

**2005 - 2006**

**Stony Brook University**



STATE UNIVERSITY OF NEW YORK

**Required  
Student Accident and Sickness  
Insurance Plan  
(RSHIP)**

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

**Policy No. 890444**

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## Where to Find Help

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

As a Chickering student health insurance 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?**

- 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
- Enrollment
- Claims Processing
- Inpatient Admission Pre-Certification
- Status of Pharmacy Claim
- Pharmacy Claim Forms
- Excluded Drugs and Pre-Authorization

*Please contact:*

Chickering Claims Administrators, Inc.  
P.O. Box 15708  
Boston, MA 02215-0014  
**(877) 373-0741**

**For questions about:**

- Student Health Insurance
- Waiver Process

*Please contact:*

Student Health Insurance Office  
**SHO-RSHIP@notes.cc.sunsb.edu**  
or call **(631) 632-6054**

**For questions about ID Cards:**

A permanent ID card will be issued as soon as possible by Chickering/Aetna. This card is for identification only. It is not a guarantee of eligibility or benefits. If you need medical attention before your permanent ID card is received, benefits will be payable according to the Policy.

**You do not need an ID card to be eligible to receive benefits.**

*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) 373-0741**

or visit ***www.chickering.com***, click on “Find Your School” and enter **890444** as your Policy Number.

**For Provider Listings (including Preferred Care Pharmacy locations):**

Access Aetna’s DocFind® Service which is available from our website ***www.chickering.com***. Click on “Find Your School” and enter **890444** 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:**

- Student Health Services ***www.stonybrook.edu/shs***
- The Chickering Group ***www.chickering.com***

**Other Important Numbers:**

SBU Student Health Services (SHS)	(631) 632-6740
SBU Counseling Center	(631) 632-6720
SBU Emergency (when Student Health Center is Closed)	(631) 632-3333
SBU Ambulance (on-campus)	(631) 632-8888
Off-campus Police	911
SBU On-campus Police	333
Stony Brook Fire Dept.	(631) 751-3434
Poison Control	(631)542-2323
Response Hotline (Crisis Counseling)	(631) 751-5000

<p style="text-align: center;"><b>Stony Brook University (Stony Brook)</b> <b>Required Student Accident and Sickness Insurance Plan (RSHIP)</b></p>
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The Stony Brook Accident and Sickness Insurance Plan (RSHIP) has been developed especially for Stony Brook students. The Plan provides coverage 365 days a year for Sickness and Injuries that occur on and off campus, and includes special cost-saving features to keep the coverage as affordable as possible. Stony Brook 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.

**Policy Period**

Coverage for all insured students enrolled for the Fall Semester will become effective at 12:01 a.m. on **August 16, 2005**, and will terminate at 12:01 a.m. on **January 16, 2006**. Coverage for all newly enrolled insured students for the Spring/Summer Semester will become effective at 12:01 a.m. on **January 16, 2006** and will terminate at 12:01 a.m. on **August 16, 2006**. Coverage for all newly enrolled insured students for the Summer Semester will become effective at 12:01 a.m. on **May 16, 2006** and will terminate at 12:01 a.m. on **August 16, 2006**.

## Premium Rates

<b>Basic Plan</b>	<b>Fall</b> 8/16/05-1/15/06	<b>Spring</b> 1/16/06-8/15/06	<b>Summer</b> 5/16/06-8/15/06
Student	\$ 383	\$ 527	\$230
Spouse / Domestic Partner	\$1,275	\$1,785	\$765
Child(ren)	\$ 638	\$ 892	\$383

<b>Health Sciences Center Plan*</b>	<b>Fall</b> 8/16/05-1/15/06	<b>Spring</b> 1/16/06-8/15/06
Student	\$1,150	\$1,600
Spouse / Domestic Partner	\$1,275	\$1,785
Child(ren)	\$ 638	\$ 892

•Applies to students enrolled in the School of Medicine and School of Dental Medicine only.

## Premium Refund Policy

Any student withdrawing from school during the first 31 days of the period for which coverage is purchased shall not be covered under the Policy, and a full refund of the premium will be made **unless payment has been issued for a submitted claim.**

Students and their dependents withdrawing after the first 31 days will remain covered under the Policy for the full period for which premium has been paid and no refund will be available. This is also true for students on leave for medical or academic reasons, and students electing to enroll in a separate comparable or better plan during the Policy Year.

