

2007 – 2008

Indiana University

Student Health Insurance Plan Brochure

For Indiana University Undergraduate and Graduate Students



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

Policy No. 890423

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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, news and more!

How do I register?

- 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 registering onto Aetna Navigator?

Registration assistance is available toll free, Monday through Friday, from 7 a.m. to 9 p.m. Eastern Time at **(800) 225-3375**.

You Can Also Find Help

For Questions About:

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

Please contact:

Chickering Claims Administrators, Inc.

P.O. Box 15708

Boston, MA 02215-0014

(877) 375-4243

For Questions at IU About:

- Enrollment
- Insurance Benefits

Please contact:

Student Health Insurance Coordinator

Phone: **(812) 856-4650**

E-mail address: *studenhc@indiana.edu*

For Questions at Indiana University at Bloomington (IUB) About:

- Campus Health

Please contact:

Indiana University Health Center

600 N. Jordan Avenue at Tenth Street

Information **(812) 855-4011**

For Questions at Indiana University – Purdue University Indianapolis (IUPUI) About:

- Campus Health

Please contact:

IUPUI Student Health Center

1140 West Michigan Street

Coleman Hall (1st Floor)

(317) 274-8214

For Questions About ID Cards:

A permanent ID card will be issued as soon as possible. This card will be mailed to the address you indicate on your application. 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 permanent 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) 375-4243 or visit www.chickering.com, click on “Find Your School” and enter **890423** as your Policy Number.

For Provider Listings:

Use Aetna’s online DocFind® service located at www.chickering.com. Click on “Find Your School” and enter **890423** as your Policy Number. You can use DocFind to find out whether a specific doctor belongs to Aetna’s network or to find preferred providers practicing in your area.

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*

<p style="text-align: center;">Student Health Insurance Plan for Indiana University Undergraduate and Graduate Students</p>
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This voluntary Student Health Insurance Plan has been developed especially for Indiana University Undergraduate and Graduate Students, and their dependents. (Dependents include eligible spouse/domestic partner [residing with the Insured student] and children. Please see the Eligibility section for further information.) The Plan provides coverage for illnesses and Injuries that occur on and off campus, and includes special cost-saving features to keep the coverage as affordable as possible.

Indiana University is pleased to offer the Plan as described in this Brochure.

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

Undergraduate and Graduate Students

Eligibility

Participation in the Student Health Insurance Plan is voluntary for Indiana University undergraduate and graduate students.

All domestic undergraduate students taking six or more credit hours are eligible to enroll in this insurance plan. All domestic graduate students taking three or more credit hours or registered for thesis or dissertation are eligible to enroll in this insurance plan.

Students must be enrolled at Indiana University for at least the first 31 days after the date for which coverage is purchased. Home study, correspondence, Internet classes (with the exception of Nursing PhD candidates) and television courses do not fulfill the eligibility requirements. Continuing studies courses for which the student receives University credit may be used to fulfill the eligibility requirement.

If and whenever The Chickering Group discovers the eligibility requirements have not been met, its only obligation is refund of premium, less any claims paid.

Eligible students who do enroll may also insure their Dependents. Eligible Dependents are the spouse/domestic partner (residing with the Insured student) and unmarried children under 19 years of age. Dependent eligibility is effective and expires concurrently with that of the insured student.

To enroll in the Plan go to www.chickering.com, click on “Find Your School” and enter **890423** as your Policy Number. The deadline for annual enrollment is **September 15, 2007**. You can also complete the enclosed Enrollment Form and mail it with the correct premium directly to Chickering Benefit Planning Insurance Agency, Inc. by the **September 15, 2007** deadline for annual coverage.

