2011 - 2012

THE NEW SCHOOL

Student Accident and Sickness Insurance Plan Brochure

Presented by:
University Health Plans, Inc.

Underwritten by:
Aetna Life Insurance Company (ALIC)

Administered by:
Aetna Student Health

Policy No. 812804

Aetna®

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Dear New School Student and Family,

In order to foster a healthy environment for students, The New School offers a program which includes on-campus Student Health Services, an Immunization Program, and a Student Health Insurance Plan. Student Health Services includes Medical and Counseling Services. Medical Services offers primary medical and women's health care to students who are ill, injured, or need routine care. Counseling Services offers short-term psychotherapy, psychiatric consultation, and referrals for specialized treatment needs. All services are provided by licensed professionals and are strictly confidential. New York State Law requires certain categories of students to provide documentation of immunizations for measles, mumps, and rubella (MMR), as well as a response to the receipt of information on Meningococcal Disease (Meningitis) and vaccine by the student or student's parent or guardian. Student Health Services schedules immunization clinics for students who have been unable to obtain MMR immunizations elsewhere. Meningococcal Disease (Meningitis) Information and Response Forms are available at Student Health Services or by accessing: **www.newschool.edu** (click on "Student Services," then "Health Services" under "Campus Services"). The Student Health Insurance Plan includes the Student Health Services and Basic Accident Plan (Plan 1) and The New School Accident and Sickness Plan (Plan 2). Both cover the costs of care rendered outside of Student Health Services. Any questions may be addressed to our health insurance administrator, University Health Plans, Inc., at **(800) 437-6448**.

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

The Student Health Services Fee (**$285** per semester) enables students to use Student Health Services. Plan 1 coverage is automatically provided for those who pay the Student Health Services Fee. The New School Student Accident and Sickness Plan Insurance Fee, Plan 2 coverage (**$2,053**/year with **$828** charged in the fall and **$1,225** charged in the spring), enables students to use services outside Student Health Services. Depending on course load and status, you may be eligible to decline these services by submitting a completed Online Waiver Form by the posted Waiver Deadline Date. Students wishing to waive may do so online at **www.universityhealthplans.com.**

Please read this Brochure carefully. It describes services, insurance coverage and limitations, waiver process, and important deadlines. It is your responsibility to understand the nature and scope of benefits and limitations as well as to abide by posted deadlines.

Please keep this Brochure as it provides a general summary of your coverage. A complete description of the benefits and full terms and conditions may be found in the Master Policy. If any discrepancy exists between this Brochure and the Policy, the Master Policy will govern and control the payment of benefits. A copy of the Master Policy can be found at The New School Student Health Services and can be seen during normal business hours.

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

Please contact Student Health Services at **(212) 229-1671** for information on services and immunization. Please contact University Health Plans at **(800) 437-6448** with any questions regarding the Student Health Insurance Plan.

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

Sincerely,

Linda Abrams Reimer
Senior Vice President for Student Services

WHERE TO FIND HELP

For Questions About:
- Enrollment Process
- Waiver Process

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

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

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

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

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

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

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

Need help with registering onto Aetna Navigator?
Registration assistance is available toll-free, Monday through Friday, from 7 a.m. to 9 p.m. Eastern Standard Time, at **1-800-225-3375**.

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

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

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

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

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

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

For Questions About:
- On Call International 24/7 Emergency Travel Assistance Services

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

THE NEW SCHOOL STUDENT HEALTH SERVICES

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

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

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

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

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

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

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

STUDENT HEALTH FEES

The Student Health Services Fee (**$285** per semester) enables students to use Medical and Counseling Services at Student Health Services. The Student Health Insurance Fee enables students to use services outside Student Health Services. The 2011-2012 Student Health Insurance Fee is **$2,053**. You will be charged **$828** in the Fall Semester and **$1,225** in the Spring Semester.

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

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

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

Undergraduate students who are registered for fewer than six (6) credits and all Graduate students may waive participation in both Student Health Services and the Student Health Insurance Plan without demonstrating comparable health insurance.

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

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

WAIVER PROCESS

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

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

Waiver Deadlines	
Fall Semester	September 26, 2011
Spring Semester	February 19, 2012

Take special note of the following:

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

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

Waiver Appeal Deadlines	
Fall Semester	November 7, 2011
Spring Semester	April 1, 2012

MEDICAL SERVICES

Medical Consultation and Treatment – We provide outpatient medical care including diagnosis and treatment of illness or injury. There is no charge for a visit to treat illness or injury, and insurance may be used to cover tests, x-rays, and other outside services. In more complicated cases, referrals may be made to medical specialists who are known to the staff. Liaison is maintained with medical specialists, hospitals, and other agencies to ensure continuity of care.

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

After-Hours Nurse Advice Line – The New School offers an after-hours Nurse Advice Line, available whenever Student Health Services is closed. Experienced nurses and nurse practitioners will provide you with medical guidance, health information, reassurance, decision-making assistance, and referrals. When New School Student Health Services is closed, during academic recess, or for inclement weather, the Nurse Advice Line can help you get the help you need.

Women's Health – Gynecological examinations and treatment include routine care, reproductive health counseling, and diagnosis of disease. Pap smears and other lab tests can be performed. Emergency contraception is available. There is no charge for routine or acute-care women's GYN visits, but you will need to pay or use your insurance coverage for tests sent to outside laboratories.

Safer Sex and Sexuality Counseling – Both medical and counseling staff are available to help students with any concerns, including sexually transmitted infections (Chlamydia, Herpes, Syphilis, HPV, etc.), sexual functioning, social and emotional issues, and birth control. In addition, therapists are available to students concerned about sexual relationships, gender issues, or body image. Free condoms and dental dams are available.

Men's Health – Men are encouraged to be active and engaged in their own wellness and health care. Depending on your history, you may benefit from a cholesterol and blood pressure check. A discussion with a medical provider about testicular self-examination may also be useful. There is no charge for a visit to be examined for sexually transmitted infections, but you will need to pay or use your insurance coverage for tests sent to outside laboratories. Contraception and other health prevention measures can be discussed with our staff. All questions and concerns specifically related to your health are welcome.

LGBTQI – Students who identify themselves as lesbian, gay, bisexual, transgender, queer, or intersex may have health questions and concerns specific to their sexual orientation or sexual identity that they want to bring up with their medical provider. The staff welcomes all health questions and concerns, and strives to create an inclusive and responsive health and wellness service for LGBTQI students.

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

Health Care Maintenance – We provide routine preventive care services including physical examinations, blood pressure screening, immunizations, nutritional guidance, smoking cessation care, and cholesterol screening. Please note that preventive laboratory testing may not be covered under your insurance plan.

Sexually Transmitted Infection (STI) Screening – Our providers are knowledgeable and experienced in the diagnosis and treatment of STIs. We offer sensitive STI care and counseling as well as screening for STIs including Chlamydia, Gonorrhea, Herpes, HIV, Human Papilloma Virus (HPV), and Syphilis.

Birth Control – Condoms are free. After reproductive health counseling, prescriptions can be written for other contraceptive methods, including birth control pills, to be filled at an outside pharmacy. Emergency contraception, advice, and treatment are also available.

Immunizations
We provide vaccinations on site as part of our focus on prevention. The following vaccines are commonly available: Hepatitis A, Hepatitis B, Meningitis, Measles-Mumps-Rubella (MMR), Tetanus, and HPV. Flu shots are available in the fall/winter season. The costs of vaccines are charged to your student account. Please call ahead to make an appointment and to ensure the vaccine is available at that time, or to discuss any questions you may have about immunizations.

Additional information about immunizations for young adults can be obtained at the Center for Disease Control (CDC) at **www.cdc.gov/vaccines/spec-grps/college.htm**.

HIV/AIDS Testing – Through partnership with the Hispanic Aids Forum, Student Health Services offers free and strictly confidential HIV testing. Call ahead to confirm testing days and times. **(212) 229-1671**, option 1. The testing site is located at Student Health Services, 80 Fifth Avenue, 3rd Floor, New York, NY 10011. Student Health Services is committed to enhancing the health and well-being and awareness of health issues of the student population. HIV testing is part of that initiative.

Prevention – Preventing an illness is preferable to treating one. To this end, Student Health Services offers certain preventive measures. These include cholesterol screening, blood pressure monitoring, tuberculosis skin testing (PPD), vision screening, and dental referral. Allergy shots are not available at Student Health Services. Referrals to allergists will be made upon request.

Referrals – Any concerns or medical issues can be discussed with the medical staff. If your concern or medical issue cannot be treated by us, we will give you a referral to an outside provider who can address your need. The medical staff collaborates with many providers and specialists in the New York City community.

Travel Health
Our medical staff is prepared to provide you with the latest health information and immunization services for travel. If we do not have the vaccines available, our staff will refer you to a local health center that has the medicines you may need for travel. The earlier you prepare for your trip abroad, the better. Please contact Student Health Services as soon as you know that you are traveling to determine your travel health requirements. We advise you to schedule appointments 4-6 weeks in advance of your trip if possible. If you're planning a long trip, i.e. Study Abroad, 8-12 weeks in advance is advisable. Please check with your insurance carrier regarding coverage. Also, bring records of prior immunizations with you to your appointment if possible.