Students, or dependents of students, who enter into the armed forces of any country will be issued a refund for the unearned pro-rata premium upon written request. Written request must be submitted and received by Chickering Claims Administrators, Inc. within 90 days of withdrawal from school.

## Student Coverage

### *Eligibility*

Participation in Stony Brook University's Student Health Insurance Plan is required for all full-time students who will be automatically enrolled in the Student Health Insurance Plan and the premium for the Plan will be added to your tuition bill. If you have alternate coverage and wish to waive coverage under the RSHIP, you must submit a Waiver. To do so, you must go to your SOLAR account and follow the instructions under "Student Requirements" on the menu bar. Waiver for the 2005-06 academic year will be accepted online until the following deadline.

Fall Deadline: **September 15, 2005**

Spring Deadline: **February 10, 2006**

Some part-time students may be eligible to enroll. You may also cover your eligible dependents, for an additional higher premium, for the same coverage you have. For Part-time and dependent coverage enrollment applications, contact the West Campus Student Health Insurance Office at ***SHO-RSHIP@notes.cc.sunysb.edu***

### *Waiver Process/Procedure*

All students will be automatically enrolled in the Plan unless a waiver is received. To file a waiver, you must first read about RSHIP benefits, and then go to your SOLAR account and follow the instructions under "Student Requirements" on the menu bar. Waivers for the 2005-06 academic year will be accepted online until the following deadline dates:

The Fall Semester deadline is **September 15, 2005**.

The Spring Semester deadline, for students whose first semester is the Spring, is **February 10, 2006**. The Summer Semester deadline, for students whose first semester is the Summer, is **14 days after classes begin**.

Coverage cannot be waived after the deadline and you will be responsible for the cost of the Plan.

## Dependent Coverage

### *Eligibility*

Covered students may also enroll their lawful spouse or domestic partner and unmarried dependent children under age 19 who are fully supported by the covered student for similar coverage.

### *Enrollment*

To enroll the eligible dependent(s) of a covered student in the Fall Semester, please complete an Enrollment Application and bring or mail it to the West Campus Student Health Insurance Office with a check payment for the proper premium, by **September 30, 2005**. The Spring Semester enrollment deadline is **February 29, 2006**, and the Summer Semester enrollment deadline is **May 15, 2006**. For information or general questions on dependent enrollment, contact the Student Health Insurance Office, or Chickering Benefit Planning Insurance Agency, Inc at **(877) 373-0741**.

### ***Newborn Infant Coverage and Adopted Child Coverage***

A newborn child shall be covered for Injury, Sickness, premature birth, and medically diagnosed congenital defects and birth abnormalities for 31 days from the date of birth. At the end of this 31-day period, coverage will cease under the RSHIP. 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 student for 31 days from the moment of placement, provided the child lives in the household of the covered student and is dependent upon the covered student 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.

For further assistance and premium information, please contact Chickering Benefit Planning Insurance Agency, Inc.

For Child Preventive and Primary Care Services (including immunizations) please review the Summary of Benefits Chart in this Brochure.

### ***Late Enrollment***

Under certain circumstances, coverage for late enrollees may be possible. Contact the Student Health Insurance Office or refer to the Master Policy for details. Any student or dependent that enrolls after the open enrollment period is considered a late enrollee, subject to the policy provisions. Late enrollees will be subject to the rules governing pre-existing conditions, exclusions, and limitations and be charged the appropriate pro-rated premiums.

## **Pre-Existing Conditions/Continuously Insured Provisions**

### **Pre-Existing Conditions (applies to dependents only)**

#### ***Definition of a Pre-Existing Condition:***

Any Injury, Sickness, or condition, for which medical advice, diagnosis, or treatment was recommended or received, within 6 months prior to the Covered Person's effective date of insurance.

#### ***Limitation:***

Expenses incurred by a dependent of a covered student as a result of a Pre-Existing Condition will not be considered covered expenses unless no charges are incurred or treatment rendered for the condition for a period of 6 months while covered under this Plan, or, the Covered Person has been covered under this Plan for 12 consecutive months, whichever happens first.

