2010 - 2011

Student Health Insurance Plan

Underwritten by:
Aetna Life Insurance Company (ALIC)

Policy Number 100116

WHERE TO FIND HELP

In case of an emergency, call **911 (Off Campus)** or **2222** your On Campus local emergency hotline, or go directly to an emergency care facility.

For non-emergency situations please visit the Student Health Center in Michael Hall or contact the Student Health Center at **(716) 829-3316** or visit ***wellness.buffalo.edu***.

For questions about:
- Insurance Benefits
- Enrollment
- Waiver Process
- Claims Processing
- Forms and Assistance

Please contact:
The SBI Student Medical Insurance Office
University at Buffalo
Student Union, Suite 223
Box 602100
Buffalo, NY 14260-2100
Telephone: **(716) 645-3044**
E-mail: ***asksmi@buffalo.edu***
Website: ***www.healthinsurance.buffalo.edu***

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

Please contact:
Aetna Student Health
P.O. Box 981106
El Paso, TX 79998
(800) 954-5793

For questions about:
- ID Cards

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

For lost ID cards, contact:
Aetna Student Health
(800) 954-5793

Note: **You can print a temporary ID card from Aetna Navigator® at *www.aetnastudenthealth.com***.

For questions about:
- Status of Pharmacy Claim
- Pharmacy Claim Forms
- Excluded Drugs and Pre-Authorization

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

For questions about:
- Provider Listings

Please contact:
Aetna Student Health
(800) 954-5793

You can use Aetna's **DocFind®** Service at ***www.aetnastudenthealth.com*** to obtain a list of Preferred Providers in your area.

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

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

IMPORTANT NOTE

Please keep this Brochure, as it provides a general summary of your coverage. A complete description of the benefits and full terms and conditions may be found in the Master Policy issued to the University at Buffalo. 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 Sub Board Inc (SBI) Student Medical 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.

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UNIVERSITY HEALTH SERVICES

STUDENT HEALTH SERVICES

If you are enrolled in the Student Medical Insurance Plan, it will be to your advantage to first seek treatment at Student Health Services in order to reduce your out-of-pocket expenses. Student Health Services provides comprehensive medical services by appointment for primary care, urgent care, and limited specialty services. Lab and Pharmacy services are also available in Michael Hall through the Sub-Board I Clinical Lab and Pharmacy.

Maximize your coverage by first seeking care at Student Health Services in Michael Hall on the South Campus, prior to utilizing a community provider. Doing so will maximize coverage available to students, since there is no limit to the number of office visits at Student Health Services and **no office visit copay**.

Student Health Services is funded in part by the University Comprehensive Fee, which is automatically charged to all students' accounts, separate from the Student Medical Insurance Plan premium. When necessary, Student Health Services can refer students to providers who participate with the Student Medical Insurance Plan. The Student Medical Insurance Plan provides benefits for services received outside Michael Hall, as described in this Brochure, as well as lab work and prescriptions filled through the Sub-Board I Lab and Pharmacy, located in Michael Hall. Spouses and dependent children do not have access to Student Health Services. They do, however, have access to the Sub-Board I Medical Facilities.

The University Health Services is the University's on-campus health facility. It is open weekdays from 8:00 a.m. to 8:00 p.m., during the Fall and Spring semesters. A physician and nurse practitioner are on call at all times, and conduct clinics during the week.

For more information, call the Health Services at **(716) 829-3316**. In the event of an emergency, call **911** or the Campus Police at **(716) 645-2222**.

POLICY PERIOD

1. **Students**: Coverage for all insured students enrolled for the Fall Semester, will become effective at 12:01 a.m. on **August 22, 2010**, and will terminate at 12:01 a.m. on **August 22, 2011**.
2. **New Spring Semester Students**: Coverage for all insured students enrolled for the Spring Semester, will become effective at 12:01 a.m. on **January 9, 2011**, and will terminate at 12:01 a.m. on **August 22, 2011**.
3. **Insured Dependents**: Coverage will become effective on the same date the insured student's coverage becomes effective, or the day after the postmarked date when the completed application and premium are sent, if later. Coverage for insured dependents terminates in accordance with the Termination Provisions described in the Master Policy. For more information on termination of covered dependents see page 32 of this Brochure. Examples include, but are not limited to: the date the student's coverage terminates, the date the dependent no longer meets the definition of a dependent.

RATES

Cost Domestic Undergraduates and Graduate Students			
	Annual 08/22/10-08/21/11	**Spring/ Summer 01/09/11-08/21/11**	**Summer Only 05/15/11-08/21/11**
Student	$1,686	$989	$431
Spouse	$3,770	$2,205	$952
Child(ren)	$2,937	$1,719	$744

Cost Medical, Dental and Nursing Students			
	Annual 08/22/10-08/21/11	**Spring/ Summer 01/09/11-08/21/11**	**Summer Only 05/15/11-08/21/11**
Student	$1,880	$1,104	$482
Spouse	$4,207	$2,461	$1,064
Child(ren)	$ 3,275	$1,917	$831

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

DEDUCTIBLES

The following Deductibles are applied after the first **$1,000** of **Covered Medical Expenses** are paid:
$300 per Policy Year (Deductible is applied after the first **$1,000** of **Covered Medical Expenses** are paid).

THE UNIVERSITY AT BUFFALO STUDENT HEALTH INSURANCE PLAN

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

STUDENT COVERAGE

ELIGIBILITY

Full-Time Students

All domestic Undergraduate* and Graduate students* (defined for insurance purposes as twelve credits or more Undergraduates, nine credits or more Graduate and professional students) and domestic medical, dental and nursing students are automatically enrolled in the Plan unless they complete the online waiver process, who are enrolled at the University at Buffalo.

Part-Time Students

Part-time students taking one or more credit hours may elect to enroll in the University at Buffalo Student Medical Insurance Plan. To enroll go to ***www.healthinsurance.buffalo.edu***.

ENROLLMENT

Full-time University at Buffalo domestic Undergraduate*, Graduate* and domestic medical, dental and nursing students will be automatically enrolled in the Plan for the entire Plan year 2010-2011 unless proof of comparable coverage is provided through the waiver process on-line by the deadline.

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

WAIVER PROCESS/PROCEDURE

Students requesting a Waiver must enter the request online and provide information regarding the Plan they are covered under, at the following address: ***www.healthinsurance.buffalo.edu***.

Failure to complete the online waiver process by:

- **October 5, 2010** – for students whose academic year begins in **August 2010**,
- **February 22, 2011** – for NEW students enrolling at the University in the Spring semester,

will result in the student being automatically enrolled in the Plan, and the applicable premium will be billed to the student's account.

Please note: **The waiver requirement must be met each academic year**. Students who had waived in a previous academic year must file a new waiver by **October 5, 2010** (**February 22, 2011** for newly enrolled spring students). It is a requirement of the University that all qualifying domestic students* have health insurance coverage. Any student that loses comparable coverage while attending the University at Buffalo must contact the Student Medical Insurance Office immediately and enroll in the University at Buffalo Student Medical Insurance Plan.

Waiver submissions may be audited by the University at Buffalo, through Aetna Student Health, and/or their contractors or representatives. You may be required to provide, upon request, any coverage documents and/or other records demonstrating that you meet the school's requirements for waiving the Student Health Insurance Plan. By submitting the waiver request, you agree that your current insurance plan may be contacted for confirmation that your coverage is in force for the applicable Policy Year and that it meets the school's waiver requirements.

** Defined for insurance purposes as twelve credits or more Undergraduates, nine credits or more Graduate and professional students.*

REFUND POLICY

Pro-rata refunds may be available for students employed by the GSEU or Research Foundation contract bargaining units and to next of kin for students who become deceased during the contract year. Please contact the SBI Student Medical Insurance Office for instructions. No other pro-rata refunds will be made.

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

DEPENDENT COVERAGE

ELIGIBILITY

Covered students may also enroll their lawful spouse, and unmarried dependent children under age 19, who are fully supported by the covered student. Coverage for a dependent may be extended beyond age 19 if the dependent is completely disabled and is covered under the Plan before his/her 19th birthday.

ENROLLMENT

(Note*: *Enrollment is per Policy Year and does not automatically renew from the previous Policy Year)

To enroll the dependent(s) of a covered student in the Fall Semester, please complete the online Enrollment Application available at ***www.healthinsurance.buffalo.edu***. Your account will be billed accordingly. If the Enrollment Application is received before **October 5, 2010**, there will be no break in coverage. The Spring Semester enrollment deadline is **February 22, 2011** and the Summer Semester enrollment deadline is **June 22, 2011**.

