2008 - 2009

Student Health Insurance Plan Brochure

The College at Brockport,
State University of New York

Aetna Student Health

Presented by:
Niagara National, Inc.

Underwritten by:
Aetna Life Insurance Company (ALIC)

Policy No. 812826

Dear Students and Parents,

The College at Brockport is pleased to provide information about health insurance coverage for our students. Health insurance is mandatory for all full-time, undergraduate and graduate students. To assist students in meeting this requirement, a Student Health Insurance Plan through Aetna Student Health has been selected for the campus for the 2008-2009 Policy Year. Coverage is effective **August 22, 2008** through **August 21, 2009**. The policy effective dates for new students enrolled for the Spring 2009 semester runs from **January 24, 2009** through **August 21, 2009**. The insurance Policy includes accidental Injury and Sickness coverage up to a maximum of **$75,000** per Accident/illness. Benefits provide coverage for hospitalization, physician office visits, laboratory tests, X-rays, and prescription medications subject to policy limitations and exclusions.

The Student Health Insurance Plan is an endorsed supplement to services provided through the Health Fee at the Student Health and Counseling Center on campus. The Plan provides worldwide coverage for a full 12 months, including holidays and vacation periods. All full-time, undergraduate and graduate students (12 credit hours or more) will be charged for the Plan on their student bill.

Students who have their own health insurance coverage can complete the waiver online at ***www.aetnastudenthealth.com***. The deadline to waive the charge off the student bill is **September 23, 2008**. New students registering for the first time in **January, 2009** have until **February 23, 2009** to waive the insurance charge.

International students may disregard this Brochure, as you are enrolled in a specific policy that is a separate and distinct plan.

Detailed information regarding the Plan and the online waiver process will be mailed in early June.

The annual cost for The College at Brockport Student Health Insurance Plan for the 2008-2009 Policy year will be **$979** (includes a $25 administrative fee.) As an option, you may also purchase a Supplemental Plan which will provide you with additional benefits.

This Insurance Plan may also be purchased by:

- Part-time students enrolled for 7 or more credit hours; and
- Eligible spouses/partners and dependents of students enrolled in the Plan.

The Health Center looks forward to working with you during your time at Brockport.

Sincerely,
Libby Caruso, Director
Health and Counseling Services
(585) 395-2414

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Enrollment/Waiver Process

Student Coverage

Eligibility

All full-time students of The College at Brockport registered for 12 credits or more are automatically enrolled in the Student Health Insurance Plan. Part-time students (registered in more than 7 but less than 12 credits) are eligible to purchase this coverage, however, they are not automatically enrolled.

Part-time students (registered in more than 3 but less than 12 credits) are eligible to purchase this coverage, however they are not automatically enrolled.

Part-Time Students

Voluntary Enrollment

To enroll for coverage, the voluntary enrollment deadline date for the Fall semester is **September 23, 2008**. The enrollment deadline date for Spring semester is **February 23, 2009**. If the Voluntary Enrollment Form and premium are received after the semester start date of coverage, then coverage becomes effective the day after the postmarked date of the Enrollment Form. To obtain an Enrollment Form, please visit ***www.aetnastudenthealth.com***, click on "Find Your School" and enter "**812826**" as your School Policy Number.

Coverage for Dependents

Eligibility

Covered students may also enroll their lawful spouse or domestic partner, and unmarried dependent children under age 19 who reside with, and are fully supported by, the covered student for the same coverage.

Enrollment

To enroll the dependent(s) of a covered student, please visit ***www.aetnastudenthealth.com*** to enroll online. The dependent enrollment deadline date for the Fall semester is **September 23, 2008**. The enrollment deadline date for the Spring semester is **February 23, 2009**.

Newborn Infant Coverage 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 College at Brockport Student Health Insurance Plan. To extend coverage for a newborn past the 31 days, the Covered Person must (1) enroll the child within 31 days of birth and (2) pay the additional premium starting from the date of birth.

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

For further assistance and premium information, please contact Aetna Student Health.

Late Enrollment

Under certain circumstances, coverage for late enrollees may be possible. For the Fall semester, any enrollment occurring after **September 23, 2008** will be considered a late enrollment. For the Spring semester, any enrollment occurring after **February 23, 2009** will be considered a late enrollment. Contact Aetna Student Health or refer to the Master Policy for details. Please refer to the Pre-Existing Conditions/Continuously Insured Provisions section of the Brochure for information on Pre-Existing Conditions, which applies to all late enrollees under this Plan.

Change in Status/Qualifying Event

Eligible students who have a change in status and lose coverage under another group insurance plan are able to purchase The College at Brockport Student Health Insurance Plan. These students must provide proof that they have lost insurance through another group (certificate and letter of ineligibility) within 30 days of the qualifying event. Coverage will be effective the day after prior coverage ends, or the date the student pays the premium and enrolls in The College at Brockport Student Health Insurance Plan, whichever is later. Premiums are not prorated, and the student will be responsible for paying the premium for the full term during which they enroll.

Waiver Process

Students with comparable health insurance coverage have the option to waive online.

- Visit ***www.aetnastudenthealth.com***.
- Click on "Find Your School" and enter **812826** as you School Policy Number.
- Click on "The College at Brockport Online Waiver System" to display your Online Waiver Form.

Simply follow the prompts on the screen by providing all information requested. A completed Online Waiver must be submitted by the posted deadline date.

Waiver Deadlines:

Fall	September 23, 2008
Spring	February 23, 2009

If you have missed the deadline and feel you have a valid exception, please go to ***www.aetnastudenthealth.com***, click "Find Your School" and enter **812826**. Additional information on requesting an exception will be available on the Enroll/Waive tab after the deadline has passed.

Take special note of the following:

It is your responsibility to verify that the appropriate credit appears on your student bill. If you do not submit the waiver by the semester deadline, you will be required to pay for the Student Health Insurance.

- **You must submit a new waiver each fall.** Those who were not registered or registered part time in the fall must submit a waiver in the spring. If you submit a waiver in the fall, you will be automatically waived for the Spring.

- Those who were registered full time and have registration activity that results in part-time status must contact the Office of Student Accounts before the deadline to have the charges removed from their account if they do not want the insurance coverage.

Withdrawal from all of your classes or taking a leave of absence before the semester deadline will result in the insurance charges being removed from your account and any payments will be refunded in full, unless claims have been filed.

- If you are approved for a medical leave of absence before the semester deadline for a covered Injury or Sickness, you may opt to remain covered in the Student Health Insurance Plan by notifying Student Health Services immediately.
- Withdrawal from all your classes or taking a leave of absence after the semester deadline will have no impact on your account balance or the status of your enrollment. You will remain covered in the Student Health Insurance Plan for the remainder of that semester. No refunds will be made for Student Health Insurance or Student Health Services Fees after the semester deadline.

