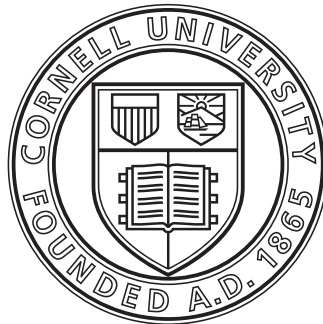


2008 - 2009

**Cornell University
Student Health Insurance Plan:
Member's Guide**



Aetna Student Health

Underwritten by:

Aetna Life Insurance Company (ALIC)

Policy No. 71115

For More Information...

Office of Student Health Insurance
409 College Avenue, Suite 211
Ithaca, NY 14850
Phone: **(607) 255-6363**
Fax: **(607) 254-5221**
E-mail: *sicu@cornell.edu*
www.studentinsurance.cornell.edu

About the Student Health Insurance Plan:

Aetna Student Health
P.O. Box 15708
Boston, MA 02215
Phone: **(800) 859-8475**

About Health Services at Cornell:

Gannett Health Services
110 Ho Plaza
Ithaca, NY 14853-3101
Phone: **(607) 255-5155**
E-mail: *gannett@cornell.edu*
Website: *www.gannett.cornell.edu*

Welcome to the SHIP

Welcome to the Cornell University Student Health Insurance Plan!

This Brochure is designed to help you get the most out of your health insurance by giving you detailed information about SHIP benefits, requirements and assistance, and services available at Gannett Health Services. We have tried to make it as clear and useful to you as possible, while abiding by New York State requirements for communicating health insurance information. If you encounter terms you do not understand, they may be explained in the Definitions section beginning on page 33. Most of the Capitalized Terms you will see in this Brochure (e.g., Covered Person, Injury, Copay) are defined in that section.

If you have any questions at all about how to access services, what the SHIP covers, what you must do to get maximum coverage, or any other aspect of this Plan, please let us help. (See “Where to Find Help,” page 5.)

The SHIP is a health insurance program featuring a managed care approach that enables Covered Persons (students, spouses, same-sex partners, and dependent children) to receive a full range of health care services. This Plan provides coverage for illnesses and Injuries (not for preventive or elective health care, except as specifically noted in benefit details) on- and off-campus, including pre-existing medical conditions. It includes special cost-saving features to keep the coverage as affordable as possible.

The SHIP has been developed especially for Cornell students and their eligible dependents and is reviewed annually by a committee of Cornell students, faculty, and staff members. The Plan is underwritten by Aetna Life Insurance Company (Aetna) and meets or exceeds all F-1 and J-1 visa requirements, as well as the health insurance standards developed by the American College Health Association.

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Where to Find Help

Got Questions? Get Answers with Aetna Navigator®

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

By logging into Aetna Navigator, you can:

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

How do I register?

- Go to *www.aetnastudenthealth.com*.
- 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 Time at **(800) 225-3375**.

For Questions About:

- Enrollment
- Claim Questions
- Pre-Certification
- Preferred Providers

Please contact:

Aetna Student Health

P.O. Box 15708

Boston, MA 02215-0014

(800) 859-8475

(617) 218-8400 (Outside the United States – Collect Calls are accepted)

For Questions About ID Cards:

ID cards will be issued as soon as possible. If you need medical attention before the ID card is received, benefits will be payable in accordance with the Policy. **You do not need an ID card to be eligible to receive benefits.** However, temporary ID cards are available at the Student Insurance Office. You are also able to obtain a temporary ID card from the Aetna Student Health Website at www.aetnastudenthealth.com (click on “Find Your School” and enter **711115** as your Policy Number), or the Student Insurance Website at www.studentinsurance.cornell.edu. Once you have received your ID card, present it to the provider to facilitate prompt payment of your claims.

For lost ID cards, contact:

Aetna Student Health

(800) 859-8475

(617) 218-8400 (Outside the United States – Collect Calls are accepted)

or you may visit the Aetna Student Health Website at www.aetnastudenthealth.com (click on “Find Your School” and enter **711115** as your Policy Number)

For Questions About:

- Pharmacy Claim
- Pharmacy Claim Forms
- Excluded Drugs and Prior Authorization

Please contact:

Aetna Pharmacy Management

(800) 238-6279 (Available 24 Hours)

For Questions About:

- Enrollment Forms
- Bursar Bill Charges
- Premium Fees
- General Questions
- Waiver Process

Please contact:

Cornell University Office of Student Health Insurance

409 College Avenue, Suite 211

Ithaca, NY 14850

(607) 255-6363

E-mail: sicu@cornell.edu

Website: www.studentinsurance.cornell.edu

For Questions About:

- Primary Care, Medical and Counseling Services
- Appointments
- Referrals

Please contact:

Gannett Health Services

110 Ho Plaza

Ithaca, NY 14853-3101

(607) 255-5155

Website: www.gannett.cornell.edu

For Provider Listings (Including Preferred Pharmacy Listings):

You can use Aetna's DocFind® Service at: www.aetnastudenthealth.com, click on "Find Your School" and enter **711115** as your Policy Number.

For a complete listing of In Area Preferred Care Providers in the Ithaca area, please contact the Student Insurance Office or Aetna Student Health.

For Questions About:

- On Call International 24/7 Emergency Travel Assistance Services

Please contact:

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

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

Student Eligibility

The following individuals are eligible for coverage under SHIP.

- All full-time registered students (as defined and reported by the University Registrar).
- Students registered in absentia.

Students on a University-approved leave of absence are also eligible to enroll prior to **August 30, 2008**, provided that they were enrolled during the previous year. Students on a University-approved leave of absence may only purchase the Student Health Insurance Plan for one year.

Please Note: Students on leave are not automatically enrolled.

Dependent Eligibility

Eligible students who enroll in the SHIP may also insure their eligible dependents. Dependents are not automatically enrolled. An Enrollment Form must be filled out and returned to the Cornell University Office of Student Health Insurance at 409 College Ave., Suite 211, Ithaca, NY 14850 each separate Policy Year in order to continue a dependents enrollment. Eligible dependents include:

- The insured student's lawful spouse/same-sex partner residing with the student;
- The insured student's unmarried children, under the age of 19, including stepchildren and foster children of the insured student who are not self-supporting and reside with the insured student or for whom the insured student is court-ordered to provide insurance.

Dependent Enrollment

Dependents are not automatically enrolled. Insured students who wish to enroll their eligible dependents in the Student Health Insurance Plan must stop by the Cornell University Office of Student Health Insurance located at 409 College Ave., Suite 211, Ithaca, NY to fill out the necessary forms and to make appropriate premium payments. An application for family coverage must be made each year.

The enrollment deadline for the Annual Policy is **September 30, 2008**. The enrollment deadline for Spring coverage is **February 28, 2009**. If the dependent experiences a significant life change that directly affects his or her insurance coverage, the deadline to enroll is 30 days after the significant life changing event. A life changing event may include a loss of coverage from a prior plan, marriage, divorce, and other reasons beyond a person's control. Coverage for dependents will begin on **August 17, 2008**, if they are enrolled prior to the **September 30, 2008** deadline.

Newborn Infant Coverage and Adopted Child Coverage

A child born to a Covered Person shall be covered for Accident, Sickness, and congenital defects for 31 days from the date of birth. At the end of this 31-day period, coverage will cease under the Cornell University Student Health Insurance Plan. To extend coverage for a newborn past the 31 days, the Covered Person must (1) enroll the child within 31 days of birth and (2) pay the additional premium starting from the date of birth.

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

Please stop by the Office of Student Health Insurance to enroll a newborn infant or a newly adopted child.

Policy Period/Coverage Dates for SHIP
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1. **Students:** Coverage for all insured students enrolled for the Fall Semester, including students in absentia or on leave, will become effective at 12:01 a.m. on **August 17, 2008**, and will terminate at 12:01 a.m. on **August 17, 2009**.
2. **New Spring Semester Students:** Coverage for all insured students enrolled for the Spring Semester will become effective at 12:01 a.m. on **January 16, 2009**, and will terminate at 12:01 a.m. on **August 17, 2009**.
3. **Insured Dependents:** Coverage will become effective on the same date the insured student's coverage becomes effective. Coverage for insured dependents terminates in accordance with the termination provisions described in the Master Policy. Examples include, but are not limited to, the date the student's coverage terminates and the date the dependent no longer meets the definition of a dependent.