Additional information about how to stay healthy while you are traveling can be obtained at the Center for Disease Control (CDC) Travel Health Site at **www.cdc.gov/travel**.

Wellness and Health Promotion
The Wellness and Health Promotion program offers a variety of health-related workshops, training, and outreach programs throughout the university. Peer Health Advocates are an integral part of the Health Education team. Peer Health Advocates are students trained in health education, communication skills, and program facilitation to support and implement the services provided by the program.

COUNSELING SERVICES

Counseling is an opportunity to talk with someone who will listen in a supportive and non-judgmental manner. The counselor will help you clarify issues, explore your feelings, and discuss problem solving strategies. We offer short-term individual treatment (up to 12 sessions per year), but the length of the counseling varies. During the initial visit, you and the counselor will discuss the problem or concern and together arrange a plan for treatment. After the initial session, you may decide with your counselor that long-term treatment and/or specialized treatment is needed. The counselor will then help to arrange a referral to the appropriate place for treatment in the community.

Some common areas of concern for students include:

- Academic Concerns
- Adjustment to School and New York City
- Alcohol and Drugs
- Anxiety
- Creativity Blocks
- Depression
- Eating and Body Image Concerns
- Family Concerns
- General Mental and Physical Health Questions
- Loss or Death of Loved One
- Relationship Abuse
- Relationship Concerns (e.g., friendships, roommates, partners)
- Self-Esteem
- Sexual Assault and Sexual Abuse
- Sexuality
- Stress
- Suicidal Thoughts
- Time Management
- Traumatic Event

If you wish to see a psychiatrist, you must first meet with a counselor to discuss your individual needs.
The staff psychiatrist is only available to provide a psychiatric evaluation and prescribe medication for students who are being seen for short-term treatment at Counseling Services. A referral to a community provider will be given if needed.

Sometimes an issue is better addressed in a group environment. Talking to other students who have had similar experiences provides support and perspective. Counseling Services offers groups throughout the year.

Counseling Services staff is also available to conduct workshops about a variety of mental health topics. We present workshops in classrooms, residence halls, college fairs, and at any university event. Please contact us at (**212) 229-1671, option 1**, if you are interested in a having one of our counselors present at an event.

THE NEW SCHOOL MMR IMMUNIZATION INFORMATION

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

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

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

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

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

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

Students may obtain the required immunizations from a medical provider. In New York City, you can call the Immunization Hotline, **(212) 349-2664**, for free immunizations at city health centers as supplies allow. During the fall and spring registration periods, Immunization Clinics will be scheduled at convenient times and places to provide required measles, mumps, and rubella immunizations to students who have been unable to obtain them elsewhere. There is a nominal fee for these immunizations. The fee will be billed to your student account.

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

THE NEW SCHOOL MENINGOCOCCAL DISEASE (MENINGITIS) INFORMATION

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

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

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

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

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

Please keep this Brochure as it provides a general summary of your coverage. A complete description of the benefits and full terms and conditions may be found in the Master Policy. If any discrepancy exists between this Brochure and the Policy, the Master Policy will govern and control the payment of benefits. A copy of the Master Policy can be found at the New School and can be seen during normal business hours.

POLICY PERIOD

Coverage for all insured students enrolled for the Fall Semester will become effective at **12:01 a.m. on August 20, 2011**, and will terminate at **11:59 p.m. on August 19, 2012**. Coverage for all newly-enrolled insured students for the Spring Semester will become effective at **12:01 a.m. on January 15, 2012,** and will terminate at **11:59 p.m. on August 19, 2012**.

PREMIUM RATES (BILLED BY SEMESTER)

Please note, if you are not enrolled for the Spring Semester, coverage will end at midnight on **January 14, 2012**.

Student	**Annual* 8/20/11-8/19/12**	**Spring 1/15/11-8/19/12**
Plan 1 – Student Health Services and Basic Accident Plan	Included in Per Semester Student Health Services Fee	Included in Per Semester Student Health Services Fee
Plan 2 – The New School Student Accident and Sickness Plan	$ 2,053	$ 1,225

***** *Fall Installment is $828*

STUDENT COVERAGE

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

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

Enrollment Class	Description	Plan 1	Plan 2*
Compulsory Students	All undergraduate students taking six (6) or more credit hours, including ESL + Design.	Student Health Services per semester charge ($285) is mandatory and cannot be declined.	$2,053 Annual Charge may be waived by submitting proof of other coverage with a completed Online Waiver Form submitted by the Waiver Deadline Date.
Optional Students	All undergraduate students who are taking fewer than six (6) credits and all graduate students.	Student Health Services per semester charge ($285) may be declined by submitting a completed Online Waiver Form by the Waiver Deadline Date.	$2,053 Annual Charge may be declined by submitting a completed Online Waiver Form by the Waiver Deadline Date.
Ineligible Students	Milano branch campuses.	Ineligible.	Ineligible.

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

ELIGIBILITY

Plan 1 – Student Health Services and Basic Accident Plan
Students who pay the Student Health Services Fee will have access to Student Health Services (SHS) and will be covered by Plan 1 – Basic Accident Plan. Coverage begins at **12:01 a.m. on August 20, 2011,** and continues until **11:59 p.m. on August 19, 2012**. Coverage under Plan 1 ends at **11:59 p.m. on January 14, 2012,** for students not returning for the Spring Semester.

Plan 2 – The New School Student Accident and Sickness Plan
Students who pay the Student Health Insurance Fee will be covered by Plan 2 – Student Accident and Sickness Plan (**$2,053** Annual, to be billed in two installments; **$828** for Fall Semester and **$1,225** for Spring Semester). Coverage begins at **12:01 a.m. on August 20, 2011,** and continues until **11:59 p.m. on August 19, 2012**.

ELIGIBILITY AND HOW TO WAIVE

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

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

Optional Students: Undergraduate students who are registered for fewer than six (6) credits and all graduate students may waive participation in both Plan 1 and Plan 2. However, if you participate in Plan 2, you will be required to participate in Plan 1. In order to have the fee(s) removed from your MyNewSchool online account, you must submit an Online Waiver Form by the posted Waiver Deadline Date.

Late Enrollment: Under certain circumstances, coverage for late enrollees may be possible. For the Fall Semester, any enrollment occurring after **September 26, 2011,** is considered a late enrollment. For the Spring Semester, any enrollment occurring after **February 19, 2012,** is considered a late enrollment. Contact University Health Plans, Inc., at **(800) 437-6448** for late enrollment. Please refer to the General Provisions section of this Brochure for Pre-Existing Conditions, which applies to all late enrollees under this Plan.

PRE-EXISTING CONDITIONS/CONTINUOUSLY INSURED PROVISIONS (APPLIES TO LATE ENROLLEES ONLY)

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.

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 New School, 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 must re-enroll for coverage by **September 26, 2011,** for the Fall Semester and by **February 19, 2012,** 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.

ENROLLMENT UPDATE PERIODS

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

Example: The Fall 2011 Semester period of coverage is **August 20, 2011,** through **January 14, 2012.** The Spring 2012 semester coverage period is **January 15, 2012,** through **August 19, 2012**. A student enrolled during the Fall 2011 semester will show as "terminated coverage" as of **January 14, 2012**. The student receives a prescription **January 15, 2012**. He/she attempts to fill the prescription and is told he/she no longer is covered. A couple of weeks later (this is the update period), the Insurance Company is notified by the university the student has registered for classes before the Waiver Deadline Date and is eligible for the Spring period insurance. The student's coverage is updated to reflect effective dates **August 20, 2011,** through **August 19, 2012,** and will no longer have a disruption in using his/her insurance.

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

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

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

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

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

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

PREMIUM REFUND POLICY

Except for a leave of absence for health reasons, any student who has not incurred any claims and who withdraws from school prior to the Waiver Deadline Date (**September 26, 2011,** for Fall Semester, and **February 19, 2012,** for Spring Semester) during the period for which coverage is purchased shall not be covered under the Plan and a full refund of the premium will be made. Students withdrawing after such Waiver Deadline Date will remain covered under this Plan for the full period for which the premium has been paid. No refund will be allowed.

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

Newborn Infant Coverage
A child born to a **Covered Person** shall be covered for **Accident**, **Sickness**, and congenital defects for 31 days from the date of birth. At the end of this 31-day period, coverage will cease under The New School Student Health Insurance Plan.

PREFERRED PROVIDER NETWORK

Aetna has arranged for you to access a Preferred Provider Network in your local community. Acute care facilities and mental health networks are available nationally if you require hospitalization outside the immediate area of The New School campus. To maximize your savings and reduce your out-of-pocket expenses, select a Preferred Provider*. It is to your advantage to use a Preferred Provider because significant savings may be achieved from the substantially lower rates these providers have agreed to accept as payment for their services.