In certain circumstances, dependents who involuntarily lose their coverage may apply to enroll after the deadline on the UB Student Medical Plan (providing the student is enrolled). **Application must be made within 31 days of loss of other coverage and must be accompanied by a letter of creditable coverage from the prior carrier**. Please contact the Student Medical Insurance Office at **(716) 645-3036** for additional information.

NEWBORN INFANT AND ADOPTED CHILD COVERAGE

A child born to a Covered Person shall be covered for accident, sickness, and congenital defects, for 31 days from the date of birth. At the end of this 31 day period, coverage will cease under the University at Buffalo 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, if necessary starting from the date of birth.

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

Please note: **Previously Covered Persons must re-enroll for dependent coverage by October 5, 2010 for the Fall Semester, and by February 22, 2011 for the Spring Semester, and June 22, 2011 for the Summer Semester in order to avoid a break in coverage for conditions which existed in prior Policy Years. Once a break in continuous coverage occurs, a condition existing during such a break which is a pre-existing condition will not be payable. See Continuously Insured Section of this Brochure**.

For information or general questions on dependent enrollment, contact the SBI Student Medical Insurance Office at **(716) 645-3036**.

CONTINUOUSLY INSURED

Continuously Insured is defined as a person, who was insured under prior Creditable Coverage, including Student Medical Insurance Policies issued to the University at Buffalo, and is now insured under this Plan.

Persons who have remained continuously insured under this Policy or other policies will be covered for any pre-existing condition, which manifests itself while continuously insured, except for expenses payable under prior policies in the absence of this Policy. Previously Covered Persons must re-enroll for coverage, including dependent coverage, by **October 5, 2010**, for the Fall Semester, and by **February 22, 2011**, for the Spring Semester and **June 22, 2011** for the Summer Semester in order to avoid a break in coverage for conditions which existed in prior Policy Years. Once a break in continuous coverage occurs, the pre-existing conditions limitation will apply (see page 10).

PREFERRED PROVIDER NETWORK

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

To maximize your savings and reduce your out-of-pocket expenses, select a Preferred Provider*. It is to your advantage to use a Preferred Provider because savings may be achieved from the Negotiated Charges these providers have agreed to accept as payment for their services. A complete listing of participating providers is available by contacting Aetna Student Health at **(800) 954-5793**. You can also use Aetna's online **DocFind®** service located at ***www.aetnastudenthealth.com***. Click on "Find Your School" and enter **100116** as your Policy Number.

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

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

PRE-CERTIFICATION PROGRAM

Pre-certification simply means calling Aetna Student Health prior to treatment to obtain approval for a medical procedure or service. Pre-certification may be done by you, your doctor, a hospital administrator, or one of your relatives. All requests for certification must be obtained by contacting Aetna Student Health at **(800) 954-5793** (attention: Managed Care Department).

If you do not secure pre-certification for non emergency inpatient admissions, or provide notification for emergency admissions, your **Covered Medical Expenses** will be subject to a **$200** per admission Deductible.

The following inpatient services require pre-certification:

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

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

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

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

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

NOTIFICATION OF EMERGENCY ADMISSIONS

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

PRE-EXISTING CONDITIONS/ CONTINUOUSLY INSURED PROVISIONS

PRE-EXISTING CONDITION (APPLIES TO DEPENDENTS ONLY)

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

LIMITATION

Pre-existing conditions are not covered during the first **six months** that you are covered under this Plan. However, there is an important exception to this general rule if you have been Continuously Insured.

CONTINUOUSLY INSURED

If a dependent has been continuously insured and has (i) had "creditable health insurance coverage*" (including but not limited to: COBRA, HMO, another group or individual policy, Medicare or Medicaid) prior to enrolling in this Plan, **and** (ii) the creditable coverage ended within **63 days** of the date you enrolled under this Plan. if both of these tests are met, then the pre-existing limitation period under this Plan will be reduced (and possibly eliminated altogether) by the number of days of your prior creditable coverage. You will be asked to provide evidence of your prior creditable coverage.

Once a break of more than **63 days** in your continuous coverage occurs, or a dependent elects coverage more than 30 days after the date such dependent becomes eligible for coverage under the plan, the definition of pre-existing conditions will apply.

**As used above: "creditable coverage means a person's prior medical coverage as defined in the New York Insurance Law section 3232.*

DESCRIPTION OF BENEFITS

Please Note:

THE UNIVERSITY AT BUFFALO PLAN MAY NOT COVER ALL OF YOUR HEALTH CARE EXPENSES.

The Plan excludes coverage for certain services and contains limitations on the amounts it will pay. Please read the University at Buffalo Student Insurance Plan Brochure carefully before deciding whether this Plan is right for you. While this document will tell you about some of the important features of the Plan, other features may be important to you and some may further limit what the Plan will pay. If you want to look at the full Plan description, which is contained in the Master Policy issued to the University at Buffalo, you may view it at the SBI Student Medical Insurance Office or you may contact Aetna Student Health at (800) 954-5793.

This Plan will never pay more than $50,000 in a Policy Year for Domestic Undergraduate and Graduate Students or never pay more than $1,000,000 in a Policy Year for Medical, Dental and Nursing Students. Additional Plan maximums may also apply. Some illnesses may cost more to treat and health care providers may bill you for what the Plan does not cover.

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

SUMMARY OF BENEFITS CHART

DEDUCTIBLES

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

Student:	**$300** per Policy Year, after **$1,000** in benefits has been paid.
Spouse:	**$300** per Policy Year, after **$1,000** in benefits has been paid.
Child:	**$300** per Policy Year, after **$1,000** in benefits has been paid.

COINSURANCE

Covered Medical Expenses are payable at the coinsurance percentage specified below, after any applicable Deductible, up to a maximum benefit of **$50,000 in a Policy Year for Domestic Undergraduate and Graduate Students or $1,000,000 in a Policy Year for Medical, Dental and Nursing Students.**

OUT OF POCKET MAXIMUMS

Once the Individual or Family **Out-of-Pocket Limit** has been satisfied, **Covered Medical Expenses** will be payable at **100%** for the remainder of the Policy Year, up to any benefit maximum that may apply.

Preferred Care Individual Out-of-Pocket:	**$2,000**
Non-Preferred Care Individual Out-of-Pocket:	**$6,000**

* Important Information: The benefit schedule below outlines copays/deductibles and maximums applicable to each benefit. Please note, that once the plan has paid a total of $1,000 in Covered Medical Expenses under this policy, the co-insurance level is reduced as outlined in the chart below. The $1,000 benefit accumulation limit is calculated on the total amount paid in Covered Medical Expenses for the policy year, not for each individual benefit.

All coverage is based on Reasonable Charges unless otherwise specified.

Inpatient Hospitalization Benefits	
Hospital Room and Board Expenses	**Covered Medical Expenses** are payable as follows: Preferred Care: After a **$200** per admission copay, **100%** of the Negotiated Charge up to **$1,000**, **80%** of the Negotiated Charge thereafter.* Non-Preferred Care: After a **$200** per admission deductible, **70%** of the Reasonable Charge up to **$1,000**, **60%** of the Reasonable Charge thereafter for a semi-private room.
Intensive Care Unit Expenses	**Covered Medical Expenses** are payable as follows: Preferred Care: After a **$200** per admission copay, **100%** of the Negotiated Charge up to **$1,000**, **80%** of the Negotiated Charge thereafter.* Non-Preferred Care: After a **$200** per admission deductible, **70%** of the Reasonable Charge up to **$1,000**, **60%** of the Reasonable Charge thereafter for the Intensive Care Room Rate for an overnight stay.
Miscellaneous Hospital Expenses	**Covered Medical Expenses** include, but are not limited to: laboratory tests, X-rays, surgical dressings, anesthesia, supplies and equipment use, and medicines. Benefits are payable as follows: Preferred Care: **100%** of the Negotiated Charge up to **$1,000**, **80%** of the Negotiated Charge thereafter.* Non-Preferred Care: **70%** of the Reasonable Charge up to **$1,000**, **60%** of the Reasonable Charge thereafter.
Physician Hospital Visit/ Consultation Expenses	**Covered Medical Expenses** for charges for the non-surgical services of the attending Physician, or a consulting Physician, are payable as follows: Preferred Care: **100%** of the Negotiated Charge up to **$1,000**, **80%** of the Negotiated Charge thereafter.* Non-Preferred Care: **70%** of the Reasonable Charge up to **$1,000**, **60%** of the Reasonable Charge thereafter. **Benefit Limit of 1 visit per day maximum.**

Surgical Benefits (Inpatient and Outpatient)	
Surgical Expenses	**Covered Medical Expenses** for charges for surgical services, performed by a Physician, are payable as follows: Preferred Care: **100%** of the Negotiated Charge up to **$1000**, **80%** of the Negotiated Charge thereafter.* Non-Preferred Care: **70%** of the Reasonable Charge up to **$1,000**, **60%** of the Reasonable Charge thereafter.
Anesthetist and Assistant Surgeon Expenses	**Covered Medical Expenses** for the charges of an anesthetist and an assistant surgeon, during a surgical procedure, are payable as follows: Preferred Care: **100%** of the Negotiated Charge up to **$1,000**, **80%** of the Negotiated Charge thereafter.* Non-Preferred Care: **70%** of the Reasonable Charge up to **$1,000**, **60%** of the Reasonable Charge thereafter.

