2009 – 2010

THE NEW SCHOOL

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

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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"). 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, 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 ($250 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 ($1,714/year with $691 charged in the fall and $1,023 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, procedures to waive, 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 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
Email address: info@univhealthplans.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:
- Insurance Benefits
- Claims Processing
- Inpatient Admission Pre-Certification
- ID Cards (including lost ID cards)

Please contact:

Aetna Student Health
P.O. Box 15708
Boston, MA 02215-0014
(800) 878-1927 or visit www.aetnastudenthealth.com, click on "Find Your School" enter 812804 as your Policy Number.

Worldwide Web Access:
Aetna Student Health: www.aetnastudenthealth.com

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, click on "Find Your School" and enter 812804 as your Policy Number.

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

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

For Provider Listings (including Preferred Care Pharmacy locations):
Refer to the list kept at The New School Student Health Services, or visit www.aetnastudenthealth.com, click on "Find Your School" and enter 812804 as your Policy Number, then click on DocFind.

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 or 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 ($250 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 2009-2010 Student Health Insurance Fee is $1,714. You will be charged $691 in the Fall Semester and $1,023 in the Spring Semester.

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 the Student Health Services Fee and the Student Health Insurance Fee. Students at the Milano branch campuses and Parsons Decorative Arts program in Washington, DC, 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 the Student Health Center.

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

If students meet the eligibility criteria, they must waive online.

- 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 29, 2009
Spring Semester	February 22, 2010

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 6, 2009
Spring Semester	April 2, 2010

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.

LGBTQ Health – Students who identify themselves as lesbian, gay, bisexual, transgender, or queer 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 LGBTQ 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 Student Health Services, 135 East 12th Street, 2nd floor. We are 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, Medical 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 Medical 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.

Health Education – The Health Education program offers a variety of health-related workshops, training, and outreach programs throughout the university. The 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 indicated. The counselor will then help to arrange a referral to the appropriate place for treatment in the community.

We see students about a variety of issues. 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 mail 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. Student 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, click 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 have a limited capacity to administer the vaccine after the start of the Fall Semester. 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, 2009, and will terminate at 12:01 a.m. on August 20, 2010. Coverage for all newly-enrolled insured students for the Spring Semester will become effective at 12:01 a.m. on January 15, 2010 and will terminate at 12:01 a.m. on August 20, 2010.

Premium Rates (billed by semester)

Please note, if you are not enrolled for the Spring Semester, coverage will end at midnight on January 14, 2010.

Student	Annual* 8/20/09-8/20/10	Spring 1/15/10-8/20/10
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	$ 1,714	$ 1,023

* Fall Installment is $691

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.	Student Health Services per semester charge ($250) is mandatory and cannot be declined.	$1,714 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 graduate students.	Student Health Services per semester charge ($250) may be declined by submitting a completed Online Waiver Form by the Waiver Deadline Date.	$1,714 Annual Charge may be declined by submitting a completed Online Waiver Form by the Waiver Deadline Date.
Ineligible Students	Milano branch campuses and Parsons Decorative Arts program, Washington, DC.	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, 2009 and continues until 12:01 a.m. on August 20, 2010. Coverage under Plan 1 ends at 12:01 a.m. on January 15, 2010 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 ($1,714 Annual, to be billed in two installments; $691 for Fall Semester and $1,023 for Spring Semester). Coverage begins at 12:01 a.m. on August 20, 2009 and continues until 12:01 a.m. on August 20, 2010.

Eligibility and How to Waive

Compulsory Students: 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 the Student Health Services Fee and the Student Health Insurance Fee. Undergraduate students who are registered for six (6) or more credits are required to pay the Student Health Services Fee 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 29, 2009 is considered a late enrollment. For the Spring Semester, any enrollment occurring after February 22, 2010 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 29, 2009 for the Fall Semester and by February 22, 2010 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 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, however we assure you this process is expedited as quickly and efficiently as possible.

Example: The Fall 2009 Semester period of coverage is August 20, 2009 through January 14, 2010. The Spring 2010 semester coverage period is January 15, 2010 through August 20, 2010. A student enrolled during the Fall 2009 semester will show as "terminated coverage" as of January 14, 2010. The student receives a prescription January 15, 2010. 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, 2009 through August 20, 2010, 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 the 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 29, 2009 for Fall Semester, and February 22, 2010 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, click on "Find Your School" and enter 812804 as your Policy Number, then click on DocFind.

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 Friday from 9:00 a.m. to 5:00 p.m. Evening and weekend hours may be available.

Summary of Benefits Chart

The following benefits are subject to the Policy limits and exclusions. All coverage is based on Reasonable 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 anesthetist, (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.

