be paid for expenses incurred by a **covered person** for a bone density screening upon the recommendation of the covered person's physician for: • an individual previously diagnosed as having osteoporosis or having a family history of osteoporosis, or • an individual with symptoms or conditions indicative of the presence, or the significant risk of osteoporosis, or • an individual on a prescribed drug regimen posing a significant risk of osteoporosis, or • an individual with lifestyle factors to such a degree as posing a significant risk of osteoporosis, or • with such age, gender, and/or physiological characteristics which pose a significant risk for osteoporosis. Benefits will also include drugs and devices approved by the FDA or generic equivalents as approved substitutes for the treatment of osteoporosis. **Covered Medical Expenses** are payable same basis as any other Sickness.
Autism Spectrum Disorder Expense	**Covered Medical Expenses include** screening, diagnosis and treatment of autism spectrum disorder. **Covered Medical Expenses** are payable as any other sickness. Applied behavior analysis is limited to **$45,000** per Policy Year per Covered Person.

Autism Spectrum Disorder Expense (continued)	"Autism spectrum disorder" means any pervasive developmental disorder as defined in the most recent edition of the diagnostic and statistical manual of mental disorders, including autistic disorder, Asperger's disorder, Rett's disorder, childhood disintegrative disorder, or pervasive developmental disorder not otherwise specified (PDD-NOS). "Applied behavior analysis" means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.

GENERAL PROVISIONS

STATE MANDATED BENEFITS

The Plan will pay benefits in accordance with any applicable New York 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.

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

EXTENSION OF BENEFITS

If Basic Accident Expense or Basic Sickness Expense coverage for a **covered person** ends while he is **totally disabled**, benefits will continue to be available for expenses incurred for that person only while the **covered person** continues to be **totally disabled**. Benefits will end thirty-one days from the date coverage ends. Benefits will continue to be available for a **covered person** who incurs medical expenses directly relating to a pregnancy that began before coverage under the Basic Sickness Expense Plan ceased. Such benefits will be covered only for the period of that pregnancy.

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

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

TERMINATION OF STUDENT COVERAGE
Insurance for a **covered student** will end on the first of these to occur:
- the date This Plan terminates,
- the last day for which any required premium has been paid,
- the date on which the **covered student** withdraws from the school because of entering the armed forces of any country. Premiums will be refunded on a pro-rata basis when application is made within 90 days from withdrawal,
- the date the **covered student** is no longer in an eligible class.

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

TERMINATION OF DEPENDENT COVERAGE
Insurance for a **covered student's dependent** will end when insurance for the **covered student** ends. Before then, coverage will end:
- For a child, on the last day of the Policy Period following the child's 26th birthday.
- The date the **covered student** fails to pay any required premium.
- For the spouse, the date the marriage ends in divorce or annulment.
- The date **dependent** coverage is deleted from This Plan.
- For a domestic partner, the earlier to occur of:
- the date This Plan no longer allows coverage for domestic partners, and
- the date of termination of the domestic partnership. In that event, a completed and signed declaration of Termination of Domestic Partnership must be provided to the Policyholder.
- The date the **dependent** ceases to be in an eligible class.

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

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

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

The child's insurance under this provision will end on the earlier of:
- the date specified under the provision entitled Termination of Dependent Coverage, or
- the date the child is no longer incapacitated and dependent on the **covered student** for support.

EXCLUSIONS

This Plan does not cover nor provide benefits for:

1. Expense incurred for services normally provided without charge by the Student Health Services or by health care providers employed by the school.

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

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

4. Aviation. This does not apply if a person is a fare paying passenger or a scheduled charter flight operated by a scheduled airline.