*** Important Information: The benefit schedule above outlines copays/deductibles and maximums applicable to each benefit. Please note, that once the plan has paid a total of $1,000 in Covered Medical Expenses under this policy, the co-insurance level is reduced as outlined in the chart below. The $1,000 benefit accumulation limit is calculated on the total amount paid in Covered Medical Expenses for the policy year, not for each individual benefit.**

Ambulatory Surgical Expenses	**Covered Medical Expenses** for outpatient surgery performed in an ambulatory surgical center are payable as follows: Preferred Care: **100%** of the Negotiated Charge up to **$1,000**, **80%** of the Negotiated Charge thereafter.* Non-Preferred Care: **70%** of the Reasonable Charge up to **$1,000**, **60%** of the Reasonable Charge thereafter. **Covered Medical Expenses** must be incurred on the day of the surgery or within 48 hours after the surgery.

Outpatient Benefits	
Emergency Room Expenses	**Covered Medical Expenses** incurred for treatment of an Emergency Medical Condition are payable as follows: Preferred Care: After a **$100** copay (waived if admitted), **100%** of the Negotiated Charge. Non-Preferred Care: After a **$100** Deductible (waived if admitted), **100%** of the Reasonable Charge. ***Please note: this per visit Deductible does not apply towards meeting the annual Deductible***.
Urgent Care Expenses	*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: After a **$20** per visit copay, **100%** of the Negotiated Charge up to **$1,000**, **80%** of the Negotiated Charge thereafter. * Non-Preferred Care: **70%** of the Reasonable Charge up to **$1,000**, **60%** of the Reasonable Charge thereafter. Office Visit, Outpatient Clinic and Consultation maximum of **20 visits** per Policy Year (includes annual Well Woman and Specialists). *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 Expenses	**Covered Medical Expenses** are payable as follows: After a **100%** of the Actual Charge for the services of a professional ambulance to or from a hospital, when required due to the emergency nature of a covered accident or sickness.
Pre-Admission Testing Expenses	**Covered Medical Expenses** for pre-admission testing charges while an outpatient before scheduled surgery are payable on the same basis as any other condition.

*** Important Information: The benefit schedule above outlines copays/deductibles and maximums applicable to each benefit. Please note, that once the plan has paid a total of $1,000 in Covered Medical Expenses under this policy, the co-insurance level is reduced as outlined in the chart below. The $1,000 benefit accumulation limit is calculated on the total amount paid in Covered Medical Expenses for the policy year, not for each individual benefit.**

Physician's Office Visit Expenses	**Covered Medical Expenses** are payable as follows: Preferred Care: After a **$20** per visit copay, **100%** of the Negotiated Charge Non-Preferred Care: **70%** of the Reasonable Charge up to a maximum of **$35** per visit. Office Visit maximum of **20 visits** per Policy Year.
Laboratory and X-Ray Expenses	**Covered Medical Expenses** are payable as follows: Preferred Care: After a **$20** per visit copay, **100%** of the Negotiated Charge up to **$1,000**, **80%** of the Negotiated Charge thereafter.* Non-Preferred Care: After a **$20** per visit Deductible, **70%** of the Reasonable Charge up to **$1,000**, **60%** of the Reasonable Charge thereafter. **$20** copay/deductible does not apply to outpatient labs.
Chemotherapy Expenses	**Covered Medical Expenses** for chemotherapy, including anti-nausea drugs used in conjunction with the chemotherapy, radiation therapy, tests and procedures, physiotherapy (for rehabilitation only after a surgery), and expenses incurred at a radiological facility. **Covered Medical Expenses** also include expenses for the administration of chemotherapy and visits by a health care professional to administer the chemotherapy. Such expenses are payable as follows: Preferred Care: **100%** of the Negotiated Charge up to **$1,000**, **80%** of the Negotiated Charges thereafter.* Non-Preferred Care: **70%** of the Reasonable Charge up to **$1,000**, **60%** of the Reasonable Charge thereafter.
Durable Medical Equipment Expenses	**Covered Medical Expenses** are payable as follows: Preferred Care: **100%** of the Negotiated Charge. Non-Preferred Care: **70%** of the Reasonable Charge. Benefits are limited to **$500** per Policy Year (Separate from Prosthetic devices).
Prosthetic Devices Expenses	Benefits include charges for: artificial limbs, or eyes, and other non-dental prosthetic devices, as a result of an accident or sickness. **Covered Medical Expenses** do **not** include: eye exams, eyeglasses, vision aids, hearing aids, communication aids, and orthopedic shoes, foot orthotics, or other devices to support the feet. **Covered Medical Expenses** are payable as follows: Preferred Care: **100%** of the Negotiated Charge up to **$1,000**, **80%** of the Negotiated Charges thereafter.* Non-Preferred Care: **70%** of the Reasonable Charge up to **$1,000**, **60%** of the Reasonable Charge thereafter. Benefits are limited to **$500** per Policy Year (Separate from Durable Medical Equipment).

*** Important Information: The benefit schedule above outlines copays/deductibles and maximums applicable to each benefit. Please note, that once the plan has paid a total of $1,000 in Covered Medical Expenses under this policy, the co-insurance level is reduced as outlined in the chart below. The $1,000 benefit accumulation limit is calculated on the total amount paid in Covered Medical Expenses for the policy year, not for each individual benefit.**

Outpatient Physical Therapy Expenses	**Covered Medical Expenses** for physical therapy are payable as follows when provided by a licensed physical therapist: Preferred Care: After a **$20** per visit copay, **100%** of the Negotiated Charge up to **$1,000**, **80%** of the Negotiated Charge thereafter.* Non-Preferred Care: **70%** of the Reasonable Charge up to **$1,000**, **60%** of the Reasonable Charge thereafter. Coverage available only when therapy is completed within **60 days** of when therapy commenced.
Dental Injury Expenses	**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: **100%** of Actual Charge.
Treatment for Breast Cancer	**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. Benefits are payable on the same basis as any other sickness.

*** Important Information: The benefit schedule above outlines copays/deductibles and maximums applicable to each benefit. Please note, that once the plan has paid a total of $1,000 in Covered Medical Expenses under this policy, the co-insurance level is reduced as outlined in the chart below. The $1,000 benefit accumulation limit is calculated on the total amount paid in Covered Medical Expenses for the policy year, not for each individual benefit.**

Allergy Testing and Treatment Expenses	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 on the same basis as any other condition.
Diagnostic Testing for Attention Disorders and Learning Disabilities Expenses	**Covered Medical Expenses** for diagnostic testing for: • Attention Deficit Disorder, or • Attention Deficit Hyperactive Disorder, or • Dyslexia. Are payable as follows: Preferred Care: After a **$20** copay, **100%** of the Negotiated Charge up to **$1,000**, **80%** of the Negotiated Charge thereafter.* Non-Preferred Care: **70%** of the Reasonable Charge up to **$1,000**, **60%** of the Reasonable Charge thereafter. Once a Covered Person has been diagnosed with one of these conditions, medical treatment will be payable as detailed under the outpatient Treatment of Mental and Nervous Disorders portion of this Policy.
Chiropractic Therapy Expenses	**Covered Medical Expenses** include charges for Chiropractic Therapy provided on an outpatient basis. 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. Preferred Care: After a **$20** per visit copay, **100%** of the Negotiated Charge up to **$1,000**, **80%** of the Negotiated Charge thereafter.* Non-Preferred Care: After a **$35** per visit deductible, **70%** of the Reasonable Charge up to **$1,000**, **60%** of the Reasonable Charge thereafter. Chiropractic Therapy Visit, maximum of **15 visits** per Policy Year.