Enrollment	Period Deadline
Annual/Fall, 2007	September 15, 2007
Spring, 2008	January 31, 2008
Quarterly, 2007/2008	September 15, 2007
Summer	May 20, 2008
Summer I	May 20, 2008
Summer II	July 8, 2008

	Student	Spouse	Child(ren)
Annual	\$1,360	\$5,615	\$5,615
Fall	\$544	\$2,245	\$2,245
Spring/Summer*	\$816	\$3,370	\$3,370
Summer Only*	\$392	\$1,617	\$1,617
Summer I*	\$185	\$765	\$765
Summer II	\$253	\$1,045	\$1,045
Quarterly**	\$341	\$1,405	\$1,405

***Please note:** Spring and Summer enrollment is only available for students newly enrolling to the University.

****Please note:** Quarterly payment option is only available for those enrolling at the beginning of the academic year for 2007-2008. The deadline to enroll in the quarterly payment option is **September 15, 2007**.

If a quarterly payment is missed the student and dependent(s) will not be able to enroll until the next annual open enrollment period and a break in coverage will apply.

The 2nd quarter deadline is **November 15, 2007**.

The 3rd quarter deadline is **February 15, 2008**.

The 4th quarter deadline is **May 15, 2008**.

To enroll online and for more details about Plan benefits available to you, visit www.chickering.com, click on “**Find Your School**” and enter **890423** as your Policy Number.

Dependent Coverage

Eligibility

If you are covered by the Student Health Insurance Plan, you may also enroll your spouse/same sex domestic partner (residing with the Insured student) and unmarried dependent children under age 19 who reside with and are fully supported by you.

Please note: If you wish to enroll your same sex domestic partner you must complete the Same Sex Domestic Partner Form at the time of enrollment. To obtain this form or get more information please contact The Chickering Group at **(877) 375-4243**.

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 Indiana 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 31 days, the Covered Person must (1) enroll the child within 31 days of placement of such child and (2) pay any additional premium starting from the date of placement.

Enrollment

To enroll the Dependent(s) of covered undergraduate and graduate students, please complete the Enrollment Form available online at www.chickering.com, click on "Find Your School" and enter **890423** as the Policy Number. A specific period of time will be allowed at the beginning of each year for enrolling in the Plan. The completed Dependent Enrollment Form should be submitted directly to Chickering Benefit Planning Insurance Agency, Inc.

Annual Policy/Fall Semester: If the Enrollment Form is submitted before **September 15, 2007**, coverage will be backdated to the beginning of the Policy Period. If the Enrollment Form is submitted after **September 15, 2007**, it will not be accepted in the absence of a significant life change, and the student will have to wait until the next open enrollment period to apply. An Enrollment Form should be submitted directly to Chickering Benefit Planning Insurance Agency, Inc.

Spring Semester: Dependents of enrolled Spring students will have an additional open enrollment period. If the Enrollment Form is submitted by **January 31, 2008**, coverage will be backdated to the beginning of the Policy Period. If the Enrollment Form is submitted **February 1, 2008** or after, it will not be accepted in the absence of a significant life change, and the student will have to wait until the next open enrollment period to enroll the Dependent. The completed Enrollment Form should be submitted directly to Chickering Benefit Planning Insurance Agency, Inc.

Mid-Year Enrollment: You may enroll your eligible Dependents after the deadline date only if there has been a significant life change (i.e., marriage, birth, loss of prior coverage). 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 the qualifying event, it will not be accepted, and the Dependent(s) will have to wait until the next annual open enrollment period to enroll. The completed Enrollment Form should be submitted directly to Chickering Benefit Planning Insurance Agency, Inc.

Policy Period

Coverage dates for the Plan are as follows:

- **Students enrolled at the University for the full academic year:** Coverage for the Annual Policy will become effective on **August 15, 2007**, and will terminate on **August 14, 2008**.
- **Students enrolled at the University for Fall Semester Only:** Coverage for the Fall Semester will become effective on **August 15, 2007**, and will terminate on **December 31, 2007**.
- **Students enrolled at the University for Spring/Summer Semester Only:** Coverage for the Spring/Summer Semester will become effective on **January 1, 2008**, and end on **August 14, 2008**.
- **Students enrolled at the University for Summer Only:** Coverage for the Summer Semester will become effective on **May 1, 2008** and end on **August 14, 2008**.
- **Students enrolled at the University for Summer I Session:** Coverage for the Summer I Session will become effective on **May 1, 2008**, and end on **June 20, 2008**.
- **Students enrolled at the University for Summer II Session:** Coverage for the Summer II Session will become effective on **June 7, 2008** and end on **August 14, 2008**.