Inpatient Hospitalization Benefits	
Hospital Room and Board Expenses	Covered Medical Expenses are payable as follows: *Preferred Care*: 90% of the Negotiated Charge for an overnight stay. *Non-Preferred Care:* 60% of the Reasonable Charge for the semi-private room rate for an overnight stay.
Miscellaneous Hospital Expenses	Covered Medical Expenses are payable as follows: *Preferred Care*: 90% of the Negotiated Charge. *Non-Preferred Care*: 60% of the Reasonable Charge.
Physician's Hospital Visit Expenses	Covered Medical Expenses for charges for the non-surgical services of the attending Physician or a consulting Physician are payable as follows, limited to one visit per day: *Preferred Care*: 90% of the Negotiated Charge. *Non-Preferred Care*: 60% of the Reasonable Charge.
Surgical Benefits (Inpatient and Outpatient)	
Surgical Expenses	Covered Medical Expenses for charges for surgical services performed by a Physician are payable as follows: *Preferred Care:* 90% of the Negotiated Charge. *Non-Preferred Care:* 60% of the Reasonable Charge.

Anesthetist and Assistant Surgeon Expenses	Covered Medical Expenses for the charges of an anesthetist and an assistant surgeon during a surgical procedure for surgical services performed during a surgical operation are payable as follows: *Preferred Care:* 90% of the Negotiated Charge. *Non-Preferred Care:* 60% of the Reasonable Charge.
Outpatient Hospital Services for Surgery Expenses	Covered Medical Expenses are payable as follows: *Preferred Care:* 90% of the Negotiated Charge. *Non-Preferred Care:* 60% of the Reasonable Charge. Covered Medical Expenses include, but are not limited to: examination, laboratory tests, X-rays, anesthesia, use of operating room, and medicines.
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, radiological facility or other similar facility licensed by the state.	
Physician's Office Visit Expenses	Covered Medical Expenses are payable as follows: *Preferred Care:* 90% of the Negotiated Charge. *Non-Preferred Care:* 60% of the Reasonable Charge after $25 Deductible.
Emergency Room Visit Expenses	Covered Medical Expenses are payable as follows: *Preferred Care:* 90% of the Negotiated Charge. *Non-Preferred Care:* 90% of the Reasonable Charge.
Lab and X-Ray (Non-Hospital) Expenses	Covered Medical Expenses are payable as follows: *Preferred Care:* 90% of the Negotiated Charge. *Non-Preferred Care:* 60% of the Reasonable Charge.
Prescription Drug Coverage Expenses	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 for each Generic Prescription Drug *Non-Preferred Care*: 60% of the Reasonable Charge To have a prescription filled you must pay for it, then submit the receipt, prescription stub, and a Prescription Drug claim form for reimbursement.
Additional Benefits	
Home Health Care Expenses	Covered Medical Expenses are payable as follows for charges incurred within 12 months from the date of the first home health care visit. The maximum number of covered visits is limited to 40 visits per Policy Year. Four hours of home health aide service shall be considered as one home care visit. *Preferred Care:* 90% of the Negotiated Charge. *Non-Preferred Care:* 60% of the Reasonable Charge.
Ambulance Expenses	Covered Medical Expenses are payable at 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.

Durable Medical and Surgical Equipment Expenses	Payable on the same basis as any other accident expense.
Injury to Sound, Natural Teeth	Covered Medical Expenses are payable as follows: *Preferred Care:* 90% of the Negotiated Charge. *Non-Preferred Care:* 90% of the Reasonable Charge.

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.

Inpatient Hospitalization Benefits	
Hospital Room and Board Expenses	Covered Medical Expenses are payable as follows: *Preferred Care:* 90% of the Negotiated Charge for an overnight stay. *Non-Preferred Care:* 60% of the Reasonable Charge for the semi-private room rate for an overnight stay.
Miscellaneous Hospital Expenses	Covered Medical Expenses are payable as follows: *Preferred Care:* 90% of the Negotiated Charge. *Non-Preferred Care:* 60% of the Reasonable Charge.
Physician's Hospital Visit Expenses	Covered Medical Expenses for charges for the non-surgical services of the attending Physician or a consulting Physician are payable as follows, limited to one visit per day: *Preferred Care:* 90% of the Negotiated Charge. *Non-Preferred Care:* 60% of the Reasonable Charge.
Intensive Care Unit Expenses	Covered Medical Expenses are payable as follows: *Preferred Care:* 90% of the Negotiated Charge for an overnight stay *Non-Preferred Care:* 60% of the Reasonable Charge for the intensive care room rate for an overnight stay.
Private Duty Nurse Expenses	Covered Medical Expenses for the services of a private duty nurse while hospital confined are payable as follows: *Preferred Care:* 90% of the Negotiated Charge. *Non-Preferred Care:* 60% of the Reasonable Charge.

