

2006 - 2007



**NORTHWESTERN
UNIVERSITY**

Student Health Insurance Plan Brochure

Offered by:
Chickering Benefit Planning Insurance Agency, Inc.
Administered by:
Chickering Claims Administrators, Inc.
Underwritten by:
Aetna Life Insurance Company (ALIC)

Policy No. 812845

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Where To Find Help

Got Questions? Get Answers with Chickering's Aetna Navigator™

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

By logging into Aetna Navigator, you can:

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

How do I register for Aetna Navigator?

- Go to *www.chickering.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 registration?

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:

- Insurance Benefits
- Claims Processing
- Enrollment
- Waiver Process
- Claims Processing

Please contact:

Chickering Claims Administrators, Inc.
P.O. Box 15708
Boston, MA 02215-0014
(877) 626-2314

For Questions About ID Cards:

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

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

For lost ID cards, contact:

Chickering Claims Administrators, Inc.

(877) 626-2314 or visit www.chickering.com, click on “Find Your School” and enter **812845** as your Policy Number.

For Questions About:

- Enrollment/Waiver Process
- On-Campus Health Service
- Referral requirements
- Dependent enrollment

Please contact:

Northwestern University

Student Insurance Office

633 Emerson Street

Evanston, IL 60208

(847) 491-2113

Provider Listings:

You can use Aetna’s DocFind® Service:

Visit www.chickering.com, click on “Find Your School” and enter **812845** as your Policy Number.

For Questions About:

- Worldwide Emergency Travel Assistance Services

Please contact:

Assist America, Inc.

(800) 872-1414 (within U.S.)

If outside the U.S., call collect **by dialing the U.S. access code plus (301) 656-4152**

E-mail address: medservices@assistamerica.com

Worldwide Web Access:

- The Chickering Group: www.chickering.com

Northwestern University Student Health Insurance Plan

This is a brief description of the Student Health Insurance Plan benefits available for Northwestern University students. The Plan is underwritten by Aetna Life Insurance Company (Aetna). The exact provisions governing this insurance are contained in the Master Policy. See the Office of Risk Management during business hours for additional information. The Plan is administered by Chickering Claims Administrators, Inc., P.O. Box 15708, Boston, MA 02215-0014.

Please Note: Two Plan options are available for the 2006-2007 Plan Year. Be sure to choose the Plan that best fit your needs by looking at the premiums in addition to the benefits. For more information about the benefits please turn to the benefit grids on pages 13-24 of this Plan Brochure.

Two Plan options:

- 1) The Basic High Deductible Plan which provides coverage for catastrophic conditions; and
- 2) The Comprehensive Plan which provides coverage with no Deductible for Preferred Care.

Student Eligibility

All full-time Northwestern University students are eligible to enroll in either Plan.

Part-time, half-time, and School of Continuing Studies students who are enrolled in at least two classes in a degree-seeking program on a continuing basis are eligible. When enrolling in the Plan, part-time students must show proof of registration in two classes on a continuing basis to be eligible to participate in the Plan.

Garrett-Evangelical Seminary and Seabury Western Seminary students can enroll in the Plan on a voluntary basis during the open enrollment period at the beginning of each academic year by returning a completed Application Form to their Seminary Student Affairs Office prior to the indicated due date.

Note: Eligible part-time, half-time, School of Continuing Studies, Garrett and Seabury students must pay the Health Clinic Use Fee each quarter. Other students enrolled in the Student Health Insurance Plan and not registered for an academic quarter of classes must pay the Health Clinic Use Fee that will enable the student to use Health Service, including obtaining outpatient referrals. The Health Clinic Use Fee for the 2006-2007 Plan year is \$117 per quarter. There is no required payment of the Health Clinic Use Fee in cases where students are only seeking referrals from Counseling and Psychological Services (CAPS) for outpatient mental health services.

Students must actively attend classes for at least the first 31 days after the date for which coverage is purchased. Internet classes and television (TV) courses may not fulfill the eligibility requirements that the covered student actively attends classes. If the eligibility requirements are not met, Aetna's only obligation is to refund the premium.

The Chickering Group maintains the right to investigate student status and attendance records to verify that the Plan Eligibility requirements have been met.

How to Enroll in a Plan or Waive Coverage

Returning Students

Returning students who wish to retain their current 2005-06 status (enrolled or waived) need do nothing. Once a student obtains full time status through the registrar, their status will roll over to the 2006-07 academic year.

Returning students who want to change their current (2005-06) status (enroll, waive or upgrade to the Comprehensive Plan) must submit a Coverage Selection Form (CSF) requesting such change. The CSF should be submitted as soon as possible, but no later than **October 16, 2006**.

ALL FULL-TIME STUDENTS MUST HAVE A COVERAGE SELECTION FORM (CSF) ON FILE WITH THE INSURANCE OFFICE BY OCTOBER 16, 2006. THOSE STUDENTS WHO DO NOT WILL BE ENROLLED IN THE BASIC HIGH DEDUCTIBLE PLAN AND WILL BE CHARGED A FULL YEAR PREMIUM. THERE WILL BE NO APPEAL PROCESS FOR STUDENTS WHO DO NOT HAVE A CSF ON FILE BY THE DEADLINE DATE.

Part-time, Continuing Studies and Seminary Students

Part-time, half-time, School of Continuing Studies students, and students from Garrett-Evangelical Seminary and Seabury Western Seminary can enroll in the Plan on a voluntary basis during the open enrollment period at the beginning of each academic year by returning a completed Part-Time Application Form to the Northwestern University Student Insurance Office prior to the indicated due date. **Note:** Garrett and Seabury Seminaries send their completed application to their respective Student Affairs Office.

Students working on their dissertations must include a letter from their department verifying their status. Students that are on an authorized medical leave of absence must include a letter from their physician and a letter from their Department Chair verifying an approved leave of absence.

In addition, all voluntary students must also pay the Health Clinic Use Fee each quarter in order to be eligible for the Student Health Insurance Plan. There is no required payment of the Health Clinic Use Fee in cases where students are only seeking referrals from Counseling and Psychological Services (CAPS) for outpatient mental health services.

Dependents

Northwestern University students who wish to purchase coverage for their eligible dependents under Northwestern University's Student Health Insurance Plan may do so by completing the Dependent Application Form and submitting it to Chickering Benefit Planning Insurance Agency, Inc. prior to **October 16, 2006** (Go to the Chickering website for the dependent application). Dependents may not be added to the Plan after this date unless a qualifying life circumstance exists, such as involuntary loss of other coverage, marriage, or birth/adoption of a child. Please note that dependents must purchase the same level of coverage as the students (i.e., a dependent cannot have the Basic High Deductible Plan while the student has the Comprehensive Plan).