Enrollment for the Fall Semester includes coverage for the winter break; enrollment for the Spring/Summer Semester includes coverage for the summer months.

Students enrolling in the Plan during the academic year should contact our Customer Service department at **(877) 375-4243** for information on how to enroll.

Premium Refund Policy

If you withdraw from Indiana University during the first 31 days of the coverage period, and no claims have been filed, 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 your coverage will remain in effect until the end of the term and you will not receive a refund.

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, including dependents, upon written request received by Chickering Claims Administrators, Inc. within 90 days of withdrawal from school.

Pre-Existing Conditions

Definition of a Pre-Existing Condition:

Any Injury, Sickness or condition that was diagnosed or treated, or would have caused a prudent person to seek diagnosis or treatment within six months prior to the Covered Person's effective date of insurance.

Limitations:

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

Special Rules As To Pre-Existing Conditions:

If a Covered Person had creditable coverage and such coverage terminated within 90 days prior to the date he or she enrolled (or was enrolled) for coverage in the Plan, then any limitation as to a Pre-Existing Condition under this Plan will not apply for that person.

“Creditable coverage” is a person’s prior medical coverage as defined in the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Such coverage includes coverage issued on a group or individual basis; Medicare; Medicaid; military-sponsored health care; a program of the Indian Health Service; a state health benefits risk pool; the Federal Employee’s Health Benefit Plan (FEHBP); a public health plan as defined in the regulations; and any health benefit plan under Section 5(e) of the Peace Corps Act.

Continuously Insured:

Persons who have remained Continuously Insured under the Plan and other prior health insurance policies will be covered for any Pre-Existing Condition that manifests itself while Continuously Insured, except for expenses payable under prior policies in the absence of the Plan. Previously Covered Persons must re-enroll for coverage by the indicated enrollment deadlines in order to avoid a break in coverage for conditions that existed in the prior Policy Year. Once a break in continuous coverage occurs for more than 90 days, the definition of Pre-Existing Conditions will apply.

Utilizing Indiana University Health Center

Your health care needs may best be satisfied in a convenient, cost-effective manner by the health care providers at one of the Indiana University Health Centers. Plan deductibles are waived for services rendered at any of the IU Health Centers. The Health Centers provide care for acute illnesses and certain on-going conditions, such as asthma, as well as contraceptive counseling and immunizations. A referral is not required to be seen at the Health Centers. However, appointments are preferred, and can be made by calling the number below.

Bloomington Campus

If you are insured under the Student Health Insurance Plan, you can minimize your out-of-pocket expenses by utilizing the IU Health Center. You will be required to pay the charge for all services received at the time of service, or defer the charge to your Bursar’s account, and will be given a bill to submit to your insurance company for possible reimbursement. The IU Health Center, located at the corner of Tenth and Jordan (diagonally across from the Main Library) offers a wide range of services to IU students, spouses, and eligible dependents (12 years old and up).

The Health Center is open 8 a.m. to 4:30 p.m. Monday through Friday, with limited hours during the holidays and semester breaks. Appointments can be made up to one week in advance for general medical care and up to two weeks in advance for the Women’s Clinic. People who fail to cancel appointments at least two hours in advance will be charged a fee. If you fail to cancel a Counseling and Psychological Services (CAPS) appointment at least 24 hours in advance, you will also be charged a fee. The intent of these fees is to insure access to students who need care, and you will be reminded of these fees when the appointment is made. The fee cannot be waived except for emergencies. The number to dial to either make or cancel an appointment is **(812) 855-7688**. A walk-in clinic is available for students who have urgent medical needs, although the service may also be used when appointment times are filled.