Preferred Providers are independent contractors and are neither employees nor agents of The New School, University Health Plans, Inc., Aetna Student Health, or Aetna Life Insurance Company (Aetna). A partial listing of participating providers is available at Student Health Services. You may also contact Aetna Student Health at* *(800) 878-1927****.*

Additionally, you can obtain information regarding Preferred Providers through the Internet by accessing Aetna's DocFind Service: visit **www.aetnastudenthealth.com**.

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 Plan 1 and Plan 2.
- If you do not secure Pre-Certification for non-emergency inpatient admissions or provide notification for emergency admissions, your Covered Medical Expenses will be subject to a **$200** per admission Deductible.

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. Eastern Standard Time

DESCRIPTION OF BENEFITS

Student Health Services (SHS)
When at college, in the absence of a Medical Emergency, and during Student Health Services normal business hours, the student should first visit Student Health Services during the academic year. Student Health Services is open Monday through Thursday, 9:00 a.m. to 5:00 p.m., and on Friday, 10:00 a.m. to 5:00 p.m. Evening and weekend hours may be available. Student Health Services is located at 80 Fifth Avenue, 3rd Floor, New York, NY 10011. Telephone: **(212) 229-1671**.

SUMMARY OF BENEFITS CHART

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

Plan 1 – Student Health Services and Basic Accident Plan

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

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

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

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

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

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

Inpatient Hospitalization Benefits	
Hospital Room and Board Expense	**Covered Medical Expenses** are payable as follows: Preferred Care: **90%** of the **Negotiated Charge**. Non-Preferred Care: **60%** of the **Recognized Charge** for a semi-private room.
Intensive Care Unit Expense	**Covered Medical Expenses** are payable as follows: Preferred Care: **90%** of the **Negotiated Charge**. Non-Preferred Care: **60%** of the **Recognized Charge** for the **Intensive Care Room Rate** for an overnight stay.
Miscellaneous Hospital Expense	**Covered Medical Expenses** include, but are not limited to: laboratory tests, x-rays, surgical dressings, anesthesia, supplies and equipment use, and medicines**.** Benefits are payable as follows: Preferred Care: **90%** of the **Negotiated Charge**. Non-Preferred Care: **60%** of the **Recognized Charge**.
Physician Hospital Visit/ Consultation Expenses	**Covered Medical Expenses** for charges for the non-surgical services of the attending **Physician**, or a consulting **Physician**, are payable as follows: Preferred Care: **90%** of the **Negotiated Charge**. Non-Preferred Care: **60%** of the **Recognized Charge**.
Surgical Benefits (Inpatient and Outpatient)	
Surgical Expense	**Covered Medical Expenses** for charges for surgical services, performed by a **Physician**, are payable as follows: Preferred Care: **90%** of the **Negotiated Charge**. Non-Preferred Care: **60%** of the **Recognized Charge**.
Anesthesia Expense	**Covered Medical Expenses** for the charges of anesthesia, during a surgical procedure, are payable as follows: Preferred Care: **90%** of the **Negotiated Charge**. Non-Preferred Care: **60%** of the **Recognized Charge**.
Assistant Surgeon Expense	**Covered Medical Expenses** for the charges of an assistant surgeon, during a surgical procedure, are payable as follows: Preferred Care: **90%** of the **Negotiated Charge**. Non-Preferred Care: **60%** of the **Recognized Charge**.
Ambulatory Surgical Expense	Benefits are payable for **Covered Medical Expenses** incurred by a **Covered Person** for expenses incurred for outpatient surgery performed in a hospital outpatient surgery department or in an ambulatory surgical center. **Covered Medical Expenses** must be incurred on the day of the surgery or within 48 hours after the surgery Preferred Care: **90%** of the **Negotiated Charge**. Non-Preferred Care: **60%** of the **Recognized Charge**. **Covered Medical Expenses** must be incurred on the day of the surgery or within 48 hours after the surgery.

Outpatient Benefits **Covered Medical Expenses** include but are not limited to: **Physician's** office visits, hospital or outpatient department or emergency room visits, durable medical equipment, clinical lab, or radiological facility.	
Emergency Room Expense	**Covered Medical Expenses** incurred for treatment of an **Emergency Medical Condition** are payable as follows: Preferred Care: **90%** of the **Negotiated Charge**. Non-Preferred Care: **90%** of the **Recognized Charge**.
Urgent Care Expense	*Benefits include charges for treatment by an urgent care provider.* **Please note: A covered person should not seek medical care or treatment from an urgent care provider if their illness, injury, or condition, is an emergency condition. The covered person should go directly to the emergency room of a hospital or call 911 for ambulance and medical assistance.** **Urgent Care** Benefits include charges for an urgent care provider to evaluate and treat an urgent condition. **Covered Medical Expenses** for urgent care treatment are payable as follows: Preferred Care: **90%** of the **Negotiated Charge**. Non-Preferred Care: After a **$25** per visit Deductible, **60%** of the **Recognized Charge**. *No benefit will be paid under any other part of this Plan for charges made by an urgent care provider to treat a non-urgent condition.*
Ambulance Expense	**Covered Medical Expenses** are payable as follows: **90%** of the **Actual Charge** for the services of a professional ambulance to or from a hospital, when required due to the emergency nature of a covered **Accident** or **Sickness**.
Pre-Admission Testing Expense	**Covered Medical Expenses** for Pre-Admission testing charges while an outpatient before scheduled surgery are payable on the same basis as any other condition.
Physician's Office Visits	**Covered Medical Expenses** are payable as follows: Preferred Care: **90%** of the **Negotiated Charge**. Non-Preferred Care: After a **$25** per visit Deductible, **60%** of the **Recognized Charge**.
Laboratory and X-Ray Expense	**Covered Medical Expenses** are payable as follows: Preferred Care: **90%** of the **Negotiated Charge**. Non-Preferred Care: **60%** of the **Recognized Charge**.

Therapy Expense	**Covered Medical Expenses** include charges incurred by a **covered person** for the following types of therapy provided on an outpatient basis: • Physical Therapy, • Chiropractic Care, • Speech Therapy, • Inhalation Therapy, or • Occupational Therapy. Expenses for Speech and Occupational Therapies are **Covered Medical Expenses,** only if such therapies are a result of **an Accident Only**. **Covered Medical Expenses** are payable as follows: Preferred Care: **90%** of the **Negotiated Charge**. Non-Preferred Care: **60%** of the **Recognized Charge**. After the 10th visit we may request verification of medical necessity in order to continue treatment.
Durable Medical Equipment Expense	**Covered Medical Expenses** are payable as follows: Preferred Care: **90%** of the **Negotiated Charge**. Non-Preferred Care: **60%** of the **Recognized Charge**.
Prosthetic Devices Expense	Benefits include charges for: artificial limbs, or eyes, and other non-dental prosthetic devices, as a result of an accident or sickness. **Covered Medical Expenses** do **not** include: eye exams, eyeglasses, vision aids, hearing aids, communication aids, and orthopedic shoes, foot orthotics, or other devices to support the feet. **Covered Medical expenses** are payable as follows: Preferred Care: **90%** of the **Negotiated Charge**. Non-Preferred Care: **60%** of the **Recognized Charge**.
Dental Injury Expense	**Covered Medical Expenses** include dental work, surgery, and orthodontic treatment needed to remove, repair, replace, restore, or reposition: • Natural teeth damaged, lost, or removed, or • Other body tissues of the mouth fractured or cut due to injury. The accident causing the injury must occur while the person is covered under this Plan. Any such teeth must have been: • Free from decay, or • In good repair, and • Firmly attached to the jawbone at the time of the injury. ***The treatment must be done in the calendar year of the accident or the next one***. If: • Crowns (caps), or • Dentures (false teeth), or • Bridgework, or • In-mouth appliances, are installed due to such injury, **Covered Medical Expenses** include only charges for: • The first denture or fixed bridgework to replace lost teeth, • The first crown needed to repair each damaged tooth, and • An in-mouth appliance used in the first course of orthodontic treatment after the injury.

	Surgery needed to: • Treat a fracture, dislocation, or wound. • Cut out cysts, tumors, or other diseased tissues. • Alter the jaw, jaw joints, or bite relationships by a cutting procedure when appliance therapy alone cannot result in functional improvement. Non-surgical treatment of infections or diseases. This does not include those of, or related to, the teeth. **Covered Medical Expenses** are payable as follows: **90%** of the Actual Charge.
Musculoskeletal/ Chiropractic Therapy Expense	**Covered Medical Expenses** include charges for Musculoskeletal Therapy provided on an outpatient basis. For purposes of this benefit, "Musculoskeletal Therapy" means the diagnosis, and treatment, by manual or mechanical means, of the musculoskeletal structure, due to lack of normal nerve, muscle, and /or joint function. Benefits for chiropractic care will be paid on the same basis as those payable for care or services provided by other health professionals in the diagnosis, treatment and management of the same or similar conditions, injuries, complaints, disorders or ailments.
Consultant or Specialist Expense	**Covered Medical Expenses** include the expenses for the services of a consultant or specialist. The services must be requested by the attending physician for the purpose of confirming or determining to confirm or determine a diagnosis. Benefits are payable as follows: Preferred Care: **90%** of the **Negotiated Charge**. Non-Preferred Care: After a **$25** per visit Deductible, **60%** of the **Recognized Charge**.