The College at Brockport's Student Health Insurance Plan, administered by Chickering Claims Administrators, Inc.

Where to Find Help

For Questions About:

- Insurance Benefits
- Enrollment
- Waiver Process
- Claims Processing
- Inpatient Admission Pre-Certification

Please contact:
Aetna Student Health
P.O. Box 15708
Boston, MA 02215-0014
(877) 623-3335

For Questions About:

- Student Health Services
- Immunizations

Please contact:
The College at Brockport
Student Health Services
(585) 395-2414

ID Cards:

Enrollees in the Student Health Insurance Plan will be issued a permanent ID card as soon as possible. This card is for identification only. It is not a guarantee of eligibility or benefits. If you need medical attention before your permanent ID card is received, benefits will be payable according to the Policy. **You do not need an ID card to be eligible to receive benefits.**

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

For lost ID cards, contact:

Aetna Student Health, **(877) 623-3335** or visit ***www.aetnastudenthealth.com***, click on "Find Your School" and enter **812826** as your School Policy Number.

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 Provider Listings (including Preferred Care Pharmacy locations):

You may access Aetna's DocFind® Services (details below) or reference the complete list of providers, including a listing of participating area providers, maintained at Student Health Services.

Aetna's DocFind® Service:

Use Aetna's online DocFind® service located at ***www.aetnastudenthealth.com***. Click on "Find Your School" and enter **812826** as your School Policy Number. You can use DocFind® to find out whether a specific provider belongs to Aetna's network or to find preferred providers practicing in your area.

For Questions About:

- On Call International 24/7 Emergency Travel Assistance Services

Please contact:

On Call International at **1-(866) 525-1956** (within U.S.).

If outside the U.S., call collect **by dialing the U.S. access code plus 1-(603) 328-1956**. Please also visit ***www.aetnastudenthealth.com*** and visit your school-specific site for further information.

Worldwide Web Access:

- Aetna Student Health
  www.aetnastudenthealth.com

Got Questions? Get Answers with Aetna Navigator®

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

By logging into Aetna Navigator, you can:

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

How do I register?

- Go to ***www.aetnastudenthealth.com***.
- Click on "Find Your School."
- Enter your school name and then click on "Search."
- Click on Aetna Navigator and then the "Access Navigator" link.
- Follow the instructions for First Time User by clicking on the "Register Now" link.
- Select a user name, password and security phrase.

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

(Please allow 10 business days from the date of your enrollment in the Plan to allow your health information to populate into Aetna Navigator.)

Need Help With Registering onto Aetna Navigator?
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**.

The College at Brockport Student Health Services

Health Center

(585) 395-2414

Monday through Friday	8 a.m. to 4:45 p.m.
Saturday	10 a.m. to 2 p.m.

**During summer and mid-semester breaks Monday-Friday, 8 a.m. to 4 p.m.*

Providing quality outpatient medical services and enhancing the health and development of The College at Brockport students is the primary focus of the Student Health Center. Inherent in this is our desire to enable a diverse student population to pursue the primary goal of acquiring an education with minimal lost time or distraction due to physical or emotional issues.

Services*:

- Office visits by appointment or walk in.
- Flu shots and other immunization.
- Allergy injections.
- Self-care treatment options.
- **Specialty clinics:** sports medicine, therapeutic massage, dietician, women's health and international travel.
- Over-the-counter and prescription medicines.
- Physicals (for employment, travel, sports, ROTC).
- Oral contraceptives and other types of birth control (e.g., morning-after pill, condoms).
- Commonly used laboratory test such as urinalysis, hematocrit, and urine pregnancy. If necessary, other tests are sent to an outside lab for processing and charges are billed to the student/students by the lab.
- Confidential HIV testing and counseling by appointment.

**There is a fee for some medications and lab tests.*

The Health Center Staff can also provide a list of specialists for students who need services not provided at the Health Center. Medical care received off campus is the student's financial responsibility.

The Health Center cannot directly bill insurance carriers. Clinic visits and most other services are included in the mandatory Student Health Fee; refer to the rates and charges list, available at the Health Center.

Counseling Center

Located at Hazen Hall, next to Dailey Hall. Hours are 8 a.m. to 5 p.m., Monday through Friday. For personal assistance, The College at Brockport students can contact the Counseling Center at **(585) 395-2207** to schedule an appointment, or visit our offices in Hazen Hall.

The Counseling Center routinely offers various groups and workshops designed to further meet the diverse needs of our students. The following is a list of some of the groups or workshops that are offered periodically:

- Alcohol and Substance Abuse
- Adult Children of Alcoholics Group
- Assertiveness Training
- Depression Management
- Eating Problems Group
- Gay, Lesbian and Bisexual Support Group
- Life After Loss
- Substance Abuse/Recovery
- Surviving Sexual Abuse
- Women's Group

Students who would like a particular group or workshop offered are encouraged to call the Counseling Center and make their interest known to us.

Appointments

The Counseling Center is open for appointments Monday through Friday from 8 a.m. to 5 p.m. during the academic year. Summer hours vary. Appointments for counseling services can be made by calling the Counseling Center at **(585) 395-2207**.

Health Promotions

Health education programming for the campus is done through the Health Promotions Office. We have a wide variety of classes and projects each semester. Check ***The Stylus*** and College Events Calendar for information on upcoming programs. Most are free or at a reduced student rate. Please feel free to offer any suggestions you may have for program topics.

Confidentiality

All medical information is confidential. Notification of parents, faculty, and administrators is considered the student's responsibility. The Student Health Center will not share information concerning the health of a student without the student's explicit and informed written authorization, within the guidelines of the law.

Fees for Service

Health Services on campus are provided through the mandatory Health Fee. Those students who paid the Health Fee receive office visits at no cost. This includes some lab tests and commonly used over-the-counter and prescription medications. There is a $20 fee for office visits for students who have not paid the Health Fee.

The College at Brockport Student Health Insurance Plan

The College at Brockport Student Health Insurance Plan has been developed especially for The College at Brockport students. The Plan provides coverage for illnesses and Injuries that occur on and off campus, and includes special cost-saving features to keep the coverage as affordable as possible. The College at Brockport is pleased to offer the Plan as described in this Brochure.

Please keep this Brochure, as it provides a general summary of your coverage. A complete description of the benefits and full terms and conditions may be found in the Master Policy. If any discrepancy exists between this Brochure and the Policy, the Master Policy will govern and control the payment of benefits.

Policy Period

Coverage for all insured students enrolled for the Fall semester will become effective at 12:01 a.m. on **August 22, 2008**, and will terminate on **August 21, 2009**.