5. Expense incurred for injury or sickness resulting from declared or undeclared war or any act thereof.

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

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

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

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

10. Expense incurred for cosmetic surgery, reconstructive surgery, or other services and supplies which improve, alter, or enhance appearance, whether or not for psychological or emotional reasons, except to the extent needed to (a) improve the function of a part of the body that is not a tooth or structure that supports the teeth and (b) is malformed as a result of a severe birth defect, including harelip, webbed fingers or toes; or (c) as direct result of disease or surgery performed to treat a disease or injury. This exclusion does not apply to reconstructive surgery when such service is incidental to

or follows surgery resulting from trauma, infection, or other diseases of the involved part and reconstructive surgery because of congenital disease or anomaly of a covered dependent child which has resulted in a functional defect. (d) Repair of 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 next calendar year.

11. Expense covered by any other valid and collectible medical, health, or accident insurance to the extent that benefits are payable under other valid and collectible insurance whether or not a claim is made for such benefits.

12. Expense for injuries sustained as the result of a motor vehicle accident to the extent that benefits are provided under any mandatory automobile “no fault” coverage.

13. Expense incurred as a result of commission of a felony.

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

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

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

17. Expense incurred for 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: (a) 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; (b) 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 (c) 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: (a) information relating to the affected person's health status; (b) reports in peer reviewed medical literature; (c) reports and guidelines published by nationally recognized health care organizations that include supporting scientific data; (d) generally recognized professional standards of safety and effectiveness in the United States for diagnosis, care, or treatment; (e) the opinion of health professionals in the generally recognized health specialty involved; and (f) any other relevant information brought to Aetna's attention. In no event will the following services or supplies be considered to be medically necessary: (a) those that do not require the technical skills of a medical, a mental health, or a dental professional; or (b) those furnished mainly for the personal comfort or convenience of the person, any person who cares for him or her, or any persons who is part of his or her family, any healthcare provider, or healthcare facility; or (c) 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 (d) 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.

18. Expenses incurred by a Covered Person who is 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 (or provides national health care).

19. Expense incurred for custodial care, except as medically necessary. Custodial care means services and supplies furnished to a person mainly to help him or her in the activities of daily life. This includes room and board and other institutional care. The person does not have to be disabled. Such services and supplies are custodial care without regard to by whom they are prescribed, by whom they are recommended, or by whom or by which they are performed.

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

21. 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; or Are recognized for treatment of the specific type of cancer for which the drug has been prescribed in one of the following reference compendia: 1. The American Medical Association Drug Evaluations; 2. The American Hospital Formulary Service Drug Information; or 3. The United States Pharmacopeia Drug Information; or 4. Recommended by review article or editorial comment in a major peer reviewed professional journal; or 5. If Aetna determines that available; scientific evidence demonstrates that the drug is effective; or shows promise of being effective; for the disease.

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

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

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

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

26. Expenses incurred for hearing exams not performed in conjunction with a routine physical exam.

27. Expense for care or services to the extent the charge would have been covered under Medicare Part A or Part B even though the covered person is eligible but did not enroll in Part B.

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

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

30. Expense for incidental surgeries and standby charges of a physician.

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

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

33. Expense for contraceptive methods, devices, or aids and charges for services and supplies for or related to gamete intrafallopian transfer, artificial insemination, in-vitro fertilization (except as required by the state law) or embryo

transfer procedures, elective sterilization or its reversal, or elective abortion unless specifically provided for in this Policy.

34. Expenses incurred for massage therapy.

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

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

37. 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).

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

DEFINITIONS

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

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

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

Ambulatory Surgical Center: a freestanding ambulatory surgical facility that:

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

Birthing Center: a freestanding facility that:

- Meets licensing standards.
- Is set up, equipped and run to provide prenatal care, delivery and immediate postpartum care.

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

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

Complications of Pregnancy: conditions requiring **hospital** stays (when the pregnancy is not terminated) whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion and similar medical and surgical conditions of comparable severity, but excluding false labor, occasional spotting, **physician**-prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum, preeclampsia and similar conditions associated with the management of difficult pregnancy not constituting a nosologically distinct complication of pregnancy.
Complications of Pregnancy also include nonelective cesarean section, ectopic pregnancy which is terminated and spontaneous termination of pregnancy, which occurs during a period of gestation in which a viable birth is not possible.