Additional Benefits	
Prescription Drug Benefit	**Prescription Drug Benefits** are payable as follows: **Covered Medical Expenses** for outpatient **Prescription Drugs** associated with a covered Accident which occurs during the Policy Year are payable as follows with a **$800 Policy Year Maximum**. Preferred Care: **90%** of the **Negotiated Charge**. Non-Preferred Care: **60%** of the **Recognized Charge**. You must pay out of pocket for **Prescriptions** at a **Non-Preferred Pharmacy** and then submit the receipt with a Prescription Claim Form for reimbursement. This **Pharmacy** benefit is provided to cover **Medically Necessary Prescriptions** associated with a covered **Accident** occurring during the **Policy Year**. Please use your Aetna Student Health ID card when obtaining your prescriptions.
Surgical Second Opinion Expense	**Covered Medical Expense**s will include expenses incurred for a second opinion consultation by a specialist on the need for surgery which has been recommended by the covered person's physician. The specialist must be board certified in the medical field relating to the surgical procedure being proposed. Coverage will also be provided for any expenses incurred for required X-rays and diagnostic tests done in connection with that consultation. Aetna must receive a written report on the second opinion consultation. Benefits are payable as follows: Preferred Care: **90%** of the **Negotiated Charge**. Non-Preferred Care: After a **$25** per visit **Deductible**, **60%** of the **Recognized Charge**.
Elective Surgical Second Opinion Expense	**Covered Medical Expenses** will include expenses incurred for a second opinion consultation by a specialist on the need for non-emergency elective surgery which has been recommended by the covered person's physician. The specialist must be board certified in the medical field relating to the surgical procedure being proposed. Coverage will also be provided for any expenses incurred for required X-rays and diagnostic tests done in connection with that consultation. Aetna must receive a written report on the second opinion consultation. Benefits are payable as follows: Preferred Care: **90%** of the **Negotiated Charge**. Non-Preferred Care: After a **$25** per visit Deductible, **60%** of the **Recognized Charge**.
Acupuncture in Lieu of Anesthesia Expense	**Covered Medical Expenses** include acupuncture therapy, when acupuncture is used in lieu of other anesthesia, for a surgical or dental procedure covered under this Plan. The acupuncture must be administered by a health care provider who is a legally qualified physician, practicing within the scope of their license. Preferred Care: **90%** of the **Negotiated Charge**. Non-Preferred Care: **60%** of the **Recognized Charge**.
Dermatological Expense	**Covered Medical Expenses** include charges for the diagnosis and treatment of skin disorders, excluding laboratory fees. Related laboratory expenses are covered under the Outpatient Expense Benefit. Benefits are payable as follows: Preferred Care: **90%** of the **Negotiated Charge**. Non-Preferred Care: After a **$25** per visit Deductible, **60%** of the **Recognized Charge**. *Covered Medical Expenses do not include treatment for acne cosmetic treatment and procedures and must be for treatment due to an accident.*

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

Plan 2 – The New School Student Accident and Sickness Plan

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

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

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

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

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

Inpatient Hospitalization Benefits	
Hospital Room and Board Expense	**Covered Medical Expenses** are payable as follows: Preferred Care: **90%** of the **Negotiated Charge**. Non-Preferred Care: **60%** of the **Recognized Charge**.
Intensive Care Unit Expense	**Covered Medical Expenses** are payable as follows: Preferred Care: **90%** of the **Negotiated Charge**. Non-Preferred Care: **60%** of the **Recognized Charge** for the **Intensive Care Room Rate** for an overnight stay.
Miscellaneous Hospital Expense	**Covered Medical Expenses** include, but are not limited to: laboratory tests, x-rays, surgical dressings, anesthesia, supplies and equipment use, and medicines**.** Benefits are payable as follows: Preferred Care: **90%** of the **Negotiated Charge**. Non-Preferred Care: **60%** of the **Recognized Charge**.
Physician Hospital Visit/ Consultation Expenses	**Covered Medical Expenses** for charges for the non-surgical services of the attending Physician, or a consulting Physician, are payable as follows: Preferred Care: **90%** of the **Negotiated Charge**. Non-Preferred Care: **60%** of the **Recognized Charge**.

Surgical Benefits (Inpatient and Outpatient)	
Surgical Expense	**Covered Medical Expenses** for charges for surgical services, performed by a Physician, are payable as follows: Preferred Care: **90%** of the **Negotiated Charge**. Non-Preferred Care: **60%** of the **Recognized Charge**.
Anesthesia Expense	**Covered Medical Expenses** for the charges of Anesthesia, during a surgical procedure, are payable as follows: Preferred Care: **90%** of the **Negotiated Charge**. Non-Preferred Care: **60%** of the **Recognized Charge**.
Assistant Surgeon Expense	**Covered Medical Expenses** for the charges of an assistant surgeon, during a surgical procedure, are payable as follows: Preferred Care: **90%** of the **Negotiated Charge**. Non-Preferred Care: **60%** of the **Recognized Charge**.
Ambulatory Surgical Expense	Benefits are payable for **Covered Medical Expenses** incurred by a covered person for expenses incurred for outpatient surgery performed in a hospital outpatient surgery department or in an ambulatory surgical center. **Covered Medical Expenses** must be incurred on the day of the surgery or within 48 hours after the surgery: Preferred Care: **90%** of the **Negotiated Charge**. Non-Preferred Care: **60%** of the **Recognized Charge**.
Outpatient Benefits **Covered Medical Expenses** include but are not limited to: Physician's office visits, hospital or outpatient department or emergency room visits, durable medical equipment, clinical lab, or radiological facility.	
Emergency Room Expense	**Covered Medical Expenses** incurred for treatment of an **Emergency Medical Condition** are payable as follows: Preferred Care: **90%** of the **Negotiated Charge**. Non-Preferred Care: **90%** of the **Recognized Charge**.
Urgent Care Expense	*Benefits include charges for treatment by an urgent care provider.* **Please note: A covered person should not seek medical care or treatment from an urgent care provider if their illness, injury, or condition, is an emergency condition. The covered person should go directly to the emergency room of a hospital or call 911 (or the local equivalent) for ambulance and medical assistance.** **Urgent Care** Benefits include charges for an urgent care provider to evaluate and treat an urgent condition. **Covered Medical Expenses** for urgent care treatment are payable as follows: Preferred Care: **90%** of the **Negotiated Charge**. Non-Preferred Care: After a **$25** per visit Deductible, **60%** of the **Recognized Charge**. *No benefit will be paid under any other part of this Plan for charges made by an urgent care provider to treat a non-urgent condition.*
Ambulance Expense	**Covered Medical Expenses** are payable as follows **90%** of the **Actual Charge** for the services of a professional ambulance to or from a hospital, when required due to the emergency nature of a covered **Accident** or **Sickness**.
Pre-Admission Testing Expense	**Covered Medical Expenses** for Pre-Admission testing charges while an outpatient before scheduled surgery are payable on the same basis as any Sickness.

Physician's Office Visits	**Covered Medical Expenses** are payable as follows: Preferred Care: **90%** of the **Negotiated Charge**. Non-Preferred Care: After a **$25** per visit Deductible, **60%** of the **Recognized Charge**.
Laboratory and X-Ray Expense	**Covered Medical Expenses** are payable as follows: Preferred Care: **90%** of the **Negotiated Charge**. Non-Preferred Care: **60%** of the **Recognized Charge**.
Therapy Expense	**Covered Medical Expenses** include charges incurred by a **covered person** for the following types of therapy provided on an outpatient basis: • Physical Therapy, • Chiropractic Care, • Speech Therapy, • Inhalation Therapy, or • Occupational Therapy. Expenses for Speech and Occupational Therapies are **Covered Medical Expenses,** only if such therapies are a result of **injury** or **sickness**. **Covered Medical Expenses** are payable as follows: Preferred Care: **90%** of the **Negotiated Charge**. Non-Preferred Care: **60%** of the **Recognized Charge**. After the 10th visit we may request verification of medical necessity in order to continue treatment.
Durable Medical Equipment Expense	**Covered Medical Expenses** are payable as follows: Preferred Care: **90%** of the **Negotiated Charge**. Non-Preferred Care: **60%** of the **Recognized Charge**.
Prosthetic Devices Expense	Benefits include charges for: artificial limbs, or eyes, and other non-dental prosthetic devices, as a result of an accident or sickness. **Covered Medical Expenses** do **not** include: eye exams, eyeglasses, vision aids, hearing aids, communication aids, and orthopedic shoes, foot orthotics, or other devices to support the feet. Preferred Care: **90%** of the **Negotiated Charge**. Non-Preferred Care: **60%** of the **Recognized Charge**.