Surgical Benefits (Inpatient and Outpatient)	
Surgical Expenses	Covered Medical Expenses for charges for surgical services performed by a Physician are payable as follows: *Preferred Care:* 90% of the Negotiated Charge. *Non-Preferred Care:* 60% of the Reasonable Charge.
Anesthetist and Assistant Surgeon Expenses	Covered Medical Expenses for the charges of an anesthetist and an assistant surgeon during a surgical procedure for surgical services performed during a surgical operation are payable as follows: *Preferred Care:* 90% of the Negotiated Charge. *Non-Preferred Care:* 60% of the Reasonable Charge.
Consultant Expenses	When ordered by the attending physician for the purpose of confirming or determining a diagnosis, Covered Medical Expenses for the charges of a consultant or specialist are payable as follows: *Preferred Care:* 90% of the Negotiated Charge. *Non-Preferred Care:* 60% of the Reasonable Charge.
Outpatient Hospital Services for Surgery Expenses	Covered Medical Expenses are payable as follows: *Preferred Care:* 90% of the Negotiated Charge. *Non-Preferred Care:* 60% of the Reasonable Charge. Covered Medical Expenses include, but are not limited to: examination, laboratory tests, X-rays, anesthesia, use of operating room, and medicines.
Outpatient Benefits Expenses	
Covered Medical Expenses include, but are not limited to: Physician's office visits, hospital or outpatient department or emergency room visits, durable medical equipment, chiropractic treatment, clinical lab, radiological facility or other similar facility licensed by the state. Covered Medical Expenses are payable as follows: *Preferred Care:* 90% of the Negotiated Charge. *Non-Preferred Care:* 60% of the Reasonable Charge, after $25 Deductible	
Emergency Room Visit Expenses	Covered Medical Expenses are payable as follows: *Preferred Care:* 90% of the Negotiated Charge. *Non-Preferred Care:* 90% of the Reasonable Charge.
Lab and X-Ray (Non-Hospital) Expenses	Covered Medical Expenses are payable as follows: *Preferred Care:* 90% of the Negotiated Charge. *Non-Preferred Care:* 60% of the Reasonable Charge.

Mental Health and Chemical Abuse Benefits	
Biologically based Mental Illness and for Children with Serious Emotional Disturbances	"Biologically Based Mental Illness" means a mental, nervous or emotional condition that is caused by a biological disorder of the brain and results in a clinically significant, psychological syndrome or pattern that substantially limits the functioning of the person with the illness. Such biologically based mental illnesses are defined as schizophrenia/psychotic disorders, major depression, bipolar disorder, delusional disorders, panic disorder, obsessive-compulsive disorder, bulimia and anorexia. "Children with Serious Emotional Disturbances" means: persons under the age of 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 on the same basis as outpatient treatment for any sickness. *Not Covered are Charges for Services*: • While incarcerated, confined or committed to a local correctional facility or a prison, or a custodial facility for youth. • Provided solely because such services are ordered by a court. • Deemed to be cosmetic in nature.

Other than Biologically based Mental Illness and Children with Serious Emotional Disturbances	*Inpatient Benefits* 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 Reasonable Charge. Inpatient benefits are payable up to a maximum of 30 days per Policy Year. Days of inpatient confinement for treatment of Biologically based Mental illness and Children with Serious Emotional Disturbances will count against and reduce this maximum. *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 Benefits* 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:* 60% of the Reasonable Charge after a $25 copay. 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.
Inpatient Expenses Chemical Abuse	Covered Medical Expenses for the treatment of chemical abuse while confined as an inpatient in a hospital or facility licensed for such treatment are payable on the same basis as for any other Sickness: Covered Medical Expenses for detoxification are payable on the same basis as any other condition, to a maximum of seven days in any one Policy Year. Covered Medical Expenses are payable on the same basis as any other condition, up to a maximum of 30 days in any one Policy Year. Covered Medical Expenses also include charges made for treatment received during partial hospitalization in a hospital or treatment facility. Prior review and approval must be obtained on a case-by-case basis by contacting Aetna Student Health. When approved, benefits will be payable in place of an inpatient admission, whereby two days of partial hospitalization may be exchanged for one day of full hospitalization.