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

Covered Dependent: a **covered student's** dependent who is insured under this Policy

Covered Medical Expense: those charges for any treatment, service or supplies
covered by this Policy which are:
- not in excess of the **reasonable and customary** charges; or
- not in excess of the charges that would have been made in the absence of this coverage; and
- incurred while this Policy is in force as to the **covered person** except with respect to any expenses payable under the Extension of Benefit Provisions.

Covered Person: a **covered student** and any **covered dependent** while coverage under this Policy is in effect

Covered Student: a student of the Policyholder who is insured under this Policy.

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 26 years.

The term “child” includes a **covered student’s** step-child, adopted child whose coverage is effective upon the earlier of the date of placement for the purpose of adoption, or the date of the entry of an order granting the adoptive parent custody of the child for purposes of adoption.
The term **dependent** does not include a person who is: (a) an eligible student, or (b) a member of the armed forces.

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:

- vasectomy;
- breast reduction;
- 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; and
- treatment of infertility.

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 medical or behavioral condition which:

- requires confinement right away as a full-time inpatient; and
- manifests itself by symptoms of sufficient severity, including severe pain, that if immediate medical attention was not given could, as determined by a prudent lay person possessing an average knowledge of medicine and health, reasonably be expected to result in:
- placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition placing the health of such person or others in serious jeopardy;
- serious impairment to such person's bodily functions;
- serious dysfunction of any bodily organ or part of such person; or
- serious disfigurement of such person.

Emergency Medical Condition: a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in:

- placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition placing the health of such person or others in serious jeopardy;
- serious impairment to such person's bodily functions;
- serious dysfunction of any bodily organ or part of such person; or
- serious disfigurement of such person.

Generic Prescription Drug or Medicine: a **prescription drug** which is not protected by trademark registration, but is produced and sold under the chemical formulation name.

Home Health Agency:

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

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

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

Home Health Care Plan: a written program 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.

Home Health Care Plan: a plan of care established and approved in writing by a **physician**

Hospice: a facility or program providing a coordinated program of home and inpatient care which treats terminally ill patients. The program provides care to meet the special needs of the patient during the final stages of a terminal illness.

Care is provided by a team made up of trained medical personnel, counselors and volunteers. The team acts under an independent **hospice** administration and it helps the patient cope with physical, psychological, spiritual, social and economic stresses. The **hospital** administration must meet the standards of the National Hospice Organization and any licensing requirements.

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

Hospital: a facility which meets all of these tests:

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

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

Hospital Confinement: a documented inpatient stay in a **hospital** as a resident bed patient.

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**.

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.

A service or supply will not be considered as medically necessary if:

- It is provided only as a convenience to the **covered person** or provider; or
- it is not the appropriate treatment for the **covered person**'s diagnosis or symptoms; or
- it exceeds (in scope, duration or intensity) that level of care which is needed to provide safe, adequate and appropriate diagnosis or treatment.

The fact that any particular **physician** may prescribe, order, recommend, or approve a service or supply does not, of itself, make the service or supply **medically necessary**.

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

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

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

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

Orthodontic treatment: any

- medical service or supply; or
- dental service or supply;

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

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

whether or not for the purpose of relieving pain.

Not included is:

- the installation of a space maintainer; or
- surgical procedure to correct malocclusion.

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

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

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

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

Preferred Care: care provided by

- a person's **Preferred Care Provider**; or
- any health care provider for an emergency condition when travel to a **Preferred Care Provider** prior to treatment is not feasible.

Preferred Care: care provided by

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

Preferred Care Provider: 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:

38. the service or supply involved; and
39. the class of covered persons of which you are member.

Preferred Care Providers may be identified as either "in-area" or "out-of-area".

"In-area" **preferred care providers** are those providers located within a defined area (of reasonable proximity), to the Policyholder, as defined by travel time, distance or Zip code. "Out-of-area" **preferred care providers** are those providers located outside the defined area.