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

Diagnostic Testing for Attention Disorders and Learning Disabilities Expense	**Covered Medical Expenses** for diagnostic testing for: • Attention deficit disorder, or • Attention deficit hyperactive disorder, or are payable as follows: Preferred Care: **90%** of the **Negotiated Charge**. Non-Preferred Care: **60%** of the **Recognized Charge**. Once a covered person has been diagnosed with one of these conditions, medical treatment will be payable as detailed under the outpatient Treatment of Mental and Nervous Disorders portion of this Plan.
Musculoskeletal/ Chiropractic Therapy Expense	**Covered Medical Expenses** include charges for Musculoskeletal Therapy provided on an outpatient basis. For purposes of this benefit, "Musculoskeletal Therapy" means the diagnosis, and treatment, by manual or mechanical means, of the musculoskeletal structure, due to lack of normal nerve, muscle, and /or joint function. Benefits for chiropractic care will be paid on the same basis as those payable for care or services provided by other health professionals in the diagnosis, treatment and management of the same or similar conditions, injuries, complaints, disorders or ailments.
Consultant or Specialist Expense	**Covered Medical Expenses** include the expenses for the services of a consultant or specialist. The services must be requested by the attending physician for the purpose of confirming or determining to confirm or determine a diagnosis. Benefits are payable as follows: Preferred Care: **90%** of the **Negotiated Charge**. Non-Preferred Care: After a **$25** per visit **Deductible**, **60%** of the **Recognized Charge**.

Treatment of Mental and Nervous Disorders	
Biologically Based Mental Illness and for Children with Serious Emotional Disturbances	"Biologically Based Mental Illness" means a mental, nervous or emotional condition that is caused by a biological disorder of the brain and results in a clinically significant, psychological syndrome or pattern that substantially limits the functioning of the person with the illness. Such biologically based mental illnesses are defined as schizophrenia/psychotic disorders, major depression, bipolar disorder, delusional disorders, panic disorder, obsessive-compulsive disorder, bulimia and anorexia, ADD/ADHD. "Children with Serious Emotional Disturbances" means: persons under the age of eighteen years who have diagnoses of attention deficit disorders, disruptive behavior disorders, or pervasive development disorders, and where there are one or more of the following: • Serious suicidal symptoms or other life-threatening self-destructive behaviors, • Significant psychotic symptoms (hallucinations, delusion, bizarre behaviors), • Behavior caused by emotional disturbances that placed the child at risk of causing personal injury or significant property damage, or • Behavior caused by emotional disturbances that placed the child at substantial risk of removal from the household. **Inpatient** **Covered Medical Expenses** include expenses incurred by a **covered person** while confined as a full-time inpatient in a **hospital** or **residential treatment facility** for the treatment of Biologically based Mental Illness or Children with Serious Emotional Disturbances. These expenses are covered on the same basis as inpatient treatment for any **sickness**. Includes the charges made for treatment received during partial hospitalization or intensive outpatient in a hospital or treatment facility. Prior review and approval must be obtained on a case-by-case basis. When approved, benefits will be payable in place of an inpatient admission, whereby 2 days of partial hospitalization or intensive outpatient treatment may be exchanged for 1 day of full hospitalization. **Outpatient** **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 as follows: Benefits are payable as follows: Preferred Care: 90% of the Negotiated Charge. Non-Preferred Care: After a $25 per visit Deductible, 60**%** of the Recognized Charge. ***Not Covered are Charges for Services*:** • While incarcerated, confined or committed to a local correctional facility or a prison, or a custodial facility for youth. • Provided solely because such services are ordered by a court. • Deemed to be cosmetic in nature.

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

Substance Abuse Benefits	
Inpatient Expense	**Covered Medical Expenses** include the treatment of a substance abuse condition while confined as a inpatient in a hospital or facility licensed for such treatment. **Covered Medical Expenses** also include the charges made for treatment received during partial hospitalization in a hospital or treatment facility. Prior review and approval must be obtained on a case-by-case basis by contacting Aetna Student Health. When approved, benefits will be payable in place of an inpatient admission, whereby 2 days of partial hospitalization may be exchanged for 1 day of full hospitalization. Benefits are payable as follows: Preferred Care: **90%** of the **Negotiated Charge**. Non-Preferred Care: **60%** of the **Recognized Charge**. Benefits will include 7 inpatient days for detoxification in any calendar year and 30 inpatient days for rehabilitation in any calendar year.
Outpatient Expense	**Covered Medical Expenses** for outpatient diagnosis and treatment of a substance abuse condition are payable as follows: Preferred Care: **90%** of the **Negotiated Charge**. Non-Preferred Care: After a **$25** per visit **Deductible**, **60%** of the **Recognized Charge**. Benefits are limited to **60** visits per Policy Year, **20** of which may be used for family counseling.
Maternity Benefits	
Maternity Expense	**Covered Medical Expenses** include inpatient care of the covered person and any newborn child for a minimum of 48 hours after a vaginal delivery and for a minimum of 96 hours after a cesarean delivery. Any decision to shorten such minimum coverages shall be made by the attending Physician**,** in consultation with the mother. In such cases, **covered medical expenses** may include at least one home care visit. This home care visit may be requested at any time within 48 hours of the time of a vaginal delivery, or within 96 hours of a delivery, and shall be delivered within 24 hours after discharge, or 24 hours of the mother's request, whichever is later. The home care visit will not be subject to any deductible, copay or insurance. **Covered Medical Expenses** for maternity care also include: • Parent education • Assistance and training in breast or bottle feeding, and • The performance of any necessary maternal and newborn clinical assessments. A referral is not required for this benefit. **Covered Medical Expenses** for pregnancy, childbirth, and complications of pregnancy are payable on the same basis as any other sickness. **Covered Medical Expenses** include services of a licensed midwife unless those services duplicate the services already provided by the covered person's physician. During the initial 48 or 96 hours, no pre-certification is required for the mother, or her newly born child. Pre-certification is required, after the 48, or 96 hours. **Covered Medical Expenses** include coverage for blood lead testing for prenatal/maternity care.

Well Newborn Nursery Care Expense	Benefits include charges for routine care of a covered person's newborn child as follows: • Hospital charges for routine nursery care during the mother's confinement, but for not more than four days for a normal delivery, • Physician's charges for circumcision, and • Physician's charges for visits to the newborn child in the hospital and consultations, but for not more than 1 visit per day. **Covered Medical Expenses** are payable as follows: Preferred Care: **90%** of the **Negotiated Charge**. Non-Preferred Care: **60%** of the **Recognized Charge**.
Additional Benefits	
Prescription Drug Benefit	**Prescription Drug Benefits** are payable as follows: Preferred Care Pharmacy: **100%** of the **Negotiated Charge**, following a **$20 Copay** for each **Brand Name Prescription Drug** or a **$10 Copay** for each **Generic Prescription Drug**. Non-Preferred Care Pharmacy: **70%** of the **Recognized Charge**, following a **$20 Copay** for each **Brand Name Prescription** or a **$10 Copay** for each **Generic Prescription Drug**. **Covered Medical Expenses** are payable up to a maximum of **$800** per **Policy Year**. You must pay out of pocket for **Prescriptions** at a **Non-Preferred Pharmacy** and then submit the receipt with a **Prescription Claim Form** for reimbursement. Please refer to prescription claim section of this brochure. This **Pharmacy** benefit is provided to cover **Medically Necessary Prescriptions** associated with a covered **Sickness** or **Accident** occurring during the **Policy Year**. Please use your Aetna Student Health ID card when obtaining your prescriptions. Prior Authorization is required for certain **Prescription Drugs**, including Imitrex, certain stimulants, growth hormones and for any Prescription quantities larger than a 30-day supply. (***This is only a partial list.)*** Medications not covered by this benefit include, but are not limited to: all medications/drugs whose sole purpose is to promote or to stimulate hair growth, appetite suppressants, smoking deterrents, fertility medications and non-self injectables. ***(This is only a partial list.)*** For assistance or **for a complete list** of **excluded medications**, or drugs requiring **prior authorization**, please contact Aetna Pharmacy Management at **(800) 238-6279** (available 24 hours). Aetna Specialty Pharmacy provides specialty medications and support to members living with chronic conditions. The medications offered may be injected, infused or taken by mouth. For additional information please go to **www.AetnaSpecialtyRx.com**. **Please Note: Covered Medical Expense**s for prescribed supplies for the treatment of diabetes will not be subject to the listed per **Policy Year Prescription Drug** limit.
Diabetic Treatment and Supplies Expenses	**Covered Medical Expenses** include expenses incurred in connection with the treatment of diabetes, including diabetic testing supplies and equipment, including: Blood glucose monitors (including monitors for the legally blind), data management systems, test strips, insulin injecting aids, cartridges for the legally blind, syringes, insulin pumps and appurtenances, insulin infusion devices and oral agents for controlling blood sugar. Benefits are payable on the same basis as any **Sickness**.