Policy Period

1. **Fall Quarter:** Coverage for the Fall Quarter will become effective **September 1, 2006**, and will terminate **August 31, 2007**.
2. **Winter Quarter:** Coverage for the Winter Quarter will become effective **January 1, 2007**, and will terminate **August 31, 2007**.
3. **Spring Quarter:** Coverage for the Spring Quarter will become effective **March 25, 2007**, and will terminate **August 31, 2007**.
4. **Summer Quarter:** Coverage for the Summer Quarter will become effective **June 25, 2007**, and will terminate **August 31, 2007**.
5. **Mid-Year Enrollment:** Students may enroll after the deadline only if 1) they register for classes during the quarter, or 2) there has been a significant life change (i.e., loss of prior coverage). If the Coverage Selection Form is submitted within 30 days of registration or qualifying event, coverage will be backdated to beginning of the quarter that coverage begins. If the Coverage Selection Form is submitted after the 30 days of qualifying event, it will not be accepted, and the student will have to wait until the next annual open enrollment period to enroll. The Coverage Selection Form can be obtained at the Northwestern University Health Service.

Premium Rates

The coverage under the Plan and the costs for the 2006-2007 Plan year are based on the quarter of entry as shown below. New students who enroll in the Plan anytime during a quarter will receive coverage retroactive to the first date of the entering quarter but must pay the fee for the entire quarter.

High Deductible Plan (\$2,000 annual deductible per insured)

| | Annual Quarter | Winter Quarter | Spring Quarter | Summer Quarter |
|-----------|---------------------------|---------------------------|---------------------------|---------------------------|
| Student | \$1,896.00 | \$1,422.00 | \$ 948.00 | \$474.00 |
| Spouse | \$3,724.00 | \$2,793.00 | \$1,862.00 | \$931.00 |
| Per Child | \$2,328.00 | \$1,746.00 | \$1,164.00 | \$582.00 |

Comprehensive Plan

| | Annual Quarter | Winter Quarter | Spring Quarter | Summer Quarter |
|-----------|---------------------------|---------------------------|---------------------------|---------------------------|
| Student | \$2,664.00 | \$1,998.00 | \$1,332.00 | \$ 666.00 |
| Spouse | \$5,260.00 | \$3,945.00 | \$2,630.00 | \$1,315.00 |
| Per Child | \$3,288.00 | \$2,466.00 | \$1,644.00 | \$ 822.00 |

Waiver Deadline Dates

| | |
|---------------------|-------------------------|
| Annual/Fall Quarter | October 16, 2006 |
| Winter Quarter* | February 1, 2007 |
| Spring Quarter* | April 9, 2007 |
| Summer Quarter* | July 2, 2007 |

*Only students whose programs begin during the Winter, Spring, or Summer Quarter are eligible to submit a Coverage Selection Form to decline the Northwestern Student Health Insurance Plan.

Enrollment Deadline Dates

| | |
|---------------------|-------------------------|
| Annual/Fall Quarter | October 16, 2006 |
| Winter Quarter* | February 1, 2007 |
| Spring Quarter* | April 9, 2007 |
| Summer Quarter* | July 2, 2007 |

*Only newly enrolled students are eligible to begin coverage in the Winter, Spring, and Summer Quarters.

Eligible Dependents

If you are covered by Northwestern University's Student Health Insurance Plan, you may purchase coverage for the following dependents, provided they are residing with you:

- Your spouse or domestic partner; and
- Your unmarried dependent children between the ages of 31 days and 19 years.

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 Northwestern 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.

Dependent Enrollment Deadlines

Northwestern University students who wish to purchase coverage for their eligible dependents under Northwestern University's Student Health Insurance Plan may do so by completing the Dependent Application Form and submitting it to Chickering Benefit Planning Insurance Agency, Inc. prior to the indicated due date (Refer to the Chickering Website to obtain the dependent enrollment application). No Dependents may be added to the Plan after this date unless a qualifying life circumstance exists, such as involuntary loss of other coverage, marriage, or birth/adoption of a child.

Annual Policy: If the Dependent Application Form is submitted before **October 16, 2006**, coverage will be backdated to the beginning of the Policy Period. If the Application Form is submitted after **October 16, 2006**, it will not be accepted in the absence of a significant life change, and the dependents will have to wait until the next annual open enrollment period to apply. A completed Dependent Enrollment Form should be submitted directly to Chickering Benefit Planning Insurance Agency, Inc.

Mid-Year Enrollment: Eligible Dependents of covered students may enroll after the deadline only if there has been a significant life change (i.e., marriage, birth, loss of job, loss of parent's insurance). If the Enrollment Form is submitted within 30 days of the qualifying event, coverage will be backdated to the date of the qualifying event. If the Enrollment Form is submitted after the 30 days of qualifying event, it will not be accepted, and the dependents will have to wait until the next annual open enrollment period to enroll. The completed Dependent Enrollment Form should be submitted directly to Chickering Benefit Planning Insurance Agency, Inc.

Premium Refund Policy

If you withdraw from the University during the first 31 days of the coverage period, and no claims have been filed for you or your covered dependents, coverage will not be in effect and you will receive a full refund of the insurance fee. If you withdraw after the first 31 days of the coverage period and no claims have been filed for you or your covered dependents, you may receive a pro-rata refund from the date of your withdrawal. You must submit a written request to the Student Insurance Office within 31 days of your withdrawal date to be eligible for consideration of a refund. Submit the Dependent Refund Request directly to The Chickering Group.

If you have graduated and no longer wish to be covered, you must submit a written request to the Student Insurance Office before the next quarter begins.

Insured students 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 Chickering Claims Administrators, Inc. within 90 days of withdrawal from school.

Utilizing Northwestern University Health Service and Counseling and Psychological Services

If you are a full-time student registered for the current quarter, you are eligible to use the Northwestern University Health Service (NUHS) and the Counseling and Psychological Services (CAPS) as your primary healthcare provider, regardless of the source of your health insurance. For regular, daytime NU students, full-time is defined as enrollment in three or more credits worth of courses, except during the Summer Quarter, when it is defined as two or more credits worth of courses. This does not apply to the School of Continuing Studies students, who must pay the Health Clinic Use Fee each quarter to use NUHS and CAPS, regardless of academic load. Please visit www.nuhs.northwestern.edu/eligible.html for specific information on the scope of Health Care services available.

Students not enrolled at Northwestern University during the current quarter may access NUHS by paying the quarterly Health Clinic Use Fee, but this opportunity is valid only to those who were enrolled as a full-time student during the previous quarter.

Part-time students, including School of Continuing Studies (evening) students, must pay on a quarterly basis to be eligible to use the Health Service. Students with the NU Student Health Insurance Plan who are enrolled during Fall Quarter only, may purchase clinic eligibility quarterly through and including summer quarter.

Please call **(847) 491-2113** if you have questions.

The same provisions apply to students seeking mental health services through CAPS; however, there is no required payment of the Health Service Clinic Use Fee in cases where students are only seeking referrals for outpatient mental health services.

Please note that having a health insurance policy does not make you eligible to use the clinic. Even if you are eligible to use the clinic and have health insurance, some costs will be charged to you if they are not covered by your insurance plan.

Preferred Provider Network

The Chickering Group has arranged for you to access a Preferred Provider Network in your local community. Acute care facilities and mental health networks are available nationally if you require hospitalization outside the immediate area of the Northwestern University campus.