Coverage for all newly enrolled insured students for the Spring semester will become effective at 12:01 a.m. on **January 24, 2009** and will terminate on **August 21, 2009**.

Premium Rates

	Annual (8/22/08-8/21/09)	Spring Semester (1/24/09-8/21/09)
Student Only*	$ 979	$ 581
Spouse or Domestic Partner	$2,323	$1,358
Child(ren)	$1,625	$ 949

**The above rates include a $25 administrative fee retained by the University to help cover the costs associated with administering the Student Health Insurance Plan.*

Pre-Existing Conditions/Continuously Insured Provisions

Pre-Existing Condition (Applies to late enrollees only):
Any Injury, Sickness, or condition for which medical advice, diagnosis, or treatment was recommended or received within six months prior to the Covered Person's effective date of insurance.

Limitation:
Expenses incurred by a Covered Person as a result of a Pre-Existing Condition will not be considered Covered Medical Expenses unless no charges are incurred or treatment rendered for the condition for a period of six months while covered under this program, or the Covered Person has been covered under this program for 12 consecutive months, whichever happens first.

Special Rules as to a Pre-existing Condition:
If a person has creditable coverage and such coverage terminated within 63 days prior to the date enrolled in this program, then any limitation as to a Pre-Existing Condition under this Plan will apply to only the extent that the limitation would have applied if the Covered Person had remained covered under the prior creditable coverage. Creditable coverage means a Covered Person's prior medical coverage as defined in the Federal Health Insurance Portability and Accountability Act (HIPAA) of 1996. Such coverage includes: coverage issued on a group or individual basis, Medicare, Medicaid, military-sponsored health care, a program of the Indian Health Service, a state health benefits risk pool, the Federal Employee's Health Benefits Plan (FEHBP), a public health plan as defined in the regulations, and any health benefit plan under Section 5(e) of Peace Corps Act.

Continuously Insured:
Continuously Insured is defined as a person who was insured under prior Creditable Coverage, including Student Health Insurance policies issued to The College at Brockport, and is now insured under this Plan. Persons who have remained continuously insured will be covered for conditions first manifesting themselves while continuously insured, except as specified in the Pre-Existing Conditions provision.

Previously insured students and dependents must re-enroll for coverage by **September 23, 2008**, for the Fall semester and by **February 23, 2009**, for the Spring 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 definition of a Pre-Existing Condition will apply in determining coverage of any condition which existed during the break.

Premium Refund Policy

Except for medical withdrawal due to a covered Accident or Sickness, any student who has not incurred any claims and who withdraws from school during the first 30 days of the period for which coverage is purchased shall not be covered under the Plan and a full refund of premium will be made. Students withdrawing after such waiver deadline date will remain covered under this Plan for the full period for which premium has been paid and be responsible for the premium billed to their tuition.

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

Preferred Provider Network

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

To maximize your savings and reduce your out-of-pocket expenses, select a Preferred Provider. It is to your advantage to use a Preferred Provider because significant savings may be achieved from the substantially lower rates these providers have agreed to accept as payment for their services. Preferred Providers are independent contractors and are neither employees nor agents of The College at Brockport, Niagara National, Inc., Aetna Student Health, or Aetna Life Insurance Company (ALIC). A complete listing of participating providers is available at Student Health Services. You may also contact Aetna Student Health at **(877) 623-3335**.

Additionally, you can obtain information regarding Preferred Providers through the Internet by accessing Aetna's DocFind® Service at ***www.aetnastudenthealth.com***. Click on "Find Your School" and enter **812826** as your School Policy Number. You can use DocFind® to find out whether a specific provider belongs to Aetna's network or to find preferred providers practicing in your area.

Inpatient Admission Pre-Certification Program

Pre-admission certification is designed to help you receive quality, cost-effective medical care.

- All inpatient admissions, including length of stay, must be certified by contacting Aetna Student Health.
- 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 Plan.

Pre-Certification of Non-Emergency Inpatient Admissions:
The patient, Physician, or hospital must telephone at least three business days prior to the planned admission.

Notification of Emergency Admissions:
The patient, patient's representative, physician, or hospital must telephone within one business day following admission.

Aetna Student Health
Attention: Managed Care Dept.
P.O. Box 15708
Boston, MA 02215-0014
(800) 286-1144

Hours: Monday through Friday, 8:30 a.m. to 5:30 p.m. (ET)

Student Health Center
When at school, in the absence of a medical emergency, and during the Student Health Center normal business hours, the student should first visit the Student Health Center to receive treatment, or be referred out to contact an appropriate health care provider.

Description of Benefits

Payment will be made as allocated herein for Covered Medical Expenses incurred for any one Accident or any one Sickness while covered under the Plan, not to exceed an Aggregate Maximum while continuously insured of $75,000 per condition, per Policy Year, for any one covered Accident or any one covered Sickness.

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

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

To maximize your savings and reduce out-of-pocket expenses, select a Preferred Provider. It is to your advantage to utilize a Preferred Provider because significant savings can be achieved from the substantially lower rates these providers have agreed to accept as payment for their services. Non-Preferred Care is subject to the Reasonable Charge allowance maximum. Any charges in excess of the Reasonable Charge allowance are not covered under the Plan.

A complete listing of participating providers is available at the Student Health Center. You may also contact Aetna Student Health at **(877) 623-3335**.

Additionally, you can obtain information regarding Preferred Providers through the Internet by using Aetna's online DocFind® service located at ***www.aetnastudenthealth.com***. Click on "Find Your School" and enter **812826** as your School Policy Number. You can use DocFind® to find out whether a specific provider belongs to Aetna's network or to find preferred providers practicing in your area.

Summary of Benefits Chart

Student Health Insurance Plan

The following benefits are subject to the Policy limitations and exclusions. All coverage is based on the Reasonable Charge allowance unless otherwise specified.

This Plan always pays benefits in accordance with any applicable New York Insurance Law(s).