Diabetic Self-Management Education Expense	**Covered Medical Expenses** will include training designed to instruct a person in the self-management of diabetes. It may include training in self-care or diet. Such education may be provided in a group setting, and when medically necessary, diabetic self-management education shall also include home visits. Benefits for Self-Management Education and Home Health Care are payable on the same basis as any Sickness.
Non Prescription Enteral Formula Expense	Benefits include charges incurred by a covered person for non-prescription enteral formulas, for which a physician has issued a written order, and are for the treatment of malabsorption caused by: • Crohn's Disease, • Ulcerative colitis, • Gastroesophageal reflux, • Gastrointestinal motility, • Chronic intestinal pseudoobstruction, and • Inherited diseases of amino acids and organic acids. **Covered Medical Expenses** for inherited diseases of amino acids and organic acids, will also include food products modified to be low protein. Benefits are payable on the same basis as any **Sickness**. Modified solid food products (MFSP) that are low in protein are covered up to **$2,500** per **Covered Person**, per **Policy Year**.
Temporomandibu-lar Joint Dysfunction (TMJ)	**Covered Medical Expenses** include charges incurred, by a **covered person,** for non-surgical treatment of Temporomandibular Joint (TMJ) Dysfunction, when the TMJ disorder is medical in origin. Benefits are payable on the same basis as any other Sickness.
Prescription Contraceptive Drugs and Devices	**Covered Medical Expenses** include: • Charges incurred for contraceptive drugs and devices that by law need a physician's prescription and that have been approved by the FDA. • Related outpatient contraceptive services such as: • Consultations, • Exams, • Procedures, and • Other medical services and supplies. Benefits are payable on the same basis as any Sickness.
Pap Smear Expense	**Covered Medical Expenses** include one annual routine pap smear screening for women age 18 and older. Benefits are payable on the same basis as any **Sickness**.

Mammography Expense	**Covered Medical Expenses** include one baseline mammogram for women between age 35 and 40. Coverage is also provided for one routine annual mammogram for women age 40 and older, as well as when medically indicated for women with risk factors who are under age 40. Risk factors for women under 40 are: • Prior personal history of breast cancer, • Positive Genetic Testings, • Family history of breast cancer, or • Other risk factors. Mammogram screenings coverage must also include comprehensive ultrasound screening for the entire breast or breasts if a mammogram demonstrates heterogeneous or dense breast tissue and when determined to be medically necessary by a licensed physician. Benefits are payable on the same basis as any **Sickness**.
Treatment for Breast Cancer	**Covered Medical Expenses** include inpatient hospital care for lymph node dissection or lumpectomy for the treatment of breast cancer, or a mastectomy covered by the policy. Benefits are payable on the same basis as any other **Sickness**.
Mastectomy Reconstruction Benefit	**Covered Medical Expenses** will include expenses incurred for: • All stages of reconstruction of the breast on which a mastectomy has been performed; and • Surgery and reconstruction of the other breast to produce a symmetrical appearance. Benefits are payable on the same basis as any **Sickness**.
Elective Abortion Expenses	If, as a result of pregnancy having its inception during the **Policy Year**, a **Covered Person** incurs expenses in connection with an elective abortion, a benefit is payable. **Covered Medical Expenses** for **Elective Abortion Expense** are covered as follows: Preferred Care: **90%** of the **Negotiated Charge**. Non-preferred Care: **60%** of the **Recognized Charge**. This benefit is in lieu of any other Policy benefits. Benefits are limited to **$250** per occurrence, per **Policy Year**.
Chlamydia Screening Test Expense	**Covered Medical Expenses** include charges incurred for an annual Chlamydia screening test. Benefits will be paid for Chlamydia screening expenses incurred for: • Women who are: - Under the age of 20 if they are sexually active, and - At least 20 years old if they have multiple risk factors. • Men who have multiple risk factors. Benefits are payable as follows: Preferred Care: **90%** of the **Negotiated Charge**. Non-preferred Care: **60%** of the **Recognized Charge**.

Routine Screening for Sexually Transmitted Disease Expense	**Covered Medical Expenses** include charges for covered persons who are at least 18 years old and who are sexually active for annual routine screening for sexually transmitted diseases. Benefits are payable as follows: Preferred Care: **90%** of the **Negotiated Charge**. Non-Preferred Care: **60%** of the **Recognized Charge**.
Routine Prostate Cancer Screening Expense	**Covered Medical Expenses** include charges incurred for the screening of cancer, as follows: • For males age 40 and over, with a family history of prostate cancer or other prostate cancer risk factors, **Standard Diagnostic Testing** once each **Policy Year**. • For males age 50 or over, who are asymptomatic, **Standard Diagnostic Testing** once each **Policy Year**. For a male, any age, with a prior history of prostate cancer, **Standard Diagnostic Testing** as recommended, by the **Covered Person's physician**. **Standard Diagnostic Testing** includes, but is not limited to: • A digital rectal examination; and • A prostate-specific antigen test. Benefits are payable on the same basis as any **Sickness**.
Second Opinion For Cancer Treatment Expense	**Covered Medical Expenses** include a second opinion consultation by a specialist for the diagnosis or recommended treatment of cancer. The specialist must be board certified in the medical field relating to the diagnosis. Coverage will also be provided for any expenses incurred for required X-rays and diagnostic tests done in connection with that consultation. Aetna must receive a written report on the second opinion consultation. If the covered person does not **obtain a referral** from a **Preferred Care** provider for **Non-Preferred Care**, the level of coinsurance for **Non-Preferred Care** may be reduced. With a referral, benefits will be payable at the same level for a **Non-Preferred Care** as it would be for **Preferred Care**. Benefits are payable on the same basis as any **Sickness**.
Surgical Second Opinion Expense	**Covered Medical Expense**s will include expenses incurred for a second opinion consultation by a specialist on the need for surgery which has been recommended by the covered person's physician. The specialist must be board certified in the medical field relating to the surgical procedure being proposed. Coverage will also be provided for any expenses incurred for required X-rays and diagnostic tests done in connection with that consultation. Aetna must receive a written report on the second opinion consultation. Benefits are payable as follows: Preferred Care: **90%** of the **Negotiated Charge**. Non-Preferred Care: After a **$25** per visit **Deductible**, **60%** of the **Recognized Charge**.

Elective Surgical Second Opinion Expense	**Covered Medical Expenses** will include expenses incurred for a second opinion consultation by a specialist on the need for non-emergency elective surgery which has been recommended by the covered person's physician. The specialist must be board certified in the medical field relating to the surgical procedure being proposed. Coverage will also be provided for any expenses incurred for required X-rays and diagnostic tests done in connection with that consultation. Aetna must receive a written report on the second opinion consultation. Benefits are payable as follows: Preferred Care: **90%** of the **Negotiated Charge**. Non-Preferred Care: After a **$25** per visit **Deductible**, **60%** of the **Recognized Charge**.
Acupuncture in Lieu of Anesthesia Expense	**Covered Medical Expenses** include acupuncture therapy, when acupuncture is used in lieu of other anesthesia, for a surgical or dental procedure covered under this Plan. The acupuncture must be administered by a health care provider who is a legally qualified physician, practicing within the scope of their license. Preferred Care: **90%** of the **Negotiated Charge**. Non-Preferred Care: **60%** of the **Recognized Charge**.
Dermatological Expense	**Covered Medical Expenses** include charges for the diagnosis and treatment of skin disorders, excluding laboratory fees. Related laboratory expenses are covered under the Outpatient Expense Benefit. Benefits are payable on the same basis as any Sickness. *Covered Medical Expenses do not include treatment for cosmetic treatment and procedures.*
Podiatric Expense	**Covered Medical Expenses** include charges for podiatric services, provided on an outpatient basis following an injury. Benefits are payable on the same basis as any Sickness. Expenses for routine foot care, such as trimming of corns, calluses, and nails, are **not Covered Medical Expenses**.
Home Health Care/Services Expenses	**Covered Medical Expenses** include charges incurred by a covered person for home health care services made by a home health agency pursuant to a home health care plan. Preferred Care: **90%** of the **Negotiated Charge**. Non-Preferred Care: **60%** of the **Recognized Charge**. Benefits are limited to 40 visits per **Policy Year**.
Transfusion or Dialysis of Blood Expense	**Covered Medical Expenses** include charges for the transfusion or dialysis of blood, including the cost of: whole blood, blood components, and the administration thereof. Benefits are payable as follows: Preferred Care: **90%** of the **Negotiated Charge**. Non-Preferred Care: **60%** of the **Recognized Charge**.