Preferred Pharmacy: a **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
- when such a **pharmacy** dispenses a **prescription drug** under the terms of its contract with Aetna.

Preferred Prescription Drug Expense: An expense incurred for a **prescription drug** that:

- is dispensed by a **Preferred Pharmacy**, or for an **emergency medical condition** only, by a **non-preferred pharmacy**; and
- is dispensed upon the **Prescription** of a **Prescriber** who falls into one or more of the categories of providers listed in the directory of **Preferred Care Providers**.

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

Prescription Drugs: any of the following:

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

Primary Care Physician:

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

- selected by a person from the list of **Primary Care Physician**s in the **directory**;
- responsible for the person's on-going health care; and
- shown on Aetna's records as the person's **Primary Care Physician**.

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

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 room and board and other necessary services and supplies. They must be regularly made at a daily or weekly rate

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

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

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

Sickness: disease or illness including related conditions and recurrent symptoms of the **sickness**. **Sickness** also includes pregnancy and **complications of pregnancy**.

All **injuries** or **sickness** due to the same or a related cause are considered one **injury** or **sickness**.

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

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

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

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

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

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

Surgical Procedure - This includes but is not limited to:

- a cutting procedure,
- suturing of a wound;
- treatment of a fracture;
- reduction of a dislocation;
- radiotherapy (excluding radioactive isotope therapy), if used in lieu of a cutting operation for removal of a tumor,
- electrocauterization;
- diagnostic and therapeutic endoscopic procedures;
- injection treatment of hemorrhoids and varicose veins;
- an operation by means of laser beam;
- cryosurgery.

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

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

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

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

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

Urgent Care Provider:

This is a freestanding medical facility which:

- Provides unscheduled medical services to treat an **urgent condition** if the **covered person's physician** is not reasonably available.
- Routinely provides ongoing unscheduled medical services for more than 8 consecutive hours.
- Makes charges.
- Is licensed and certified as required by any state or federal law or regulation.
- Keeps a medical record on each patient.
- Provides an ongoing quality assurance program. This includes reviews by physicians other than those who own or direct the facility.
- Is run by a staff of **physicians**. At least one such **physician** must be on call at all times.
- Has a full-time administrator who is a licensed **physician.**

Also, 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: this is a clinic with a group of **physicians;** which is not affiliated with a hospital; that provides:

- diagnostic services;
- observation;
- treatment;
- and rehabilitation;
- on an outpatient basis.

CLAIM PROCEDURE

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

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

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

1. Bills must be submitted within 120 days from the date of treatment.
2. Payment for **Covered Medical Expenses** will be made directly to the hospital or physician concerned, unless bill receipts and proof of payment are submitted.
3. If itemized medical bills are available at the time the claim form is submitted, attach them to the claim form. Subsequent medical bills should be mailed promptly to the above address.
4. You will receive an "Explanation of Benefits" when your claims are processed. The Explanation of Benefits will explain how your claim was processed, according to the benefits of your Student Accident and Sickness Insurance Plan.

HOW TO APPEAL A CLAIM

In the event a Covered Person disagrees with how a claim was processed, he/she may request a review of the decision. The Covered Person's request must include why he/she disagrees with the way the claim was processed. The request must also include any additional information that supports the claim (e.g., medical records, Physician's office notes, operative reports, Physician's letter of medical necessity, etc.). Please submit all requests to:

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

Or call in the appeal to Customer Service using the toll-free telephone number shown on the member ID card.

INTERNAL APPEALS PROCEDURE

Aetna has established a procedure for resolving appeals by **covered persons**. If the **covered person** has an appeal, please follow this procedure:

- An Appeal is defined as an oral or written request to Aetna to reconsider an **adverse benefit determination**.

First Level Appeals Procedure

- An Appeal must be submitted to Aetna within 180 days of the date Aetna provides notice of denial. The Aetna address is on the **covered person's** ID card. The Appeal may be submitted by the **covered person,** or by a representative, designated by the **covered person**.