### ***Special Rules as to a Pre-Existing Condition***

If a dependent of a covered student has Creditable Coverage and such coverage terminated within 63 days prior to the date he or she enrolled (or was enrolled) in this Program, then any limitation as to a Pre-Existing Condition under this Program will apply for that Late Enrollee only to the extent that such limitation would have applied if he or she had remained covered under the prior Creditable Coverage.

Also, if a dependent of a covered student enrolls (or is enrolled) in this Program immediately after any applicable probationary period has been served, and that person had Creditable Coverage which terminated within 63 days prior to the first day of such probationary period, then any limitation as to a Pre-Existing Condition will apply for that person only to the extent that such limitation would have applied if he or she had remained covered under the prior Creditable Coverage.

As used above, “creditable coverage” means a person’s prior medical coverage as defined in the Federal Health Insurance Portability and Accountability Act (HIPAA) of 1996. Such coverage includes the following: coverage issued on a group or individual basis, Medicare, Medicaid, military-sponsored health care, a program of Indian Health Service, a state health benefits risk pool, the Federal Employees’ 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.

Pre-Existing Conditions will apply to covered dependents of covered students who elect coverage more than 31 days after the date such person becomes eligible for coverage under the Plan.

### ***Continuously Insured (Applies to Late Enrollees Only)***

Continuously Insured is defined as: A person who was covered under prior Creditable Coverage, including Student Accident and Sickness Insurance Policies issued to Stony Brook, and is now covered under this Plan. Persons who have remained Continuously Insured will be covered for conditions first manifesting themselves while Continuously Insured except as specified in the Pre-Existing Conditions provision.

Previously covered students and dependents must re-enroll for coverage by: Annual coverage – **September 30, 2005**; Spring/Summer Semester (for newly enrolled students and their dependents) – **February 29, 2006**; Summer Semester (for newly enrolled students and their dependents) – **within 14 days** of their first day of classes, in order to avoid a break in coverage for conditions which existed in prior Policy Years. Once a break in continuous coverage occurs, the definition of a Pre-Existing Condition will apply in determining coverage of any condition which existed during the break.

## Student Health Services

The Student Health Services (SHS) at Stony Brook University is your on-campus source for meeting your primary health care needs. Our staff of physicians, physician assistants, nurse practitioners, nurses, social workers, health educators, laboratory technologists, and technical and administrative staff are dedicated to our mission of providing students with quality medical care, and the services necessary to optimize preventative health and wellness. We encourage you to take some time to explore our web site and discover those rich resources available to you. To your good health!

SHS is located in the West Campus Student Health Services Building, and offers comprehensive and cost-effective health services for both medical and psychosocial health problems. Services include: a pharmacy, laboratory, a social worker, gynecological services (Women's Clinic), a dermatology clinic, a self-care center cold clinic, health educators, and a substance abuse/addictions counselor. All registered students are eligible for medical care.

### Hours of operation:

Walk-in Clinic	Monday – Friday	8:00 a.m. – 12:00 p.m. 1:00 p.m. – 5:30 p.m.
	Tuesdays	1:00 p.m. – 7:00 p.m.
The Women's Clinic	Monday – Friday	8:00 a.m. – 12:00 p.m. 1:00 p.m. – 3:45 p.m.
	Every other Tuesday	1:00 p.m. – 7:30 p.m.
Walk-in Clinic Summer and intersession hours:		
	Monday – Friday	8:00 a.m. – 12:00 p.m. 1:00 p.m. – 4:00 p.m.
Women's Clinic Summer and intersession hours:		
	Monday – Friday	8:00 a.m. – 12:00 p.m. 1:00 p.m. – 3:30 p.m.

For additional information call **(631) 632-6740**, or visit the Student Health Services Web site <http://www.studentaffairs.stonybrook.edu/shs/insurance>.

### Pharmacy and Self-Care Center

The Student Health Services Pharmacy is staffed by a full-time pharmacist. Prescriptions are filled, at substantial savings, for registered student's who have paid the health fee. The pharmacy will only fill prescriptions written by student health service providers. The Student Health Services Pharmacy is located in the Infirmary Building on the 1st floor.

#### Hours of Operation:

##### Fall/Spring Semester

Monday – Friday	8:30 a.m. – 12:00 p.m. 1:00 p.m. – 5:30 p.m.
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##### Summer and Intersession

Monday – Friday	8:30 a.m. – 4:30 p.m.
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For more information call the Pharmacy at **(631) 632-6804**.