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. **(Please note:** Students who are seeking outpatient mental health services may also access the CAPS Provider Resource Network in the Evanston and Chicago areas.) Preferred Providers are independent contractors and are neither employees nor agents of Northwestern University, Chickering Claims Administrators, Inc., or Aetna.

You may contact Chickering Claims Administrators, Inc., at **(877) 626-2314**. Additionally, you can obtain information regarding Preferred Providers through the internet by accessing Aetna's online DocFind® service located at www.chickering.com. Click on "Find Your School" and enter **812845** as your Policy Number. You can use DocFind to find out whether a specific provider belongs to Aetna's network or to find Preferred Providers practicing in your area.

Inpatient Admission Pre-Certification Program

Pre-Admission Certification is designed to help you receive quality, cost-effective medical care. All inpatient admissions, including length of stay, must be certified by contacting Chickering Claims Administrators, Inc.

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.

Pre-Certification of Non-Emergency Inpatient Admissions

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

Notification of Emergency Admissions

The patient, patient's representative, Physician, or hospital must telephone within one business day following admission.

Chickering Claims Administrators, Inc.
Attention: Managed Care Dept.
P.O. Box 15708
Boston, MA 02215-0014
(877) 626-2314

Referral Requirements

Northwestern University Health Service (NUHS) and Counseling and Psychological Services (CAPS)

Students health care needs can best be satisfied when an organized system of health care providers at the Northwestern University Health Service (NUHS) or Counseling and Psychological Services (CAPS) manages the treatment.

Only registered students are eligible to utilize the Health Service or Counseling and Psychological Services.

Insured dependents, including spouses, domestic partners, and children are not eligible to utilize the Health Services or Counseling and Psychological Services and, as such, are not subject to the referral requirements and penalties described in this brochure.

Referrals for Medical Services Outside NUHS

A referral from the Northwestern University Health Service is required for all Covered Persons (excluding covered dependents) prior to receiving outpatient medical services outside of Northwestern University Health Service (NUHS). Expenses incurred for services for which no prior referral has been obtained are subject to a \$500 Deductible per condition in addition to any plan Copay or Deductible which may apply. Referrals are required on a per Accident or illness basis, and must be renewed each Policy Year. A referral is not necessary under the following conditions:

1. Treatment of an Emergency Medical Condition. The student must return to the Northwestern University Health Service for necessary follow-up care or a referral.
2. Medical care received when the student is outside Cook and Lake County boundaries.
3. When the Northwestern University Health Service is closed or when care is initiated at another treatment facility, the student must return to the NUHS for necessary follow-up care or for a referral.
4. Routine Gynecological services.

Referrals for Counseling and Psychological Services Outside Northwestern (CAPS)

A referral from Northwestern Counseling and Psychological Services (CAPS) is required for all Covered Persons (excluding covered dependents) prior to receiving mental health services. Referrals are required on a per illness basis, and must be renewed each Policy Year. A referral is not necessary under the following conditions:

1. Treatment of an Emergency Mental Health Condition. It is expected that the Hospital Discharge Planning will include a CAPS authorization for outpatient mental health referral. However, it is not expected that the student will be required to return to CAPS for continued care.
2. Mental health care received when the student is outside Cook and Lake County boundaries.

Description of Benefits

Payment will be made as allocated herein for Covered Medical Expenses incurred for any one Accident or any one Sickness while insured under the Plan, not to exceed an Aggregate Maximum of \$500,000 for per person per Policy Year.

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

To maximize savings and reduce out-of-pocket expenses, a Covered Person should select a Preferred Provider. It is to their 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. (**Please note:** In cases where students are seeking referrals for outpatient mental health services, the CAPS Provider Resource Network may also be accessed in the Evanston and Chicago areas.) Non-Preferred Care is subject to the Reasonable Charge allowance maximums. Any charges in excess of the Reasonable Charge allowance are not covered under the Plan.

Note: All foreign claims incurred for Covered Medical Expenses under The Northwestern University Student Health Insurance Plan will be payable at the Preferred Care benefit level of the selected Plan.

Summary of Benefits Chart - Comprehensive Plan

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.

| | |
|---|--|
| Aggregate Maximum Deductibles | \$500,000 per person per Policy Year Deductible: Preferred Care: None Non-Preferred Care: \$250 (waived for treatment of an Emergency Medical Condition, outpatient behavioral health, and well woman services) Expenses incurred for services for which no prior referral has been obtained are subject to a \$500 Deductible per condition in addition to any plan Copay or Deductible which may apply. |
| Inpatient Services | |
| Inpatient Hospitalization Expenses | Covered Medical Expenses are payable as follows: Preferred Care: 100% of the Negotiated Charge for an overnight stay. Non-Preferred Care: 70% of the Reasonable Charge for the semi-private room rate for an overnight stay. |
| Intensive Care Unit Expenses | Covered Medical Expenses are payable as follows: Preferred Care: 100% of the Negotiated Charge for an overnight stay. Non-Preferred Care: 70% of the Reasonable Charge for the intensive care room rate for an overnight stay. |
| Physician Hospital Visit Expenses | Covered Medical Expenses are payable as follows: Preferred Care: 100% of the Negotiated Charge. Non-Preferred Care: 70% of the Reasonable Charge. |
| Surgical Benefit Expenses (Inpatient and Outpatient) | |
| Surgical Expenses | Covered Medical Expenses for charges for surgical services performed by a Physician are payable as follows: Preferred Care: 100% of the Negotiated Charge, after a \$20 per surgical procedure Copay. Non-Preferred Care: 70% of the Reasonable Charge, after a \$20 per surgical procedure Deductible. |
| Assistant Surgical Expenses | Covered Medical Expenses are payable as follows: Preferred Care: 100% of the Negotiated Charge, after a \$20 per surgical procedure Copay. Non-Preferred Care: 70% of the Reasonable Charge, after a \$20 per surgical procedure Deductible. |
| Anesthetist Expenses | Covered Medical Expenses for the charges of an anesthetist during a surgical procedure for surgical services performed during a surgical operation are payable as follows: Preferred Care: 100% of the Negotiated Charge, after a \$20 per surgical procedure Copay. Non-Preferred Care: 70% of the Reasonable Charge, after a \$20 per surgical procedure Deductible. |

Outpatient Benefits Expenses

Covered Medical Expenses include, but are not limited to: Physician's office visits, hospital or outpatient department or emergency room visits, durable medical equipment, chemotherapy, radiation therapy, tests and procedures, clinical lab, radiological facility, or other similar facility licensed by the state.