*** Important Information: The benefit schedule above outlines copays/deductibles and maximums applicable to each benefit. Please note, that once the plan has paid a total of $1,000 in Covered Medical Expenses under this policy, the co-insurance level is reduced as outlined in the chart below. The $1,000 benefit accumulation limit is calculated on the total amount paid in Covered Medical Expenses for the policy year, not for each individual benefit.**

Well Baby Care Expenses	Benefits include charges for routine preventive and primary care services, rendered to a covered dependent child on an outpatient basis. **Routine preventive and primary care** services are services rendered to a covered dependent child, from the date of birth through the attainment of **19 years** of age. Services include: initial hospital check-ups, other hospital visits, physical examinations, including routine hearing and vision examinations, medical history, developmental assessments, and materials for the administration of appropriate and necessary immunizations and laboratory tests, when given in accordance with the prevailing clinical standards of the American Academy of Pediatrics. Coverage for such services shall be provided only to the extent that such services are provided by, or under the supervision of a physician, or other licensed professional. **Covered Medical Expenses** are payable as follows: Preferred Care: • **100%** of the Negotiated Charge up to **$1,000**, **80%** of the Negotiated Charge thereafter.* Benefits are payable for scheduled visits in accordance with the prevailing clinical standards of the American Academy of Pediatrics, or • Same as any other accident or sickness. Non-Preferred Care: • **70%** of the Reasonable Charge up to **$1,000**, **60%** of the Reasonable Charge thereafter • Benefits are payable for scheduled visits in accordance with the prevailing clinical standards of the American Academy of Pediatrics, or Same as any other accident of sickness.
Immunizations Expenses	**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 26, 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. Adult TB and All Routine Child to 19, in accordance with American Academy of Pediatrics standards. Preferred Care: **100%** of the Negotiated Charge up to **$1,000**, **80%** of the Negotiated Charge thereafter.* Non-Preferred Care: **70%** of the Reasonable Charge up to **$1,000**, **60%** of the Reasonable Charge thereafter. **Covered Medical Expenses do not include** a physician's office visit in connection with immunization or testing for tuberculosis.

*** Important Information: The benefit schedule above outlines copays/deductibles and maximums applicable to each benefit. Please note, that once the plan has paid a total of $1,000 in Covered Medical Expenses under this policy, the co-insurance level is reduced as outlined in the chart below. The $1,000 benefit accumulation limit is calculated on the total amount paid in Covered Medical Expenses for the policy year, not for each individual benefit.**

Consultant or Specialist Expenses	**Covered Medical Expenses** include the expenses for the services of a consultant or specialist. The services must be requested by the attending physician for the purpose of confirming or determining to confirm or determine a diagnosis. Benefits are payable as follows: Preferred Care: After a **$20** per visit copay, **100%** of the Negotiated Charge up to **$1,000**, **80%** of the Negotiated Charge thereafter.* Non-Preferred Care: **70%** of the Reasonable Charge up to a maximum of **$35** per visit. Office Visit, Outpatient Clinic and Consultation max of **20 visits** per Policy Year (includes annual Well Woman and Specialists).

Treatment of Mental and Nervous Disorders	
Biologically Based Mental Illness and for Children with Serious Emotional Disturbances Expenses	"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**. **Covered Medical Expenses** are payable as follows: Preferred Care: After a **$200** per admission copay, **100%** of the Negotiated Charge up to **$1,000**, **80%** of the Negotiated Charge thereafter.* Non-Preferred Care: After a **$200** per admission deductible, **70%** of the Reasonable Charge up to **$1,000**, **60%** of the Reasonable Charge thereafter for a semi-private room.

*** Important Information: The benefit schedule above outlines copays/deductibles and maximums applicable to each benefit. Please note, that once the plan has paid a total of $1,000 in Covered Medical Expenses under this policy, the co-insurance level is reduced as outlined in the chart below. The $1,000 benefit accumulation limit is calculated on the total amount paid in Covered Medical Expenses for the policy year, not for each individual benefit.**

Biologically Based Mental Illness and for Children with Serious Emotional Disturbances Expenses (continued)	*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 two days of partial hospitalization or intensive outpatient treatment may be exchanged for one day of full hospitalization.* ***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. Preferred Care: **100%** of the Negotiated Charge up to **$1,000**, **80%** of the Negotiated Charge thereafter.* Non-Preferred Care: **80%** of the Reasonable Charge up to a maximum of **$50** per visit. Outpatient treatment is covered up to a maximum of **50 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.
Other than Biologically Based Mental Illness and Children with Serious Emotional Disturbances Expenses	***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. **Covered Medical Expenses** are payable as follows: Preferred Care: After a **$200** per admission copay, **100%** of the Negotiated Charge up to **$1,000**, **80%** of the Negotiated Charge thereafter.* Non-Preferred Care: After a **$200** per admission deductible, **70%** of the Reasonable Charge up to **$1,000**, **60%** of the Reasonable Charge thereafter for a semi-private room. *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 two days of partial hospitalization or intensive outpatient treatment may be exchanged for one 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: **100%** of the Negotiated Charge up to **$1,000**, **80%** of the Negotiated Charge thereafter.* Non-Preferred Care: **80%** of the Reasonable Charge up to a maximum of **$50** per visit. Outpatient treatment is covered up to a maximum of **50 visits** per Policy Year.

*** Important Information: The benefit schedule above outlines copays/deductibles and maximums applicable to each benefit. Please note, that once the plan has paid a total of $1,000 in Covered Medical Expenses under this policy, the co-insurance level is reduced as outlined in the chart below. The $1,000 benefit accumulation limit is calculated on the total amount paid in Covered Medical Expenses for the policy year, not for each individual benefit.**

Other than Biologically Based Mental Illness and Children with Serious Emotional Disturbances Expenses (continued)	***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.

Substance Abuse Benefits	
Inpatient Expenses	**Covered Medical Expenses** include the treatment of a substance abuse condition while confined as an 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 two days of partial hospitalization may be exchanged for one day of full hospitalization. Benefits are payable as follows: Preferred Care: After a **$200** per admission copay, **100%** of the Negotiated Charge up to **$1,000**, **80%** of the Negotiated Charge thereafter.* Non-Preferred Care: After a **$200** per admission deductible, **70%** of the Reasonable Charge up to **$1,000**, **60%** of the Reasonable Charge thereafter. Benefits will include seven inpatient days for detoxification in any calendar year and **30 inpatient days** for rehabilitation in any calendar year.
Outpatient Expenses	**Covered Medical Expenses** for outpatient diagnosis and treatment of a substance abuse condition are payable as follows: Preferred Care: **100%** of the Negotiated Charge up to **$1,000**, **80%** of the Negotiated Charge thereafter.* Non-Preferred Care: **70%** of the Reasonable Charge up to **$1,000**, **60%** of the Reasonable Charge thereafter. Benefits are limited to **60 visits** per Policy Year, **20** of which may be used for family counseling.

*** Important Information: The benefit schedule above outlines copays/deductibles and maximums applicable to each benefit. Please note, that once the plan has paid a total of $1,000 in Covered Medical Expenses under this policy, the co-insurance level is reduced as outlined in the chart below. The $1,000 benefit accumulation limit is calculated on the total amount paid in Covered Medical Expenses for the policy year, not for each individual benefit.**

Maternity Benefits	
Maternity Expenses	**Covered Medical Expenses** include inpatient care of the Covered Person and any newborn child for a minimum of 48 hours after a vaginal delivery and for a minimum of 96 hours after a cesarean delivery. Any decision to shorten such minimum coverages shall be made by the attending Physician, in consultation with the mother. In such cases, **Covered 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 cesarean 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, • 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. **Covered Medical Expenses** include services of a licensed midwife unless those services duplicate the services already provided by the Covered Person's physician. 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. **Covered Medical Expenses** include coverage for blood lead testing for prenatal/maternity care.
Well Newborn Nursery Care Expenses	Benefits include charges for routine care of a Covered Person's newborn child as follows: • hospital charges for routine nursery care during the mother's confinement, but for not more than four days for a normal delivery, • physician's charges for circumcision, and • physician's charges for visits to the newborn child in the hospital and consultations, but for not more than one visit per day. **Covered Medical Expenses** are payable as follows: Preferred Care: **100%** of the Negotiated Charge up to **$1,000**, **80%** of the Negotiated Charge thereafter.* Non-Preferred Care: **70%** of the Reasonable Charge up to **$1,000**, **60%** of the Reasonable Charge thereafter.