Outpatient Expenses Chemical Abuse	Covered Medical Expenses for the care or treatment of chemical abuse by a licensed or accredited health service organization or hospital or by a fully licensed practitioner are payable as any other covered condition up to a maximum of 60 visits per Policy Year for outpatient treatment including up to a maximum of 20 visits per Policy Year for family counseling.
Prescription Contraceptive Medical Expenses	Covered Medical Expenses are payable on the same basis as any expense. Covered Medical Expenses also include any expenses incurred for office visits in conjunction with the administration of a covered prescription contraceptive. Coverage of oral contraceptives, Lunelle, Depo-Provera, Patch, and Ring are provided under the separate Prescription Drug Benefit portion of the Plan.
Prescription Drug Coverage Expenses	Covered Medical Expenses for outpatient Prescription Drugs associated with a covered Sickness or covered Accident which occurs during the Policy Year are payable as follows with a $800 Policy Year Maximum. *Preferred Care*: 100% of the Negotiated Charge after a $10 Copay for each Generic Prescription Drug and a $20 Copay for each Brand-Name Prescription Drug. *Non-Preferred Care*: 70% of the Reasonable Charge after a $10 Deductible for each Generic Prescription Drug and a $20 Deductible for each Brand-Name Prescription Drug. *Please note*: You are required to pay in full at the time of service for all Prescriptions dispensed at a Non-Participating Pharmacy. (Please refer to the Prescription Drug Claim Procedures section of this Brochure for information regarding the claim submission and reimbursement process.) Medications not covered by this benefit include, but are not limited to, drugs whose sole purpose is to promote or to stimulate hair growth, appetite suppressants, smoking deterrents, immunization agents and vaccines, and non-self injectables. Covered medications include oral contraceptives, Lunelle, Implanon, IUD, Depo-Provera, Patch, and Ring. Expenses incurred for office visits in conjunction with the administration of a covered prescription contraceptive are provided under the Medical portion of the Plan. Prior authorization is required for growth hormones and drugs which are used for the treatment of malaria. For assistance, or for a complete list of excluded medications and drugs available with prior authorization, please contact (800) 238-6279.
Home Health Care Expenses	Covered Medical Expenses are payable as follows for charges incurred within 12 months from the date of the first home health care visit. The maximum number of covered visits is limited to 40 visits per Policy Year. Four hours of home health aide service shall be considered as one home care visit. *Preferred Care:* 90% of the Negotiated Charge. *Non-Preferred Care:* 60% of the Reasonable Charge.
Ambulance Expenses	Covered Medical Expenses are payable at 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.

Maternity Expenses	Covered Medical Expenses for pregnancy, childbirth, and complications of pregnancy are payable on the same basis as any other Sickness. In the event of an inpatient confinement, such benefits are payable for inpatient care of the Covered Person, and any newborn child, for a minimum of 48 hours after a vaginal delivery and for a minimum of 96 hours after a cesarean delivery. In the event of an early discharge, coverage is available for at least one home care visit; this visit will be payable at 100% and will not be subject to any Plan Copays or Deductibles, if applicable. Coverage also includes parent education, assistance and training in breast or bottle feeding, and the performance of any necessary maternal and newborn clinical assessments.
Voluntary Termination of Pregnancy Expenses	Covered Medical Expenses for voluntary termination of pregnancy are payable on the same basis as any other Sickness up to a maximum of $250 per occurrence.
Diabetic Treatment and Self-Management Education Expenses	Covered Medical Expenses are payable as follows: *Preferred Care:* 90% of the Negotiated Charge. *Non-Preferred Care:* 60% of the Reasonable Charge. *Please note*: Coverage of diabetic test strips, lancets, insulin, and syringes are a covered expense under the Prescription Drug Plan.
Prostate Cancer Screening Expenses	Covered Medical Expenses include one annual (or more frequently if recommended by a Physician) Digital Rectal Exam and Prostate Specific Antigen (PSA) test. Covered Medical Expenses are payable on the same basis as any other expense.
Durable Medical and Surgical Equipment Expenses	Payable on the same basis as any other Sickness.
Women's Health Benefit Expenses	The Plan will pay for one baseline mammogram for women between the ages of 35 and 40. Women age 40 and over have coverage for one annual mammogram per Policy Year thereafter. Coverage will be provided more frequently if recommended by a Physician for a Covered Person who has a prior history of breast cancer or who has a first degree relative with a prior history of breast cancer. Covered Medical Expenses are payable on the same basis as any X-ray expense. The Plan will pay for two routine annual Pap smear screenings, including the office visit, for women age 18 and older. Covered Medical Expenses are payable on the same basis as any other expense.
Breast Cancer Treatment Expenses and Reconstructive Breast Surgery Expense Benefit	Benefits will be payable for inpatient hospital care for an insured person undergoing (a) a lumpectomy or lymph node dissection for the treatment of breast cancer; or (b) a mastectomy which is covered under this Plan.. Benefits will be payable for breast reconstruction surgery after a mastectomy including (a) all stages of reconstruction of the breast on which the mastectomy has been performed, and (b) surgery and reconstruction of the other breast to produce symmetry in a manner determined by the attending Physician and the insured person to be appropriate. Covered Medical Expenses are payable on the same basis as any other expense.