IU Health Center
600 N. Jordan Avenue at Tenth Street
Information (812) 855-4011

Phone Numbers:

Medical Questions (812) 855-5001
Appointments (812) 855-7688
Cancellations (812) 855-9805
Billing and Registration (812) 855-4030
Sexual Assault Crisis Service – 24-hour hotline (812) 855-8900
Counseling and Psychological Services (812) 855-5711

Indianapolis Campus

For clinic visits in the IUPUI Health Center, you will be required to pay the charge for services received at the time of service. You will be given a statement of your bill to submit to your insurance company for possible reimbursement. Services rendered at IUPUI are not subject to the annual deductible. You may be required to pay certain additional charges for ancillary testing (e.g., lab test, X-ray). The IUPUI Health Center provides health services to IU students and eligible beneficiaries. Minor dependents (<18 years old) are not seen at the Health Center.

The Student Health Center is located at:

Coleman Hall (1st Floor)
1140 West Michigan Street
Indianapolis, IN 46202

The Health Center is open the following hours:

Monday	7:30 a.m. to 5:00 p.m.
Tuesday	7:30 a.m. to 5:00 p.m.
Wednesday	7:30 a.m. to 5:00 p.m.
Thursday	9:00 a.m. to 5:00 p.m.
Friday	7:30 a.m. to 5:00 p.m.

Student Health Center provides health services to IU students and their spouses. Minor dependents are not seen because the Student Health Center has no facilities for pediatric patients.

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 Indiana University campus.

To maximize your savings and reduce your out-of-pocket expenses, select a Preferred Provider. It is to your advantage to use a Preferred Provider because significant savings may be achieved from the substantially lower rates these providers have agreed to accept as payment for their services. Preferred Providers are independent contractors and are neither employees nor agents of Indiana University, Chickering Claims Administrators, Inc., or Aetna Life Insurance Company. You may also contact Chickering Claims Administrators, Inc. at (877) 375-4243 to obtain a list of participating providers. Additionally, you can obtain information regarding Preferred Providers through the Internet by using Aetna’s online DocFind® service located at www.chickering.com. Click on “**Find Your School**” and enter **890423** 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.
- If you do not secure Pre-Certification for non-emergency inpatient admissions or provide notification for emergency admissions, your Covered Medical Expenses will be subject to a \$200 per admission Deductible.

Pre-Certification of Non-Emergency Inpatient Admissions

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

Notification of Emergency Admissions

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

Chickering Claims Administrators, Inc.

P.O. Box 15708

Attention: Managed Care Dept.

Boston, MA 02215-0014

(877) 375-4243

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

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 Annual Maximum per Injury or Sickness while continuously insured of \$75,000 for any one covered Accident or any one covered Sickness.

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

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

Summary of Benefits Chart

The following benefits are subject to the imposition of Policy limits and exclusions. All coverage is based on the Reasonable Charge allowance unless otherwise specified. Any charges in excess of the Reasonable Charge allowance are not covered under the Plan.

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

Annual Plan Maximum	\$75,000 per Injury or Sickness
Plan Deductible (Does not apply to IU Health Center)	Preferred Care: \$250 Non-Preferred Care: \$500
Inpatient Hospitalization Benefits	
Hospital Room and Board Expense (Includes Inpatient Miscellaneous Expenses and Intensive Care Expenses)	Covered Medical Expenses are payable as follows: Preferred Care: 80% of the Negotiated Charge for an overnight stay. Non-Preferred Care: 50% of the Reasonable Charge for the semi-private room rate for an overnight stay.
Physician's Hospital Visit Expenses	Covered Medical Expenses for charges for the non-surgical services of the attending Physician or a consulting Physician are payable as follows: Preferred Care: 80% of the Negotiated Charge. Non-Preferred Care: 50% of the Reasonable Charge.
Surgical Benefits (Inpatient and Outpatient)	
Inpatient Surgical Expenses	Covered Medical Expenses for charges for surgical services performed by a Physician are payable as follows: Preferred Care: 80% of the Negotiated Charge. Non-Preferred Care: 50% of the Reasonable Charge.
Outpatient Surgical Expenses	Covered Medical Expenses for charges for surgical services performed by a Physician are payable as follows: Preferred Care: 80% of the Negotiated Charge. Non-Preferred Care: 50% of the Reasonable Charge. Covered Medical Expenses are subject to a maximum of \$5,000 per surgical procedure.
Anesthetist Expenses	Covered Medical Expenses for the charges of an anesthetist are payable as follows: Preferred Care: 80% of the Negotiated Charge. Non-Preferred Care: 50% of the Reasonable Charge.
Assistant Surgeon Expenses	Covered Medical Expenses for the charges of an assistant surgeon during a surgical procedure for surgical services performed during a surgical operation are payable as follows: Preferred Care: 80% of the Negotiated Charge. Non-Preferred Care: 50% of the Reasonable Charge.