## **Preferred Provider Network**

The Chickering Group has arranged for you to access a Preferred Provider Network in your local community. Acute care facilities, hospitals, and specialty providers are available nationally if you require care outside the immediate area of the Stony Brook campus.

To maximize your savings and reduce your out-of-pocket expenses, select a Preferred Provider. It is to your advantage due to 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 Stony Brook, Chickering Claims Administrators, Inc., or Aetna Life Insurance Company (called Aetna). You may contact Chickering Claims Administrators, Inc. at **(877) 373-0741** for help finding a provider, or the SHS can refer you to a participating provider. Additionally, you can obtain information regarding Preferred Providers through the internet by accessing the DocFind® link from our website, [www.chickering.com](http://www.chickering.com). Click on “Find Your School” and enter **890444** as your Policy Number.

## **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 Accident and Sickness 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) 373-0741**

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

## **Description of Benefits**

Payment will be made herein for Covered Medical Expenses for an Accident or Sickness. Benefits will be payable up to a Plan Maximum of \$100,000 for any one Accident or any one Sickness per Policy Year.

All Covered Medical Expenses are subject to the coinsurance limitations and exclusions defined within the Policy. The payment of any Copays, the balance above any Coinsurance amount, and any medical expenses not covered are the responsibility of the Covered Person.

To maximize your savings and reduce out-of-pocket expenses, select an Aetna 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. 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.

A complete listing of Preferred Providers is available at the Student Health Services or you can contact Chickering Claims Administrators, Inc. at **(877) 373-0741** for specific provider information. You can also use the internet, by accessing the DocFind® link from our website, [www.chickering.com](http://www.chickering.com). Click on “Find Your School” and enter **890444** as your Policy Number.

## Summary of Benefits Chart

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

*The Plan pays in accordance with any applicable New York Insurance Law(s).*

Basic Accident and Sickness Plan	
Plan Maximum	\$100,000 per Accident or Sickness per Policy Year
Plan Deductible	<p><b>Students:</b> \$200 per condition per Policy Year.</p> <p>Plan Deductible will be decreased to \$150 in the following circumstances:</p> <ol style="list-style-type: none"> <li>1) if treatment is rendered at SHS;</li> <li>2) if treatment is rendered at SHS Counseling Center;</li> <li>3) if SHS is closed and the covered student has an emergency medical condition that must be addressed immediately.</li> </ol> <p><b>Dependents:</b> \$200 per Policy Year.</p> <p>Dependents cannot decrease their \$200 annual Deductible on this Plan.</p> <p><b>For students registered in HSC the Clinical-Related Insurance Plan for 1st year School of Medicine and School of Dental Medicine students, your benefit maximum under this Plan is increased to \$1,000,000 per incident, per lifetime for Clinical Related Injuries.*</b></p> <p><i>*Clinical Related Injury: Any incident which exposes a Covered Person acting as a student in a clinical capacity to illness, disease, or Injury that requires testing and/or treatment will be covered under the Plan. Incidents include, but are not limited to: needle sticks, unprotected exposure to blood, and unprotected exposure to highly contagious pathogens.</i></p>
Benefit Allocation	<p>Unless otherwise stated, benefit allocation will be payable as follows:</p> <p><b>Preferred Care:</b> 80% of the Negotiated Charge up to the \$3,000 out-of-pocket maximum, then 100% of the Negotiated Charge to the Plan Maximum</p> <p><b>Non-Preferred Care:</b> 50% of the Reasonable Charge up to the \$6,000 out-of-pocket maximum, then 100% of the Reasonable Charge to the Plan Maximum.</p> <p><b>Note:</b> Copays and non-covered services do not apply to the out-of-pocket maximum.</p>
Pre-Existing Condition Coverage	<p><b>Students:</b> Pre-Existing Conditions are covered.</p> <p><b>Dependents:</b> Pre-Existing Conditions are not a Covered Medical Expense for a period of 12 consecutive months on the Plan or six months with no treatment rendered for the condition while covered on the Plan. However, if the Covered Person has credible coverage and such coverage terminated within 63 days prior to the date enrolled in this Plan, then any limitation as to a Pre-existing condition under this Plan will apply to only the extent that the limitation would have applied if the Covered Person had remained covered under the prior credible coverage.</p>