| | |
|------------------------------------|---|
| Office Visit Expenses | <p>Covered Medical Expenses are payable as follows: Preferred Care: 100% of the Negotiated Charge, after a \$20 per visit Copay. Non-Preferred Care: 70% of the Reasonable Charge, after a \$20 per visit Deductible.</p> |
| Pre-Admission Testing Expenses | <p>Covered Medical Expenses are payable as follows: Preferred Care: 100% of the Negotiated Charge, after a \$20 per visit Copay. Non-Preferred Care: 70% of the Reasonable Charge, after a \$20 per visit Deductible.</p> |
| Physiotherapy Expenses | <p>Covered Medical Expenses are payable as follows: Preferred Care: 100% of the Negotiated Charge, after a \$20 per visit Copay. Non-Preferred Care: 70% of the Reasonable Charge, after a \$20 per visit Deductible.</p> |
| Lab/X-ray Expenses | <p>Covered Medical Expenses are payable as follows: Preferred Care: 100% of the Negotiated Charge, after a \$20 per visit Copay. Non-Preferred Care: 70% of the Reasonable Charge, after a \$20 per visit Deductible. Note: the Copay is waived for services at the Health Service.</p> |
| Durable Medical Equipment Expenses | <p>Covered Medical Expenses are payable as follows: Preferred Care: 100% of the Negotiated Charge, after a \$20 per visit Copay. Non-Preferred Care: 70% of the Reasonable Charge, after a \$20 per visit Deductible.</p> |
| Emergency Room Expenses | <p>Covered Medical Expenses for treatment of an Emergency Medical Condition are payable as follows: Preferred Care: 90% of the Negotiated Charge. Non-Preferred Care: 90% of the Reasonable Charge.</p> |

| Outpatient Benefits Expenses (continued) | |
|---|---|
| Mammography Expenses | <p>Coverage will be provided for one baseline mammogram for women between ages 35 and 40 and one annual mammogram for women aged 40 and older.</p> <p>Covered Medical Expenses are payable as follows: Preferred Care: 100% of the Negotiated Charge, after a \$20 per visit Copay. Non-Preferred Care: 70% of the Reasonable Charge, after a \$20 per visit Deductible.</p> |
| Routine Pap Smear Screening Expenses | <p>Coverage will be provided for one annual routine Pap smear screening for women age 18 and older.</p> <p>Covered Medical Expenses are payable as follows: Preferred Care: 100% of the Negotiated Charge, after a \$20 per visit Copay. Non-Preferred Care: 70% of the Reasonable Charge, after a \$20 per visit Deductible.</p> |
| Mental Health & Substance Abuse | |
| Inpatient Expenses – Mental Health | <p>Covered Medical Expenses for the treatment of a mental health condition while confined as an inpatient in a hospital or facility licensed for such treatment are payable on the same basis as any other condition.</p> <p>Covered Medical Expenses also include the charges made for treatment received during partial hospitalization in a hospital or treatment facility. Prior review and approval must be obtained on a case-by-case basis by contacting Chickering Claims Administrators, Inc. When approved, benefits will be payable the same basis as any other condition.</p> |
| Outpatient Expenses – Mental Health | <p>Covered Medical Expenses for the care or treatment of a mental health condition by a licensed or accredited health service organization or hospital or by a licensed practitioner are payable as follows: Preferred Care: 75% of the Negotiated Charge. Non-Preferred Care: 75% of the Reasonable Charge.</p> <p>Outpatient treatment is payable up to a maximum of 36 visits per Policy Year.</p> |
| Inpatient Expenses – Substance Abuse | <p>Covered as any other Accident or Sickness.</p> |

| Mental Health & Substance Abuse (continued) | |
|--|--|
| Outpatient Expenses – Substance Abuse | <p>Covered Medical Expenses for outpatient treatment of Substance Abuse are payable as follows:</p> <p>Preferred Care: 75% of the Negotiated Charge.</p> <p>Non-Preferred Care: 75% of the Reasonable Charge.</p> <p>Outpatient treatment is payable up to a maximum of 24 visits per Policy Year.</p> |
| Maternity Benefits | |
| Maternity Expenses | <p>Covered Medical Expenses for pregnancy, childbirth, and complications of pregnancy are payable on the same basis as any other condition. 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 maximum of 48 hours after a vaginal delivery and for a minimum of 96 hours after a cesarean delivery. Upon discharge, benefits will be payable for one post-delivery home visit by a health care provider, if the visit is prescribed by the attending Physician. If a Covered Person is discharged earlier, benefits will be payable for one post-delivery home visit by a health care provider within 24 hours of discharge and, if prescribed by the attending Physician, one additional home visit.</p> |
| Additional Benefits | |
| Ambulance Expenses | <p>Covered Medical Expenses are payable at the following levels for the services of a professional ambulance to or from a hospital when required due to the emergency nature of a covered Accident or Sickness.</p> <p>Preferred Care: 100% of the Negotiated Charge.</p> <p>Non-Preferred Care: 100% of the Reasonable Charge.</p> |
| Dental Injury Expenses | <p>Covered Medical Expenses are payable at 100% of the Actual Charge up to \$200 per tooth for the treatment of an Injury to sound, natural teeth.</p> |
| Home Health Care Expenses | <p>Covered Medical Expenses are payable as follows:</p> <p>Preferred Care: 100% of the Negotiated Charge.</p> <p>Non-Preferred Care: 70% of the Reasonable Charge.</p> <p>Covered Medical Expenses are limited to a maximum of 40 visits per Policy Year; four hours of home health aide service shall be considered as one home care visit.</p> |
| Prescription Contraceptive Medical Expenses | <p>Covered Medical Expenses are payable on the same basis as any expense. Covered Medical Expenses also include any expenses incurred for office visits in conjunction with the administration of a covered Prescription contraceptive.</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> |

Additional Benefits (continued)

Prescription Drug
Benefit Expenses

Covered Medical Expenses for outpatient Prescription Drugs associated with a covered Sickness or Accident which occurs during the Policy Year are payable as follows:

Covered Medical Expenses are payable as follows:

Preferred Care: 100% of the Negotiated Charge after a \$10 Copay for Generic Prescription Drugs, and 100% after a \$25 Copay for Brand Name Prescription Drugs.

Non-Preferred Care: 50% of the Reasonable Charge after a \$10 Copay for Generic Prescription Drugs, and 50% after a \$25 Copay for Brand Name Prescription Drugs.

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.)

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.

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 are provided under the Medical portion of the Plan.

Prior authorization is required for growth hormones and drugs, which are for the treatment of malaria. For assistance, or for more information on excluded medications and drugs available with prior authorization, please contact **(800) 238-6279**.

Please use your Chickering ID card when obtaining your Prescriptions.

**Summary of Benefits Chart –
High Deductible Plan (\$2,000 Annual Deductible per insured)**

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.