End of Life Care Expenses	Covered Medical Expenses include care provided at acute care facilities which specialize in the treatment of terminally ill patients diagnosed with advanced cancer. Reimbursement for services is provided at 100% of the Negotiated Charge. In the absence of a Negotiated Charge, reimbursement is provided at 100% of the acute care facility's reimbursement rate under the Medicare program, after any applicable Deductible.
Outpatient Physical Therapy Expense	Benefits are payable for Covered Medical Expenses incurred by a covered person for physical therapy when provided by a licensed physical therapist and only when physical therapy begins within 6 months of the onset of symptoms. *Preferred Care*: 90% of the Negotiated Charge. *Non-preferred Care:* 60% of the Reasonable Charge a copay/deductible of $25 per visit will apply.
Therapy Expense	Covered Medical Expenses also include expenses incurred by a covered person for: chemotherapy, including anti-nausea drugs used in conjunction with the chemotherapy, radiation therapy, tests and procedures, physiotherapy (for rehabilitation only after a surgery), and expenses incurred at a radiological facility. Covered medical expenses also include expenses for the administration of chemotherapy and visits by a health care professional to administer the chemotherapy. Such expenses are payable at 90% for preferred care and 60% for non-preferred care.
Occupational Therapy Expense	Benefits are payable for Covered Medical Expenses incurred by a covered person for occupational therapy when provided by a licensed occupational therapist and only when occupational therapy begins within 6 months of the onset of symptoms. *Preferred Care*: 90% of the Negotiated Charge. *Non-preferred Care:* 60% of the Reasonable Charge a copay/deductible of $25 per visit will apply.
Speech and Hearing Therapy Expense	Benefits are payable for Covered Medical Expenses incurred by a covered person for speech and hearing therapy when provided by a licensed speech and hearing therapist and only when speech and hearing therapy begins within 6 months of the onset of symptoms. *Preferred Care*: 90% of the Negotiated Charge. *Non-preferred Care:* 60% of the Reasonable Charge a copay/deductible of $25 per visit will apply.
Allergy Testing and Treatment Expense	Covered Medical Expenses include charges incurred by a covered person for diagnostic testing and treatment of allergies and immunology services, when the covered person is referred by School Health 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, *Preferred Care*: 90% of the Negotiated Charge. *Non-preferred Care:* 60% of the Reasonable Charge a copay/deductible of $25 per visit will apply.

Bone Density Screening	Bone Density Screening Expense benefits are payable for charges incurred by a covered person for bone mineral density measurements or tests. The charges must be incurred while a covered person is insured for these benefits. Benefits for these expenses are provided to the same extent as benefits for any other illness.
Second Medical Opinion for Cancer Diagnosis	A plan that provides medical, major medical, or similar comprehensive-type coverage must provide coverage for a second medical opinion by an appropriate specialist in the event of a positive or negative diagnosis of cancer or a recurrence of cancer or a recommendation of a course of treatment for cancer. Second medical opinion by a non-par provider specialist must be at no additional cost to the member than if provided by a par provider specialist, so long as attending provider provides a written referral to the non-par. Member also has the right to obtain a second medical opinion from a non-participating specialist without a written referral, subject to payment of additional coinsurance as specified in the policy. Insurer must compensate the non-participating specialist at the usual, customary, and reasonable rate, or at a rate listed on a fee scheduled filed and approved by the DOI. Coverage may be subject to annual deductibles and coinsurance that are consistent with those established for other benefits within a given policy.
Temporomandibular Joint Dysfunction Expense	Covered Medical Expenses include charges incurred by a covered person for non-surgical treatment of Temporomandibular Joint (TMJ) Dysfunction. *Preferred Care*: 90% of the Negotiated Charge. *Non-preferred Care:* 60% of the Reasonable Charge a copay/deductible of $25 per visit will apply.
Dietary Formulas	Covered Expenses include non-prescription enteral formulas for which a physician has issued a written order, and modified solid food products that are low in protein (MFSP). MFSP is limited to $2,500 per policy year. Benefits shall be subject to all Deductible, copayment, coinsurance, limitations or any other provisions of the policy.
Intensive Care Unit Expenses	Covered Medical Expenses are payable as follows: *Preferred Care:* 90% of the Negotiated Charge for an overnight stay *Non-Preferred Care:* 60% of the Reasonable Charge for the intensive care room rate for an overnight stay.
Injury to Sound, Natural Teeth	Covered Medical Expenses are payable as follows: *Preferred Care:* 90% of the Negotiated Charge. *Non-Preferred Care:* 90% of the Reasonable Charge.