Outpatient Benefits	
<p>Covered Medical Expenses are payable up to a combined maximum of \$2,500 per condition.</p> <p>Covered Medical Expenses include, but are not limited to, non-surgical services of a Physician, hospital outpatient department or emergency room, and clinical laboratory and radiological facility.</p>	
Physician's Office Visit Expenses	<p>Covered Medical Expenses are payable as follows:</p> <p>Preferred Care: 80% of the Negotiated Charge.</p> <p>Non-Preferred Care: 50% of the Reasonable Charge.</p>
Lab and X-ray Expenses	<p>Covered Medical Expenses are payable as follows:</p> <p>Preferred Care: 80% of the Negotiated Charge.</p> <p>Non-Preferred Care: 50% of the Reasonable Charge.</p>
High Cost Procedure Expenses	<p>Covered Medical Expenses for high cost procedures in excess of \$200, such as, but not limited to, outpatient diagnostic C.A.T. Scans, Magnetic Resonance Imaging and Laser treatments are payable as follows:</p> <p>Preferred Care: 80% of the Negotiated Charge.</p> <p>Non-Preferred Care: 50% of the Reasonable Charge.</p>
Women's Health Benefit Expenses	<p>Covered Medical Expenses will include one baseline mammogram for women between the ages of 35 and 40. Women age 40 and older have coverage for an annual mammogram per Policy Year. Covered Medical Expenses are payable on the same basis as any X-ray expense. Covered Medical Expenses include an annual Pap smear screening for women age 18 and older. Covered Medical Expenses are payable on the same basis as any outpatient expense. If follow-up diagnostic Pap smears are Medically Necessary, they will be covered on the same basis as any outpatient expense.</p>
Emergency Medical Condition Expenses	<p>Covered Medical Expenses are payable as follows:</p> <p>Preferred Care: 80% of the Negotiated Charge.</p> <p>Non-Preferred Care: 80% of the Reasonable Charge.</p>
Durable Medical Equipment Expenses	<p>Covered Medical Expenses are payable as follows:</p> <p>Preferred Care: 80% of the Negotiated Charge.</p> <p>Non-Preferred Care: 50% of the Reasonable Charge.</p> <p>Covered Medical Expenses are subject to a lifetime maximum of \$10,000.</p>

Outpatient Benefits (continued)	
Mastectomy and Mastectomy-Related Services Expenses	<p>Covered Medical Expenses include charges incurred for mastectomy and mastectomy-related services including:</p> <ul style="list-style-type: none"> • Reconstruction and surgery to achieve symmetry between breasts; • Prosthesis; and • Treatment of physical complications of all stages of mastectomy, including lymphedemas. <p>Covered Medical Expenses are payable on the same basis as any other expense.</p>
Physical Therapy Expenses	<p>Covered Medical Expenses are payable as follows:</p> <p>Preferred Care: 80% of the Negotiated Charge.</p> <p>Non-Preferred Care: 50% of the Reasonable Charge.</p>
Mental Health and Substance Abuse Benefits	
Inpatient and Outpatient Expenses – Mental Health	<p>Inpatient: 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 for any other Sickness.</p> <p>Outpatient: Covered Medical Expenses for outpatient treatment of a mental health condition are payable on the same basis as any other illness.</p>
Pervasive Developmental Disorders Expenses	<p>Covered Medical Expenses include both the diagnosis and treatment of these conditions as long as they are included in a Physician’s treatment plan. Exclusions such as medical necessity, experimental and investigational treatments, and learning disabilities are waived for these expenses only if these expenses are for services specifically indicated in the Physician’s treatment plan. Covered Medical Expenses are payable on the same basis as any expense.</p>
Inpatient and Outpatient Expenses – Substance Abuse	<p>Inpatient: Covered Medical Expenses for the treatment of substance abuse while confined as an inpatient in a hospital or facility licensed for such treatment are payable on the same basis as for any other Sickness up to 20 days per Policy Year.</p> <p>Outpatient: Covered Medical Expenses for outpatient treatment of substance abuse are payable on the same basis as any other illness up to a maximum of 30 visits per Policy Year.</p>