Policy Year Maximum	$75,000 per condition
Inpatient Hospitalization Benefits	
All Covered Medical Expenses are subject to a $250 Copay per admission.	
Hospital Room and Board Expenses	Covered Medical Expenses are payable as follows: ***Preferred Care:*** 80% of the Negotiated Charge for an overnight stay. ***Non-Preferred Care:*** 60% of the Reasonable Charge for the semi-private room rate for an overnight stay.
Intensive Care Unit Expenses	Covered Medical Expenses are payable as follows: ***Preferred Care:*** 80% of the Negotiated Charge for an overnight stay. ***Non-Preferred Care:*** 60% of the Reasonable Charge for the intensive care room rate for an overnight stay.
Skilled Nursing Facility Expenses	Covered Medical Expenses are payable as follows: ***Preferred Care:*** 80% of the Negotiated Charge. ***Non-Preferred Care:*** 60% of the Reasonable Charge.
Miscellaneous Hospital Expenses	Covered Medical Expenses are payable as follows: ***Preferred Care:*** 80% of the Negotiated Charge. ***Non-Preferred Care:*** 60% of the Reasonable Charge. Covered Medical Expenses include, but are not limited to: laboratory tests, X-rays, anesthesia, use of special equipment, medicines and use of operating room.
Physician's Hospital Visit Expenses	Covered Medical Expenses for charges for the non-surgical services of the attending Physician or a consulting Physician are payable as follows: ***Preferred Care:*** 80% of the Negotiated Charge. ***Non-Preferred Care:*** 60% of the Reasonable Charge.
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:*** 80% of the Negotiated Charge. ***Non-Preferred Care:*** 60% of the Reasonable Charge.
Second Surgical Opinions Expenses	Covered Medical Expenses for charges for a second surgical opinion are payable as follows: ***Preferred Care:*** 80% of the Negotiated Charge. ***Non-Preferred Care:*** 60% of the Reasonable Charge.

Surgical Benefits (Inpatient and Outpatient) (continued)	
Anesthetist Expenses and Assistant Surgeon Expenses	Covered Medical Expenses for the charges of an anesthetist and an assistant surgeon during a surgical procedure for surgical services performed during a surgical operation are payable as follows: ***Preferred Care:*** 80% of the Negotiated Charge. ***Non-Preferred Care:*** 60% of the Reasonable Charge.
Outpatient Benefits	
Covered Medical Expenses include, but are not limited to: Physician's office visits, hospital or outpatient department or emergency room visits, durable medical equipment, physical therapy, chiropractic care, allergy testing, clinical lab, radiological facility or other similar facility licensed by the state.	
Physician's Office Visits Expenses	Covered Medical Expenses are payable as follows: ***Preferred Care:*** 100% of the Negotiated Charge after a $25 Copay per visit. ***Non-Preferred Care:*** 80% of the Reasonable Charge.
Emergency Care Expenses	Covered Medical Expenses for treatment of an Emergency Medical Condition are payable as follows: ***Preferred Care:*** 100% of the Negotiated Charge after a $75 Copay per visit; waived if admitted as an inpatient. ***Non-Preferred Care:*** 100% of the Reasonable Charge after a $75 Deductible per visit; waived if admitted as an inpatient.
Lab and X-ray Expenses *(Non-Hospital)*	Covered Medical Expenses are payable as follows: ***Preferred Care:*** 80% of the Negotiated Charge. ***Non-Preferred Care:*** 60% of the Reasonable Charge.
Durable Medical Equipment, Supplies and Prosthetic Devices	Covered Medical Expenses are payable as follows: ***Preferred Care:*** 80% of the Negotiated Charge. ***Non-Preferred Care:*** 60% of the Reasonable Charge.
Mental Health Benefits	
Biologically based Mental Illness and for Children with Serious Emotional Disturbances "Biologically Based Mental Illness" means a mental, nervous or emotional condition that is caused by a biological disorder of the brain and results in a clinically significant, psychological syndrome or pattern that substantially limits the functioning of the person with the illness. Such biologically based mental illnesses are defined as schizophrenia/psychotic disorders, major depression, bipolar disorder, delusional disorders, panic disorder, obsessive-compulsive disorder, bulimia and anorexia. "Children with Serious Emotional Disturbances" means persons under the age of 18 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:	

Mental Health Benefits (continued)	
• Serious suicidal symptoms or other life-threatening self-destructive behaviors; • Significant psychotic symptoms (hallucinations, delusion, bizarre behaviors); • Behavior caused by emotional disturbances that place the child at risk of causing personal Injury or significant property damage; or • Behavior caused by emotional disturbances that place the child at substantial risk of removal from the household.	
Inpatient Expenses	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. 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 Expenses	Covered Medical Expenses include expenses while a covered person is not confined as a full-time inpatient in a hospital, for the treatment of Biologically based Mental Illness or Children with Serious Emotional Disturbances. These expenses are covered on the same basis as outpatient treatment for any other Sickness. Not covered are Charges for Services: • While incarcerated, confined or committed to a local correctional facility or a prison, or a custodial facility for youth. • Provided solely because such services are ordered by a court. • Deemed to be cosmetic in nature.
Other than Biologically based Mental Illness and Children with Serious Emotional Disturbances	
Inpatient Benefits Expenses	Covered Medical Expenses include expenses incurred by a Covered Person while confined as a full-time inpatient in a hospital or residential treatment facility for the treatment of Mental Illness other than Biologically based Mental Illness or Children with Serious Emotional Disturbances. ***Preferred Care:*** Covered Medical Expenses are payable at 80% after a $250 per admission Copay. ***Non-Preferred Care:*** Covered Medical Expenses are payable at 60% after a $250 per admission Deductible. Benefits are payable to a maximum of 30 days per Policy Year.

Mental Health Benefits (continued)	
Inpatient Benefits 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 or partial hospitalization or intensive outpatient treatment may be exchanged for one day of full hospitalization.
Outpatient Treatment Expenses	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:*** Covered Medical Expenses are payable at 100% after a $25 per visit Copay. ***Non-Preferred Care:*** Covered Medical Expenses are payable at 80%. Benefits are payable up to 20 visits per Policy Year. Not Covered are Charges for Services: • While incarcerated, confined or committed to a local correctional facility or a prison, or a custodial facility for youth. • Provided solely because such services are ordered by a court. • Deemed to be cosmetic in nature.
Inpatient Expense – Chemical Abuse	Covered Medical Expenses for the treatment of chemical abuse, including detoxification, while confined as an inpatient in a hospital or facility licensed for such treatment are payable on the same basis as any other inpatient admission for any other Sickness. Covered Medical Expenses for inpatient treatment is limited to a maximum of 60 days per Policy Year per condition for any one or related chemical abuse condition. 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.
Outpatient Expenses – Chemical Abuse	Covered Medical Expenses for the care and treatment of chemical abuse by a licensed or accredited health service organization or hospital or by a fully licensed practitioner are payable as follows: ***Preferred Care:*** 80% of the Negotiated Charge. ***Non-Preferred Care:*** 60% of the Reasonable Charge. Covered Medical Expenses for outpatient treatment of chemical abuse is payable up to a maximum of 60 visits (20 of these visits are available for family counseling) per Policy Year for outpatient treatment.