Additional Services and Discounts

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

Aetna Vision℠ Discount Program[1]	The Aetna Vision discount program helps you save on vision exams and many eye care products, including sunglasses, contact lenses, non-prescription sunglasses, contact lens solutions and other eye care accessories. Plus, you can receive up to a 15% discount on LASIK surgery (the laser vision correction procedure).
Aetna's Informed Health® Line[2]	Get answers from a registered nurse at any time — just call our toll-free Informed Health Line. With one simple call, you can: ■ Learn more about health conditions that you or your family members have. ■ Find out more about a medical test or procedure. ■ Come up with questions to ask your doctor. Talk to a registered nurse: Our nurses can discuss more than 5,000 health and wellness topics. Call them anytime you have a health question. Listen to our Audio Health Library:* Call and learn about a topic that interests you. Choose from thousands of health conditions. Listen in English or Spanish. You can also transfer to a registered nurse at any time during your call. **Not all topics discussed within the Audio Health Library are covered expenses under your health insurance plan.* Go online for even more health information If you like to go online for health information, check out the Healthwise® Knowledgebase. You can learn more about a health condition you have, medications you take, and more. Link to it through your secure Aetna Navigator® website at www.aetnanavigator.com.
Fitness Program[1]	Aetna's Fitness discount program provides members with access to preferred membership rates at nearly 10,000 fitness clubs nationwide and in Canada in the GlobalFit™ network. Members can also save on GlobalFit's other programs and services, such as at-home weight loss programs, home fitness equipment and videos and even one-on-one health coaching services* to help them quit smoking, reduce stress, lose weight, or meet any other health goal. **Offered by WellCall, Inc. through GlobalFit*
Aetna Natural Products and Services℠ Program[1,2,3]	Offers members access to reduced rates on services from natural therapy professionals, including acupuncturists, chiropractors, massage therapists and dietetic counselors, and access to discounts on over-the-counter vitamins, herbal and nutritional supplements and health-related products, such as foot care and natural body care products.
Health and Wellness Portal[2]	This dynamic, interactive website will give you health care and assessment tools to calculate body mass index, financial health, risk activities and health and wellness indicators. The site provides resources for wellness programs and activities.

Vital Savings by Aetna℠	Vital Savings℠ on Dental is a dental discount program helping you save an average of 15% to 50% on a wide array of dental services – with one low annual fee of $25 per person. Enroll online at www.aetnastudenthealth.com. * *Actual costs and savings vary by provider and geographic area.* Annual membership is September 1, 2009 through August 31, 2010. For complete details and to enroll, visit www.aetnastudenthealth.com. *The Vital Savings by Aetna® program (the "Program") is not insurance. The Program provides Members with access to discounted fees pursuant to schedules negotiated by Aetna Life Insurance Company for the Vital Savings by Aetna® discount program. The Program does not make payments directly to the providers participating in the Program. Each Member is obligated to pay for all services or products but will receive a discount from the providers who have contracted with the Discount Medical Plan Organization to participate in the Program. Aetna Life Insurance Company, 151 Farmington Avenue, Hartford, CT 06156, 1-877-698-4825, is the Discount Medical Plan Organization.*

1. *Discount programs provide access to discounted prices and are NOT insured benefits.*
2. *Health information programs provide general health information and are not a substitute for diagnosis or treatment by a physician or other health care professionals.*
3. *These services, programs or benefits are offered by vendors who are independent contractors and not employees or agents of Aetna.*

General Provisions

State Mandated Benefits

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

Subrogation/Reimbursement Right of Recovery Provision

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

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

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

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

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

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

Coordination of Benefits

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

Definitions

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

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

Aggregate Maximum: The lifetime maximum benefit that will be paid under the Policy for all Covered Medical Expenses incurred by a Covered Person.

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

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

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

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

Covered Person: A covered student whose coverage is in effect under the Policy. See the Eligibility sections of this Brochure for additional information.

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

Emergency Medical Condition: A medical or behavioral condition, the onset of which is sudden, and manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate, medical attention to result in (a) placing the health of the person afflicted with such condition in severe jeopardy, or, in the case of a behavioral condition placing the health of such person or others in serious jeopardy, (b) serious impairment to such person's bodily functions, (c) serious dysfunction of any bodily organ or part of such person, or (d) serious disfigurement of such person. It does not include elective care, routine care, or care for non-emergency Sickness.

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

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

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

In order for a treatment, service, or supply to be considered Medically Necessary, the service or supply must:

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

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

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

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

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

Non-Preferred Care: A health care service or supply furnished by a health care provider that is not a Preferred Care Provider, if, as determined by Aetna (a) the service or supply could have been provided by a Preferred Care Provider and (b) the provider is of a type that falls into one or more of the categories of providers listed in the Directory.

Non-Preferred Care Provider (or Non-Preferred Provider): A health care provider that has not contracted to furnish services or supplies at a Negotiated Charge.

Non-Preferred Pharmacy: A Pharmacy not party to a contract with Aetna, or a Pharmacy that is party to such a contract but which does not dispense Prescription Drugs in accordance with its terms.