*** Important Information: The benefit schedule above outlines copays/deductibles and maximums applicable to each benefit. Please note, that once the plan has paid a total of $1,000 in Covered Medical Expenses under this policy, the co-insurance level is reduced as outlined in the chart below. The $1,000 benefit accumulation limit is calculated on the total amount paid in Covered Medical Expenses for the policy year, not for each individual benefit.**

Additional Benefits	
Prescription Drug Benefit Expenses	Prescription Drug Benefits are payable as follows: **Sub-Board I Prescription Drug Coverage** (Available to covered student and dependents) Prescriptions filled at the Sub-Board I Pharmacy will be paid **100%** after a **$10** copay, per Prescription, not to exceed the aggregate Policy maximum. Covered prescriptions include, but are not limited to, oral contraceptives. Please contact the Sub-Board I Pharmacy for their hours of operation (including winter and summer recesses during which the Sub-Board I Pharmacy may be closed) at **(716) 829-2368** or online at ***www.subboard.com***. Prescription Drug Benefits are payable at: **100%** Following a **$45** copay for each Brand Name Prescription Drug, or a **$30** copay for each Generic Prescription Drug. Prescriptions filled through Aetna Pharmacy Management are payable up to a maximum of **$600** per Policy Year. This Pharmacy benefit is provided to cover Medically Necessary Prescriptions associated with a covered sickness or accident occurring during the Policy Year. Please use your Aetna Student Health ID card when obtaining your prescriptions. Prior Authorization is required for certain Prescription Drugs, including, Imitrex, certain stimulants, growth hormones and for any Prescription quantities larger than a 30-day supply. (***This is only a partial list***.) Medications not covered by this benefit include, but are not limited to: allergy sera (see allergy benefit), drugs whose sole purpose is to promote or to stimulate hair growth, appetite suppressants, immunization agents and vaccines (see immunization benefit), and non-self injectables. (***This is only a partial list***.) For assistance or for a complete list of excluded medications, or drugs requiring **prior authorization**, please contact Aetna Pharmacy Management at **(800) 238-6279** (available 24 hours). Aetna Specialty Pharmacy provides specialty medications and support to members living with chronic conditions. The medications offered may be injected, infused or taken by mouth. For additional information please go to ***www.AetnaSpecialtyRx.com***.
Diabetic 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. Benefits are payable as any sickness.
Diabetic Self-Management Education Expenses	**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. ***Please see definition of Diabetic Self-Management Education on page 36 for more detailed information on this benefit.*** Benefits for Self-Management Education and Home Health Care are payable as any sickness.

*** <u>Important Information</u>: The benefit schedule above outlines copays/deductibles and maximums applicable to each benefit. Please note, that once the plan has paid a total of $1,000 in Covered Medical Expenses under this policy, the co-insurance level is reduced as outlined in the chart below. The $1,000 benefit accumulation limit is calculated on the total amount paid in Covered Medical Expenses for the policy year, not for each individual benefit.**

Non Prescription Enteral Formula Expenses	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 on the same basis as any other condition. Modified solid food products (MFSP) that are low in protein are covered up to the maximum of **$2,500** per Covered Person, per Policy Year.
Temporomandibular Joint Dysfunction (TMJ)	**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. Benefits are payable on the same basis as any other condition.

Prescription Contraceptive Drugs and Devices Expenses	**Covered Medical Expenses** include:
	• Charges incurred for contraceptive drugs and devices that by law need a physician's prescription, and that have been approved by the FDA.
	• Related outpatient contraceptive services such as:
	  • Consultations,
	  • Exams,
	  • Procedures, and
	  • Other medical services and supplies.
	
	Benefits are payable as any condition.

Pap-Smear Expenses	**Covered Medical Expenses** include one annual routine Pap-smear screening for women age 18 and older. Benefits are payable as any condition.
Mammography Expenses	**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. Benefits are payable as any condition.

*** <u>Important Information</u>: The benefit schedule above outlines copays/deductibles and maximums applicable to each benefit. Please note, that once the plan has paid a total of $1,000 in Covered Medical Expenses under this policy, the co-insurance level is reduced as outlined in the chart below. The $1,000 benefit accumulation limit is calculated on the total amount paid in Covered Medical Expenses for the policy year, not for each individual benefit.**

Mastectomy Reconstruction Benefit Expenses	**Covered Medical Expenses** will include expenses incurred for: • all stages of reconstruction of the breast on which a mastectomy has been performed; and • surgery and reconstruction of the other breast to produce a symmetrical appearance. Benefits are payable as any condition.
Voluntary Termination of Pregnancy Expenses	If, as a result of pregnancy having its inception during the Policy Year, a Covered Person incurs expenses in connection with a voluntary termination of the pregnancy, a benefit is payable. **Covered Medical Expenses** for Elective Abortion Expense are covered as follows: Preferred Care: **100%** of the Negotiated Charge up to **$1,000**, **80%** of the Negotiated Charge thereafter.* Non-Preferred Care: **70%** of the Reasonable Charge up to **$1,000**, **60%** of the Reasonable Charge thereafter.
Routine Screening for Sexually Transmitted Disease Expenses	**Covered Medical Expenses** include charges for Covered Persons who are at least 18 years old and who are sexually active for annual routine screening for sexually transmitted diseases. Benefits are payable on the same basis as any other condition.
Routine Prostate Cancer Screening Expenses	**Covered Medical Expenses** include charges incurred for the screening of cancer as follows: • For males age 40 and over, with a family history of prostate cancer or other prostate cancer risk factors, Standard Diagnostic Testing once each Policy Year. • for males age 50 or over, who is asymptomatic, Standard Diagnostic Testing once each Policy Year. For a male, any age, with a prior history of prostate cancer, Standard Diagnostic Testing as recommended by the Covered Person's physician. Standard Diagnostic Testing includes, but is not limited to: • a digital rectal examination; and • a prostate-specific antigen test. Benefits are payable as any sickness.
Second Opinion For Cancer Treatment Expenses	**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. Benefits are payable as any sickness.

*** Important Information: The benefit schedule above outlines copays/deductibles and maximums applicable to each benefit. Please note, that once the plan has paid a total of $1,000 in Covered Medical Expenses under this policy, the co-insurance level is reduced as outlined in the chart below. The $1,000 benefit accumulation limit is calculated on the total amount paid in Covered Medical Expenses for the policy year, not for each individual benefit.**

Surgical Second Opinion Expenses	**Covered Medical Expense**s will include expenses incurred for a second opinion consultation by a specialist on the need for surgery which has been recommended by the Covered Person's physician. The specialist must be board certified in the medical field relating to the surgical procedure being proposed. Coverage will also be provided for any expenses incurred for required X-rays and diagnostic tests done in connection with that consultation. Aetna must receive a written report on the second opinion consultation. Benefits are payable as follows: Preferred Care: After a **$20** per visit copay, **100%** of the Negotiated Charge up to **$1,000**, **80%** of the Negotiated Charge thereafter.* Non-Preferred Care: **70%** of the Reasonable Charge up to a maximum of **$35** per visit. Office Visit, Outpatient Clinic and Consultation maximum of **20 visits** per Policy Year (includes annual Well Woman and Specialists).
Elective Surgical Second Opinion Expenses	**Covered Medical Expenses** will include expenses incurred for a second opinion consultation by a specialist on the need for non-emergency elective surgery which has been recommended by the Covered Person's physician. The specialist must be board certified in the medical field relating to the surgical procedure being proposed. Coverage will also be provided for any expenses incurred for required X-rays and diagnostic tests done in connection with that consultation. Aetna must receive a written report on the second opinion consultation. Benefits are payable as follows: Preferred Care: After a **$20** per visit copay, **100%** of the Negotiated Charge up to **$1,000**, **80%** of the Negotiated Charge thereafter.* Non-Preferred Care: **70%** of the Reasonable Charge up to a maximum of **$35** per visit. Office Visit, Outpatient Clinic and Consultation maximum of **20 visits** per Policy Year (includes annual Well Woman and Specialists).
Acupuncture in Lieu of Anesthesia Expenses	**Covered Medical Expenses** include acupuncture therapy, when acupuncture is used in lieu of other anesthesia, for a surgical or dental procedure covered under this Plan. The acupuncture must be administered by a health care provider who is a legally qualified physician, practicing within the scope of their license. Preferred Care: **100%** of the Negotiated Charge up to **$1,000**, **80%** of the Negotiated Charge thereafter.* Non-Preferred Care: **70%** of the Reasonable Charge up to **$1,000**, **60%** of the Reasonable Charge thereafter.
Dermatological Expenses	**Covered Medical Expenses** include charges for the diagnosis and treatment of skin disorders, excluding laboratory fees. Related laboratory expenses are covered under the Outpatient Expense Benefit. Benefits are payable on the same basis as any other condition. ***Covered Medical Expenses*** *do not include treatment for cosmetic treatment and procedures.*