The **covered person** may submit an oral grievance in connection with:

- A denial of, or failure to pay for, a referral, or
- A determination as to whether a benefit is covered under This Plan, by calling Member Services. Aetna's Member Services telephone number is on the **covered person's** ID card. If the **covered person** is required to leave a recorded message, the **covered person's** message will be acknowledged within one business day after the call was recorded.

An acknowledgment letter will be sent to the **covered person** within 1 day of Aetna's receipt of an oral Appeal, and 5 days of Aetna's receipt of a written Appeal. This letter may request additional information. If so, the additional information must be submitted to Aetna within 15 days of the date of the letter.

The **covered person** will be sent a response within 30 days of Aetna's receipt of the Appeal. The response will be based on the information provided with, or subsequent to, the Appeal.

If the Appeal concerns an eligibility issue, and if additional information is not submitted to Aetna after receipt of Aetna's response, the decision is considered Aetna's final response, 45 days after receipt of the Appeal. For all other Appeals, if additional information is to be submitted to Aetna after receipt of Aetna's response, it must be submitted within 15 days of the date of Aetna's response letter. Aetna's response will be sent within 30 days from the date of Aetna's first response letter.

In any urgent or emergency situation, the Expedited Appeal procedure may be initiated by a telephone call to Member Services. Aetna's Member Services telephone number is on the **covered person's** ID card. A verbal response to the Appeal will be given to the **covered person** and **covered person's** provider within 2 days, provided that all necessary information is available. Written notice of the decision will be sent within 2 business days of Aetna's verbal response.

Second Level Appeals Procedure

If the **covered person** is dissatisfied with Aetna's grievance determination, the **covered person,** or a representative designated by the **covered person,** may submit a written appeal within 60 business days after receipt of such determination.

An acknowledgement letter will be sent to the **covered person** within 15 days of Aetna's receipt of the written appeal. This letter may request additional information. If so, the additional information must be submitted to Aetna within 15 days of the date of the letter.

Aetna's final response for an urgent or emergency situation will be sent within 2 business days. For all other situations, a response will be sent within 30 business days from the date of Aetna's receipt of all necessary information.

If additional time is needed to resolve an Appeal, except in an urgent or emergency situation, Aetna will provide a written notification, indicating that additional time is needed, explaining why such time is needed, and setting a new date for a response. The additional time will not be extended beyond another 30 days.

The **covered person** must exhaust the Internal Appeals Procedure before requesting an External Appeal. However, the **covered person** is not required to exhaust the Internal Appeals Procedure prior to requesting an External Appeal, if the **covered person** and Aetna have agreed that the matter may proceed directly to an External Appeal.

Aetna will keep the records of the **covered person's** complaint for 7 years.

EXTERNAL REVIEW PROCESS

EXTERNAL APPEAL

RIGHT TO AN EXTERNAL APPEAL
Under certain circumstances, the **covered person** has a right to an external appeal of a denial of coverage. Specifically, if Aetna has denied coverage on the basis that the service is not necessary, or is an experimental or investigational treatment, the **covered person** may appeal that decision to an External Appeal Agent, an independent entity certified by the State, to conduct such appeals.

RIGHT TO APPEAL A DETERMINATION THAT A SERVICE IS NOT NECESSARY
If Aetna has denied coverage on the basis that the service is not necessary, the **covered person** may appeal to an External Appeal Agent, if the **covered person** satisfies the following criteria listed below:

The service, procedure, or treatment, must otherwise be a Covered Medical Expense under This Plan, and
The **covered person** must have received a final adverse determination through the first level of Aetna's internal review process, and Aetna must have upheld the denial, or the **covered person** and Aetna must agree in writing, to waive any internal appeal.

RIGHT TO APPEAL A DETERMINATION THAT A SERVICE IS EXPERIMENTAL OR INVESTIGATIONAL
If the **covered person** has been denied coverage on the basis that the service is an experimental or investigational treatment, the **covered person** must satisfy the following criteria:

- The service must otherwise be a Covered Medical Expense under This Plan, and
- The **covered person** must have received a final adverse determination through the first level of Aetna's internal appeal process, and Aetna must have upheld the denial, or the **covered person** and Aetna must agree in writing to waive any internal appeal.