<b>Basic Accident and Sickness Plan (continued)</b>	
Student Health Services Coverage	If initial treatment is received at SHS or SHS Counseling Center, the \$200 deductible will be reduced to \$150 for students only.
<b>Inpatient Benefits</b>	
Hospital Room and Board Expenses	Covered Medical Expenses are payable as referenced above: <b><i>Preferred Care:</i></b> Negotiated Charge for overnight stay. <b><i>Non-Preferred Care:</i></b> Reasonable Charge for the semi-private room rate for an overnight stay.
Intensive Care Unit Expenses	Covered Medical Expenses are payable as referenced above: <b><i>Preferred Care:</i></b> Negotiated Charge for an overnight stay. <b><i>Non-Preferred Care:</i></b> the intensive care room rate for an overnight stay.
Miscellaneous Hospital Expenses	Covered Medical Expenses are payable as referenced above: <b><i>Preferred Care:</i></b> Negotiated Charge. <b><i>Non-Preferred Care:</i></b> Reasonable Charge.  Covered Medical Expenses include, but are not limited to: laboratory tests, X-rays, anesthesia, use of special equipment, medicines, and use of operating room.
Physician Hospital Visit Expenses	Covered Medical Expenses for charges for the non-surgical services of the attending Physician or a consulting Physician are payable as referenced above: <b><i>Preferred Care:</i></b> Negotiated Charge. <b><i>Non-Preferred Care:</i></b> Reasonable Charge.
<b>Surgical Benefits (Inpatient and Outpatient)</b>	
Surgical Expenses	Covered Medical Expenses for charges for surgical services performed by a Physician are payable as referenced above: <b><i>Preferred Care:</i></b> Negotiated Charge. <b><i>Non-Preferred Care:</i></b> Reasonable Charge.
Anesthetist Expenses & Assistant Surgeon Expenses	Covered Medical Expenses for charges of an anesthetist and an assistant surgeon during a surgical procedure for surgical services performed during a surgical operation are payable as referenced above: <b><i>Preferred Care:</i></b> Negotiated Charge. <b><i>Non-Preferred Care:</i></b> Reasonable Charge.
<b>Outpatient Benefits</b>	
Covered Medical Expenses incurred by a Covered Person which does not require hospital confinement or admittance, include, but are not limited to: Physician's office visits, hospital or outpatient department or emergency room visits, durable medical equipment, physical therapy, clinical lab, radiological facility or other similar facility licensed by the state.	

<b>Outpatient Benefits (continued)</b>	
Physician's Office Visits ( <i>not subject to the per condition/annual deductible</i> )	Covered Medical Expenses are payable as referenced above: <b>Preferred Care:</b> 100% of the Negotiated Charge following a \$25 per visit Copay. <b>Non-Preferred Care:</b> 100% of the Reasonable Charge following a \$25 per visit Deductible.
Emergency Care Expenses	Covered Medical Expenses for treatment of an Emergency Medical Condition are payable as referenced above: <b>Preferred Care:</b> 80% of the Negotiated Charge. <b>Non-Preferred Care:</b> 80% of the Reasonable Charge.
Lab and X-Ray Expenses	Covered Medical Expenses are payable as referenced above: <b>Preferred Care:</b> Negotiated Charge. <b>Non-Preferred Care:</b> Reasonable Charge.
<b>Mental Health and Substance Abuse Benefits</b>	
Inpatient Expenses – Mental Health	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 as referenced above: <b>Preferred Care:</b> Negotiated Charge. <b>Non-Preferred Care:</b> Reasonable Charge.  Inpatient treatment is limited to a maximum of \$20,000 per Policy Year. 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 in place of an inpatient admission, whereby 2 days of partial hospitalization may be exchanged for 1 day of full hospitalization.
Outpatient Expenses – Mental Health	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: <b>Preferred Care:</b> 100% of the Negotiated Charge, following a \$10 Copay per visit. <b>Non-Preferred Care:</b> 100% of the Reasonable Charge, following a \$10 Deductible per visit.  Outpatient treatment is limited to a maximum of \$2,500 per Policy Year.