Mental Health Benefits (continued)	
Learning Disability and Attention Deficit Disorder Testing and Treatment Expenses	Covered Medical Expenses are payable as follows: ***Preferred Care:*** 80% of the Negotiated Charge. ***Non-Preferred Care:*** 60% of the Reasonable Charge.
Additional Benefits	
Women's Health Benefits Expenses *(No Referral Required)*	Covered Medical Expenses will include one baseline mammogram for women between the ages of 35 and 40. Women ages 40 and older have coverage for one annual mammogram per Policy Year thereafter. Coverage will be provided more frequently if recommended by a Physician for a Covered Person who has a prior history of breast cancer or who has a first degree relative with a prior history of breast cancer. Covered Medical Expenses are payable on the same basis as any X-ray expense. The Plan will pay for one routine annual Pap smear screening, including the office visit, gonorrhea and Chlamydia testing, for women ages 18 and older. Covered Medical Expenses are payable on the same basis as any outpatient expense.
Voluntary Termination of Pregnancy Expenses	***Preferred Care:*** 80% of the Negotiated Charge. ***Non-Preferred Care:*** 60% of the Reasonable Charge.
Prescription Contraceptive Medical Expenses	Covered Medical Expenses are payable on the same basis as any expense. Covered Medical Expenses also include any expenses incurred for office visits in conjunction with the administration of a covered prescription contraceptive. Coverage for MAP is included. Coverage of oral contraceptives Lunelle, Depo-Provera, Norplant, Patch or Ring is provided under the separate Prescription Drug portion of the Plan.
Prescription Drug Coverage Expenses	Covered Medical Expenses for outpatient Prescription Drugs associated with a covered Sickness or covered Accident which occurs during the Policy Year are payable as follows with a $1,000 Policy Year Maximum: ***Preferred Care:*** 100% of the Negotiated Charge after a $10 Copay for each Generic Prescription Drug and a $25 Copay for each Brand-Name Prescription Drug. ***Non-Preferred Care:*** 100% of the Reasonable Charge after a $10 Deductible for each Generic Prescription Drug and a $25 Deductible for each Brand-Name Prescription Drug. **Please note:** You are required to pay in full at the time of service for all Prescriptions dispensed at a Non-Participating Pharmacy (Please refer to the Prescription Drug Claim Procedure section of this Brochure for information regarding the claim submission and reimbursement process.).

Additional Benefits (continued)	
Prescription Drug Coverage Expenses *(continued)*	Medications not covered by this benefit include, but are not limited to, drugs whose sole purpose is to promote or stimulate hair growth, appetite suppressants, smoking deterrents, immunization agents and vaccines, and non-self injectables. Covered medications include oral contraceptives Lunelle, Depo-Provera, Norplant, Patch and Ring. Expenses incurred for office visits in conjunction with the administration of a covered prescription contraceptive is provided under the Medical portion of the Plan. Prescriptions for insulin, syringes, and diabetic supplies will be covered as follows: ***Preferred Care:*** 100% of the Negotiated Charge after a $10 Copay for each Generic Prescription Drug and a $20 Copay for each Brand-Name Prescription Drug. ***Non-Preferred Care:*** 100% of the Reasonable Charge after a $10 Deductible for each Generic Prescription and a $25 Deductible for each Brand-Name Prescription Drug. Prior authorization is required for growth hormones and drugs which are used for the treatment of malaria. Benefits are not payable for more than a 30 day supply per prescription or refill without prior authorization.
Ambulance Expenses	Covered Medical Expenses are payable as follows: ***Preferred Care:*** 80% of the Actual Charge. ***Non-Preferred Care:*** 80% of the Actual Charge.
Maternity Expenses	Covered Medical Expenses for pregnancy, childbirth, and complications of pregnancy are payable on the same basis as any other Sickness. In the event of an inpatient confinement, such benefits are payable for 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. In the event of an early discharge, coverage is available for at least one home care visit; this visit will be payable at 100% and will not be subject to any Plan Copays or Deductibles, if applicable. Coverage also includes parent education, assistance and training in breast or bottle feeding, and the performance of any necessary maternal and newborn clinical assessments.
Diabetic Treatment Expenses	Covered Medical Expenses including, but not limited to, Equipment and Self-Management Education are payable as follows: ***Preferred Care:*** 100% of the Negotiated Charge. ***Non-Preferred Care:*** 80% of the Reasonable Charge.

Additional Benefits (continued)	
Prostate Cancer Screening Expenses	Covered Medical Expenses include one annual (or more frequently if recommended by a Physician) digital rectal exam and Prostate Specific Antigen (PSA) test. Covered Medical Expenses are payable on the same basis as any other expense.
Reconstructive Breast Surgery Expenses Benefit	Benefits will be payable for inpatient hospital care for an insured person undergoing (a) a lumpectomy or lymph node dissection for the treatment of breast cancer; or (b) a mastectomy which is covered under this Plan. Coverage is limited to a time frame determined by the insured person's Physician to be medically appropriate. Benefits will also be payable for breast reconstruction surgery after a mastectomy including (a) all stages of reconstruction of the breast on which the mastectomy has been performed, and (b) surgery and reconstruction of the other breast to produce symmetry in a manner determined by the attending Physician and the insured person to be appropriate. Covered Medical Expenses are payable on the same basis as any other expense.
Home Health Care Expenses	Covered Medical Expenses are payable as follows for charge incurred within 12 months from the date of the first home health care visit. The maximum number of covered visits is limited to 40 visits per Policy Year. Four hours of home health aide service shall be considered as one home care visit. ***Preferred Care:*** 80% of the Negotiated Charge. ***Non-Preferred Care:*** 60% of the Reasonable Charge.
End of Life Care Expenses	Covered Medical Expenses include care provided at acute care facilities which specialize in the treatment of terminally ill patients diagnosed with advanced cancer. Reimbursement for services is provided at 100% of the Negotiated Charge. In the absence of a Negotiated Charge, reimbursement is provided at 100% of the acute care facility's reimbursement rate under the Medicare program, after any applicable Deductible.
Supplemental Medical Coverage	The per condition, Policy Year Maximum benefit under the Student Health Insurance Plan described above is $75,000. If you have purchased the Basic Student Health Insurance Plan at The College at Brockport, you are eligible to purchase this Supplemental Plan to extend coverage past the $75,000 maximum to a $250,000 per condition Aggregate Maximum for students. Benefits in excess of $75,000 will be payable at 80% for both Preferred and Non-Preferred providers. The cost of this Plan is $155 per Policy Year for a student.