Pharmacy: An establishment where Prescription Drugs are legally dispensed.

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

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

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

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

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

Prescription: An order of a prescriber for a Prescription Drug. If it is an oral order, it must be promptly put in writing by the Pharmacy.

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

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

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

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

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

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

Exclusions

This list is only a partial list. Please refer to the School's Master Policy on file at the school for a complete list of exclusions. The Plan neither covers nor provides benefits for the following:

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

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

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

4. 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.

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

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

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

8. 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.

9. Expense for injuries sustained as the result of a motor vehicle accident; to the extent that benefits are payable under other valid and collectible insurance; whether or not claim is made for such benefits.

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

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

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

13. 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.

14. Expense incurred for injury resulting from the play or practice of collegiate or intercollegiate sports; including collegiate or intercollegiate club sports and intermurals.

15. 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.

16. 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.

17. Expense incurred as a result of dental care or treatment; except for such care or treatment due to accidental injury to sound natural teeth within 12 months of the accident, and except for dental care or treatment necessary due to congenital disease or anomaly

18. Expense incurred by a covered person for services performed within the covered person's home country; if the covered person's home country has a socialized medicine program. This exclusion does not apply to expenses incurred by a covered person for services performed within the covered person's home country; if the covered person's home country is Canada..

19. Expense incurred for acupuncture; unless services are rendered for anesthetic purposes.

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

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

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

Extension of Benefits

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

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 the Policy ceased. This benefit will be covered only for the period of the pregnancy.

Termination of Student Coverage

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

Claim Procedure

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

Aetna Student Health
P.O. Box 15708
Boston, MA 02215-0014
(800) 878-1927
(617) 218-8400 (outside United States)
Customer Service Representatives are available 8:30 a.m. to 5:30 p.m. (ET), Monday through Friday, for any questions.

1. Bills must be submitted within 90 days from the date of treatment.
2. Payment for Covered Medical Expenses will be made directly to the hospital or Physician concerned unless bill receipts and proof of payment are submitted.
3. When using a claim form, if itemized medical bills are available at the time the claim form is submitted, attach them to the claim form. Subsequent medical bills should be mailed promptly to the address listed above.
4. In the event of a disagreement over the payment of a claim, a written request to review the claim must be mailed to Aetna Student Health, within 180 days from the date appearing on the Explanation of Benefits (EOB).

Prescription Drug Claim Procedure

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

When you need to fill a Prescription and do not have your ID card with you, you may obtain your Prescription from an Aetna Preferred Pharmacy and be reimbursed by submitting a completed Aetna Prescription Drug claim form. A claim form can be obtained by calling (800) 238-6279. You will be reimbursed for covered medications directly by Aetna. Please note, in addition to your Copay, you may be required to pay the difference between the retail price you paid for the prescription drug and the amount Aetna would have paid if you had presented your ID card and the Pharmacy had billed Aetna directly. Information regarding Preferred Care Pharmacy locations is available by accessing the Internet at www.aetnastudenthealth.com.
Non-Preferred Care: You may obtain your Prescription from a Non-Preferred Pharmacy and be reimbursed by submitting a completed Aetna Prescription Drug claim form. You will be reimbursed for covered medications at the Reasonable Charge allowance, less any applicable Deductible, directly by Aetna. You will be responsible for any amount in excess of the Reasonable Charge.

Please note: You will be required to pay in full at the time of service for all Prescriptions dispensed at a Non-Participating Pharmacy. Claim forms, Pharmacy locations, and claims status information can be obtained by contacting Aetna Pharmacy Management at (800) 238-6279.
When submitting a claim, please include all Prescription receipts, indicate that you attend The New School and include your name, address, and student identification number.

Complaints and Appeals Procedures

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

The complaints and appeals process is designed to address coverage issues, complaints, and problems. If you have a coverage issue or other problem, call Aetna Student Health Customer Service at (800) 878-1927. A representative will address your concern. If you are dissatisfied with the outcome of the initial contact, the decision may be appealed.

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

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

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

Internal Appeals Procedure

Aetna has established a procedure for resolving appeals. If you have an appeal, please follow this procedure:

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

First Level Appeals Procedure

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

You may submit an oral grievance in connection with:

- A denial of, or failure to pay for, a referral; or
- A determination as to whether a benefit is covered under this Plan, by calling Customer Services. The Customer Services telephone number is on your ID card. If you are required to leave a recorded message, your message will be acknowledged within one business day after the call was recorded.

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

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

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

Second Level Appeals Procedure

If you are dissatisfied with Aetna's grievance determination, you or a representative designated by you, may submit a written appeal within 60 business days after receipt of such determination.