In addition, the **covered person's** attending physician must certify that the **covered person** has a life-threatening or disabling condition or disease. A "life-threatening condition or disease" is one which, according to the current diagnosis of the attending physician, has a high probability of death. A "disabling condition or disease" is any medically determinable physical or medical impairment that can be expected to result in death, or that has lasted, or can be expected to last, for a continuous period of not less than 12 months, which renders the **covered person** unable to engage in any substantial gainful activities. In the case of a dependent child under the age of 18, a "disabling condition or disease" is any medically determinable physical or mental impairment of comparable severity.

The **covered person's** attending physician must also certify that the life-threatening or disabling condition or disease is one for which standard health services are ineffective, or medically inappropriate, or one for which there does not exist a more beneficial standard service or procedure covered under This Plan, or one for which there exists a clinical trial (as defined by law) or **rare disease**. In the case of a **rare disease**, the attending **physician** may not be the treating **physician**.

In addition, the **covered persons** attending physician must have recommended at least one of the following:

- A service, procedure or treatment that 2 documents from available medical and scientific evidence indicate is likely to be more beneficial to the **covered person** than any standard Covered Medical Expense (only certain documents will be considered in support of this recommendation – the **covered person's** attending physician should contact the State in order to obtain current information as to what documents will be considered acceptable) or in the case of a **rare disease**, based on the **physician's** certification and such other evidence as you, your designee of the attending **physician** may present; or
- A clinical trial for which the **covered person** is eligible (only certain clinical trials can be considered).

For the purposes of this section, the **covered person's** attending **physician** must be a licensed, board certified, or board eligible **physician**, qualified to practice in the area appropriate to treat the **covered person's** life-threatening or disabling condition or disease. In the case of a **rare disease**, the attending **physician** may not be the treating **physician**.

THE EXTERNAL APPEAL PROCESS
If, through the Aetna's internal appeal process, the **covered person** has received a final adverse determination upholding a denial of coverage on the basis that the service is not necessary, or is an experimental or investigational treatment, the **covered person** has 45 days from receipt of such notice to file a written request for an external appeal. If the **covered**

person and Aetna have agreed to waive any internal appeal, the **covered person** has 45 days from the receipt of such waiver to file a written request for an external appeal. Aetna will provide an external appeal application with the final adverse determination issued through the Aetna's internal appeal process or its written waiver of an internal appeal.

The **covered person** may also request an external appeal application from the New York State Department of Insurance at **1-800-400-8882**. The completed application must be submitted to the New York State Department of Insurance at the address listed in the application. If the **covered person** satisfies the criteria for an external appeal, the State will forward the request to a certified External Appeal Agent.

The **covered person** will have the opportunity to submit additional documentation with the request. If the External Appeal Agent determines that the information the **covered person** submit represents a material change from the information on which Aetna based its denial, the External Appeal Agent will share this information with Aetna in order for it to exercise its right to reconsider its decision. If Aetna chooses to exercise this right, Aetna will have 3 business days to amend or confirm its decision. Please note that in the case of an expedited appeal (described below), Aetna does not have a right to reconsider its decision.

In general, the External Appeal Agent must make a decision within 30 days of receipt of the completed application. The External Appeal Agent may request additional information from the **covered person**, the **covered person's** physician or Aetna. If the External Appeal Agent requests additional information, it will have 5 additional business days to make its decision. The External Appeal Agent must notify the **covered person** in writing of its decision within 2 business days.

If the **covered person's** attending physician certifies that a delay in providing the service that has been denied poses an imminent or serious threat to the **covered person's** health, the **covered person** may request an expedited external appeal. In that case, the External Appeal Agent must make a decision within 3 days of receipt of the completed application. Immediately after reaching a decision, the External Appeal Agent must try to notify the **covered person** and Aetna by telephone or facsimile of that decision. The External Appeal Agent must also notify the **covered person** in writing of its decision.