Premium Rates

Annual Policy	
Student	\$1,514
Spouse/Same-Sex Partner	\$3,282
Child(ren)	\$2,032

Installment Plan

Premiums for graduate and professional students and for dependents of all students may be paid in installments. Please contact the Cornell University Office of Student Health Insurance for further details. The deadline to enroll in the installment plan is **September 30, 2008**.

Premium Refund Policy

Except for medical withdrawal due to a covered Accident or Sickness, any student withdrawing from Cornell University during the first 31 days of the period for which coverage is purchased shall not be covered under the Policy and a full refund of the premium will be made. Students withdrawing after such 31 days will remain covered under the Policy for the full period for which premium has been billed. **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, and any covered dependents, upon written request received by Aetna Student Health within 90 days of withdrawal from school.

NOTE: If claims from any provider have been submitted and paid for any period, no refund will be provided under any circumstances.

Early Graduation Plan Option

A student graduating mid-year may be eligible for a five-month plan. To be eligible for this Plan, you must obtain a letter from your department or school indicating that you have fulfilled the requirements for graduation. Bring the letter to the Cornell University Office of Student Health Insurance and apply for the Early Graduation Option. You will be billed in August for the entire Plan Year, but will be credited for seven months of the premium once the paperwork is completed and processed. All paperwork must be completed prior to **January 31, 2009**. No requests will be granted after this date.

Late Enrollment

Under certain circumstances, coverage for late enrollees may be possible. Contact the Cornell University Office of Student Health Insurance.

Continuation Privilege

Once a student's eligibility through the Cornell University Student Health Insurance Plan expires, a student may be eligible to continue coverage by purchasing one of three different periods of coverage. To continue coverage, you must enroll online by the stated deadline dates and make the premium payment within 31 days after the termination of eligibility under the active Student Health Insurance Plan. You must have been insured under the active Student Health Insurance Plan for at least six months prior to termination of your coverage in order to be eligible for the Continuation Plan. Once an election of coverage is made, a later application requesting an increase or a decrease of the initially elected coverage period will not be processed, even if received prior to the deadline. Information on the Continuation Plan is available by visiting www.aetnastudenthealth.com and clicking on "Students," and then clicking on "Find Your School."

Gannett Health Services

Gannett offers responsive, convenient, confidential, and high-quality primary care medical services: counseling and psychological services, physical therapy, and health promotion services to all full-time, registered Cornell students. Gannett facilitates access to urgent and emergency services and provides referrals to area specialty medical care. Most services are also available to the eligible dependents of Cornell students.

Gannett's high standard of services has been recognized by the Accreditation Association for Ambulatory Health Care, Inc.

Primary Care

For students and dependents (age 14 or over) enrolled in the SHIP, Gannett is your primary care provider and, therefore, your first stop for health care. When you are in the Ithaca area and need health care (except in an emergency), you must begin at Gannett to receive the maximum benefit for services.

When you are away from campus, you may seek care from a participating provider in Aetna's nationwide network, "Open Choice® PPO." You also have the option to seek Non-Preferred Care for standard limited coverage.

Appointments

To make the best possible use of your time and Gannett’s resources, appointments are required for most services. Call ahead (**255-5155**) to make an appointment for assessment and care. Same- or next-day appointments are available for more urgent needs. Visit www.gannett.cornell.edu for recommendations about scheduling appointments for a particular service (search “making appointments”).

Emergency Care

Cayuga Medical Center is the emergency medical care provider for the Ithaca area. Directions to Cayuga Medical Center are available online (www.gannett.cornell.edu) and at entrances to Gannett Health Services.

If you need emergency medical care, call **911** for assistance or pick up a Blue-Light Phone on campus. You also can consult by phone any time of day or night, with a health care provider or counselor at Gannett – **255-5155** – who can offer advice and, if needed, help to arrange transportation to the hospital emergency room.

In the event of your treatment or hospitalization at Cayuga Medical Center, Gannett, and Cayuga Medical Center will share relevant medical information as needed for the continuity of your care.

Fees

The Student Health Insurance Plan (SHIP) covers most services at Gannett (including most X-rays, lab tests, and special procedures). Visit charges are paid by the SHIP member: For those enrolled in the SHIP, most services at Gannett are covered, except for a visit charge (listed below). (**Remember:** the SHIP is an Accident and Illness Policy; see “Exclusions” inside this Brochure.)

- Registered full-time students, enrolled spouse/same-sex partners, and dependents over age 14: \$10
- Student who is not a full-time student any time of year: \$20
- Consultant office visits at Gannett: \$20
- Consultant office procedures at Gannett: \$50 or 50% of charge if over \$100

You have several options for paying for services: a charge to your bursar bill, cash, personal check, or credit card (VISA, MasterCard, or Discover). A listing of fees is available from the billing office for your review. Inability to pay should never be a barrier to receiving needed health care. If you have concerns about expenses connected to medical or mental health care, discuss them with the billing office staff before or during your visit to Gannett.

Pharmacy

With over 1,000 Prescription medications and 100 non-prescription (over-the-counter) supplies, The Gannett Pharmacy is well-stocked to meet your health and wellness needs. Located on central campus (the main floor of Gannett), you will find it convenient to consult and shop with us. The Pharmacy has a 24 hour phone number (4-MEDS) for messages, refills, and phoned-in Prescriptions.

Referrals

(see Referral Requirements on page 14)

If your care cannot be provided at Gannett, a Gannett clinician may refer you to a “Preferred Provider”. When in the Ithaca area, you must have a written referral to a Preferred Provider in order to receive the maximum benefit for services covered by the SHIP. When you are away from campus, you do not need a referral to seek Preferred Care from Aetna’s Open Choice PPO network or to seek Non-Preferred Care.

Care In Progress

If you just joined the SHIP and are receiving care for a medical condition, you must call Gannett to establish a relationship with a primary care provider. If necessary, he or she will provide a referral to a Preferred Provider for specialty care. If you have been continuously enrolled in the SHIP, a new referral is required each Plan Year for on-going treatment.

Students In Absentia and On Leave

Students enrolled in the SHIP who are registered in absentia or are on a leave of absence from the University must obtain primary care medical and counseling services from external (non-Cornell) providers. Those students residing in Ithaca while on leave must obtain a referral from Gannett to receive in-network benefits from local providers.

Gannett Hours

Academic Year

Monday-Friday	8:30 a.m. – 5 p.m.
Saturday	10 a.m. – 4 p.m.
Sunday and after hours	Building closed
Thanksgiving break	Building closed
December break	Building closed

Winter Session, Spring Break, Summer Session

Monday-Friday	8:30 a.m. – 4:30 p.m.
Saturdays, Sundays, and Holidays	Building closed

Whenever Gannett is closed (and any time of day or night), you may consult by phone with a health care provider or counselor who can offer advice and, if necessary, arrange transportation to the Convenient Care Center or Cayuga Medical Center Emergency Room. Call **255-5155**.

Services at Gannett

- Alcohol and other drug services/resources: 255-4782
- Allergy shots: 255-5155
- Billing office: 255-7492
- Cornell Healthy Eating Program: 255-5155
- Counseling and Psychological Services (CAPS): 255-5208
- Pharmacy: 255-6976
- General medicine: 255-5155
- Health promotion: 255-4782
- HIV antibody testing: 255-5155
- Information: 255-5155
- Immunizations: 255-5155
- Laboratory services: 255-6099
- Massage therapy: 255-5985
- Nutrition counseling: 255-5155
- Patient advocate: 255-3564
- Pharmacy (4-MEDS): 254-6337
- Physical therapy: 255-7217
- Radiology: 255-6207
- Sexuality services: 255-5155
- Sports medicine: 255-3892
- Tobacco cessation: 255-5155
- Travel clinic: 255-5155
- Victim advocacy: 255-1212

Website

The Gannett website www.gannett.cornell.edu provides a wealth of information about student health topics and outlines how to access the vast range of services at Gannett. Information for first year students, international students, grads and other special populations is located under the section entitled “Who Are You?” Common student health concerns (e.g., stress, depression, sleep, etc.) are located under the section entitled “Top Ten Topics.” We encourage you to bookmark the Gannett website and to use it as a resource throughout your time at Cornell.

Preferred Provider Network

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

The Cornell University Student Health Insurance Plan for the 2008-2009 Policy Year has a Preferred Provider Network through Aetna. To maximize your savings and reduce your out-of-pocket expenses, select a Preferred Provider. It is to your advantage to utilize a Preferred Provider because significant savings can be achieved from the substantially lower rates these providers have agreed to accept as payment for their services. Preferred Providers are independent contractors and are neither employees nor agents of Cornell University, Aetna Student Health, or Aetna.