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| Aggregate Maximum | \$500,000 per person per Policy Year Deductible: \$2,000 Annual Deductible per insured (waived for Behavioral Health Services and Prescriptions) Expenses incurred for services for which no prior referral has been obtained are subject to a \$500 Deductible per condition in addition to any plan Copay or Deductible which may apply. Referrals are required on a per Accident or illness basis. |
| Inpatient Services | |
| Inpatient Hospitalization Expenses | Covered Medical Expenses are payable as follows: Preferred Care: 100% of the Negotiated Charge for an overnight stay. Non-Preferred Care: 70% of the Reasonable Charge for the semi-private room rate for an overnight stay. |
| Intensive Care Unit Expenses | Covered Medical Expenses are payable as follows: Preferred Care: 100% of the Negotiated Charge for an overnight stay. Non-Preferred Care: 70% of the Reasonable Charge for the intensive care room rate for an overnight stay. |
| Physician Hospital Visit Expenses | Covered Medical Expenses are payable as follows: Preferred Care: 100% of the Negotiated Charge. Non-Preferred Care: 70% of the Reasonable Charge. |
| Surgical Benefit Expenses | |
| Surgical Expenses | Covered Medical Expenses for charges for surgical services performed by a Physician are payable as follows: Preferred Care: 100% of the Negotiated Charge, after a \$20 per surgical procedure Copay. Non-Preferred Care: 70% of the Reasonable Charge, after a \$20 per surgical procedure Deductible. |
| Assistant Surgical Expenses | Covered Medical Expenses are payable as follows: Preferred Care: 100% of the Negotiated Charge, after a \$20 per surgical procedure Copay. Non-Preferred Care: 70% of the Reasonable Charge, after a \$20 per surgical procedure Deductible. |
| Anesthetist Expenses | Covered Medical Expenses for the charges of an anesthetist during a surgical procedure for surgical services performed during a surgical operation are payable as follows: Preferred Care: 100% of the Negotiated Charge, after a \$20 per surgical procedure Copay. Non-Preferred Care: 70% of the Reasonable Charge, after a \$20 per surgical procedure Deductible. |

Outpatient Benefits Expenses

Covered Medical Expenses include, but are not limited to: Physician's office visits, hospital or outpatient department or emergency room visits, durable medical equipment, chemotherapy, radiation therapy, tests and procedures, clinical lab, radiological facility, or other similar facility licensed by the state.

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| Office Visit Expenses | <p>Covered Medical Expenses are payable as follows: Preferred Care: 100% of the Negotiated Charge, after a \$20 per visit Copay. Non-Preferred Care: 70% of the Reasonable Charge, after a \$20 per visit Deductible.</p> |
| Pre-Admission Testing Expenses | <p>Covered Medical Expenses are payable as follows: Preferred Care: 100% of the Negotiated Charge, after a \$20 per visit Copay. Non-Preferred Care: 70% of the Reasonable Charge, after a \$20 per visit Deductible.</p> |
| Physiotherapy Expenses | <p>Covered Medical Expenses are payable as follows: Preferred Care: 100% of the Negotiated Charge, after a \$20 per visit Copay. Non-Preferred Care: 70% of the Reasonable Charge, after a \$20 per visit Deductible.</p> |
| Lab/X-ray Expenses | <p>Covered Medical Expenses are payable as follows: Preferred Care: 100% of the Negotiated Charge, after a \$20 per visit Copay. Non-Preferred Care: 70% of the Reasonable Charge, after a \$20 per visit Deductible. Note: the Copay is waived for services at the Health Service.</p> |
| Durable Medical Equipment Expenses | <p>Covered Medical Expenses are payable as follows: Preferred Care: 100% of the Negotiated Charge, after a \$20 per visit Copay. Non-Preferred Care: 70% of the Reasonable Charge, after a \$20 per visit Deductible.</p> |
| Emergency Room Expenses | <p>Covered Medical Expenses for treatment of an Emergency Medical Condition are payable as follows: Preferred Care: 90% of the Negotiated Charge. Non-Preferred Care: 90% of the Reasonable Charge.</p> |

| Outpatient Benefits Expenses (continued) | |
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| Mammography Expenses | <p>Coverage will be provided for one baseline mammogram for women between ages 35 and 40 and one annual mammogram for women aged 40 and older.</p> <p>Covered Medical Expenses are payable as follows: Preferred Care: 100% of the Negotiated Charge, after a \$20 per visit Copay. Non-Preferred Care: 70% of the Reasonable Charge, after a \$20 per visit Deductible.</p> |
| Routine Pap Smear Screening Expenses | <p>Coverage will be provided for one annual routine Pap smear screening for women age 18 and older.</p> <p>Covered Medical Expenses are payable as follows: Preferred Care: 100% of the Negotiated Charge, after a \$20 per visit Copay. Non-Preferred Care: 70% of the Reasonable Charge, after a \$20 per visit Deductible.</p> |
| Mental Health & Substance Abuse | |
| Inpatient Expenses | <p>Covered Medical Expenses for the treatment of a mental health condition while confined as an inpatient in a hospital or facility licensed for such treatment are payable on the same basis as any other condition.</p> <p>Covered Medical Expenses also include the charges made for treatment received during partial hospitalization in a hospital or treatment facility. Prior review and approval must be obtained on a case-by-case basis by contacting Chickering Claims Administrators, Inc. When approved, benefits will be payable on the same basis as any other condition.</p> |
| Outpatient Expenses – Mental Health | <p>Covered Medical Expenses for the care or treatment of a mental health condition by a licensed or accredited health service organization or hospital or by a licensed practitioner are payable as follows: Preferred Care: 75% of the Negotiated Charge. Non-Preferred Care: 75% of the Reasonable Charge.</p> <p>Outpatient treatment is payable up to a maximum of 36 visits per Policy Year.</p> |
| Inpatient Expenses – Substance Abuse | <p>Covered as any other Accident or Sickness.</p> |
| Outpatient Expenses – Substance Abuse | <p>Covered Medical Expenses for outpatient treatment of Substance Abuse are payable as follows: Preferred Care: 75% of the Negotiated Charge. Non-Preferred Care: 75% of the Reasonable Charge.</p> <p>Outpatient treatment is payable up to a maximum of 36 visits per Policy Year.</p> |

| Maternity Benefits | |
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| Maternity Expenses | Covered Medical Expenses for pregnancy, childbirth, and complications of pregnancy are payable on the same basis as any other condition. 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 maximum of 48 hours after a vaginal delivery and for a minimum of 96 hours after a cesarean delivery. Upon discharge, benefits will be payable for one post-delivery home visit by a health care provider, if the visit is prescribed by the attending Physician. If a Covered Person is discharged earlier, benefits will be payable for one post-delivery home visit by a health care provider within 24 hours of discharge and, if prescribed by the attending Physician, one additional home visit. |
| Additional Benefits | |
| Ambulance Expenses | Covered Medical Expenses are payable at the following levels for the services of a professional ambulance to or from a hospital when required due to the emergency nature of a covered Accident or Sickness. Preferred Care: 100% of the Negotiated Charge. Non-Preferred Care: 100% of the Reasonable Charge. |
| Dental Injury Expenses | Covered Medical Expenses are payable at 100% of the Actual Charge up to \$200 per tooth for the treatment of an Injury to sound, natural teeth. |
| Home Health Care Expenses | Covered Medical Expenses are payable as follows: Preferred Care: 100% of the Negotiated Charge. Non-Preferred Care: 70% of the Reasonable Charge. Covered Medical Expenses are limited to a maximum of 40 visits per Policy Year; four hours of home health aide service shall be considered as one home care visit. |
| Prescription Contraceptive Medical Expenses | Covered Medical Expenses are payable on the same basis as any expense. Covered Medical Expenses also include any expenses incurred for office visits in conjunction with the administration of a covered Prescription contraceptive. Coverage of oral contraceptives, Lunelle, Depo-Provera, Patch, and Ring are provided under the separate Prescription Drug Benefit portion of the Plan. |
| Prescription Drug Benefit Expenses | Covered Medical Expenses for outpatient Prescription Drugs associated with a covered Sickness or Accident which occurs during the Policy Year are payable as follows: Covered Medical Expenses are payable at 100% of the Negotiated Charge after a \$10 Copay for Generic Prescription Drugs, and 100% after a \$25 Copay for Brand Name Prescription Drugs. |