Maternity Benefits	
Maternity Expenses	Covered Medical Expenses for pregnancy, childbirth, and complications of pregnancy are payable on the same basis as any other Sickness. In the event of an inpatient confinement, such benefits would be payable for inpatient care of the Covered Person and any newborn child, for a minimum of 48 hours after a vaginal delivery and for a minimum of 96 hours after a cesarean delivery.
Additional Benefits	
Ambulance Expenses	Covered Medical Expenses are payable at 100% of the Reasonable Charge to a maximum of \$500 per trip.
Prescription Drug Benefit Expenses	<p>Covered Medical Expenses for outpatient Prescription Drugs associated with a covered Sickness or covered Accident occurring during the Policy Year, are payable at 100% of the Reasonable Charge up to a maximum of \$200 per Policy Year.</p> <p>New this Year! Vital Savings on Pharmacy by Aetna The first step toward lowering your prescription drug costs! The Vital Savings on PharmacySM card is a discount program helping you and your dependents lower your prescription drug costs. Instead of paying full price for prescription medications, you can present your card to participating pharmacies and receive a discount at the time of purchase. This card is included in the plan at no additional cost.</p> <p>Be sure to present your Vital Savings Discount Card to the pharmacist at the time of purchase in order to receive the discount.</p>
Diabetic Treatment Expenses	<p>Covered Medical Expenses for diabetic self-management or for supplies not covered by the Prescription Drug program are payable as follows:</p> <p>Preferred Care: 80% of the Negotiated Charge. Non-Preferred Care: 50% of the Reasonable Charge.</p>
Dental Expenses	Covered Medical Expenses are payable at 80% of the Reasonable Charge for the treatment of an Injury to sound, natural teeth.
Hospice Care Expenses	Covered Medical Expenses for inpatient care will be covered on the same basis as any inpatient expense.
Home Health Care Expenses	Covered Medical Expenses are payable at 100% of the Reasonable Charge for expenses incurred within 12 months from the date of the first home health care visit. The maximum number of covered visits is limited to 40. Four hours of home health aide service shall be considered as one home health care visit.

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.

<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 on to <i>www.chickering.com</i>. Click on “Find Your School” and enter 890423 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> <ul style="list-style-type: none"> • Learn about medical procedures and possible treatment options. • Improve the way you communicate with your health care providers. <p>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.</p> <p>To reach an Informed Health[®]Line Nurse, please call (800) 556-1555. For TDD (hearing and speech impaired only), please call (800) 270-2386.</p> <p>2. Audio Health Library</p> <p>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. Each health topic in the audio health library has a corresponding topic code. View a complete list of topic codes by clicking on one of the PDF files below.</p> <p>To access the audio health library system, call the Informed Health Line toll-free number and simply enter the topic codes</p>

Additional Services and Discounts (continued)

	<p>you're interested in. And if you have questions, you can transfer easily to an Informed Health Line nurse at any time.</p> <p>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.</p> <p>3. Healthwise® Knowledgebase If you prefer to view health information online, simply click on this link 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.</p> <p><i>*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.</i></p>
<p>Aetna Natural Products and Services ProgramSM</p>	<p>Save money on many alternative therapies and products through our Aetna Natural Products and Services Program. 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.</p> <p>These participating providers and vendors are independent contractors and are neither agents nor employees of the University, Chickering, or Aetna.</p>

General Provisions

State Mandated Benefits

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

Subrogation/Reimbursement Right of Recovery Provision

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

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

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

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

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

retained by the Covered Person or for the benefit of the Covered Person.