*** Important Information: The benefit schedule above outlines copays/deductibles and maximums applicable to each benefit. Please note, that once the plan has paid a total of $1,000 in Covered Medical Expenses under this policy, the co-insurance level is reduced as outlined in the chart below. The $1,000 benefit accumulation limit is calculated on the total amount paid in Covered Medical Expenses for the policy year, not for each individual benefit.**

Podiatric Expenses	**Covered Medical Expenses** include charges for podiatric services, provided on an outpatient basis following an injury or sickness. Benefits are payable on the same basis as any other condition. Expenses for routine foot care, such as trimming of corns, calluses, and nails, are **not Covered Medical Expenses**.
Home Health Care/Services Expenses	**Covered Medical Expenses** include charges incurred by a Covered Person for home health care services made by a home health agency pursuant to a home health care plan. ***Please see definitions on page 40 for more detailed information on this benefit.*** Preferred Care: **100%** of the Negotiated Charge up to **$1,000**, **80%** of the Negotiated Charge thereafter.* Non-Preferred Care: **70%** of the Reasonable Charge up to **$1,000**, **60%** of the Reasonable Charge thereafter.
Transfusion or Dialysis of Blood Expenses	**Covered Medical Expenses** include charges for the transfusion or dialysis of blood, including the cost of: whole blood, blood components, and the administration thereof. Benefits are payable on the same basis as any other condition.
Hospice Benefit Expenses	**Covered Medical Expenses** include charges for hospice care provided for a terminally ill Covered Person during a hospice benefit period, including acute care services at an acute care facility. Benefits are payable as follows: Preferred Care: **100%** of the Negotiated Charge. Non-Preferred Care: **100%** of the Reasonable Charge. ***Please see definition on page 41 for more information on Hospice Care Expenses.***
Licensed Nurse Expenses	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 Medical Expenses** for a Licensed Nurse are covered as follows: Preferred Care: **100%** of the Negotiated Charge up to **$1,000**, **80%** of the Negotiated Charge thereafter.* Non-Preferred Care: **70%** of the Reasonable Charge up to **$1,000**, **60%** of the Reasonable Charge thereafter.

*** Important Information: The benefit schedule above outlines copays/deductibles and maximums applicable to each benefit. Please note, that once the plan has paid a total of $1,000 in Covered Medical Expenses under this policy, the co-insurance level is reduced as outlined in the chart below. The $1,000 benefit accumulation limit is calculated on the total amount paid in Covered Medical Expenses for the policy year, not for each individual benefit.**

Skilled Nursing Facility Expenses	**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: After a **$200** per admission copay, **100%** of the Negotiated Charge for the semi-private room rate up to **$1,000**, **80%** of the Negotiated Charge thereafter.* Non-Preferred Care: After a **$200** per admission Deductible, **70%** of the Reasonable Charge up to **$1,000**, **60%** of the Reasonable Charge thereafter for the semi-private room rate.
Rehabilitation Facility Expenses	**Covered Medical Expenses** include charges incurred by a Covered Person for confinement as a full time inpatient in a rehabilitation facility. Confinement in the rehabilitation facility must follow within 24 hours of, and be for the same or related cause(s) as, a period of hospital or skilled nursing facility confinement. **Covered Medical Expenses** for Rehabilitation Facility Expense are covered as follows: Preferred Care: After a **$200** per admission copay, **100%** up to **$1,000**, **80%** of the Negotiated Charge thereafter for the rehabilitation facility's daily room and board maximum for semi-private accommodations.* Non-Preferred Care: After a **$200** per admission Deductible, **70%** of the Reasonable Charge up to **$1,000**, **60%** of the Reasonable Charge thereafter for the rehabilitation facility's daily room and board maximum for semi-private accommodations.
Bone Density Screening Expenses	**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: 1. an individual previously diagnosed as having osteoporosis or having a family history of osteoporosis; or 2. an individual with symptoms or conditions indicative of the presence, or the significant risk of osteoporosis; or 3. an individual on a prescribed drug regimen posing a significant risk of osteoporosis; or 4. an individual with lifestyle factors to such a degree as posing a significant risk of osteoporosis; or 5. 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. Benefits are payable as any sickness.

*** Important Information: The benefit schedule above outlines copays/deductibles and maximums applicable to each benefit. Please note, that once the plan has paid a total of $1,000 in Covered Medical Expenses under this policy, the co-insurance level is reduced as outlined in the chart below. The $1,000 benefit accumulation limit is calculated on the total amount paid in Covered Medical Expenses for the policy year, not for each individual benefit.**

ADDITIONAL SERVICES AND DISCOUNTS

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

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

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

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

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

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

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

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

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

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

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

Discount programs and other programs above provide access to discounted prices and are NOT insured benefits. The member is responsible for the full cost of the discounted services. Discount programs may be offered by vendors who are independent contractors and not employees or agents of Aetna.

Aetna's Informed Health® Line:
Call toll free **1-800-556-1555** 24 hours a day, 7 days a week.
Get health answers 24/7. When you have an Aetna health benefits and health insurance plan, you have instant access to the information you need. Our tools and resources can help you:

- Make more informed decisions about your care
- Communicate better with your doctors
- Save time and money, by showing you how to get the right care at the right time

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

Listen to the **Audio Health Library:***
It explains thousands of health conditions in English and Spanish. Transfer easily to a registered nurse at any time during the call.
** Not all topics in the audio health service are covered expenses under your plan.*

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

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

Beginning Right® Maternity Program: Make healthy choices for you and your baby**.** Learn what decisions are good ones for you and your baby. Our Beginning Right maternity program helps prepare you for the exciting changes pregnancy brings.

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

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

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

Vital Savings[SM*] on Pharmacy is a discount program helping you and your dependents lower your prescription drug costs. Present your card to participating pharmacies and receive a discount at the time of purchase, no claims to file. Enroll online at ***www.aetnastudenthealth.com***.

Price: $25 Student
$44 Student + 1 Dependent
$63 Student + 2 or More Dependents

Vital Savings[SM*] on Dental is a dental discount program helping you and your dependents save – with one low annual fee of $25 per Student. In most instances, savings range from 15-50 percent on services from general dentistry and cleanings to root canals, crowns, and orthodontia (braces). No claims to file. Enroll online at ***www.aetnastudenthealth.com***.

Price: $25 Student
$44 Student + 1 Dependent
$63 Student + 2 or More Dependents
*Actual costs and savings vary by provider and geographic area.

Vital Savings[SM*] on Pharmacy and Dental is a discount program helping you and your dependents save on prescription drug costs and a wide array of dental services. Enroll online at ***www.aetnastudenthealth.com***. Save time and money on enrollment fees by joining both programs in one step. In most instances, for dental, savings range from 15-50 percent on services from general dentistry and cleanings to root canals, crowns, and orthodontia (braces). No claims to file.

Price: $40 Student
$70 Student + 1 Dependent
$100 Student + 2 or More Dependents

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

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 Sickness Expense coverage for a **Covered Person** ends while he is totally disabled, benefits will continue to be available for expenses incurred for that person only while the **Covered Person** continues to be totally disabled. Benefits will end three months from the date coverage ends. Benefits will continue to be available for a **Covered Person** who incurs medical expenses directly relating to a pregnancy that began before coverage under this Policy ceased. Such benefits will be covered only for the period of that pregnancy.