For a complete listing of participating providers you may contact Aetna Student Health at **(800) 859-8475**.

Additionally, you can obtain information regarding Preferred Providers through the Internet by accessing DocFind at www.aetnastudenthealth.com, click on "Find Your School" and enter **711115** as your Policy Number.

Referral Requirements

Gannett Referral for Students and Dependents (ages 14 and over)

When you are in the Ithaca area and need health care, you must use the resources of Gannett first. If you need a referral, it must be issued by a Gannett health care provider. You do not need to obtain a referral when you are out of the Ithaca area, or when Gannett is closed for holidays or breaks.

Note: Covered Medical Expenses incurred for medical treatment, except physical therapy, received outside Gannett for which no referral has been obtained are payable at the Non-Preferred Care rate. No coverage will be available for physical therapy service rendered without a referral.

No referral will be issued after the date services are first rendered.

A new Gannett referral is required:

- For each separate medical condition.
- Each Plan Year for continuing treatment with a Non-Gannett Provider.
- For outpatient mental health services with a Non-Gannett Provider.
- For physical therapy services provided by Gannett Physical Therapy Department at Schoellkopf or a participating provider in the Ithaca area.
- For follow up care after an Emergency Room visit, when the care is not rendered at Gannett Health Center.

A Gannett referral is not required for the following conditions only:

- An Emergency Medical Condition as defined in the Definitions section of this Brochure; however, you must return to Gannett for any necessary follow-up care, or for a referral to a specialist for follow-up care.
- Maternity care.
- One annual routine Pap smear and visit for women age 18 and older.
- Care received when outside of the Ithaca area, when Gannett is closed, or during Summer and school breaks.

Referral Information for Dependent Children

Dependent children under age 14 are not eligible to use Gannett, but are required to establish a relationship with a Preferred Provider and to receive a referral from them if specialty care is required.

Note: Covered Medical Expenses incurred for specialty medical care for which no referral has been obtained are payable at the Non-Preferred Care rate. No referral will be issued after the date services are first rendered.

A new referral is required:

- For each separate medical condition.
- Each Plan Year for continuing treatment with a specialist.

A referral is not required for the following conditions only:

- An Emergency Medical Condition as defined in the Definitions section of this Brochure.
- One annual routine Pap smear and visit for women age 18 and older.

Inpatient Admission Pre-Certification Program

Pre-certification is the processes of collecting information prior to inpatient admissions and performance of selected ambulatory procedures and services. The process permits advance eligibility verification, determination of coverage, and communication with the physician and/or you. All inpatient admissions, including length of stay, must be certified by contacting Aetna Student Health.

Pre-Certification does not guarantee the payment of benefits for your inpatient admission. Each claim is subject to medical policy review in accordance with the exclusions and limitations contained in the Policy, as well as a review of eligibility, adherence to notification guidelines, and benefit coverage under the Student Health Insurance Plan.

If you do not secure Pre-Certification for non-emergency hospital admissions or provide notification for emergency admissions, your Covered Medical Expenses will be paid at 50% of the allowable expenses.

Pre-Certification of Non-Emergency Inpatient Admissions

The patient, Physician, clinician, or hospital must telephone at least three business days prior to the planned admission.

Notification of Emergency Admissions

The patient, patient's representative, Clinician, 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) 859-8475

Description of Benefits

Payment will be made for Covered Medical Expenses incurred for any covered Accident or any covered Sickness while insured under the Plan, not to exceed an Aggregate Maximum while continuously insured of \$1,000,000 for any one covered Accident or any one covered Sickness. In addition to the Plan's Aggregate Maximum the Policy may contain benefit level maximums. Please review the Summary of Benefits section of this Brochure for any additional benefit level maximums.

Please note the following:

- To maximize your savings and reduce out-of-pocket expenses, select a Preferred Provider. It is to your advantage to be referred to a Preferred Provider because significant savings can be achieved from the substantially lower rates these providers have agreed to accept as payment for their services.
- When in the Ithaca area, all non-referred medical treatment (except physical therapy) will be covered at the Non-Preferred Care benefit level regardless of whether or not the provider is a participating network provider. No benefits will be available for physical therapy services received in the Ithaca area without a referral.
- Non-Preferred Providers are subject to the Reasonable Charge allowance maximums. Any charges in excess of the Reasonable Charge allowance are not covered under the Plan.
- Any Deductible, Copay, or balance of the Coinsurance percentage is the responsibility of the Covered Person.
- The Out-of-Pocket Maximum for Preferred Care (Out-of-Area) and Non-Preferred Care Expenses is \$1,500 per Covered Person and \$3,000 per family. Any applicable Deductible or Copay does not apply towards meeting the Out-of-Pocket Maximum. Any amount payable as a result of failure to secure Pre-Certification for inpatient admissions also does not apply towards meeting the Out-of-Pocket Maximum. Charges over the Reasonable Charge allowance do not apply towards meeting the Out-of-Pocket Maximum.
- Pre-Certification is required for all inpatient admissions for medical, mental health, and chemical abuse treatment.

Summary of Benefits Chart

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

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

Notes: The references to In Area and Out-of-Area Preferred Care are to differentiate participating providers according to their physical proximity to Cornell University.

Some tests and procedures may be considered surgical in nature and, as such, would require a Surgical Copay in accordance with the Plan.

Aggregate Maximum	\$1,000,000 per Covered Person.
Out-of-Pocket Maximum	\$1,500 per Covered Person, not to exceed \$3,000 per family. (Applies to Preferred Care (Out-of-Area) and Non-Preferred Care Covered Medical Expenses only.)
Inpatient Hospitalization Benefits	
All Covered Medical Expenses are subject to a \$200 Copay/Deductible per admission.	
Hospital Room and Board Expenses	Covered Medical Expenses are payable as follows: <i>Preferred Care (In Area):</i> 100% of the Negotiated Charge. <i>Preferred Care (Out-of-Area):</i> 80% of the Negotiated Charge. <i>Non-Preferred Care:</i> 70% of the Reasonable Charge.
Intensive Care Unit Expenses	Covered Medical Expenses are payable as follows: <i>Preferred Care (In Area):</i> 100% of the Negotiated Charge. <i>Preferred Care (Out-of-Area):</i> 80% of the Negotiated Charge. <i>Non-Preferred Care:</i> 70% of the Reasonable Charge.
Miscellaneous Hospital Expenses	Covered Medical Expenses are payable as follows: <i>Preferred Care (In Area):</i> 100% of the Negotiated Charge. <i>Preferred Care (Out-of-Area):</i> 80% of the Negotiated Charge. <i>Non-Preferred Care:</i> 70% of the Reasonable Charge.
Physician's Hospital Visit Expenses	Covered Medical Expenses are payable as follows: <i>Preferred Care (In Area):</i> 100% of the Negotiated Charge. <i>Preferred Care (Out-of-Area):</i> 80% of the Negotiated Charge. <i>Non-Preferred Care:</i> 70% of the Reasonable Charge.