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

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

Coordination of Benefits

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

Definitions

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

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

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

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

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

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

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

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

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; temporomandibular joint (TMJ) dysfunction; immunization; vaccines; 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 as significant positive outcome as any alternative service or supply, both as to the Sickness or Injury involved and the person's overall health condition. It must be no more likely to produce a negative outcome than any alternative service or supply, both as to the Sickness or Injury involved and the person's overall health condition;
- Be a diagnostic procedure which is indicated by the health status of the person. It must be as likely to result in information that could affect the course of treatment as any alternative service or supply, both as to the Sickness or Injury involved and the person's overall health condition.

It must be no more likely to produce a negative outcome than any alternative service or supply, both as to the Sickness or Injury involved and the person's overall health condition; and

- As to diagnosis, care, and treatment, be no more costly (taking into account all health expenses incurred in connection with the treatment, service, or supply) than any alternative service or supply to meet the above tests.

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

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

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

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

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

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

Pharmacy: An establishment where Prescription Drugs are legally dispensed.

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.

Pre-Existing Condition: A disease or physical condition for which medical advice, diagnosis, care, or treatment was received by the Insured, or recommended to the Insured, during the six months before the Insured's Effective Date under the policy. Pregnancy will not be considered a Pre-existing Condition.

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

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

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

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

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

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

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

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

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

Aetna may take into account factors, such as:

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

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

Exclusions

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 or the removal of impacted wisdom teeth as provided else where in the Policy.
2. Expenses incurred for services normally provided without charge by the Policyholder's health service, infirmary or hospital, or by health care providers employed by the Policyholder.
3. Expenses incurred for eye refractions, vision therapy, radial keratotomy, 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. Upon the Covered Person entering the armed forces of any country, the unearned pro-rata premium will be refunded to the Policyholder.
8. Expenses incurred for treatment provided in a governmental hospital unless there is a legal obligation to pay such charges in the absence of insurance.
9. Expenses incurred for, or related to, services, treatment, education testing, or training related to learning disabilities or developmental delays unless provided elsewhere in the Policy.
10. 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 a 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.

11. Expenses incurred for allergy shots and injections, preventive medicines, serums, vaccines, or oral contraceptives unless otherwise provided in the Policy.
12. Expenses incurred for a treatment, service, or supply, which is not Medically Necessary, as determined by Aetna, for the diagnosis care or treatment of the Sickness or Injury involved. This applies even if they are prescribed, recommended, or approved, by the person's attending Physician or dentist.

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

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

In determining if a service or supply is appropriate under the circumstances, Aetna will take into consideration information relating to the affected person's health status, reports in peer reviewed medical literature, reports and guidelines published by nationally recognized health care organizations that include supporting scientific data, generally recognized professional standards of safety and effectiveness in the United States for diagnosis, care, or treatment, the opinion of health professionals in the generally recognized health specialty involved, and any other relevant information brought to Aetna's attention.

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

- Those that do not require the technical skills of a medical, a mental health, or a dental professional; or
- Those furnished mainly for the personal comfort or convenience of the person, any person who cares for him or her, or any 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.

(Note: this exclusion does not apply to Covered Medical Expenses incurred for the diagnosis or treatment of a Pervasive Developmental Disorder if such expenses are specifically indicated on a Physician's treatment plan.)

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.
16. Expenses incurred for the repair or replacement of existing artificial limbs, orthopedic braces, or orthotic devices.
17. 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.
18. Expenses incurred after the date insurance terminates for a Covered Person except as may be specifically provided in the Extension of Benefits provision.
19. Expenses incurred for Injury resulting from the play or practice of intercollegiate sports (participation in sports clubs or intramural athletic activities are not excluded).
20. Expenses incurred for services normally provided without charge by the school and covered by the school fee for services.
21. 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.
22. Expenses incurred as a result of commission of a felony.
23. Expenses incurred for treatment of mental or nervous disorders unless otherwise provided in the Policy.
24. Expenses incurred for the treatment of alcoholism or drug addiction unless otherwise provided in the Policy.
25. Expenses incurred for which no member of the Covered Person's immediate family has any legal obligation for payment.