<b>Mental Health and Substance Abuse Benefits (continued)</b>	
Inpatient Expenses – Chemical Abuse and Chemical Dependency	<p>Covered Medical Expenses for the treatment of alcohol and 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.</p> <p>Inpatient treatment is limited to a maximum of 7 days for detoxification treatment and 30 days of rehabilitation services per Policy Year, per condition. 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 in place of an inpatient admission, whereby 2 days of partial hospitalization may be exchanged for 1 day of full hospitalization.</p>
Outpatient Expenses – Chemical Abuse and Chemical Dependency	<p>Covered Medical Expenses for the care or treatment of substance abuse by a licensed or accredited health service organization or hospital or by a fully licensed practitioner are payable on the same basis as for any other Sickness.</p> <p>Outpatient treatment is payable up to a maximum of 60 visits for outpatient treatment and to a maximum of 20 visits for counseling per Policy Year, per condition.</p>
<b>Maternity Benefits</b>	
Maternity Expenses <i>(dependent pre-existing condition limitation does not apply)</i>	<p>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.</p>
Voluntary Termination of Pregnancy Expenses	<p>Covered Medical Expenses for voluntary termination of pregnancy are payable on the same basis as any other Sickness to a maximum of \$800 per Policy Year.</p>
<b>Additional Benefits</b>	
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 referenced above:</p> <p><b>Preferred Care:</b> Negotiated Charge.  <b>Non-Preferred Care:</b> Reasonable Charge.</p>

<b>Additional Benefits (Continued)</b>	
Women's Health Benefit	<p>Covered Medical Expenses will include one baseline mammogram for women between the ages of 35 and 40. Women under age 35 with a family history (mother, sister, grandmother) of breast cancer, and a physician referral may have coverage for an annual mammogram per Policy Year. Covered Medical Expenses are payable on the same basis as any X-ray expense.</p> <p>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>
Ambulance Expenses	<p>Covered Medical Expenses are payable at the Actual Charge for the services of a professional ambulance to or from a hospital when required due to the emergency nature of a covered Accident or Sickness.</p>
Prescription Drug Benefit	<p>Covered Medical Expenses for outpatient Prescription Drugs associated with a covered Sickness or covered Accident, as well as for mental health conditions occurring during the Policy Year, and for birth control purposes, are payable as follows:</p> <p><b>Preferred Care:</b> 100% of Negotiated Rate following a \$15 Copay for each 30-day Prescription dispensed by SHS.</p> <p><b>Non-Preferred Care:</b> 100% of Reasonable Charge, following a \$20 Copay for each 30-day Generic Prescription Drug, and \$30 for each 30-day Brand-Name Prescription Drug dispensed at all other Pharmacies.</p> <p><b>Please Note:</b> You are required to pay in full at the time of service for all Prescriptions dispensed at a Pharmacy outside of the SHS Pharmacy.</p> <p>Covered Medical Expenses are payable up to a maximum of \$2,000 per Policy Year.</p> <p>Medications not covered by this benefit include, but are not limited to: allergy sera, drugs whose sole purpose is to promote or to stimulate hair growth, appetite suppressants, smoking deterrents, immunization agents and vaccines, and non-self injectables.</p>
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 or Ring is provided under the separate Prescription Drug portion of the Plan.</p>
Dental Expenses	<p>Covered Medical Expenses are payable as any other Sickness for the treatment of an Injury to sound, natural teeth.</p>

<b>Additional Benefits (Continued)</b>	
End of Life Care Expenses	Covered Medical Expenses include care provided at acute care facilities which specialize in the treatment of terminally ill patients diagnosed with advanced cancer. Reimbursement for services is provided at 100% of the Negotiated Charge. In the absence of a Negotiated Charge, reimbursement is provided at 100% of the acute care facility's reimbursement rate under the Medicare program, after any applicable Deductible.
Home Health Care Expenses	Covered Medical Expenses are payable at 100% of the Reasonable Charge 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 care visit.
Diabetic Treatment Expenses	Covered Medical Expenses for the treatment of diabetes are payable as referenced above: <b>Preferred Care:</b> Negotiated Charge. <b>Non-Preferred Care:</b> Reasonable Charge. <b>Please Note:</b> Insulin, syringes, testing supplies are covered under the prescription benefit.
Prostate Cancer Screening Expenses	Covered Medical Expenses include one annual (or more frequently if recommended by a Physician) Digital Rectal Exam and Prostate Specific Antigen (PSA) test. Covered Medical Expenses are payable on the same basis as any other expense
Reconstructive Breast Surgery Expenses	Benefits will be payable for inpatient hospital and outpatient care for a Covered Person undergoing (a) a lumpectomy or lymph node dissection for the treatment of breast cancer; or (b) a mastectomy which is covered under this Plan. Coverage is limited to a time frame determined by the Covered Person's Physician to be medically appropriate.  Benefits will also be payable for breast reconstruction surgery after a mastectomy including (a) all stages of reconstruction of the breast on which the mastectomy has been performed, and (b) surgery and reconstruction of the other breast to produce symmetry in a manner determined by the attending Physician and the Covered Person to be appropriate. Covered Medical Expenses are payable on the same basis as any other expense.
Child Preventive and Primary Care Services (including immunizations)	Covered Medical Expenses are payable as referenced above: <b>Preferred Care:</b> Negotiated Charge. <b>Non-Preferred Care:</b> Reasonable Charge.