End of Life Care at an Acute Care Facility Benefit	**Covered Medical Expenses** include charges for end of life services provided for a terminally ill covered person, including Acute Care services at an Acute Care Facility. Benefits are payable as follows: Preferred Care: **100%** of the **Negotiated Charge**. Non-Preferred care: **100%** of the **Recognized Charge**.
Licensed Nurse Expense	Benefits include charges incurred by a covered person who is confined in a hospital as a resident bed-patient, and requires the services of a registered nurse or licensed practical nurse. **Covered Medical Expenses** are payable as follows: Preferred Care: **90%** of the **Negotiated Charge**. Non-Preferred Care: **60%** of the **Recognized Charge**.
Skilled Nursing Facility Expense	**Covered Medical Expenses** include charges incurred by a covered person for confinement in a skilled nursing facility for treatment rendered: • In lieu of confinement in a hospital as a full-time inpatient, or • Within 24 hours following a hospital confinement and for the same or related cause(s) as such hospital confinement. **Covered Medical Expenses** are payable as follows: Preferred Care: **90%** of the **Negotiated Charge** for the semi-private room rate. Non-Preferred Care: **60%** of the **Recognized Charge** for the semi-private room rate.
Rehabilitation Facility Expense	**Covered Medical Expenses** include charges incurred by a covered person for confinement as a full-time inpatient in a rehabilitation facility. Confinement in the rehabilitation facility must follow within 24 hours of, and be for the same or related cause(s) as, a period of hospital or skilled nursing facility confinement. **Covered Medical Expenses** for Rehabilitation Facility Expense are covered as follows: Preferred Care: **90%** of the Negotiated Charge for the rehabilitation facility's daily room and board maximum for semi-private accommodations. Non-Preferred Care: **60%** of the Recognized Charge for the rehabilitation facility's daily room and board maximum for semi-private accommodations.
Bone Density Screening Expense	**Covered Medical Expenses** include bone mineral density measurements or tests. Benefits will be paid for expenses incurred by a **covered person** for a bone density screening upon the recommendation of the covered person's physician for: (1) An individual previously diagnosed as having osteoporosis or having a family history of osteoporosis, or (2) An individual with symptoms or conditions indicative of the presence, or the significant risk of osteoporosis, or (3) An individual on a prescribed drug regimen posing a significant risk of osteoporosis, or (4) An individual with lifestyle factors to such a degree as posing a significant risk of osteoporosis, or (5) With such age, gender, and/or physiological characteristics which pose a significant risk for osteoporosis. Benefits will also include drugs and devices approved by the FDA or generic equivalents as approved substitutes for the treatment of osteoporosis. Benefits are payable on the same basis as any **Sickness**.

ADDITIONAL SERVICES AND DISCOUNTS

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

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

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

Aetna Hearing℠ discount program: Access to discounts on hearing aids and hearing tests from HearPO. Guaranteed lowest pricing* on over 1000 models from seven leading manufacturers.
**Competitor copy required for verification of price and model. Limited to manufacturers offered through the HearPO program. Local provider quotes only will be matched, no internet quotes*

Aetna Natural Products and Services℠ discount program: Access to reduced rates on services from participating providers for acupuncture, chiropractic care, massage therapy and dietetic counseling. Also, access to discounts on over-the-counter vitamins, herbal and nutritional supplements and natural products. All products and services are provided through American Specialty Health Incorporated (ASH) and its subsidiaries.

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

Aetna Weight Management℠ discount program: Access to discounts on eDiets® diet plans and products, Jenny Craig® weight loss programs and products, and Nutrisystem® weight loss meal plans.

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

Zagat discounts: Discount off a one-year online membership to ZAGAT.com, with access to ratings and reviews of over 40,000 restaurants, hotels and more in hundreds of cities worldwide.

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

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

These services, programs or benefits are offered by vendors who are independent contractors and not employees or agents of Chickering Claims Administrators, Inc., Aetna Life Insurance Company or their affiliates. Discount programs and other programs above provide access to discounted prices and are NOT insured benefits. The member is responsible for the full cost of the discounted services. Discount programs may be offered by vendors who are independent contractors and not employees or agents of Aetna. Aetna may receive a percentage of the fee you pay to the discount vendor.

Vital Savings by Aetna® on Dental* is a dental discount program helping you save – with one low annual fee of $25 per person. In most instances, savings range from 15-50 percent on services from general dentistry and cleanings to root canals, crowns, and orthodontia (braces) No claims to file. Enroll online at **www.aetnastudenthealth.com**.
*Actual costs and savings vary by provider and geographic area.
The rate above includes both fees for Vital Savings by Aetna®, as well as The New School's administrative fee.

The Vital Savings by Aetna® program (the "Program") is not insurance. *The program does not meet the Minimum Creditable Coverage requirements in Massachusetts. It provides Members with access to discounted fees according to schedules negotiated by Aetna Life Insurance Company for the Vital Savings by Aetna discount program. The range of discounts provided under the Program will vary depending on the type of provider and type of service received. The Program does not make payments directly to the participating providers. Each Member must 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,* ***1-888-BeVital****, is the Discount Medical Plan Organization.*

Health programs provide general health information and are not a substitute for diagnosis or treatment by a physician or other health/dental care professional. The availability and terms of specific discount programs and wellness services are subject to change without notice. Not all programs are available in all states.

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

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

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

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

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

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

GENERAL PROVISIONS

State Mandated Benefits

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

Subrogation/Reimbursement

Right of Recovery Provision

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

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

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

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

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

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

Coordination of Benefits

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

EXTENSION OF BENEFITS

If Basic Sickness Expense coverage for a **covered person** ends while he is **totally disabled**, benefits will continue to be available for expenses incurred for that person only while the **covered person** continues to be **totally disabled**. Benefits will end 31 days from the date coverage ends. Benefits will continue to be available for a **covered person on plan 2** who incurs medical expenses directly relating to a pregnancy that began before coverage under this Plan ceased. Such benefits will be covered only for the period of that pregnancy.

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

Termination of Insurance

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

Termination of Student Coverage

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

(a) The date this Plan 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.

EXCLUSIONS

This Plan does not cover nor provide benefits for:

1. Expense incurred as a result of dental treatment, except for treatment resulting from **injury** to **sound natural teeth** as provided elsewhere in this Plan.

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

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

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

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

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

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

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

10. Expense incurred for cosmetic surgery, reconstructive surgery, or other services and supplies which improve, alter, or enhance appearance, whether or not for psychological or emotional reasons, except to the extend needed to:

    Improve the function of a part of the body that: is not a tooth or structure that supports the teeth, and is malformed as a result of a severe birth defect, including harelip, webbed fingers, or toes, or as direct result of: disease, or surgery performed to treat a disease or **injury**.

    Repair of an **injury** (including reconstructive surgery for prosthetic device for a **covered person** who has undergone a mastectomy) which occurs while the **covered person** is covered under this Plan. Surgery must be performed in the next calendar year.

    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.

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

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

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

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

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

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

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

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

19. Expense incurred by a **covered person** who is not a United States citizen for services performed within the **covered person's** home country if the **covered person's** home country has a socialized medicine program (or provides national health care).

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

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

22. 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 established reference compendia: the American Hospital Formulary Service - Drug Information (AJFSDI); the National Comprehensive Cancer Networks Drugs and Biologics Compendium; Thomson Micromedex Drugdex; Elsevier Gold Standard's Clinical Pharmacology or other authoritative compendia as identified by the federal Secretary of Health and Human Services or the Centers for Medicare & Medicaid; or recommended by review article or editorial comments in a major peer reviewed professional journal.

If Aetna determines that available, scientific evidence demonstrates that the drug is effective, or shows promise of being effective, for the disease.

23. Expense incurred for acupuncture, unless services are rendered for anesthetic purposes.

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

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

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

27. Expenses incurred for hearing exams.

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

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

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

31. Expense for incidental surgeries, and standby charges of a **physician**.

32. Expense for treatment and supplies for programs involving cessation of tobacco use.

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

34. 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 Plan.

35. Expenses incurred for massage therapy.

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

37. Expense for charges that are not **Recognized Charges**, as determined by Aetna, except that this will not apply if the charge for a service, or supply, does not exceed the **Recognized Charge** for that service or supply, by more than the amount or percentage, specified as the Allowable Variation.

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

39. Expenses for treatment of **injury** or **sickness** to the extent payment is made, as a judgment or settlement, by any person deemed responsible for the **injury** or **sickness** (or their Insurers).

40. Expenses arising from a **pre-existing condition**, 12 months or less from the covered person's enrollment date (applies to late enrollees only).

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

DEFINITIONS

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

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

Aggregate Maximum
The maximum benefit that will be paid under this Plan for all **Covered Medical Expenses** incurred by a covered person that accumulate **from one Policy Year to the next.**

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

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

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

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

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

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

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

Covered Medical Expense
Those charges for any treatment, service or supplies covered by this Plan which are:
- Not in excess of the **Recognized Charges**, or
- Not in excess of the charges that would have been made in the absence of this coverage, and
- Incurred while this Plan 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** while coverage under this Plan is in effect.

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

Deductible
The amount of **Covered Medical Expenses** that are paid by each **covered person** during the **policy year** before benefits are paid.

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

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

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

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

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

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

Emergency Medical Condition
A medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in:
(1) Placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition placing the health of such person or others in serious jeopardy,
(2) Serious impairment to such person's bodily functions,
(3) Serious dysfunction of any bodily organ or part of such person, or
(4) Serious disfigurement of such person.