If a **Covered Person** is confined to a **hospital** or under treatment for a covered condition on the date his or her Basic Sickness Expense coverage terminates, charges incurred during the continuation of that hospital confinement or for that treatment of the covered condition shall also be included in the term "Expense", but only while they are incurred during the 31 day period following such termination of insurance.

TERMINATION OF INSURANCE

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

TERMINATION OF STUDENT COVERAGE

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

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

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

TERMINATION OF DEPENDENT COVERAGE

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

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

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

INCAPACITATED DEPENDENT CHILDREN

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

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

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

EXCLUSIONS

This Policy does not cover nor provide benefits for:

1. Expenses incurred for services normally provided without charge by the Policyholder's Health Service, Infirmary or **Hospital**, or by health care providers employed by the Policyholder.

2. Expenses incurred for eye refractions, vision therapy, 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**. Expense for radial keratotomy, unless medically necessary.

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

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

5. Expenses 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.

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

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

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

9. Expenses incurred for cosmetic surgery, reconstructive surgery, or other services and supplies which improve, alter, or enhance appearance, whether or not for psychological or emotional reasons.

   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.

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

11. Expenses incurred as a result of commission of a felony.

12. Expenses incurred after the date insurance terminates for a **Covered Person** except as may be specifically provided in the Extension of Benefits Provision.

13. Expenses incurred for services normally provided without charge by the school and covered by the school fee for services.

14. Expenses incurred for any services rendered by a member of the **Covered Person's** immediate family or a person who lives in the **Covered Person's** home.

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

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

17. Expenses 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.

18. 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:
        - The American Medical Association Drug Evaluations,
        - The American Hospital Formulary Service Drug Information, or
        - The United States Pharmacopeia Drug Information, or
        - Recommended by review article or editorial comment in a major peer reviewed professional journal, or
            - If Aetna determines that available, scientific evidence demonstrates that the drug is effective, or shows promise of being effective, for the disease.

19. Expenses incurred for acupuncture, unless services are rendered for anesthetic purposes.

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

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

22. Expenses for **injuries** sustained as the result of a motor vehicle **accident**, to the extent that benefits are payable under other valid and collectible insurance, whether or not claim is made for such benefits. The Policy will only pay for those losses, which are not payable under the automobile medical payment insurance Policy.

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

24. Expenses incurred for hearing aids, the fitting, or prescription of hearing aids.

25. Expenses incurred for hearing exams.

26. Expenses for care or services to the extent the charge would have been covered under Medicare Part A or Part B, even though the **Covered Person** is eligible, but did not enroll in Part B.

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

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

29. Expenses for incidental surgeries, and standby charges of a **physician**.

30. Expenses for treatment and supplies for programs involving cessation of tobacco use.

31. Expenses 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. Expenses incurred for **injury** resulting from the plan or practice of intercollegiate sports, in excess of $500 (participating in sports clubs, or intramural athletic activities, is not excluded).

33. Expenses for contraceptive methods, devices or aids, and charges for services and supplies for or related to gamete intrafallopian transfer, artificial insemination, in vitro fertilization (except as required by the state law), or embryo transfer procedures, elective sterilization or its reversal, or elective abortion, unless specifically provided for in this Policy.

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

35. Expenses for charges that are not **Reasonable Charges**, as determined by Aetna.

36. Expenses 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.

37. Expenses for treatment of **covered students** who specialize in the mental health care field, and who receive treatment as a part of their training in that field.

38. Expenses arising from a **pre-existing condition**, twelve months or less from the **Covered Person's** enrollment date.

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 two operating rooms and one recovery room.
- Provides, or arranges with a medical facility in the area for, diagnostic X-ray and lab services needed in connection with surgery.
- Does not have a place for patients to stay overnight.
- Provides, in the operating and recovery rooms, full-time skilled nursing services directed by a R.N.
- Is equipped and has trained staff to handle medical emergencies.
- It must have:
  - a physician trained in cardiopulmonary resuscitation, and
  - a defibrillator, and
  - a tracheotomy set, and
  - a blood volume expander.
- Has a written agreement with a **hospital** in the area for immediate emergency transfer of patients. Written procedures for such a transfer must be displayed and the staff must be aware of them.
- Provides an ongoing quality assurance program. The program must include reviews by physicians who do not own or direct the facility.
- Keeps a medical record on each patient.

Birthing Center
A freestanding facility that:

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

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

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

Complications of Pregnancy
Conditions which require **hospital** stays before the pregnancy ends and whose diagnoses are distinct from but are caused or affected by pregnancy. These conditions are:
- acute nephritis or nephrosis, or
- cardiac decompensation or missed abortion, or
- similar conditions as severe as these.

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

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

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

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

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

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

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

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

Deductible
The amount of **Covered Medical Expenses** that are paid by each **Covered Person** during the **Policy Year** before benefits are paid.

Dependent
(a) the **covered student's** spouse residing with the **covered student**, or (b) the person identified as a domestic partner in the "Declaration of Domestic Partnership" which is completed and signed by the **covered student**, and (c) the **covered student's** unmarried child under the age of 19 years. The child must reside with, and be fully supported by, the **covered student**.

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

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

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

Designated Care Provider
A health care provider or **pharmacy** that is affiliated with, and has an agreement with, the **School Health Services** to furnish services and supplies at a **Negotiated Charge**.

Diabetic Self-Management Education
Training designed to instruct a person in the self-management of diabetes. It may include training in self-care or diet. If a physician, nurse practitioner or clinical nurse specialist diagnoses diabetes, or diagnoses a significant change in the person's diabetic symptoms, or condition that requires a change in the person's self-management of the disease or determines that a person who is a diabetic needs re-education, or refresher education, this diabetic self-management education may be provided by the physician or other licensed health care provider legally qualified by the State of New York to provide diabetic management education, or their staff, as part of an office visit for diabetes diagnosis or treatment, or by a certified diabetes nurse educator, certified nutritionist, certified dietitian or registered dietitian upon the referral of a physician, or other licensed health care provider legally qualified by the State of New York to provide diabetic management education. When diabetic self-management education is provided be a certified diabetes nurse educator, certified nutritionist, certified dietitian or registered dietitian upon referral by a physician, such education may be provided in a group setting. When medically necessary, diabetic self-management education shall also include home visits.

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

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

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

Emergency Admission
One where the **physician** admits the person to the **hospital** or **residential treatment facility** right after the sudden and at that time, unexpected onset of a change in a person's 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:
  (1) 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;
  (2) serious impairment to such person's bodily functions;
  (3) serious dysfunction of any bodily organ or part of such person; or
  (4) 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:
(1) 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;
(2) serious impairment to such person's bodily functions;
(3) serious dysfunction of any bodily organ or part of such person; or
(4) 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 a R.N., L.P.N., or L.V.N., primarily to 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**. 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 facility**, and the services must be furnished by, or under arrangements made by, a licensed home health agency.

Home Health Care Plan
A written plan of care established and approved in writing by a physician, for continued health care and treatment in a **Covered Person's** home. It must follow within seven days of discharge and be for the same or related cause(s) as a period of hospital or skilled nursing confinement. The physician must examine the **Covered Person** at least once a month, and the physician must renew the written plan every 60 days.

Home Health Care Services

- Part-time or intermittent nursing care by: a registered nurse (R.N.), a licensed Practical nurse (L.P.N.), or under the supervision on a R.N. if the services of a R. N. are not available,
- Part time or intermittent home health aide services, that consist primarily of care of a medical or therapeutic nature by other than a R.N.,
- Physical, occupational. speech therapy, or respiratory therapy,

- Medical supplies, drugs and medicines, and laboratory services. However, these items are covered only to the extent they would be covered if the patient was confined to a hospital,
- Medical social services by licensed or trained social workers,
- Nutritional counseling.

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

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

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**.

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

Medically Necessary
a service or supply that is necessary and appropriate for the diagnosis or treatment of a **sickness** or **injury** based on generally accepted current medical practice. 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.* Important Information: The benefit schedule above outlines copays/deductibles and maximums applicable to each benefit. Please note, that once the plan has paid a total of $1,000 in Covered Medical Expenses under this policy, the co-insurance level is reduced as outlined in the chart below. The $1,000 benefit accumulation limit is calculated on the total amount paid in Covered Medical Expenses for the policy year, not for each individual benefit.