### Health Sciences Center Plan

Covered Medical Expenses for the coverage of clinical related incidents in association with students in the School of Medicine and the School of Dental Medicine, who have paid the higher premium, are payable to a maximum of \$1,000,000 per incident, per lifetime. For all other conditions not related to clinical incidents, benefits will be payable under the Basic Accident and Sickness Plan up to \$100,000.

### Other Program Benefits

As a participant in the Stony Brook RSHIP, you may 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 <b>(800) 793-8616</b> for additional Program information and provider locations, or simply visit <a href="http://www.chickering.com">www.chickering.com</a>. Click on “Find Your School” and enter <b>890444</b> as your Policy Number to find a Vision One provider near you.</p>
<p>Informed Health® Line Service</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"> <li>• Learn about medical procedures and possible treatment options.</li> <li>• Improve the way you communicate with your health care providers.</li> <li>• 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.</li> </ul> <p>To reach an Informed Health Line Nurse, please call <b>(800) 556-1555</b> For TDD (hearing and speech impaired only): <b>(800) 270-2386</b></p>

## Other Program Benefits (continued)

<p>Informed Health® Line Service (continued)</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.</p> <ul style="list-style-type: none"> <li>• 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.</li> <li>• To access the Informed Health Line audio health library, please call <b>(800) 556-1555</b>. For TDD (hearing and speech impaired only): <b>(800) 270-2386</b></li> </ul> <p>3. Healthwise® Knowledgebase</p> <p>If you prefer to view health information online, simply log on 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.</p> <p>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.</p>
<p>Fitness Program</p>	<p>Aetna's Fitness Program, offered in conjunction with GlobalFit™, offers discounted membership rates at over 1,500 independent fitness clubs nationwide, as well as discounts on certain home exercise equipment. There are no long term contracts and GlobalFit offers convenient payment options. Contact Chickering Claims Administrators, Inc. for more information.</p>

## Optional Dental Coverage

<p>Vital Savings by Aetna<sup>SM</sup></p>	<p>Offers you a great way to get significant discounts on a wide array of services. The Vital Savings card gives you access to savings on dental and vision care.</p> <p>The cost is <b>\$25</b> for students for annual membership <b>September 1, 2005</b> through <b>August 31, 2006</b>. For complete details and to enroll, visit <b><i>www.chickering.com</i></b>. Click on "Find Your School" and enter <b>890444</b> as your Policy Number.</p>
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## General Provisions

### **State Mandated Benefits**

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

### **Subrogation/Reimbursement Right of Recovery Provision**

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

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

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

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

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

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

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

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

**Covered Person:** A covered student 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 by, 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 that 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 immunization; vaccines; treatment of infertility; and routine physical examinations.

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

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

***Hospital:*** A facility that meets all of these tests:

- It provides inpatient services for the care and treatment of injured and sick people; and
- It provides room and board services and nursing services 24 hours a day; and
- It has established facilities for diagnosis and major surgery; and
- It is run as a **hospital** under the laws of the jurisdiction which it is located.

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

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

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

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

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

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

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

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

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

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

***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 that must by law be recognized as a doctor legally qualified to render treatment.

***Pre-Existing Condition:*** Any Injury, Sickness, or condition for which medical advice, diagnosis, or treatment was recommended or received within 6 months prior to the Covered Person's effective date of insurance.