Surgical Benefits (Inpatient and Outpatient)	
Surgical Expenses	<p>Following the appropriate per Surgery Copay/Deductible listed below, Covered Medical Expenses are payable as follows:</p> <p>Inpatient or Outpatient Hospital: \$200 Physician's Office/Clinic (Charges over \$100): \$50</p> <p><i>Preferred Care (In Area):</i> 100% of the Negotiated Charge. <i>Preferred Care (Out-of-Area):</i> 80% of the Negotiated Charge. <i>Non-Preferred Care:</i> 70% of the Reasonable Charge.</p> <p>For Physician's Office/Clinic Expenses for charges below \$100, Covered Medical Expenses are payable as follows: <i>Preferred Care (In Area and Out-of-Area):</i> 50% of the Negotiated Charge. <i>Non-Preferred Care:</i> 50% of the Reasonable Charge.</p> <p>Elective Termination of Pregnancy Surgeon's services for elective termination of pregnancy are payable as outlined in Surgical Expenses after the applicable Copay and are limited to \$500 per condition.</p>
Anesthetist Expenses	<p>Covered Medical Expenses are payable as follows:</p> <p><i>Preferred Care (In Area):</i> 100% of the Negotiated Charge. <i>Preferred Care (Out-of-Area):</i> 80% of the Negotiated Charge. <i>Non-Preferred Care:</i> 70% of the Reasonable Charge.</p>
Second Surgical Opinion Expenses	<p>Following a \$20 Copay/Deductible per visit, Covered Medical Expenses are payable as follows:</p> <p><i>Preferred Care (In Area):</i> 100% of the Negotiated Charge. <i>Preferred Care (Out-of-Area):</i> 80% of the Negotiated Charge. <i>Non-Preferred Care:</i> 70% of the Reasonable Charge.</p>
Outpatient Day Surgery Facility Expenses	<p>Covered Medical Expenses are payable as follows:</p> <p><i>Preferred Care (In Area):</i> 100% of the Negotiated Charge. <i>Preferred Care (Out-of-Area):</i> 80% of the Negotiated Charge. <i>Non-Preferred Care:</i> 70% of the Reasonable Charge.</p>
Outpatient Benefits	
Emergency Outpatient Hospital Care Expenses	<p>Following a \$50 Copay/Deductible per visit, Covered Medical Expenses are payable as follows:</p> <p><i>Preferred Care (In Area):</i> 100% of the Negotiated Charge. <i>Preferred Care (Out-of-Area):</i> 100% of the Negotiated Charge. <i>Non-Preferred Care:</i> 100% of the Reasonable Charge.</p> <p>Notes:</p> <ul style="list-style-type: none"> • The Copay/Deductible will be waived for emergency room care if admitted as an inpatient. • A referral is required for follow up care when the follow up care is not rendered at Gannett Health Center. • You should contact Aetna Student Health to report Accident or Injury details following your emergency visit.

Outpatient Benefits (continued)	
Non-Emergency Outpatient Hospital Expenses	Following a \$50 Copay/Deductible per visit, Covered Medical Expenses are payable as follows: <i>Preferred Care (In Area):</i> 100% of the Negotiated Charge. <i>Preferred Care (Out-of-Area):</i> 80% of the Negotiated Charge. <i>Non-Preferred Care:</i> 70% of the Reasonable Charge.
Physician's Expenses in Outpatient Hospital <i>(For treatment of an Emergency Medical Condition)</i>	Covered Medical Expenses are payable as follows: <i>Preferred Care (In Area):</i> 100% of the Negotiated Charge. <i>Preferred Care (Out-of-Area):</i> 100% of the Negotiated Charge. <i>Non-Preferred Care:</i> 100% of the Reasonable Charge.
Physician's Expenses in Outpatient Hospital <i>(For Non-Emergency Care)</i>	Covered Medical Expenses are payable as follows: <i>Preferred Care (In Area):</i> 100% of the Negotiated Charge. <i>Preferred Care (Out-of-Area):</i> 80% of the Negotiated Charge. <i>Non-Preferred Care:</i> 70% of the Reasonable Charge.
Clinic/Ambulatory Care Center/ Convenient Care Center Expenses	Following a \$30 Copay/Deductible per visit, Covered Medical Expenses are payable as follows: <i>Preferred Care (In Area):</i> 100% of the Negotiated Charge. <i>Preferred Care (Out-of-Area):</i> 80% of the Negotiated Charge. <i>Non-Preferred Care:</i> 70% of the Reasonable Charge.
Physician's/ Clinician's Expenses <i>(At Gannett)</i>	Following the appropriate Gannett visit charge or Plan Copay (see page 11) per visit, Covered Medical Expenses are payable at 100% of the Negotiated Charge.
Physician's Office Expenses <i>(Outside Gannett)</i>	Following a \$20 Copay/Deductible per visit, Covered Medical Expenses are payable as follows: <i>Preferred Care (In Area):</i> 100% of the Negotiated Charge. <i>Preferred Care (Out-of-Area):</i> 80% of the Negotiated Charge. <i>Non-Preferred Care:</i> 70% of the Reasonable Charge.

Outpatient Benefits (continued)	
<p>Physician's Office Expenses for Well Child Care (For a Covered Dependent Child to age 19)</p>	<p>Covered Medical Expenses are payable as follows: Preferred Care (In Area): 100% of the Negotiated Charge. Preferred Care (Out-of-Area): 80% of the Negotiated Charge. Non-Preferred Care: 70% of the Reasonable Charge.</p> <p>Covered Medical Expenses include the following services:</p> <ul style="list-style-type: none"> • physical examination; • history; • measurements; • sensory screening; • neuropsychiatric evaluation; and, • development screening, and assessment at the following age intervals: <ul style="list-style-type: none"> 12 months (6 exams per year) 1-2 years of age (2 exams per year) 2-19 years of age (1 exam every 12 months) <p>Services shall include hereditary and metabolic screening at birth, appropriate immunizations and tuberculin tests, hematocrit, hemoglobin, or other appropriate blood tests and urinalysis as recommended by the Physician.</p>
<p>Physician's Expenses for Accidental Injury to Sound, Natural Teeth</p>	<p>Covered Medical Expenses are payable at 100% of the Actual Charge.</p>
Treatment of Mental and Nervous Disorders	
<p>Biologically based Mental Illness and for Children with Serious Emotional Disturbances</p>	<p>“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.</p> <p>“Children with Serious Emotional Disturbances” means: persons under the age of 18 years who have diagnoses of attention deficit disorders, disruptive behavior disorders, or pervasive development disorders, and where there are one or more of the following:</p> <ul style="list-style-type: none"> • Serious suicidal symptoms or other life-threatening self-destructive behaviors; • Significant psychotic symptoms (hallucinations, delusion, bizarre behaviors);

Treatment of Mental and Nervous Disorders (continued)

<p>Biologically based Mental Illness and for Children with Serious Emotional Disturbances <i>(continued)</i></p>	<ul style="list-style-type: none"> • 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. <p>Inpatient</p> <p>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.</p> <p><i>Includes the charges made for treatment received during partial hospitalization or intensive outpatient in a hospital or treatment facility. Prior review and approval must be obtained on a case-by-case basis. When approved, benefits will be payable in place of an inpatient admission, whereby two days of partial hospitalization or intensive outpatient treatment may be exchanged for one day of full hospitalization.</i></p> <p>Outpatient</p> <p>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.</p> <p>Following a \$10 Copay/Deductible per visit, Covered Medical Expenses are payable as follows:</p> <p>Preferred Care (In Area): 100% of the Negotiated Charge. Preferred Care (Out-of-Area): 80% of the Negotiated Charge. Non-Preferred Care: 70% of the Reasonable Charge.</p> <p>Not Covered are Charges for Services:</p> <ul style="list-style-type: none"> • 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.
<p>Other than Biologically based Mental Illness and Children with Serious Emotional Disturbances</p>	<p>Inpatient Benefits</p> <p>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.</p> <p>Following a \$200 Copay/Deductible per admission, Covered Medical Expenses are payable as follows:</p> <p>Preferred Care (In Area): 100% of the Negotiated Charge. Preferred Care (Out-of-Area): 80% of the Negotiated Charge. Non-Preferred Care: 70% of the Reasonable Charge.</p>

Treatment of Mental and Nervous Disorders (continued)	
Other than Biologically based Mental Illness and Children with Serious Emotional Disturbances <i>(continued)</i>	<p><i>Includes the charges made for treatment received during partial hospitalization or intensive outpatient in a hospital or treatment facility. Prior review and approval must be obtained on a case-by-case basis. When approved, benefits will be payable in place of an inpatient admission, whereby two days of partial hospitalization or intensive outpatient treatment may be exchanged for one day of full hospitalization.</i></p> <p>Outpatient Treatment</p> <p>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.</p> <p>Following a \$10 Copay/Deductible per visit, Covered Medical Expenses are payable as follows up to a maximum of 40 visits per Policy Year. Please note a referral is required for care received outside of Gannett.</p> <p>Preferred Care (In Area): 100% of the Negotiated Charge. Preferred Care (Out-of-Area): 80% of the Negotiated Charge. Non-Preferred Care: 70% of the Reasonable Charge.</p> <p>Not Covered are Charges for Services:</p> <ul style="list-style-type: none"> • 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.
Chemical Abuse Benefits	
Inpatient Facility Expenses	<p>Following a \$200 Copay/Deductible per admission, Covered Medical Expenses are payable as follows subject to a maximum of seven days per Policy Year for detoxification and up to a maximum of 30 days per Policy Year for rehabilitation:</p> <p>Preferred Care (In Area): 100% of the Negotiated Charge. Preferred Care (Out-of-Area): 80% of the Negotiated Charge. Non-Preferred Care: 70% of the Reasonable Charge.</p>
Inpatient Physician's Expenses	<p>Covered Medical Expenses are payable as follows:</p> <p>Preferred Care (In Area): 100% of the Negotiated Charge. Preferred Care (Out-of-Area): 80% of the Negotiated Charge. Non-Preferred Care: 70% of the Reasonable Charge.</p>
Outpatient Care Expenses	<p>Note: A referral is required for care received outside of Gannett. Covered Medical Expenses are payable as follows, subject to a maximum of 60 visits per Policy Year (up to 20 of these visits are available for family members):</p> <p>Preferred Care (In Area): 100% of the Negotiated Charge. Preferred Care (Out-of-Area): 80% of the Negotiated Charge. Non-Preferred Care: 70% of the Reasonable Charge.</p>