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

If additional time is needed to resolve an Appeal, except in an urgent or emergency situation, Aetna will provide a written notification, indicating that additional time is needed, explaining why such time is needed, and setting a new date for a response. The additional time will not be extended beyond another 30 days. You must exhaust the Internal Appeals Procedure before requesting an External Appeal. However you are not required to exhaust the Internal Appeals Procedure prior to requesting an External Appeal, if you and Aetna have agreed that the matter may proceed directly to an External Appeal. Aetna will keep the records of your complaint for three years.

External Appeal

Right to an External Appeal

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

Right to Appeal a Determination That a Service is Not Necessary

If Aetna has denied coverage on the basis that the service is not necessary, you may appeal to an External Appeal Agent, if you satisfy the criteria listed below:

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

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

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

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

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

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

In addition, your attending Physician must have recommended at least one of the following:

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

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

The External Appeal Process

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

You may also request an external appeal application from the New York State Department of Insurance at 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 you satisfy the criteria for an external appeal, the State will forward the request to a certified External Appeal Agent. You will have the opportunity to submit additional documentation with the request. If the External Appeal Agent determines that the information you submit represents a material change from the information on which Aetna based its denial, the External Appeal Agent will share this information with Aetna in order for it to exercise its right to reconsider its decision. If Aetna chooses to exercise this right, Aetna will have three business days to amend or confirm its decision. Please note that in the case of an expedited appeal (described below); Aetna does not have a right to reconsider its decision.

In general, the External Appeal Agent must make a decision within 30 days of receipt of the completed application. The External Appeal Agent may request additional information from you, your Physician or Aetna. If the External Appeal Agent requests additional information, it will have five additional business days to make its decision. The External Appeal Agent must notify you in writing of its decision within two business days.

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

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

The External Appeal Agent's decision is binding on both you and Aetna. The External Appeal Agent's decision is admissible in any court proceeding.

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

Responsibilities

It is your responsibility to initiate the external appeal process. You may initiate the external appeal process by filing a completed application with the New York State Department of Insurance. If the requested service has already been provided to you, your attending Physician may file an expedited appeal application on your behalf, but only if you have consented to this in writing.

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

Covered Services and Exclusions

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

On Call International*

Aetna Student Health has contracted with On Call International (On Call) to provide Covered Persons with access to certain accidental death and dismemberment benefits, worldwide emergency travel assistance services and other benefits.

A brief description of these benefits is outlined below. Should you have any questions or need to file a claim, please contact (800) 437-6448.

Accidental Death and Dismemberment (ADD) Benefits

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

NOTE: For most school plans, ADD benefits are provided by Aetna Life Insurance Company (ALIC). However, in some states, ADD benefits may be provided through a contractual relationship between Chickering Claims Administrators, Inc. (CCA) and On Call International (On Call). ADD coverage provided through On Call is underwritten by United States Fire Insurance Company (USFIC). Please refer to your school's policy to determine whether ALIC or USFIC underwrites ADD benefits for your specific Plan. Should you have any questions or need to file a claim, please contact (800) 878-1927.

Medical Evacuation and Repatriation (MER) Benefits

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

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

Worldwide Emergency Travel Assistance (WETA) Services

On Call provides the following travel assistance services:

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

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

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

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

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

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

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

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

Important Note

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

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

This insurance Policy provides limited benefits for Student Health Insurance ONLY. It does NOT provide basic hospital, basic medical, major medical insurance, Medicare Supplement, long-term care insurance, nursing home insurance only, home health care insurance only, a nursing home and home health care insurance as defined by the New York State Insurance Department. This insurance coverage is being offered on a primary basis. The insurance Policy itself sets forth the rights and obligations of both you and the insurance company. It is therefore important to read this brochure carefully.

This above disclosure is included as required by New York State Insurance Regulation Section 52.10 and 52.59. The New School Student Health Insurance benefits are described in this Brochure.

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

Policy No. 812804

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

Notice

Aetna considers nonpublic personal member information confidential and has policies and procedures in place to protect the information against unlawful use and disclosure. When necessary for your care or treatment, the operation of your health plan, or other related activities, we use personal information internally, share it with our affiliates, and disclose it to health care providers (doctors, dentists, Pharmacies, hospitals, and other caregivers), vendors, consultants, government authorities, and their respective agents. These parties are required to keep personal information confidential as provided by applicable law. Participating Network/Preferred Providers are also required to give you access to your medical records within a reasonable amount of time after you make a request.

By enrolling in the plan, you permit us to use and disclose this information as described above on behalf of yourself and your dependents. To obtain a copy of our Notice of Privacy Practices describing in greater detail our practices concerning use and disclosure of personal information, please call the toll-free Customer Service number on your ID card or visit Aetna Student Health's Student Connection Link on the Internet at www.aetnastudenthealth.com.