Additional Services and Discounts

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

Aetna Vision℠ Discount Program[1]	The Aetna Vision discount program helps you save on many eye care products, including sunglasses, contact lenses, non-prescription sunglasses, contact lens solutions and other eye care accessories. Plus, you can receive up to a 15% discount on LASIK surgery (the laser vision correction procedure).
Aetna Fitness℠ Discount Program[1]	Aetna's Fitness Program provides members with access to services provided by GlobalFit™, the nation's most comprehensive provider of fitness clubs and programs supporting members' healthy lifestyles. Members can access GlobalFit's national network of nearly 10,000 fitness clubs at preferred rates* or GlobalFit's other programs and services, such as at-home weight loss programs, home fitness options and even one-on-one health coaching services. **At some clubs, participation may be restricted to new club members.*
eDiets®[1]	25% discount on weekly dues for an eDiet membership.
Zagat Survey® Healthy Dining[1]	30% discounts on online subscriptions to restaurant and lifestyle guides.
SpaWish® Gift Certificate[1]	Spa gift certificates redeemable at a national network of 1,300 day spas.
Mayo Clinic Bookstore.com[1]	Discounts for books on health and wellness.
Aetna's Informed Health® Line[2]	Get credible health information 24 hours a day from Informed Health Line. Call us toll-free, anytime day or night, 365 days a year. You never know when a health question might come up. Informed Health Line connects you to a team of registered nurses experienced in providing information on a variety of health topics – 24 hours a day, 7 days a week. You also have access to our Audio Health Library, a recorded collection of thousands of health topics that's available in English or Spanish. Transfer easily to an Informed Health Line registered nurse at any time during your call. Or, to get credible health information online, register for Aetna Navigator® (visit ***www.aetnastudenthealth.com*** to register), our password-protected member website. After logging in, click on *Take Action on Your Health, Treating Illness* and then *Health A-Z.*

Additional Services and Discounts (continued)	
Aetna's Informed Health® Line[2] *(continued)*	To reach an Informed Health Line Nurse, please call **(800) 556-1555**. For TDD (hearing and speech impaired only), please call **(800) 270-2386**. **Health information programs provide general health information and are not a substitute for diagnosis or treatment by a physician or other health care professional. Also, the topics discussed by the nurses, on the audio tapes or online may not necessarily be covered by your health Plan.*
Health and Wellness Resources[2]	This dynamic, interactive website will give you health care and assessment tools to calculate body mass index, financial health, risk activities and health and wellness indicators. The site provides resources for wellness programs and activities.
Aetna Natural Products and Services℠ Program[1,2,3]	Save on acupuncture, chiropractic care, massage therapy and dietetic counseling. Also, save on over-the-counter vitamins, herbal and nutritional supplements and other health-related products. All products and services are delivered through American Specialty Health Networks, Inc. and Healthyroads, Inc.
Vital Savings℠ on Dental[4]	Vital Savings℠ on Dental is a dental discount program helping you and your dependents save an average of 30- to 50-percent on a wide array of dental service.[1] The cost to enroll is as follows: **Student:** $25 **Student + 1 Dependent:** $44 **Student + 2 or more Dependents:** $63 Enroll online at ***www.aetnastudenthealth.com***.

[1]*Discount programs provide access to discounted prices and are NOT insured benefits.*

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

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

[4]*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 always 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.

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

Coordination of Benefits

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

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 Actual Charge made for a covered service by the provider that furnishes it.

Aggregate Maximum: The maximum benefit that will be paid under the Policy for all Covered Medical Expenses incurred by a Covered Person from one Policy year to the next.

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

Copay: The amount that must be paid by the Covered Person at the time services are rendered by a Preferred Provider. Copay amounts are the responsibility of the Covered Person.

Covered Medical Expenses: Those charges for any treatment, service or supplies covered by the Policy which are (a) not in excess of the Reasonable Charges, or (b) not in excess of the charges that would have been made in the absence of this coverage, and (c) incurred while the 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 whose coverage is in effect under the Policy. See the Eligibility sections of this Brochure for additional information.

Deductible: A specific amount of Covered Medical Expenses that must be incurred by, and paid for by, the Covered Person before benefits are payable under the Plan. Deductible amounts are the responsibility of the Covered Person.

Emergency Medical Condition: A medical or behavioral condition, the onset of which is sudden, and 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:

(a) Placing the health of the person afflicted with such condition in severe jeopardy, or, in the case of a behavioral condition placing the health of such person or others in serious jeopardy;
(b) Serious impairment to such person's bodily functions;
(c) Serious dysfunction of any bodily organ or part of such person; or
(d) Serious disfigurement of such person. It does not include elective care, routine care, or care for non-emergency Sickness.

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.

Injury: Bodily Injury caused by an Accident; this includes related conditions and recurrent symptoms of such Injury.

Medically Necessary: A service or supply that is necessary, and appropriate, for the diagnosis or treatment of a Sickness, or Injury, based on generally accepted current medical practice. In order for a treatment, service, or supply to be considered Medically Necessary, the service or supply must:

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

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

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

In no event will the following services or supplies be considered to be Medically Necessary:

- Those that do not require the technical skills of a medical, a mental health, or a dental professional; or
- Those furnished mainly for the personal comfort or convenience of the person, any person who cares for him or her or any person who is part of his or her family, any health care provider, or health care facility; or
- Those furnished solely because the person is an inpatient on any day on which the person's Sickness or Injury could safely and adequately be diagnosed or treated while not confined; or

- Those furnished solely because of the setting if the service or supply could safely and adequately be furnished in a Physician's or a dentist's office or other less costly setting.

Non-Preferred Care: A health care service or supply furnished by a health care provider that is not a Preferred Care Provider, if, as determined by Aetna (a) the service or supply could have been provided by a Preferred Care Provider and (b) 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 (or Non-Preferred 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 that is party to such a contract but which does not dispense Prescription Drugs in accordance with its terms.

Pharmacy: An establishment where Prescription Drugs are legally dispensed.

Preferred Care: Care provided by a Preferred Care Provider, or any health care provider for an emergency condition when travel to a Preferred Care Provider is not feasible.

Preferred Care Provider (or Preferred 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 which the Covered Person is a member.

Physician: A legally qualified Physician licensed by the state in which they practice, and any other practitioner that must, by law, be recognized as a doctor legally qualified to render treatment.

Preferred Pharmacy: A Pharmacy which is party to a contract with Aetna to dispense drugs to persons covered under the Policy, but only while the contract remains in effect, and when the Pharmacy dispenses a Prescription Drug under the terms of its contract with Aetna.

Pre-Existing Condition: Any Injury, Sickness, or condition for which medical advice, diagnosis, or treatment was recommended or received within six months prior to the Covered Person's effective date of insurance.

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.

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.

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

Exclusions

This list is only a partial list. Please refer to the School's Master Policy on file at the school for a complete list of exclusions.

The Plan neither covers nor provides benefits for the following:

1. Expenses incurred as a result of dental treatment, except for treatment resulting from Injury to sound, natural teeth as provided elsewhere in the Policy.