Partial Hospitalization Benefits	
Partial Hospital Inpatient Admission Expenses	<p>Following a \$200 Copay/Deductible per admission, Covered Medical Expenses for treatment of Mental Health Disorders and Substance Abuse provided in lieu of hospital admission, are payable as follows:</p> <p>Preferred Care (In Area): 100% of the Negotiated Charge. Preferred Care (Out-of-Area): 80% of the Negotiated Charge. Non-Preferred Care: 70% of the Reasonable Charge.</p> <p>Please note: Prior review and approval must be obtained on a case-by-case basis by contacting Aetna Student Health.</p>
Maternity Benefits	
Maternity Benefits	<p>Please note the following:</p> <ul style="list-style-type: none"> • In the event of an inpatient confinement, such benefits would be 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 delivery charges, parent education, assistance and training in breast or bottle-feeding, and the performance of any necessary maternal and newborn clinical assessments.
Inpatient Admission Expenses	<p>Following a \$200 Copay/Deductible per admission, Covered Medical Expenses are payable as follows:</p> <p>Preferred Care (In Area): 100% of the Negotiated Charge. Preferred Care (Out-of-Area): 80% of the Negotiated Charge. Non-Preferred Care: 70% of the Reasonable Charge.</p>
Birthing Center Admission Expenses	<p>Following a \$100 Copay/Deductible per admission, Covered Medical Expenses are payable as follows:</p> <p>Preferred Care (In Area): 100% of the Negotiated Charge. Preferred Care (Out-of-Area): 80% of the Negotiated Charge. Non-Preferred Care: 70% of the Reasonable Charge.</p> <p>Please note: Please contact Aetna Student Health at (800) 859-8475, or the Student Insurance Office at (607) 255-6363 for participating provider information.</p>
Physician's Care Expenses (For global maternity treatment)	<p>Following a \$100 Copay/Deductible per condition, Covered Medical Expenses are payable as follows:</p> <p>Preferred Care (In Area): 100% of the Negotiated Charge. Preferred Care (Out-of-Area): 80% of the Negotiated Charge. Non-Preferred Care: 70% of the Reasonable Charge.</p>

Allergy Care (Including Injection and Serum)	
Office Visit Expenses (At Gannett)	Following the appropriate Gannett visit charge or Plan Copay (see page 11) per visit, Covered Medical Expenses are payable at 100% of the Negotiated Charge. Please note: Copay does not apply if purpose of visit is for injection only.
Office Visit Expenses (Outside Gannett)	Following a \$20 Copay/Deductible per visit, Covered Medical Expenses are payable as follows: Preferred Care (In Area): 100% of the Negotiated Charge. Preferred Care (Out-of-Area): 80% of the Negotiated Charge. Non-Preferred Care: 70% of the Reasonable Charge.
Therapy Expenses	
Radiation Therapy/ Chemotherapy Expenses	Covered Medical Expenses are payable as follows: Preferred Care (In Area): 100% of the Negotiated Charge. Preferred Care (Out-of-Area): 80% of the Negotiated Charge. Non-Preferred Care: 70% of the Reasonable Charge.
Dialysis/Respiratory Therapy Expenses	Covered Medical Expenses are payable as follows: Preferred Care (In Area): 100% of the Negotiated Charge. Preferred Care (Out-of-Area): 80% of the Negotiated Charge. Non-Preferred Care: 70% of the Reasonable Charge.
Physical Therapy Expenses (Must start within six months of onset of condition)	Following a \$5 Copay/Deductible per visit at Gannett or a \$20 Copay/ Deductible per visit with a non-Gannett provider, Covered Medical Expenses are payable as follows: Preferred Care (In Area): 100% of the Negotiated Charge. Preferred Care (Out-of-Area): 80% of the Negotiated Charge. Non-Preferred Care: 70% of the Reasonable Charge. Please note: A referral is required for all Physical Therapy Treatment in the Ithaca area. If no referral is received, no benefits are payable. Some Physicians may require a referral for their records, regardless of Plan requirements.
Occupational Therapy Expenses (Must start within six months of onset of condition)	Following a \$20 Copay/Deductible per visit, Covered Medical Expenses are payable as follows: Preferred Care (In Area): 100% of the Negotiated Charge. Preferred Care (Out-of-Area): 80% of Negotiated Charge. Non-Preferred Care: 70% of the Reasonable Charge.
Chiropractic Care Expenses	Covered Medical Expenses are payable as follows subject to a maximum of 60 visits per lifetime: Preferred Care (In Area/Out-of-Area): 70% of the Negotiated Charge. Non-Preferred Care: 70% of the Reasonable Charge.

Therapy Expenses (continued)																											
Acupuncture Expenses	<p>Covered Medical Expenses are payable as follows for any of the following indications when it is administered by a health care provider who is a legally qualified Physician practicing within the scope of his/her license.</p> <ul style="list-style-type: none"> • Adult postoperative and chemotherapy nausea and vomiting • Nausea of pregnancy • Postoperative dental pain • Fibromyalgia/myofascial pain • Chronic low back pain secondary to osteoarthritis <p>Preferred Care (In Area/Out-of-Area): 70% of the Negotiated Charge. Non-Preferred Care: 70% of the Reasonable Charge.</p> <p>The following conditions are not covered under this benefit.</p> <table border="0"> <tr> <td>Acute low back pain</td> <td>Obesity</td> </tr> <tr> <td>Addiction</td> <td>Painful neuropathies</td> </tr> <tr> <td>AIDS</td> <td>Phantom leg pain</td> </tr> <tr> <td>Allergic rhinitis</td> <td>Psychiatric disorders</td> </tr> <tr> <td>Asthma</td> <td>Raynaud's disease pain</td> </tr> <tr> <td>Carpal tunnel syndrome</td> <td>Rheumatoid arthritis</td> </tr> <tr> <td>Chronic pain syndrome (e.g., RSD)</td> <td>Sensorineural deafness</td> </tr> <tr> <td>Fibrotic contractures</td> <td>Shoulder pain (e.g., bursitis)</td> </tr> <tr> <td>Headache (migraine, tension)</td> <td>Smoking cessation</td> </tr> <tr> <td>Hypertension</td> <td>Stroke rehabilitation</td> </tr> <tr> <td>Menstrual cramps</td> <td>Tennis elbow/epicondylitis</td> </tr> <tr> <td>Neck pain/cervical spondylosis</td> <td>Tinnitus</td> </tr> <tr> <td></td> <td>Whiplash</td> </tr> </table>	Acute low back pain	Obesity	Addiction	Painful neuropathies	AIDS	Phantom leg pain	Allergic rhinitis	Psychiatric disorders	Asthma	Raynaud's disease pain	Carpal tunnel syndrome	Rheumatoid arthritis	Chronic pain syndrome (e.g., RSD)	Sensorineural deafness	Fibrotic contractures	Shoulder pain (e.g., bursitis)	Headache (migraine, tension)	Smoking cessation	Hypertension	Stroke rehabilitation	Menstrual cramps	Tennis elbow/epicondylitis	Neck pain/cervical spondylosis	Tinnitus		Whiplash
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	Whiplash																										
Additional Benefits																											
Prescription Contraceptive	<p>Covered Medical Expenses are payable on the same basis as any expense. Covered Medical Expenses also include any expenses incurred for office Medical Expenses visits in conjunction with the administration of a covered Prescription contraceptive.</p> <p>Coverage of oral contraceptives, Lunelle, Depo-Provera, Patch, and Ring are provided under the separate Prescription Drug Benefit portion of the Plan.</p>																										
Ambulance Expenses	<p>Covered Medical Expenses are payable per trip at 100% of the Reasonable Charge for the first \$150 and at 80% of the Reasonable Charge thereafter.</p>																										
Prescription Drug Benefit Expenses	<p>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:</p> <p>Preferred Care: 100% after a \$25 Copay for each Brand-Name Prescription Drug or a \$10 Copay for each Generic Prescription Drug.</p>																										