If the External Appeal Agent overturns Aetna's decision that a service is not necessary, or approves coverage of an experimental or investigational treatment, Aetna will provide coverage subject to the other terms and conditions of This Plan. If the External Appeal Agent approves coverage of an experimental or investigational treatment that is part of a clinical trial, Aetna will only cover the costs of services required to provide treatment to the **covered person** according to the design of the trial. Aetna shall not be responsible for the costs of investigational drugs or devices, the costs of non-health care services, the costs of managing research, or costs which would not be covered under This Plan for non-experimental or non-investigational treatments provided in such clinical trial.

The External Appeal Agent's decision is binding on both the **covered person** and Aetna. The External Appeal Agent's decision is admissible in any court proceeding.

Carriers and hospitals are permitted to agree to alternative dispute resolution mechanism in lieu of this External Appeals process. A **covered person** has the right to External Appeals for concurrent adverse determinations. Providers are prohibited from pursuing reimbursement from a **covered person**, except for copay, coinsurance and deductible, when External Review determination for a concurrent adverse determination is upheld.

RESPONSIBILITIES

It is the **covered person's** responsibility to initiate the external appeals process. The **covered person** may initiate the external appeal process by filing a completed application with the New York State Department of Insurance. If the requested service has already been provided to the **covered person**, the **covered person's** attending physician may file an expedited appeal application on the **covered person's** behalf, but only if the **covered person** has consented to this in writing.

Under New York State law, the **covered person's** completed request for appeal must be filed within 45 days of either the date upon which the **covered person** receives written notification from Aetna that it has upheld a denial of coverage, or the date upon which the **covered person** receives a written waiver of any internal appeal. Aetna has no authority to grant an extension of this deadline.

COVERED SERVICES AND EXCLUSIONS

In general, This Plan does not cover experimental or investigational treatments. However, This Plan shall cover an experimental or investigational treatment approved by an External Appeal Agent in accordance with this section. If the External Appeal Agent approves coverage of an experimental or investigational treatment that is part of a clinical trial, Aetna will only cover the costs of services required to provide treatment to **the covered person,** according to the design of the trial. Aetna shall not be responsible for the costs of investigational drugs or devices, the costs of non-health care services, the costs of managing research, or costs which would not be covered under This Plan for non-experimental or non-investigational treatments provided in such clinical trial.

PRESCRIPTION DRUG CLAIM PROCEDURE

Preferred Care

When obtaining a covered Prescription, please present your Aetna ID card to Preferred Pharmacy along with your applicable Copay. 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 Student Health Services or by calling **(888) RX-AETNA or (888) 792-3862**. You will be reimbursed for covered medications directly by Aetna. Please note, in addition to your Copay, you may be required to pay the difference between the retail price you paid for the prescription drug and the amount Aetna would have paid if you had presented your ID card and the Pharmacy had billed Aetna directly.

Information regarding Preferred Care Pharmacy locations is available by accessing the Internet by accessing DocFind at **www.aetna.com/docfind/custom/studenthealth/index.html**

Non-Preferred Care

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

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

Claim forms, Pharmacy locations, and claims status information can be obtained by contacting Aetna Pharmacy Management at **(888) RX-AETNA or (888) 792-3862**.

When submitting a claim, please include all Prescription receipts, indicate that you attend The New School and include your name, address, and student identification number.

WORLDWIDE TRAVEL ASSISTANCE SERVICES

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 medical, travel and security assistance services and other benefits.

Services rendered without On Call International's coordination and approval are not covered. No claims for reimbursement will be accepted. If the Member is able to leave the Member's host country by normal means, On Call International will assist the Member in rebooking flights or other transportation. Expenses for non-emergency transportation are the Member's responsibility.

On Call phone number: 1-866-525-1956 or collect 1-603-328-1956

A brief description of these benefits is outlined below.