Additional Benefits (continued)

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| <p>Prescription Drug Benefit Expenses (continued)</p> | <p>Non-Preferred Care: 50% of the Reasonable Charge after a \$10 Copay for Generic Prescription Drugs, and 50% after a \$25 Copay for Brand Name Prescription Drugs.</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>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 are provided under the Medical portion of the Plan.</p> <p>Prior authorization is required for growth hormones and drugs, which are for the treatment of malaria. For assistance, or for more information on excluded medications and drugs available with prior authorization, please contact (800) 238-6279.</p> <p>Please use your Chickering ID card when obtaining your Prescriptions.</p> |
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Additional Services and Discounts

As a participant in the Student Health Insurance Plan, you can also take advantage of the following services, discounts, and programs. These services, discounts, and programs are not underwritten by Aetna.

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| <p>Vision One® Discount Program</p> | <p>The Vision One 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 25% discount on LASIK surgery (the laser vision correction procedure). Call (800) 793-8616 for additional Program information and provider locations, or simply log onto <i>www.chickering.com</i>, click on “Find Your School” and enter 812845 as your Policy Number to find a Vision One provider near you.</p> |
| <p>Informed Health Line</p> | <p>Aetna’s Informed Health® Line gives you easy access credible health information. All Informed Health Line services are available 24 hours a day, 365 days a year on demand from any touch-tone phone or computer within the United States (including Alaska and Hawaii).</p> <p>1. 24-Hour Nurse Line</p> <p>Call our toll free number to access registered nurses who are experienced in providing information on a variety of health topics.* The nurses can help you:</p> |

Additional Discounts and Services (continued)

Informed Health Line
(continued)

- Learn about medical procedures and possible treatment options.
- Improve the way you communicate with your health care providers. Find out how to describe health symptoms more effectively, ask the right questions and provide a clear history of your eating, exercise and lifestyle habits.

To reach an Informed Health® Line Nurse, please call **(800) 556-1555**.
For TDD (hearing and speech impaired only), please call **(800) 270-2386**.

2. Audio Health Library

The Informed Health® Line audio health library contains information on thousands of health topics such as common conditions and diseases, gender- and age-specific health issues, dental care, mental health and substance abuse, weight loss and much more.

To access the audio health library system, call the Informed Health Line toll-free number and simply enter the topic codes you're interested in. And if you have questions, you can transfer easily to an Informed Health Line nurse at any time.

To access the Informed Health Line audio health library, please call **(800) 556-1555**.

For TDD (hearing and speech impaired only), please call **(800) 270-2386**.

3. Healthwise® Knowledgebase

If you prefer to view health information online, simply logon to your Aetna Navigator account and click on "Take Action On Your Health" which will link you to the Healthwise® Knowledgebase, one of the most advanced health databases available. The Healthwise Knowledgebase contains detailed information about health conditions, medical tests and procedures, medications and treatment options. It also features illustrations and decision-focused tools to help you make more informed health care decisions.

**Informed Health Line nurses cannot diagnose, prescribe or give medical advice. Contact your physician with any questions or concerns regarding your health care needs. Also, the topics discussed by the nurses, on the audio tapes or online may not necessarily be covered by your health plan.*

| Additional Discounts and Services (continued) | | | | | | | | | |
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| Alternative Health Care Programs | Save money on many alternative therapies and products through our Alternative Health Care Programs. Take advantage of discounted rates on chiropractic manipulation, acupuncture and massage therapy, and nutritional counseling. Through participating retailers, you can also save on vitamins, supplements, and natural products such as aromatherapy, yoga tools, and homeopathy. | | | | | | | | |
| Optional Dental Program – Aetna Advantage™ Dental | <p>This is an optional dental plan, which is not inclusive of the Student Health Insurance Plan premium, nor is it included as part of the Student Health Insurance Plan as described in this Brochure.</p> <p>The optional Aetna Dental Plan, which emphasizes prevention and early treatment, provides access to participating private practice dentists for quality dental care. It covers preventative, diagnostic, and amalgam restorative care with no lifetime maximum or annual Deductible. In addition, there are no claim forms or Pre-Existing Condition limitations. You may obtain enrollment and premium information, as well as a list of participating providers, by contacting Chickering Claims Administrators, Inc. at (877) 626-2314. Please see the enrollment coverage periods and deadline dates below.</p> <p>Optional Dental Program Enrollment Deadline Dates</p> <table> <tr> <td>Annual/Fall Quarter</td> <td>October 16, 2006</td> </tr> <tr> <td>Winter Quarter*</td> <td>February 1, 2007</td> </tr> <tr> <td>Spring Quarter*</td> <td>April 9, 2007</td> </tr> <tr> <td>Summer Quarter*</td> <td>July 2, 2007</td> </tr> </table> | Annual/Fall Quarter | October 16, 2006 | Winter Quarter* | February 1, 2007 | Spring Quarter* | April 9, 2007 | Summer Quarter* | July 2, 2007 |
| Annual/Fall Quarter | October 16, 2006 | | | | | | | | |
| Winter Quarter* | February 1, 2007 | | | | | | | | |
| Spring Quarter* | April 9, 2007 | | | | | | | | |
| Summer Quarter* | July 2, 2007 | | | | | | | | |

General Provisions

State Mandated Benefits

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

Reimbursement

When a Covered Person’s Injury appears to be someone else’s fault, benefits otherwise payable under this Policy for Covered Medical Expenses incurred as a result of that Injury will not be paid unless the Covered Person or his legal representative agrees:

- (a) To repay Aetna for such benefits to the extent they are for losses for which compensation is paid to the Covered Person by or on behalf of the person at fault;
- (b) To allow Aetna a lien on such compensation and to hold such compensation in trust for Aetna; and
- (c) To execute and give to Aetna any instruments needed to secure the rights under (a) and (b).

Subrogation

Further, when Aetna has paid benefits to or on behalf of the injured Covered Person, Aetna will be subrogated to all rights or recovery that the Covered Person has against the person at fault. These subrogation rights will extend only to recovery of the amount Aetna has paid. The Covered Person must execute and deliver any instruments needed and do whatever else is necessary to secure those rights to Aetna.

Subrogation/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. 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 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 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 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 judgement 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 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.

Effect of Other Plan Coverage

This provision applies if a covered student:

- (a) Is covered by any other group or blanket health care plan; and
- (b) Would, as a result, receive medical expense or service benefits in excess of the actual expenses incurred.

In this case, the medical expense benefits the Plan will pay will be reduced by such excess.