Additional Benefits (continued)	
<p>Prescription Drug Benefit Expenses (continued)</p>	<p>Non-Preferred Care: 70% of the Reasonable Charge after a \$25 Deductible for each Brand-Name Prescription Drug or a \$10 Deductible for each Generic Prescription Drug.</p> <p>Please note: You are required to pay in full at the time of service for all Prescriptions dispensed at a Non-Participating Pharmacy. (Please refer to the Prescription Drug Claim Procedure section of this Brochure for information regarding the claim submission and reimbursement process.)</p> <p>Prescription coverage includes prescribed drugs that are not approved for a certain type of cancer providing if recognized in one of the established reference compendia.</p> <p>Covered Medical Expenses are payable up to a maximum of \$2,000 per Policy Year.</p> <p>Medications not covered by this benefit include, but are not limited to, allergy sera, drugs whose sole purpose is to promote or to stimulate hair growth, appetite suppressants, smoking deterrents, immunization agents and vaccines, and non-self injectables.</p> <p>Covered medications include oral contraceptives Lunelle, 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.</p> <p>Prior authorization is required for growth hormones, and drugs which are for treatment of malaria.</p> <p>For assistance, or for a complete list of excluded medications and drugs available with prior authorization, please contact (800) 238-6279.</p> <p>Please note: FDA approved drugs will be considered a Covered Medical Expense for Prescription Drugs filled at a Pharmacy located outside the United States. Please submit these claims directly to Aetna Student Health for reimbursement.</p>
<p>X-ray and Lab Expenses</p>	<p>Covered Medical Expenses are payable as follows: Preferred Care (In Area): 100% of the Negotiated Charge. Preferred Care (Out-of-Area): 80% of the Negotiated Charge. Non-Preferred Care: 70% of the Reasonable Charge.</p>
<p>Home Health Care Expenses</p>	<p>Covered Medical Expenses are payable as follows subject to a lifetime maximum of 365 visits: Preferred Care (In Area): 100% of the Negotiated Charge. Preferred Care (Out-of-Area): 80% of the Negotiated Charge. Non-Preferred Care: 70% of the Reasonable Charge.</p>

Additional Benefits (continued)	
Hospice Care Expenses	<p>Covered Medical Expenses are payable as follows subject to a lifetime maximum of 210 visits:</p> <p>Preferred Care (In Area): 100% of the Negotiated Charge. Preferred Care (Out-of-Area): 80% of the Negotiated Charge. Non-Preferred Care: 70% of the Reasonable Charge.</p> <p>Please Note: End of Life Care provided at an acute care facility which specializes in the treatment of terminally ill patients for members diagnosed with advanced cancer, will be reimbursed 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.</p>
Durable Medical Equipment Expenses (You should contact Aetna Student Health to confirm what is considered Durable Medical Equipment.)	<p>The Covered Medical Expenses are payable as follows:</p> <p>Preferred Care (In Area): 100% of the Negotiated Charge. Preferred Care (Out-of-Area): 80% of the Negotiated Charge. Non-Preferred Care: 70% of the Reasonable Charge.</p> <p>Please Note: Flow Meters for asthma are available at Gannett Health Center for \$25. Glucose Monitors are available free of charge by calling Aetna Pharmacy Management at (800) 238-6279.</p>
Temporomandibular Joint Dysfunction Expenses (TMJ)	<p>Covered Medical Expenses incurred for surgical and non-surgical treatment of Temporomandibular Joint Dysfunction and associated myofascial pain are payable as follows:</p> <p>Preferred Care (In Area): 100% of the Negotiated Charge. Preferred Care (Out-of-Area): 80% of the Negotiated Charge. Non-Preferred Care: 70% of the Reasonable Charge.</p>
Diabetic Treatment Expenses	<p>Covered Medical Expenses are payable as follows:</p> <p>Preferred Care (In Area): 100% of the Negotiated Charge. Preferred Care (Out-of-Area): 80% of the Negotiated Charge. Non-Preferred Care: 70% of the Reasonable Charge.</p> <p>Please Note: Some diabetic supplies are covered under the Prescription Drug Benefit and others are covered under the Durable Medical Equipment (DME) benefit in the Policy.</p> <p>The following diabetic supplies are covered using your Rx Card and the claims are processed through Aetna Pharmacy Management. The costs for the following will be subject to a \$20 Prescription Copay and will accumulate towards the \$2,000 annual Prescription maximum.</p> <ul style="list-style-type: none"> • Insulin • Injectable glucagon • Oral Hypoglycemics • Glucose tablets

Additional Benefits (continued)	
Diabetic Treatment Expenses <i>(continued)</i>	<p>The following diabetic supplies are covered using your Rx Card and the claims are processed through Aetna Pharmacy Management. These supplies will not be subject to the Prescription Copay and will not accumulate towards the \$2,000 annual Prescription maximum.</p> <ul style="list-style-type: none"> • Lancets • Lancing devices • Visual reading and urine test strips • Diabetic needles and syringes (including pen needles) • Test strips for glucose monitors • Alcohol swabs <p>The following equipment is covered under the Durable Medical Equipment benefit of the Plan and claims will be processed by Aetna Student Health:</p> <ul style="list-style-type: none"> • Cartridges for the legally blind • Insulin infusion devices • Monitors* • Injection aids • Insulin pumps and appurtenances • Podiatric appliances • Monitors for the legally blind* <p><i>*Provided free of charge under Aetna's program.</i></p>
Well Women Expenses	<p>The Plan will cover one baseline mammogram for women between the ages of 35 to 40. Women age 40 and over have coverage for one mammogram per Policy Year thereafter. Upon a Physician's recommendation 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, the Plan will cover all mammograms, regardless of age or frequency. Covered Medical Expenses are payable on the same basis as any X-ray expense.</p> <p>The Plan will cover one routine annual Pap smear and two routine gynecological exams per year for women age 18 and older. Covered Medical Expenses are payable on the same basis as any other expense. Referral requirements do not apply.</p>
Prostate Cancer Screening Expenses	<p>Covered Medical Expenses include one annual, or more frequently if recommended by a Physician, Digital Rectal Exam and Prostate Specific Antigen Test. Covered Medical Expenses are payable on the same basis as any other outpatient Physician's Office Visit or Laboratory expense.</p>
Bone Density Testing Expenses	<p>Covered Medical Expenses are payable on the same basis as any expense.</p>

Additional Benefits (continued)	
Attention Deficit Disorder Expenses	Treatment of this condition is a Covered Medical Expense payable subject to the Plan provisions/limitations applicable to Outpatient Treatment of Other Than Biologically Based Mental Illness.
Breast Surgery and Reconstructive Breast Surgery Expenses	Benefits will be payable for inpatient hospital care for an insured person undergoing (a) a lumpectomy or lymph node dissection for the treatment Benefit of breast cancer; or (b) a mastectomy which is covered under this Plan. Coverage is limited to a time frame determined by the insured person's Physician to be medically appropriate. Benefits will also be payable for breast reconstruction surgery after a mastectomy including (a) all stages of reconstruction of the breast on which the mastectomy has been performed, and (b) surgery and reconstruction of the other breast to produce symmetry in a manner determined by the attending Physician and the insured person to be appropriate. Covered Medical Expenses are payable on the same basis as any other expense.
Enteral Formula	The Plan will cover enteral formulas and modified solid food products that are low in protein or contain modified protein for certain inherited diseases of amino acid and organic acid metabolism which are medically necessary and prescribed by a physician. The enteral formula will be covered under the Medical Benefit. Modified solid food products are limited to \$2,500 in paid benefits per policy year. Covered Medical Expenses are subject to applicable Plan deductible, co-payments and coinsurance.

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 SM Discount Program ¹	Aetna VisionSM Discount Program: The Aetna Vision discount program helps you save on many eye care products, including sunglasses, contact lenses, non-prescription sunglasses, contact lens solutions and other eye care accessories. Plus, you can receive up to a 15% discount on LASIK surgery (the laser vision correction procedure).
Aetna Fitness SM Discount Program ¹	Aetna FitnessSM Discount Program: Aetna's Fitness Program provides members with access to preferred membership rates at nearly 10,000 fitness clubs nationwide in the GlobalFit TM network, as well as discounts on home fitness equipment, exercise videos and more!