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.

(Note: this exclusion does not apply to Covered Medical Expenses incurred for the diagnosis or treatment of a Pervasive Developmental Disorder if such expenses are specifically indicated on a Physician's treatment plan.)

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. Those 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 for 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 specified in the Policy.
31. Expenses incurred for gastric bypass, and any restrictive procedures, for weight loss.
32. Expenses incurred for breast reduction/mammoplasty.
33. Expenses incurred for gynecomastia (male breasts).
34. Expenses for charges that are not reasonable charges, as determined by Aetna.
35. Expenses for treatment of covered students who specialize in the mental health care field, and who receive treatment as part of their training in that field.
36. Expenses for: (a) care of flat feet; (b) supportive devices for the foot; (c) care of corns, bunions, or calluses; (d) care of toenails; and (e) care of fallen arches, weak feet, or chronic foot strain; except that (c) and (d) are not excluded when Medically Necessary because the Covered Person is diabetic or suffers from circulatory problems.
37. Expenses incurred for elective treatment or elective surgery except as specifically provided elsewhere in the Policy and performed while the Policy is in effect.
38. Expenses arising as a result of a Pre-Existing Condition.

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

Extension of Benefits

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

Termination of Insurance

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

Continuation Privilege

All insured persons who have been continuously insured under the school's regular student Policy for at least six consecutive months and who are no longer eligible under the Plan are eligible to continue their coverage at a higher premium rate for a period not to exceed six months under the school's Policy currently in effect on the termination date of the Plan. You may continue coverage as long as the premium is received by Chickering Benefit Planning Insurance Agency, Inc. within 14 days of your expiration date.

Claim Procedure

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

Chickering Claims Administrators, Inc.

P.O. Box 15708

Boston, MA 02215-0014

(877) 375-4243 or **(617) 218-8400** (outside United States)

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

1. Bills must be submitted within 90 days from the date of treatment.
2. Payment for Covered Medical Expenses will be made directly to the hospital or Physician concerned unless bill receipts and proof of payment are submitted.
3. When submitting a claim form, attach available itemized medical bills to the claim form. Subsequent medical bills should be mailed promptly to the above address.
4. Out of country claims should be submitted with appropriate medical service and payment information from the provider of service.
5. In the event of a disagreement over the payment of a claim, a written request to review the claim must be mailed to Chickering Claims Administrators, Inc. within 60 days from the date appearing on the Explanation of Benefits.

Appeals and Complaints Procedure

Our complaints and appeals process is designed to address Covered Person 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

If you (a) need assistance of the governmental agency that regulates insurance; or (b) have a complaint you have been unable to resolve with your insurer you may contact the Department of Insurance by mail, telephone or email:

State of Indiana Department of Insurance
Consumer Services Division
311 West Washington Street, Suite 300
Indianapolis, Indiana 46204
Consumer Hotline: **(800) 622-4461; (317) 232-2395**
Complaints can be filed electronically at *www.in.gov/idoi*

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 Service 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 Benefit

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 **(877) 375-4243** for the appropriate claim forms.

Worldwide Emergency Travel Assistance Services

These services are designed to protect Indiana University Undergraduate and Graduate Students 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 (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 and full terms and conditions may be found in the Master Policy. If any discrepancy exists between this Brochure and the Policy, the Master Policy will govern and control the payment of benefits.

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

Offered by:



Chickering Benefit Planning Insurance Agency, Inc.

Administered by:

Chickering Claims Administrators, Inc.
P.O. Box 15708
Boston, MA 02215-0014
(877) 375-4243
www.chickering.com

Underwritten by:



Aetna Life Insurance Company (ALIC)
151 Farmington Avenue
Hartford, CT 06156
Policy No. 890423

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.

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www.chickering.com

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