2. Expenses incurred for services normally provided without charge by the Policyholder's Health Service, infirmary, or hospital, or by health care providers employed by the Policyholder.

3. Expenses incurred for eye refractions, vision therapy, radial keratotomy (except as medically necessary), 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.

4. Expenses incurred as a result of Injury due to participation in a riot. “Participation in a riot” means taking part in a riot in any way, including inciting the riot or conspiring to incite it.

It does not include actions taken in self-defense, so long as they are not taken against persons who are trying to restore law and order.

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

6. Expenses incurred as a result of an Injury or Sickness due to working for wage or profit, or for which benefits are provided under any Workers’ Compensation or Occupational Disease Law.

7. Expenses incurred as a result of Injury sustained or Sickness contracted while in the service of the armed forces of any country. Upon the Covered Person’s entering the armed forces of any country, the unearned pro-rata premium will be refunded to the Policyholder.

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

9. Expenses incurred for cosmetic surgery, reconstructive surgery, or other services and supplies that 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 for Injuries sustained as a result of a motor vehicle accident 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 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.

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

13. Expenses incurred by a Covered Person who is not a United States Citizen for services performed within the Covered Person’s home country if the Covered Person’s home country provides national health insurance.

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

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

16. Expenses 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.

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

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

19. 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 Pharmacopoeia 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.

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

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

22. 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.

23. Expenses arising from a Pre-Existing Condition, 12 months or less from the Covered Person's enrollment date. (Applies to Late Enrollees only.)

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

25. Expenses for routine physical exams, including expenses in connection with well newborn care, routine vision exams, routine dental exams, routine hearing exams, immunizations, or other preventive services and supplies, except to the extent coverage of such exams, immunizations, services, or supplies is specifically provided in the Policy.

26. Expense incurred for a treatment, service, or supply which is not Medically Necessary as determined by Aetna, for the diagnosis care or treatment of the Sickness or Injury involved. This applies even if they are prescribed recommended or approved by the person's attending Physician or dentist.

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

Extension of Benefits

If a Covered Person is confined to a hospital on the date their insurance terminates, expenses incurred after the termination date and during the continuance of that hospital confinement shall be payable in accordance with the Policy, but only while they are incurred during the 90-day period following such termination of insurance.

Termination of Student Coverage

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

(a) The date the 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.

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 Student Health
P.O. Box 15708
Boston, MA 02215-0014
(877) 623-3335
(617) 218-8400 (outside United States) Customer Service Representatives are available 8:30 a.m. to 5:30 p.m. (ET), Monday through Friday, for any questions.

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. When using a claim form, 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 address listed above.

4. In the event of a disagreement over the payment of a claim, a written request to review the claim must be mailed to Aetna Student Health within 60 days from the date appearing on the Explanation of Benefits (EOB).

Prescription Drug Claim Procedure

Preferred Care: When obtaining a covered Prescription, please present your Aetna Student Health ID card to an Aetna Preferred Pharmacy along with your applicable 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 at Aetna's online DocFind® service located at ***www.aetnastudenthealth.com***. Click on "Find Your School" and enter **812826** as your School Policy Number.

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 College at Brockport and include your name, address, and student identification number.

Complaint and Appeals Procedures

New York State mandates that the following information be provided to all insureds:

The complaints and appeals process is designed to address coverage issues, complaints and problems. If you have a coverage issue or other problem, call Aetna Student Health Customer Service at **(877) 623-3335**. A representative will address your concern. If you are dissatisfied with the outcome of the initial contact, the decision may be appealed.

You may also submit a request, in writing, along with all pertinent correspondence, to:

Aetna Student Health
P.O. Box 15708
Boston, MA 02215-0014

For purposes of the following section, the term "you" pertains to you or your covered dependent.

Internal Appeals Procedure

Aetna has established a procedure for resolving appeals. If you have 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 address is on your ID card. The Appeal may be submitted by you, or by a representative designated by you.

You 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 Customer Services. The Customer Services telephone number is on your ID card. If you are required to leave a recorded message, your message will be acknowledged within one business day after the call was recorded.

Aetna will summarize the nature of the grievance in writing. You will be required to sign a written acknowledgement of the grievance. Such acknowledgement will be mailed promptly to you. You 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 you within one day of Aetna's receipt of an oral Appeal, and within 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.

You 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 Customer Services. The Customer Services telephone number is on your ID card. A verbal response to the Appeal will be given to you and to your 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 you are dissatisfied with Aetna's grievance determination, you or a representative designated by you may submit a written appeal within 60 business days after receipt of such determination.

An acknowledgement letter will be sent to you 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.

You must exhaust the Internal Appeals Procedure before requesting an External Appeal. However, you are not required to exhaust the Internal Appeals Procedure prior to requesting an External Appeal, if you and Aetna have agreed that the matter may proceed directly to an External Appeal.

Aetna will keep the records of your complaint for 3 years.

External Appeal

Right to an External Appeal

Under certain circumstances, you have 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, you 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, you may appeal to an External Appeal Agent, if you satisfy the criteria listed below:

- The service, procedure, or treatment, must otherwise be a Covered Medical Expense under this Plan; and
- You must have received a final adverse determination through the first level of the internal review process, and Aetna must have upheld the denial, or you and Aetna must agree in writing, to waive any internal appeal.

Right to Appeal a Determination that a Service is Experimental or Investigational

If you have been denied coverage on the basis that the service is an experimental or investigational treatment, you must satisfy the following criteria:

- The service must otherwise be a Covered Medical Expense under this Plan; and
- You must have received a final adverse determination through the first level of the Internal Appeal Process, and Aetna must have upheld the denial, or you and Aetna must agree in writing to waive any internal appeal.

In addition, your attending Physician must certify that you have a life-threatening or disabling condition or disease. A "life-threatening condition or disease" is one which, according to the current diagnosis of the attending Physician, has a high probability of death. A "disabling condition or disease" is any medically determinable physical or medical impairment that can be expected to result in death, or that has lasted, or can be expected to last, for a continuous period of not less than 12 months, which renders you 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.

Your 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, your 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 you than any standard Covered Medical Expense (only certain documents will be considered in support of this recommendation – your 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 you are eligible (only certain clinical trials can be considered).

For the purposes of this section, your attending Physician must be a licensed, board certified, or board eligible Physician, qualified to practice in the area appropriate to treat your life-threatening or disabling condition or disease.

External Appeal Process

If, through Aetna's Internal Appeal Process, you have 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, you have 45 days from receipt of such notice to file a written request for an external appeal. If you and Aetna have agreed to waive any internal appeal, you have 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 Aetna's Internal Appeal Process or its written waiver of an internal appeal.

You 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 you satisfy the criteria for an external appeal, the State will forward the request to a certified External Appeal Agent.