Additional Benefits (continued)	
Aetna Weight Management SM Discount Program ¹	<p>Aetna Weight ManagementSM Discount Program: Helps you achieve your weight loss goals and develop a balanced approach to your active lifestyle. This program provides members and their eligible family members access to discounts on Jenny Craig[®] weight loss programs and products. Start with a FREE 30-day trial membership* then choose either a 6* -or 12* -month program** that's right for you. You also receive individual weight loss consultations, personalized menu planning, tailored activity planning, motivational materials and much more.</p> <p><i>*Offers good at participating centers in the United States, Canada and Puerto Rico and through Jenny Direct at-home. Additional cost for all food purchases and shipping where applicable.</i></p> <p><i>**Additional weekly food discounts will grow throughout the year, based on active participation.</i></p>
eDiets ^{®1}	eDiets[®]: 25% discount on weekly dues for an eDiet membership.
Zagat Survey [®] Healthy Dining ¹	Zagat Survey[®] Healthy Dining: 30% discounts on online subscriptions to restaurant and lifestyle guides.
SpaWish [®] Gift Certificate ¹	SpaWish[®] Gift Certificate: Spa gift certificates redeemable at a national network of 1,300 day spas.
Mayo Clinic Bookstore.com ¹	Mayo Clinic Bookstore.com: Discounts for books on health and wellness.
Health and Wellness Resources ²	Health and Wellness Resources: 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.
Beginning Right SM Maternity Program ²	Beginning RightSM Maternity Program: Offers members the resources and tools to help give babies a healthy start. You will have a one-on-one relationship with an obstetrics-trained nurse and a physician – in person or by phone – throughout your pregnancy and up to four months after delivery. Support will be available for depression, pre-term labor, and healthy initiatives, such as dental screening.
Aetna Natural Products and Services SM Discount Program ^{1,2,3}	Aetna Natural Products and ServicesSM Discount Program: Offers members access to reduced rates from natural therapy professionals, including acupuncturists, chiropractors, massage therapists and diet counselors, and access to discounts on health-related products, such as over-the-counter vitamins, supplements and more!

Additional Benefits (continued)	
Quit&Fit™ Tobacco Cessation Program ^{2,3}	Quit&Fit™ Tobacco Cessation Program: This tobacco cessation program provides support and collaboration as you quit smoking. A coaching program can be combined with counseling, interactive web tools and education. You will also be eligible for awards and rewards.
<p>¹Discount programs provide access to discounted prices and are NOT insured benefits.</p> <p>²Health information programs provide general health information and are not a substitute for diagnosis or treatment by a physician or other health care professionals.</p> <p>³These services, programs or benefits are offered by vendors who are independent contractors and not employees or agents of Aetna.</p>	

General Provisions

State Mandated Benefits

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

Subrogation/Reimbursement Right of Recovery Provision

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

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

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

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

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

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

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

Coordination of Benefits

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

Definitions

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

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

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

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

Coinsurance: The percentage of Covered Medical Expenses payable by Aetna under the Student Health 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 Benefits provision.

Covered Person: A covered student or dependent 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 and paid for by the Covered Person before benefits are payable under the Plan. Deductible amounts are the responsibility of the Covered Person.

Durable Medical and Surgical Equipment: No more than one item of equipment for the same or similar purpose, and the accessories needed to operate it, that is:

- Made to withstand prolonged use;
- Made for and mainly used in the treatment of a disease or Injury;
- Suited for use in the home;
- Not normally of use to persons who do not have a disease or Injury;
- Not for use in altering air quality or temperature;
- Not for exercise or training.

Not included is equipment such as whirlpools, portable whirlpool pumps, sauna baths, massage devices, overbed tables, elevators, communication aids, vision aids, and telephone alert systems.

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.

Generic Prescription Drug or Medicine: A Prescription Drug that 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, mental health, or 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.

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

Non-Preferred Care: A health care service or supply furnished by a health care provider who 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 who 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 does not dispense Prescription Drugs in accordance with its terms.

Out-of-Pocket Limit: The amount that must be paid, by the covered student, or the covered student and their covered dependents, before Covered Medical Expenses will be payable at 100%, for the remainder of the Policy Year.

The following expenses do not apply toward meeting the Out-of-Pocket Limit:

- Deductibles;
- Copays;
- Expenses that are not Covered Medical Expenses;
- Penalties;
- Expenses for Prescription Drugs; and
- Other expenses not covered by this Policy.

Pharmacy: An establishment where Prescription Drugs are legally dispensed.

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

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.

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.

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

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

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

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

In determining the Reasonable Charge for a service or supply that is:

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

Aetna may take into account factors, such as:

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

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

Exclusions

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

The Plan neither covers nor provides benefits for the following:

1. Expenses incurred for services normally provided without charge by the University Health Service, infirmary or hospital, or by health care providers employed by the Policyholder.
2. 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.
3. Expense incurred as a result of dental treatment, including extraction of wisdom teeth, except for treatment resulting from injury to sound natural teeth, as provided elsewhere in this Policy.
4. Expenses incurred as a result of Injury due to participation in a riot. "Participation in a riot" means taking part in a riot in any way, including inciting the riot or conspiring to incite it. It does not include actions taken in self-defense, so long as they are not taken against persons who are trying to restore law and order.
5. Expenses incurred as a result of commission of a felony.
6. Expenses incurred as a result of an Accident occurring in consequence of riding as a passenger or otherwise in any vehicle or device for aerial navigation, except as a fare-paying passenger in an aircraft operated by a scheduled airline maintaining regular published schedules on a regularly established route.
7. Expense incurred for eye refractions, vision therapy, radial keratotomy (except as medically necessary), eyeglasses, contact lenses (except when required after cataract surgery), or other vision or hearing aids, or prescriptions or examinations except as required for repair caused by a covered injury.
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. This exclusion does not apply to reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered dependent child which has resulted in a functional defect.
9. Expenses for routine physical exams, including expenses in connection with well newborn care, routine vision exams, routine dental exams, routine hearing exams, immunizations, or other preventive services and supplies, except to the extent coverage of such exams, immunizations, services, or supplies is specifically provided in the Policy.

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

11. 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.

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

In order for a treatment, service, or supply, to be considered medically necessary, the service or supply must:

- Be care, or treatment, which is likely to produce a significant positive outcome as, and no more likely to produce a negative outcome than, any alternative service or supply, both as to the sickness or injury involved, and the person's overall health condition;
- Be a diagnostic procedure which is indicated by the health status of the person, and be as likely to result in information that could affect the course of treatment as, and no more likely to produce a negative outcome than, any alternative service or supply, both as to the sickness or injury involved, and the person's overall health condition; and
- 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 persons who is part of his or her family, any healthcare provider, or healthcare 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.

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

14. 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.

15. Expenses incurred for Injury resulting from the play or practice of intercollegiate sports. This does not include club or intramural sports.

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

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

18. Expense incurred for the use of orthotics, unless used exclusively to promote healing.

19. 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. The Policy will only pay for those losses, which are not payable under the automobile medical payment insurance Policy.

20. Expenses incurred for or in connection with: procedures, services, or supplies that are, as determined by Aetna, to be experimental or investigational. A drug, a device, a procedure, or treatment will be determined to be experimental or investigational if:

- There are insufficient outcomes data available from controlled clinical trials published in the peer reviewed literature, to substantiate its safety and effectiveness, for the disease or injury involved; or
- If required by the FDA, approval has not been granted for marketing; or
- A recognized national medical or dental society or regulatory agency has determined, in writing, that it is experimental, investigational, or for research purposes; or
- The written protocol or protocols used by the treating facility, or the protocol or protocols of any other facility studying substantially the same drug, device, procedure, or treatment, or the written informed consent used by the treating facility, or by another facility studying the same drug, device,

procedure, or treatment, states that it is experimental, investigational, or for research purposes. However, this exclusion will not apply with respect to services or supplies (other than drugs) received in connection with a disease, if Aetna determines that:

- The disease can be expected to cause death within one year, in the absence of effective treatment; and
- The care or treatment is effective for that disease, or shows promise of being effective for that disease, as demonstrated by scientific data. In making this determination, Aetna will take into account the results of a review by a panel of independent medical professionals. They will be selected by Aetna. This panel will include professionals who treat the type of disease involved.