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| Definitions |
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This section includes some of the definitions applicable to the Plan. Please refer to the Master Policy for a complete list of definitions.

Accident: An occurrence, which (a) is unforeseen; (b) is not due to 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 that accumulate from one 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 this 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 Benefit provisions.

Covered Person: A covered student, or dependent, whose coverage is in effect under the Policy. See the Eligibility section 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.

Designated Care: Care provided by a Designated Care Provider.

Designated Care Provider: A health provider that is affiliated and has an agreement with a third party to furnish services and supplies at a Negotiated Charge.

Elective Treatment: Medical treatment which is not necessitated by a pathological change in the function or structure in any part of the body occurring after the Covered Person's effective date of coverage. Elective treatment includes, but is not limited to: tubal ligation; vasectomy; breast reduction; sexual reassignment surgery; submucous resection and/or other surgical correction for deviated nasal septum, other than necessary treatment of covered acute purulent sinusitis; treatment for weight reduction; learning disabilities; non-surgical treatment of temporomandibular joint (TMJ) dysfunction; immunizations; vaccines, treatment of infertility; and routine physical examinations.

Emergency Medical Condition: This means a recent and severe medical condition, including, but not limited to, severe pain, which would lead a prudent layperson possessing an average knowledge of medicine and health, to believe that his or her condition, Sickness, or Injury is of such a nature that failure to get immediate medical care could result in:

- Placing the person's health in serious jeopardy; or
- Serious impairment to bodily function; or
- Serious dysfunction of a body part or organ; or
- In the case of a pregnant woman, serious jeopardy to the health of the fetus.

It does include an Accident or serious illness such as heart attack, stroke, poisoning, loss of consciousness or respiration, and convulsions. It does not include elective care, routine care, or care for non-emergency illness.

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

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

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: 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.

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.

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| Exclusions |
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The Plan neither covers nor provides benefits for the following:

1. Expenses incurred as a result of dental treatment, except for treatment resulting from Injury to sound, natural teeth as provided elsewhere in the Policy.
2. Expenses incurred for services normally provided without charge by the Policyholder's Health Service, infirmary, or hospital, or by health care providers employed by the Policyholder. (Does not apply to services currently billed to the Student Health Insurance Plan.)
3. Expenses incurred for eye refractions, vision therapy, radial keratotomy, eyeglasses, contact lenses (except when required after cataract surgery), or other vision or hearing aids, or Prescriptions or examinations except as required for repair caused by a covered Injury.
4. Expenses incurred as a result of Injury due to participation in a riot. "Participation in a riot" means taking part in a riot in any way, including inciting the riot or conspiring to incite it. It does not include actions taken in self-defense, so long as they are not taken against persons who are trying to restore law and order.
5. Expenses incurred as a result of an Accident occurring in consequence of riding as a passenger or otherwise in any vehicle or device for aerial navigation, except as a fare-paying passenger in an aircraft operated by a scheduled airline maintaining regular published schedules on a regularly established route.
6. Expenses incurred as a result of an Injury or Sickness for which benefits are payable under any Workers' Compensation or Occupational Disease Law.
7. Expenses incurred as a result of Injury sustained or Sickness contracted while in the service of the armed forces of any country. When the Covered Person enters the armed forces of any country, the unearned pro-rata premium will be refunded to the Policyholder.
8. Expenses incurred for treatment provided in a governmental hospital unless there is a legal obligation to pay such charges in the absence of insurance.

9. Expenses incurred for plastic surgery, cosmetic surgery, reconstructive surgery, or other services and supplies that improve, alter or enhance appearance, whether or not for psychological or emotional reasons. This exclusion will not apply to the extent needed to:

- a) Improve the function of a part of the body that is not a tooth or structure that supports the teeth, and is malformed as a result of a severe birth defect (including harelip and webbed fingers or toes), or as direct result of disease, or surgery performed to treat a Sickness or Injury.
- b) Repair an Injury (including reconstructive surgery for prosthetic device for a Covered Person who has undergone a mastectomy) which occurs while the Covered Person is covered under the Plan. Surgery must be performed in the Policy Year of the Accident, which causes the Injury, or in the next Policy Year.

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

11. Expenses incurred as a result of allergy shots and injections, preventive medicines, serums, vaccines or oral contraceptives unless otherwise provided in the Policy.

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, 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 persons 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.

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

14. Expenses incurred for blood or blood plasma, except charges by a hospital for the processing or administration of blood.

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

16. Expenses incurred for the treatment of temporomandibular joint (TMJ) dysfunction and associated myofascial pain unless otherwise provided in the Policy.

17. Expenses incurred for the repair or replacement of existing artificial limbs, orthopedic braces or orthotic devices.

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

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

20. Expenses incurred for Injury resulting from the play or practice of intercollegiate sports (participation in sports clubs or intramural athletic activities are not excluded).

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

22. Expenses for treatment for Injury to the extent benefits are payable under any state no-fault automobile coverage, or any first-party medical benefits payable under any other mandatory no-fault law.

23. Expenses for the contraceptive methods, devices or aids, and charges for or related to artificial insemination, in vitro fertilization or embryo transfer procedures, elective sterilization or its reversal, or elective abortion unless otherwise provided in the Policy.

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

25. Expenses incurred for which no member of the Covered Person's immediate family has any legal obligation to pay.

26. 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;
- If Aetna determines that available, scientific evidence demonstrates that the drug is effective, or shows promise of being effective, for the disease.

27. 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).

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

29. Expenses incurred for routine physical exams, routine vision exams, routine dental exams, routine hearing exams, immunizations or other preventive services and supplies, except to the extent coverage for such exams, immunizations, services or supplies is specifically provided in the Policy.
30. Expenses incurred for gastric bypass, and any restrictive procedures, for weight loss.
31. Expenses incurred for breast reduction/mammoplasty.
32. Expenses incurred for gynecomastia (male breasts).
33. Expenses incurred for any sinus surgery, except for acute purulent sinusitis.
34. Expense for charges that are not Reasonable Charges.
35. Expense for treatment of covered students who specialize in the mental health care field, and who receive treatment as a part of their training in that field.

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

Extension of Benefits

For those students who have graduated from NU or who are no longer eligible to enroll in the Plan because they have lost their eligibility status, the Plan will pay expenses incurred within 52 weeks of the date of a covered Accident or the date that first treatment for a covered Sickness was rendered. This benefit allows those students to continue treatment for a condition which was established/manifested while they were insured under the Plan for up to 52 weeks from the date of the covered Accident or Sickness. This provision is not applicable to those students who continue enrollment as NU students and who have waived participation in the Plan.

Termination of Insurance

Coverage will terminate at 12:01 a.m. on the earliest to occur of the following:

1. On the date the Policy is terminated.
2. At the end of the period for which payment was made.
3. On the date of entry of the Covered Person into military service, except for temporary duty of 30 days.

In the event the Covered Person ceases to be a student of the University and no refund of premium has been made, the insurance will terminate on the same date as indicated above for the quarter for which the premium was paid.