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** or **Designated 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 **Designated Care Provider**, or that is not a **Preferred Care Provider**, if, as determined by Aetna:
- the service or supply could have been provided by a Preferred Care Provider, and
- the provider is of a type that falls into one or more of the categories of providers listed in the directory.

Non-Preferred Care Provider
- a health care provider that has not contracted to furnish services or supplies at a **Negotiated Charge**,

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

Non-Preferred Prescription Drug Expense
An expense incurred for a **prescription drug** that is not a **Preferred prescription drug expense**.

One Sickness
A **sickness** and all recurrences and related conditions which are sustained by a **Covered Person**.

Orthodontic Treatment
Any:
- medical service or supply, or
- dental service or supply,

furnished to prevent or to diagnose or to correct a misalignment:
- of the teeth, or
- of the bite, or
- of the jaws or jaw joint relationship,

whether or not for the purpose of relieving pain. Not included is:
- the installation of a space maintainer, or
- surgical procedure to correct malocclusion.

Out-of-Pocket Limit
The amount that must be paid, by the **covered student**, or the **covered student** and their **covered dependents**, before **Covered Medical Expenses** will be payable at 100%, for the remainder of the **Policy Year**.
The following expenses do not apply toward meeting the **Out-of-Pocket Limit**:
- **Deductibles**,
- **copays**,
- expenses that are not **Covered Medical Expenses**,
- expenses for **designated care** or **Non-Preferred Car**e,
- penalties,
- expenses for prescription drugs, and
- other expenses not covered by this Policy.

Partial Hospitalization
Continuous treatment consisting of not less than four hours and not more than twelve hours in any 24 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/she practices, and (b) any other practitioner that must by law be recognized as a doctor legally qualified to render treatment.

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

Pre-Existing Condition
Any **injury**, **sickness**, or condition that was diagnosed or treated, or would have caused a prudent person to seek diagnosis or treatment, within six months prior to the **Covered Person's** enrollment date.

For purposes of this definition, "enrollment date" means the **Covered Person's** effective date of insurance or, if earlier, the first day of any applicable waiting period.

Preferred Care
Care provided by:
- a **Covered Person's primary care physician**, or a **Preferred Care Provider** of the **primary care physician**, or
- a health care provider that is not a **Preferred Care Provider** for an **emergency medical condition** when travel to a **Preferred Care Provider**, is not feasible, or
- a **Non-Preferred Urgent Care Provider** when travel to a **Preferred Urgent Care Provider** for treatment is not feasible, and if authorized by Aetna.

Preferred Care Provider
A health care provider that has contracted to furnish services or supplies for a **Negotiated Charge**, but only if the provider is, with Aetna's consent, included in the **directory** as a **Preferred Care Provider** for:
- the service or supply involved, and
- the class of **Covered Persons** of which you are member.

Preferred Pharmacy
A **pharmacy**, including a **mail order pharmacy**, which is party to a contract with Aetna to dispense drugs to persons covered under this Policy, but only:
- while the contract remains in effect, and
- while such a **pharmacy** dispenses a **prescription drug**, under the terms of its contract with Aetna.

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

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

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

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

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

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

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

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

In determining the **Reasonable Charge** for a service or supply that is:
- Unusual; or
- Not often provided in the area; or
- Provided by only a small number of providers in the area.

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

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

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

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

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

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

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

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

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

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

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

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

Surgical Procedure
- a cutting procedure,
- suturing of a wound,
- treatment of a fracture,
- reduction of a dislocation,
- radiotherapy (excluding radioactive isotope therapy), if used in lieu of a cutting operation for removal of a tumor,

- electrocauterization,
- diagnostic and therapeutic endoscopic procedures,
- injection treatment of hemorrhoids and varicose veins,
- an operation by means of laser beam,
- cryosurgery.

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

Urgent Admission
One where the **physician** admits the person to the **hospital** due to:
- the onset of or change in a disease, or
- the diagnosis of a disease, or
- an **injury** caused by an **accident**,

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

Urgent Condition
This means a sudden illness, **injury**, or condition, that:
- is severe enough to require prompt medical attention to avoid serious deterioration of the **Covered Person's** health,
- includes a condition which would subject the **Covered Person** to severe pain that could not be adequately managed without urgent care or treatment,
- does not require the level of care provided in the emergency room of a **hospital**, and
- requires immediate outpatient medical care that cannot be postponed until the **Covered Person's physician** becomes reasonably available.

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

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

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

CLAIM PROCEDURE

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

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

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

1. Bills must be submitted within 90 days from the date of treatment.
2. Payment for **Covered Medical Expenses** will be made directly to the hospital or physician concerned, unless bill receipts and proof of payment are submitted.
3. If itemized medical bills are available at the time the claim form is submitted, attach them to the claim form. Subsequent medical bills should be mailed promptly to the above address.
4. You will receive an "Explanation of Benefits" when your claims are processed. The Explanation of Benefits will explain how your claim was processed, according to the benefits of your Student Accident and Sickness Insurance Plan.

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

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 a written request for review of a decision that has been denied in whole or in part, after consideration of any relevant information, a request for: claim payment, certification, eligibility, referral, etc.

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.

Aetna will summarize the nature of the grievance in writing. The **Covered Person** will be required to sign a written acknowledgement of the grievance. Such acknowledgement will be mailed promptly to the **Covered Person**. The **Covered Person** must sign and return the acknowledgement, with any amendments, in order to initiate the grievance. Upon receipt of the signed acknowledgement, the process below will be followed.

- An acknowledgment letter will be sent to the **Covered Person** within one day of Aetna's receipt of an oral Appeal, and five 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 two days, provided that all necessary information is available. Written notice of the decision will be sent within two 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 two 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 Persons** complaint for three 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 twelve 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).

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

- A service, procedure or treatment that two 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
- 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.

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 **(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 three 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 five additional business days to make its decision. The External Appeal Agent must notify the **Covered Person** in writing of its decision within two 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 three 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.

The **Covered Person** will be charged a fee of $50 for an external appeal. The external appeal application will instruct the **Covered Person** on the manner in which the **Covered Person** must submit the fee. Aetna will also waive the fee if Aetna determines that paying the fee would pose a hardship to the **Covered Person**. If the External Appeal Agent overturns the denial of coverage, the fee shall be refunded to the **Covered Person**.

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 **(800) 238-6279**. You will be reimbursed for covered medications directly by Aetna. Please note, in addition to your copay, you may be required to pay the difference between the retail price you paid for the prescription drug and the amount Aetna would have paid if you had presented your ID card and 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 Reasonable Charge allowance, less any applicable Deductible, directly by Aetna. You will be responsible for any amount in excess of the Reasonable Charge.

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

Claim forms, Pharmacy locations, and claims status information can be obtained by contacting Aetna Pharmacy Management at **(800) 238-6279**.

When submitting a claim, please include all Prescription receipts, indicate that you attend the University at Buffalo and include your name, address, and student identification number.

ON CALL INTERNATIONAL

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

A brief description of these benefits is outlined below.

ACCIDENTAL DEATH AND DISMEMBERMENT (ADD) BENEFITS

Benefits are payable for the Accidental Death and Dismemberment of Covered Persons, up to a maximum of $10,000.

NOTE: **For most school plans, ADD benefits are provided by Aetna Life Insurance Company (ALIC). However, in some states, ADD benefits may be provided through a contractual relationship between Chickering Claims Administrators, Inc. (CCA) and On Call International (On Call). ADD coverage provided through On Call is underwritten by United States Fire Insurance Company (USFIC). Please refer to your school's policy to determine whether ALIC or USFIC underwrites ADD benefits for your specific Plan. Should you have questions or need to file a claim please contact Aetna Student Health at (800) 954-5793**.

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

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

MEDICAL EVACUATION AND REPATRIATION (MER) BENEFITS

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

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

WORLDWIDE EMERGENCY TRAVEL ASSISTANCE (WETA) SERVICES

On Call provides the following travel assistance services:

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

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

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

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

AETNA NAVIGATOR®

GOT QUESTIONS? GET ANSWERS WITH AETNA'S NAVIGATOR®

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

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

HOW DO I REGISTER?

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

NEED HELP WITH REGISTERING ONTO AETNA NAVIGATOR?

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

NOTICE

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

Administered by:
Aetna Student Health
P.O. Box 981106
El Paso, TX 79998
(800) 954-5793
www.aetnastudenthealth.com

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

Policy No. 100116

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