Also, this exclusion will not apply with respect to drugs that:

- Have been granted treatment investigational new drug (IND), or Group c/treatment IND status; or
- Are being studied at the Phase III level in a national clinical trial; sponsored by the National Cancer Institute; or
- Are recognized for treatment of the specific type of cancer for which the drug has been prescribed in one of the following reference compendia:
 - The American Medical Association Drug Evaluations;
 - The American Hospital Formulary Service Drug Information; or
 - The United States Pharmacopeia Drug Information; or
 - Recommended by review article or editorial comment in a major peer reviewed professional journal; or
- If Aetna determines that available, scientific evidence demonstrates that the drug is effective, or shows promise of being effective, for the disease.

21. Expenses for treatment of Injury or Sickness to the extent payment is made, as a judgment or settlement, by any person deemed responsible for the Injury or Sickness (or their insurers).

22. Expenses incurred for, or related to, sex change surgery or to any treatment of gender identity disorders. (Please note that outpatient mental health counseling and prescribed drugs, including hormones, (subject to the plan provisions applicable to the Prescription Drug Plan) are considered to be Covered Medical Expenses.)

23. Expense for services or supplies provided for the treatment of obesity and/or weight control.

24. Expense for charges that are not Reasonable Charges, as determined by Aetna.

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

26. Expenses for: (a) care of flat feet; (b) supportive devices for the foot; (c) care of corns, bunions, or calluses; (d) care of toenails; and (e) care of fallen arches, weak feet, or chronic foot strain, except that (c) and (d) are not excluded when Medically Necessary, because the Covered

Persons diabetic or suffers from circulatory problems.

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

28. Expense for contraceptive methods, devices or aids, and charges for services and supplies for or related to gamete intrafallopian transfer, artificial insemination, in-vitro fertilization (except as required by the state law), or embryo transfer procedures, elective sterilization nor its reversal, or elective abortion, unless specifically provided for in this Policy.

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

30. 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.

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

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

33. Expenses incurred for massage therapy.

Any exclusion above will not apply to the extent that coverage of the charge 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 his or her 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 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 Insurance

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

Claim Procedure

1. In the event of an Accident or Sickness, you should report to the nearest qualified provider or hospital to secure treatment. For non-emergency services when on campus or in the Ithaca area, you should first go to Gannett for treatment or to obtain a referral for specialty medical care.
2. Most providers of services will file a claim for you. Payment for Covered Medical Expenses will be made directly to the hospital or Physician unless you attach paid receipts to the itemized bills.
3. In the event your provider of services does not file a claim on your behalf, it is your responsibility to initiate a claim in order to obtain reimbursement. Please send all itemized medical bills as soon as possible after treatment is rendered. No claim form is needed. Your name, Cornell ID Number, and University Name should be written clearly and attached to your medical bills. All information should be mailed to:

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

4. In the event that additional information is needed to determine benefits, Aetna Student Health will request the necessary additional information from you or your provider.
5. You will receive an “Explanation of Benefits” form after your claims are processed. The Explanation of Benefits will explain how your claim was processed according to the benefits of your Student Health Insurance Plan. If you have questions regarding the Explanation of Benefits, you may contact the Customer Service Department at Aetna Student Health.

For assistance in filing a claim or inquiring about the status of a claim, you may contact the Customer Service Department at Aetna Student Health directly at **(800) 859-8475** between the hours of 8:30 a.m. and 8:30 p.m. (ET) Monday through Friday.

Prescription Drug Claim Procedure

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

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

Information regarding Preferred Care Pharmacy locations is available by accessing the Internet at: www.aetnastudenthealth.com, click on “Find Your School” and enter **711115** as your Policy Number.

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

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

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

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

How To Appeal a Claim

Complaint and Appeals Procedures

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

The complaints and appeals process is designed to address coverage issues, complaints and problems. If you have a coverage issue or other problem, call Aetna Student Health Customer Services at **(800) 859-8475**. A representative will address your concern. If you are dissatisfied with the outcome of the initial contact, the decision may be appealed.

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

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

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

Internal Appeals Procedure

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

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

First Level Appeals Procedure

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

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

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

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

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

Second Level Appeals Procedure

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

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

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

You must exhaust the Internal Appeals Procedure before requesting an External Appeal. However, you are not required to exhaust the Internal Appeals Procedure prior to requesting an External Appeal, if you and Aetna have agreed that the matter may proceed directly to an External Appeal. Aetna will keep the records of your complaint for 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 **(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, 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 appeals process. You may initiate the external appeal process by filing a completed application with the New York State Department of Insurance. If the requested service has already been provided to you, your attending Physician may file an expedited appeal application on your behalf, but only if you have consented to this in writing.

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

Covered Services and Exclusions

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

General Information

Patient Management Program

Aetna evaluates and determines the appropriateness of medical care resources utilized by our members. To accomplish these goals, Aetna has developed a comprehensive Patient Management Program.

Only medical directors make decisions denying coverage for services for reasons of Medical Necessity. Coverage denial letters delineate any unmet criteria, standards and guidelines, and inform the provider and member of the appeal process. Our patient management staff uses national guidelines and resources to guide the precertification, concurrent review and retrospective review process.

Pre-Certification

You must obtain Pre-Certification for certain types of care rendered by Non-Preferred Providers to avoid a reduction in benefits paid for that care.

To request Pre-Certification, you must call the toll-free number shown on your ID card ((800) 859-8475). Such Pre-Certification must be obtained before care is received, or in the case of an emergency admission, procedure, or treatment, within one business day after the start of a confinement as a full-time inpatient or the performance of the procedure or treatment, or as soon as reasonably possible.

Concurrent Review

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

Discharge Planning

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

Retrospective Record Review

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

Provider Reimbursement

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

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

Aetna Pharmacy Management negotiates discounts from independent Pharmacies and chain Pharmacies that participate in the Aetna network. The reimbursement formula is based on Average Wholesale Price (AWP) less a negotiated discount, plus a dispensing fee. The dispensing fee is a contractual fee negotiated between Aetna Pharmacy Management and the network pharmacy. With Internet access, you can conduct an online search for participating Pharmacies through DocFind®, which is available on our website at www.aetnastudenthealth.com, click on “Find Your School” and enter **711115** as your Policy Number. A paper directory is also available to members.

Any charge for a service or supply furnished by a participating provider in excess of such provider’s Negotiated Charge for that service or supply will not be a Covered Expense under the group contract. It will be the responsibility of Aetna and the participating provider to resolve the amount deemed to be in excess.

Confidentiality

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

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

Notice to Enrollees

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

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

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

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

On Call International

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.

Accidental Death and Dismemberment (ADD) Benefits¹

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

- Benefits are payable for the Accidental Death and Dismemberment of Covered Persons, up to a maximum of \$20,000.

Medical Evacuation and Repatriation (MER) Benefits¹

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) Services¹

On Call provides the following travel assistance services:

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

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

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

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

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

Aetna Student Health is the brand name for products and services provided by Aetna Life Insurance Company and Chickering Claims Administrators, Inc, (CCA). CCA and On Call are independent contractors and not employees or agents of the other. CCA provides access to ADD, MER and WETA benefits/services through a contractual arrangement with On Call. However, neither CCA nor any of its affiliates provides or administers ADD, MER or WETA benefits/services and neither CCA nor any of its affiliates is responsible in any way for the benefits/services provided by or through On Call, USFIC or VSC. Premiums/fees for benefits/services provided through On Call, USFIC and VSC are included in the Rates outlined in this brochure.

Important Note

The SHIP provides limited benefit for 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 insurance only or nursing home and home health care insurance as defined by the NY State Insurance Department. The insurance policy itself sets forth the rights and obligations of both you and the insurance company. It is therefore important that you READ THIS BROCHURE carefully.

This above disclosure is included as required by New York Insurance Regulation Section 52.10 and 52.59. Cornell Student Health Insurance Plan benefits are described in the enclosed chart. The Plan meets all the student health insurance standards developed by the American College Health Association.

This Brochure provides a general summary of the Student Health Insurance Plan. The Plan is underwritten by Aetna Life Insurance Company (Aetna). Exact provisions governing this insurance are contained in the Master Policy. See the Cornell University Student Insurance Office for additional information. If any discrepancy exists between the Brochure and the Policy, the Master Policy will govern and control the payment of benefits. The Plan is administered by Chickering Claims Administrators, Inc., P.O. Box 15708, Boston, MA 02215-0014.

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

Administered by:

Aetna Student Health
P.O. Box 15708
Boston, MA 02215-0014
(800) 859-8475 (toll free)
www.aetnastudenthealth.com



Underwritten by:

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

Policy No. 711115

The Cornell University Student Health Insurance Plan (the “Plan”) is underwritten by Aetna Life

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

NOTICE

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

Notes

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