Claim Procedure

In the event of an Injury or Sickness, report immediately to Student Health Service, Counseling and Psychological Services or a qualified provider or hospital so that proper treatment can be prescribed or approved. As described in the Preferred Provider section of the Brochure, it is to your advantage to utilize participating providers because of the savings for services and reduced out-of-pocket expenses.

Most providers of service will file a claim for you. In the event your provider of service 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 to Chickering Claims Administrators, Inc. Your name, social security number, and university name should be written clearly and attached to your medical bills. All information should be mailed to:

Chickering Claims Administrators, Inc.

P.O. Box 15708

Boston, MA 02215-0014

(877) 626-2314

(617) 582-5000 (outside United States)

Subsequent itemized medical bills should also be mailed promptly to the same address.

Payment for Covered Medical Expenses will be made directly to the hospital or Physician unless you submit paid receipts attached to the itemized bills.

For assistance in filing a claim, or to inquire about the status of a claim, please contact the Customer Service Department at Chickering Claims Administrators, Inc., directly at **(877) 626-2314** between the hours of 8:30 a.m. and 5:30 p.m. (ET), Monday through Friday.

You will receive an "Explanation of Benefits" form after your claim is 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 any questions regarding the Explanation of Benefits, please contact the Customer Service Department at Chickering Claims Administrators, Inc., at **(877) 626-2314**.

Customer Service Representatives are available Monday through Friday, 8:30 a.m. to 5:30 p.m. (ET).

Prescription Drug Claim Procedure

Preferred Care: When obtaining a covered Prescription, please present your Chickering 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.chickering.com. Click on "Find Your School" and enter **812845** 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 Northwestern University and include your name, address, and student identification number.

Appeals and Complaints Procedure

Our complaints and appeals process is designed to address member coverage issues, complaints, and problems. If you have a coverage issue or other problem, call the Customer Service toll-free number on your ID card or review your Plan documents for more information.

You can also contact Customer Services at the toll-free number on your ID card for more information. A representative will address your concern. If you are dissatisfied with the outcome of your initial contact, you may appeal the decision. Your appeal will be decided in accordance with the procedure applicable to your Plan.

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

Chickering Claims Administrators, Inc.
P.O. Box 15717
Boston, MA 02215-0014

You may also seek additional information on the web page for the applicable State Insurance Department or other agency regarding your rights, including how to obtain regulatory review of Covered Person concerns. The applicable internet address for the State Insurance Department for your Plan is: www.state.il.us/ins.

External Review

Aetna has developed an external review process to give Covered Persons an added option of requesting an objective and timely external review of certain coverage denials. Once the Aetna internal coverage decision review process is exhausted, eligible Covered Persons may elect external review if the coverage denial for which the Covered Person would be financially responsible involves more than \$500 (or the amount specified by your State) and is based on lack of Medical Necessity or on the experimental or investigational nature of the proposed service or treatment.

An external review organization will refer the case to be reviewed by an independent Physician with appropriate expertise in the area in question. After all necessary information is submitted, external review generally will be decided within 30 days of the request. Expedited reviews are available when a Covered Person's Physician certifies that a delay in service would jeopardize the Covered Person's health. Once the review is complete, the Plan will abide by the decision of the external reviewer.

Certain states mandate external review of additional benefit or service issues or require a filing fee. In addition, certain states mandate the use of their own external review providers for medical necessity and experimental/investigational coverage decisions. For further details regarding your Plan's grievance and external review process, call the Customer Services toll-free number on your ID card, or visit Aetna's website at www.aetna.com, where you may obtain an external review request form. You may also call your State Insurance or Health Department for additional information regarding state mandated external review procedures.

Accidental Death and Dismemberment Benefits

This insurance coverage provides Accidental Death and Dismemberment coverage underwritten by Unum Provident Life Insurance Company of America.

Benefits are payable for the Accidental Death and Dismemberment of the eligible insureds of up to a maximum of \$10,000. (Exclusions and limitations may apply. For definitions of eligibility and a complete loss schedule, detailing the benefits received for accidental death, dismemberment, loss of sight, speech, or hearing, please refer to your Master Policy available at your school.)

To file a claim for Accidental Death and Dismemberment, please contact Chickering Claims Administrators, Inc., at **(800) 236-5243** for the appropriate claim forms.

Worldwide Emergency Travel Assistance Services

These services are designed to protect Northwestern University students and/or eligible dependents when traveling more than 100 miles from home anywhere in the world. Medical Repatriation and Return of Mortal Remains services are also available at the participant's campus location.

If you experience a Medical Emergency while traveling more than 100 miles from home or campus, you have access to a comprehensive group of emergency assistance services provided by Assist America, Inc.

Eligible participants have immediate access to doctors, hospitals, Pharmacies, and other services when faced with an emergency while traveling. The Assist America Operations Center can be reached 24 hours a day, 365 days a year to provide services including: medical consultation and evaluation; medical referrals; foreign hospital admission guarantee; Prescription assistance; lost luggage assistance; legal and interpreter assistance; and travel information such as Visa and passport requirements, travel advisories, etc.

Medical Evacuation and Return of Mortal Remains Services

In the event that a participant becomes injured and adequate medical facilities are not available locally, Assist America will use whatever mode of transport, equipment, and personnel necessary to evacuate you to the nearest facility capable of providing required care. In the event of death of a participant, Assist America will render every possible assistance in return of mortal remains including locating a sending funeral home, preparing the deceased for transport, procuring required documentation, providing necessary shipping container, as well as paying for transport. **Please note:** Any third party expenses incurred are the responsibility of the Participant.

An Assist America ID card will be supplied to you once you enroll in The Chickering Student Health Insurance Plan. Please remember to carry your Assist America card and call toll-free within the U.S. at **(800) 872-1414** or outside the U.S. call collect **(dial U.S. access code) plus (301) 656-4152**, in the event of an emergency when you are traveling. With one phone call, you will be connected to a global network of over 600,000 pre-qualified medical providers. Assist America Operations Centers have worldwide assistance capabilities and are known throughout the world as a premier Emergency Assistance Services provider.

NOTE: Assist America pays for all Assistance Services it provides. All Assistance Services must be arranged and provided by Assist America. Assist America does not reimburse for services not provided by Assist America.

The Assist America program meets and exceeds the requirements of USIA for International Students & Scholars.

Emergency Travel Assistance Services are administered by Assist America, Inc.

Important Note

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

This student Plan fulfills the definition of Creditable Coverage explained in the Health Insurance Portability 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.

Offered by:



The
Chickering
GroupSM

An Aetna Company

Chickering Benefit Planning Insurance Agency, Inc.

Administered by:

Chickering Claims Administrators, Inc.

P.O. Box 15708

Boston, MA 02215-0014

(877) 626-2314

www.chickering.com

Underwritten by:



Aetna Life Insurance Company (ALIC)

151 Farmington Avenue

Hartford, CT 06156

Policy No. **812845**

The Chickering Group is an internal business unit of Aetna Life Insurance Company.

NOTICE

Aetna considers non-public 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 Chickering's Student Connection Link on the Internet at: www.chickering.com.