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

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

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

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

Home Health Care Plan
A written plan of care established and approved in writing by a physician, for continued health care and treatment in a covered person's home. It must follow within 7 days of discharge and be for the same or related cause(s) as a period of hospital or skilled nursing confinement. The physician must examine the covered person at least once a month, and the physician must renew the written plan every 60 days.

Home Health Care Services
- Part-time or intermittent nursing care by: a registered nurse (R. N.), a licensed Practical nurse (L.P.N.), or under the supervision on an R.N. if the services of an R. N. are not available,
- Part time or intermittent home health aide services, that consist primarily of care of a medical or therapeutic nature by other than an R.N.,
- Physical, occupational. speech therapy, or respiratory therapy,
- Medical supplies, drugs and medicines, and laboratory services. However, these items are covered only to the extent they would be covered if the patient was confined to a hospital,
- Medical social services by licensed or trained social workers,
- Nutritional counseling.

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

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

Hospital
A facility which meets all of these tests:
- It provides in-patient services for the case and treatment of injured and sick people, and
- It provides room and board services and nursing services 24 hours a day, and
- It has established facilities for diagnosis and major surgery, and
- It is run as a **hospital** under the laws of the jurisdiction which it is located.

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

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

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

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

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

Medically Necessary
A service or supply that is necessary and appropriate for the diagnosis or treatment of a **sickness** or **injury** based on generally accepted current medical practice. A service or supply will not be considered as **medically necessary** if:

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

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

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

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

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

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

Non-Preferred Care Provider

- A health care provider that has not contracted to furnish services or supplies at a **negotiated charge**, or
- A **Preferred Care Provider** that is furnishing services or supplies without the referral of a **School Health Services**.

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

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

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

Orthodontic Treatment
Any
- Medical service or supply, or
- Dental service or supply,

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

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

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

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

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

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

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

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

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

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

Preferred Pharmacy
A **pharmacy**, including a **mail order pharmacy**, which is party to a contract with Aetna to dispense drugs to persons covered under this Plan, but only:

- While the contract remains in effect, and
- While such a **pharmacy** dispenses a **prescription drug,** under the terms of its contract with Aetna.

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

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

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

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

Prescription Drugs
Any of the following:

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

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

- Selected by a person from the list of **Primary Care Physician**s in the **directory**,
- Responsible for the person's on-going health care, and
- Shown on Aetna's records as the person's **Primary Care Physician**.

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

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

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

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

In determining the **recognized charge** for a service or supply that is:

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

Aetna may take into account factors, such as:

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

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

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

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

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

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

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

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

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

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

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

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

Surgical Expense
Charges by a **physician** for:

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

Surgical Procedure

- A cutting procedure,
- Suturing of a wound,
- Treatment of a fracture,
- Reduction of a dislocation,
- Radiotherapy (excluding radioactive isotope therapy), if used in lieu of a cutting operation for removal of a tumor,
- Electrocauterization,
- Diagnostic and therapeutic endoscopic procedures,
- Injection treatment of hemorrhoids and varicose veins,
- An operation by means of laser beam,
- Cryosurgery.

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

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

- The onset of or change in a disease, or
- The diagnosis of a disease, or
- An **injury** caused by an **accident**,

which, while not needing an **emergency admission**, is severe enough to require confinement as an inpatient in a **hospital** within 2 weeks from the date the need for the confinement becomes apparent.

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

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

Urgent Care Provider
This is:

- A freestanding medical facility which:
  - Provides unscheduled medical services to treat an **urgent condition** if the **covered person's physician** is not reasonably available.
  - Routinely provides ongoing unscheduled medical services for more than 8 consecutive hours. Makes charges.
  - Is licensed and certified as required by any state or federal law or regulation.
  - Keeps a medical record on each patient.
  - Provides an ongoing quality assurance program. This includes reviews by **physicians** other than those who own or direct the facility.
  - Is run by a staff of **physicians**. At least one such **physician** must be on call at all times.
  - Has a full-time administrator who is a licensed **physician.**
- A **physician's** office, but only one that:
  Has contracted with Aetna to provide urgent care, and is, with Aetna's consent, included in the Provider **Directory** as a Preferred Urgent Care Provider.

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

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

CLAIM PROCEDURE

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

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

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

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

PRESCRIPTION DRUG CLAIM PROCEDURE

Preferred Care
When obtaining a covered Prescription, please present your Aetna ID card to Preferred Pharmacy along with your applicable Copay. The Pharmacy will submit a claim to Aetna for the drug.

When you need to fill a Prescription and do not have your ID card with you, you may obtain your Prescription from an Aetna Preferred Pharmacy and be reimbursed by submitting a completed Aetna Prescription Drug claim form. A claim form is available at Student Health Services or by calling **(800) 238-6279**. You will be reimbursed for covered medications directly by Aetna. Please note, in addition to your Copay, you may be required to pay the difference between the retail price you paid for the prescription drug and the amount Aetna would have paid if you had presented your ID card and the Pharmacy had billed Aetna directly.

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

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

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

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

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

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

Aetna
P.O. Box 14464
Lexington, KY 40512

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

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

First Level Appeals Procedure

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

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

- A denial of, or failure to pay for, a referral, or
- A determination as to whether a benefit is covered under this Plan,

by calling Member Services. Aetna's Member Services telephone number is on the **covered person's** ID card. If the **covered person** is required to leave a recorded message, the **covered person's** message will be acknowledged within one business day after the call was recorded.

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

- An acknowledgment letter will be sent to the **covered person** within 1 day of Aetna's receipt of an oral Appeal, and 5 days of Aetna's receipt of a written Appeal. This letter may request additional information. If so, the additional information must be submitted to Aetna within 15 days of the date of the letter.
- The **covered person** will be sent a response within 30 days of Aetna's receipt of the Appeal. The response will be based on the information provided with, or subsequent to, the Appeal.
- If the Appeal concerns an eligibility issue, and if additional information is not submitted to Aetna after receipt of Aetna's response, the decision is considered Aetna's final response, 45 days after receipt of the Appeal. For all other Appeals, if additional information is to be submitted to Aetna after receipt of Aetna's response, it must be submitted within 15 days of the date of Aetna's response letter.
- Aetna's response will be sent within 30 days from the date of Aetna's first response letter.

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

Second Level Appeals Procedure

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

- An acknowledgement letter will be sent to the **covered person** within 15 days of Aetna's receipt of the written appeal. This letter may request additional information. If so, the additional information must be submitted to Aetna within 15 days of the date of the letter.
- Aetna's final response for an urgent or emergency situation will be sent within 2 business days. For all other situations, a response will be sent within 30 business days from the date of Aetna's receipt of all necessary information.

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

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

Aetna will keep the records of the **covered persons** complaint for 3 years.

EXTERNAL REVIEW PROCESS

EXTERNAL APPEAL

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

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

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

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

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

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

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

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

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

For the purposes of this section, the **covered person's** attending physician must be a licensed, board certified, or board eligible physician, qualified to practice in the area appropriate to treat the **covered person's** life-threatening or disabling condition or disease.

THE EXTERNAL APPEAL PROCESS

If, through the Aetna's internal appeal process, the **covered person** has received a final adverse determination upholding a denial of coverage on the basis that the service is not necessary, or is an experimental or investigational treatment, the **covered person** has 45 days from receipt of such notice to file a written request for an external appeal. If the **covered person** and Aetna have agreed to waive any internal appeal, the **covered person** has 45 days from the receipt of such waiver to file a written request for an external appeal. Aetna will provide an external appeal application with the final adverse determination issued through the Aetna's internal appeal process or its written waiver of an internal appeal.

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

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

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

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

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

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

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

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

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

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

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

ON CALL INTERNATIONAL

Chickering Claims Administrators, Inc. (CCA) has contracted with On Call International (On Call) to provide **Covered Person**s 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 Person**s, up to a maximum of **$10,000**.

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

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

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

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

- 24/7 Emergency Travel Arrangements
- Translation Assistance
- Emergency Travel Funds Assistance
- Lost Luggage and Travel Documents Assistance
- Assistance with Replacement of Credit Card/Travelers Checks
- Medical/Dental/Pharmacy Referral Service
- Hospital Deposit Arrangements
- Dispatch of **Physician**
- Emergency Medical Record Assistance
- Legal Referral
- Bail Bonds 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, WETA, and NDPE benefits and services available through On Call, USFIC, VSC and CV. For a copy of the plan documents applicable to the ADD, MER, WETA and NDPE coverage, including a full description of coverage, exclusions and limitations, please contact Aetna Student Health at www.aetnastudenthealth.com or (800) 966-7772.

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

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

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

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

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. To obtain a copy of our Notice of Privacy Practices describing in greater detail our practices concerning use and disclosure of personal information, please call the toll-free Customer Services number on your ID card or visit **www.aetnastudenthealth.com**.

Presented by:
University Health Plans, Inc.
One Batterymarch Park
Quincy, MA 02169
(800) 437-6448
www.**universityhealthplans.com**

Administered by:
Aetna Student Health.
P.O. Box 15708
Boston, MA 02215-0014
(800) 878-1927
www.aetnastudenthealth.com

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

Policy No. **812804**

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