Accidental Death and Dismemberment (ADD) Benefits
These benefits are underwritten by United States Fire Insurance Company (USFIC) and include the following:
Benefits are payable for the Accidental Death and Dismemberment of **Covered Persons**, up to a maximum of **$10,000.**

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

- Unlimited Emergency Medical Evacuation
- Unlimited Medically Supervised Repatriation
- Unlimited Return of Deceased Remains
- Unlimited Family Reunion (airfare only)
- **$2,500** Return of Traveling Companion
- **$2,500** Return of Dependent Children
- **$2,500** Bereavement Reunion - in the event of a Covered Person's death, On Call will fly a family member to identify the remains and accompany the remains back to the deceased's home country
- **$2,500** Emergency Return Home in the event of death or life-threatening illness of a parent, sibling or spouse
- **$1,000** Return of Personal Belongings

Natural Disaster and Political Evacuation Services (NDPE)
The following benefits are underwritten by United States Fire Insurance Company (USFIC) with medical, travel, and security assistance services provided by On Call.

If a **Covered Person** requires emergency evacuation due to governmental or social upheaval, which places him/her in imminent bodily harm (as determined by On Call security personnel in accordance with local and U.S. authorities), On Call will arrange and pay for his/her transportation to the nearest safe location, and then a one-way economy class airline ticket to his/her home country.

If a **Covered Person** requires emergency evacuation due to a natural disaster, which makes his/her location Uninhabitable, On Call will arrange and pay for his/her evacuation from a safe departure point to the nearest safe haven, and then home.

If the **Covered Person** is delayed at the safe haven, On Call shall arrange and pay for reasonable lodging expenses up to **$100** per day for a maximum of three days. (Economy airfare and lodging costs shall not exceed a combined single limit of **$5,000** USD per **Covered Person**).

Subject to a maximum benefit of **$100,000** per Covered Person per Event.

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

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

The On Call International Global Response Center can be reached 24 hours a day, 365 days a year.

The information contained above is a just summary of the ADD, MER, WETA, and NDPE benefits and services available through On Call. For a copy of the plan documents applicable to the ADD, MER, WETA and NDPE coverage, including a full description of coverage, exclusions and limitations, please contact Aetna Student Health at www.aetnastudenthealth.com or (800) 878-1927.

NOTE: In order to obtain coverage, all MER, WETA and NDPE services must be provided and arranged through On Call. Reimbursement will not be provided for any services not provided and arranged through On Call. Although certain emergency medical services may be covered under the terms of the Covered Person's student health insurance plan (the "Plan"), neither On Call nor its contracted insurance providers provide coverage for emergency 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, limitations and benefit maximums may apply. Neither CCA, nor Aetna Life Insurance Company, nor their affiliates provide medical care or treatment and they are not responsible for outcomes.

To file a claim for ADD benefits, or to obtain MER, WETA or NDPE 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 at **(866) 525-1956** or Collect at **(603) 328-1956**. All Covered Persons should carry their On Call ID card when traveling.

Chickering Claims Administrators, Inc. (CCA) provides access to certain Accidental Death and Dismemberment (AD&D); Medical Evacuation/Repatriation (MER); Natural Disaster and Political Evacuation (NDPE); and Worldwide Emergency Travel Assistance (WETA) coverages and services through a contractual relationship with On Call International, LLC (On Call). AD&D coverage is underwritten by Fairmont Specialty dba United States Fire Insurance Company (USFIC). MER, NDPE and WETA membership services are administered by On Call.

CCA and On Call are independent contractors and not employees or agents of the each other. Neither CCA nor any of its affiliates provides or administers ADD, MER, NPDE and WETA benefits/services and neither CCA nor any of its affiliates is responsible in any way for the benefits/services provided by or through On Call.

These services, programs or benefits are offered by vendors who are independent contractors and not employees or agents of Aetna.

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**

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 Standard Time at **(800) 225-3375**.

NOTICE

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

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www.universityhealthplans.com

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Policy No. **812804**

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