You will have the opportunity to submit additional documentation with the request. If the External Appeal Agent determines that the information you 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 you, your 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 you in writing of its decision within 2 business days.

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

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

Responsibilities

It is your responsibility to initiate the external appeals process. You 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 you, your attending Physician may file an expedited appeal application on your behalf, but only if you have consented to this in writing.

Under New York State law, your completed request for appeal must be filed within 45 days of either the date upon which you receive written notification from Aetna that it has upheld a denial of coverage, or the date upon which you receive 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 you, 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.

General Information

Patient Management Program

Aetna evaluates and determines the appropriateness of medical care resources utilized by our Covered Persons. To accomplish these goals, Aetna has developed a comprehensive Patient Management Program. Only medical directors make decisions denying coverage for services for reasons of medical necessity. Coverage denial letters delineate any unmet criteria, standards and guidelines, and inform the provider and Covered Person of the appeal process. Our patient management staff uses national guidelines and resources to guide the pre-certification, concurrent review, discharge planning and retrospective review process.

Pre-Certification

You must obtain pre-certification for certain types of care rendered by non-preferred providers to avoid a reduction in benefits paid for that care. To request pre-certification, you must call the number shown on your ID card. Such pre-certification must be obtained before care is received, or in the case of an emergency admission, procedure or treatment, within one business day after the start of a confinement as a full-time inpatient or the performance of the procedure or treatment, or as soon as reasonably possible.

Concurrent Review

The concurrent review process assesses the necessity for continued stay, level of care, and quality of care for Covered Persons receiving inpatient services. All inpatient services extending beyond the initial certification period will require concurrent review.

Discharge Planning

Discharge planning may be initiated at any stage of the patient management process and begins immediately upon identification of post-discharge needs during pre-certification or concurrent review. The discharge plan may include initiation of a variety of services/benefits to be utilized by the Covered Person upon discharge from an inpatient stay.

Retrospective Record Review

The purpose of retrospective review is to retrospectively analyze potential quality and utilization issues, initiate appropriate follow-up action based on quality or utilization issues, and review all appeals of inpatient concurrent review decisions. Aetna's effort to manage the services provided to Covered Persons includes the retrospective review of claims submitted for payment, and medical records submitted for potential quality and utilization concerns.

Provider Reimbursement

Participating providers are reimbursed on a discounted fee-for-service basis. Where the Covered Person is responsible for a coinsurance payment based on a percentage of the bill, the Covered Person's obligation is to be determined on the basis of the charges established by contract, if any, rather than on the basis of the provider's billed charges.

Non-Participating providers, providing covered services, are compensated on a fee-for-service basis.

Any charge for a service or supply furnished by a Participating provider in excess of such provider's negotiated charge for that service or supply will not be a covered expense under the group contract. It will be the responsibility of Aetna and the Participating provider to resolve the amount deemed to be excess.

Confidentiality

Aetna protects the privacy of confidential Covered Person medical information. We require that participating providers keep Covered Person information confidential in accordance with applicable laws. Furthermore, you have the right to access your medical records from Participating providers at any time.

Aetna (including its affiliates and authorized agents, collectively "Aetna") and Participating providers require access to Covered Person medical information for a number of important and appropriate purposes including claims payment, fraud prevention, coordination of care, data collection, performance measurement, fulfilling state and federal requirements, quality management, utilization review, research and accreditation activities, preventive health, early detection and disease management programs. Accordingly, for these purposes, Covered Persons authorize the sharing of Covered Person medical information about themselves and their dependents between Aetna and Participating providers and health delivery systems.

Notice to Enrollees

While the paper directory (available upon request) is believed to be accurate as of the print date, it is subject to change without notice. Consult Aetna's online provider directory on our website (***www.aetnastudenthealth.com***) for the most current provider listings. Participating providers are independent contractors in private practice and are neither employees nor agents of Aetna, the University, Niagara National, Inc., or Aetna Student Health. The availability of any particular provider cannot be guaranteed for referred or in network benefits, and provider network composition is subject to change without notice. Certain primary care Physicians may be affiliated with an Independent Practice Association (IPA), a Physician Medical Group (PMG), an integrated delivery system or one of other provider groups.

Not every provider listed in the directory will be accepting new patients. Although Aetna has identified providers who were not accepting patients as known to Aetna at the time the provider directory was created, the status of a provider's practice may have changed. For the most current information, please contact the selected Physician or Customer Services at the toll-free number on your ID card.

In the event of a problem with coverage, Covered Persons should contact Customer Services at the toll-free number on their ID cards for information on how to utilize the complaint and appeal procedure when appropriate.

All Covered Person care and related decisions are the sole responsibility of Participating providers. Aetna does not provide health care services and, therefore, cannot guarantee any results or outcomes.

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[1]

These benefits are underwritten by United States Fire Insurance Company (USFIC) and include the following:

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

Medical Evacuation and Repatriation (MER) Benefits[1]

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

- Unlimited Emergency Medical Evacuation
- Unlimited Medically Supervised Repatriation (while traveling or on campus)
- Unlimited Return of Mortal Remains (while traveling or on campus)
- $2,500 Joining of Ill Family Member Accommodations
- Return of Traveling Companion

Worldwide Emergency Travel Assistance (WETA) Services[1]

On Call provides the following travel assistance services:

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

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

The information contained above is a just summary of the ADD, MER and WETA benefits and services available through On Call, USFIC and VSC. For a copy of the plan documents applicable to the ADD, MER and WETA coverage, including a full description of coverage, exclusions and limitations, please contact Aetna Student Health at *www.aetnastudenthealth.com* or 800-966-7772.

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 services not provided and arranged through On Call. Although certain emergency medical services may be covered under the terms of the Covered Person's student health insurance plan (the "Plan"), neither On Call, USFIC nor WETA provides coverage for emergency medical treatment rendered by doctors, hospitals, pharmacies or other health care providers. Coverage for such services will be provided in accordance with the terms of the Plan and exclusions and limitations may apply.

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

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

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

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. If any discrepancy exists between this Brochure and the Policy, the Master Policy will govern and control the payment of benefits.

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.

Administered by:

Aetna Student Health
P.O. Box 15708
Boston, MA 02215-0014
(877) 623-3335 (toll free)
www.aetnastudenthealth.com

Underwritten by:

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

Policy No. 812826

The Student Health Insurance Plan (the “Plan”) is underwritten by Aetna Life Insurance Company (ALIC). The Plan is administered by Chickering Claims Administrators, Inc. **Aetna Student Health is the brand name for products and services provided by these companies.**

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 Aetna Student Health's Student Connection Link on the Internet at: ***www.aetnastudenthealth.com***.

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