***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 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.
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's 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 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
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 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 healthcare provider, or healthcare facility; or
- Those furnished solely because the person is an inpatient on any day on which the person's Sickness or Injury could safely and adequately be diagnosed or treated while not confined, or those furnished solely because of the setting if the service or supply could safely and adequately be furnished in a physician's or a dentist's office, or other less costly setting.

13. 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.

[This exclusion also applies if you are not a permanent resident of the United States]

16. Expenses incurred for the repair or replacement of existing artificial limbs, orthopedic braces, or orthotic devices in excess of \$1,000 per Policy Year.

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 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.

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

24. 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.

25. 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).

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

27. 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.

28. Expenses incurred for gastric bypass and any restrictive procedures for weight loss.

29. Expenses incurred for breast reduction/mammoplasty.

30. Expenses incurred for gynecomastia (male breasts).

31. Expenses incurred for sinus surgery, except for acute purulent sinusitis.

32. Expenses for charges that are not reasonable charges, as determined by Aetna.

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

34. Expenses arising from a Pre-Existing Condition. (Applies to dependents only.)

35. Expenses incurred for elective treatment or elective surgery except as specifically provided elsewhere in the Policy and performed while the Policy is in effect.

36. Expenses incurred for Injury resulting from the play or practice of collegiate or intercollegiate sports; including collegiate or intercollegiate club sports and intramurals.

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

### **Extension of Benefits**

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

Benefits will continue to be available for a Covered Person who incurs medical expenses directly relating to a pregnancy that began before coverage under the Policy ceased. This benefit will be covered only for the period of the pregnancy.

## Termination of Coverage

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

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

If withdrawal from school is for other than entering the armed forces, no premium refund will be made. Students will be covered for the policy term for which they are enrolled and for which premium has been paid.

Dependent Coverage will automatically terminate the same day as the covered student.

## 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) 373-0741**

**(617) 218-8400** (outside United States)

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

1. Bills must be submitted within 90 days from the date of treatment.
2. Payment for Covered Medical Expenses will be made directly to the hospital or Physician concerned unless bill receipts and proof of payment are submitted.
3. When using a claim form, if itemized medical bills are available at the time the claim form is submitted, attach them to the claim form. Subsequent medical bills should be mailed promptly to the address listed above.
4. In the event of a disagreement over the payment of a claim, a written request to review the claim must be mailed to Chickering Claims Administrators, Inc., within 60 days from the date appearing on the Explanation of Benefits (EOB).

## Prescription Drug Claim Procedure

When obtaining a covered Prescription, you will need to pay for the Prescription at the Pharmacy and submit your receipt with a Prescription claim form for reimbursement to:

Chickering Claims Administrators, Inc.

P.O. Box 15708

Boston, MA 02215-0014

**(877) 373-0741**

**(617) 218-8400** (outside United States)

Claim forms, Pharmacy locations, and claims status information can be obtained by contacting Chickering Claims Administrators, Inc. **(877) 373-0741**. You may also download claim forms at [www.chickering.com](http://www.chickering.com). Click on “Find Your School” and enter **890444** as your Policy Number, then click on Prescriptions.

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

## How To Appeal a Claim

### Complaint and Appeals Procedures

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

The complaints and appeals process is designed to address coverage issues, complaints, and problems. If you or your covered dependent have a coverage issue or other problem, call Chickering Customer Services at **(877) 373-0741**. A representative will address your concern. If you or your covered dependent are dissatisfied with the outcome of the initial contact, the decision may be appealed.

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

Chickering Claims Administrators, Inc.

P.O. Box 15717

Boston, MA 02215-0014

**(877) 373-0741**

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

### *Internal Appeals Procedure*

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

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

### ***First Level Appeals Procedure***

- An Appeal must be submitted to Aetna within 180 days of the date Aetna provides notice of denial. The address is on your ID card. The Appeal may be submitted by you, or by a representative designated by you.
- You may submit an oral grievance in connection with:
  - A denial of or failure to pay for a referral; or
  - A determination as to whether a benefit is covered under this Plan, by calling Customer Services. The Customer Services telephone number is on your ID card. If you are required to leave a recorded message, your message will be acknowledged within 1 business day after the call was recorded.

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

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

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

### ***Second Level Appeals Procedure***

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

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

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

You must exhaust the Internal Appeals Procedure before requesting an External Appeal. However; you are not required to exhaust the Internal Appeals Procedure prior to requesting an External Appeal, if you and Aetna have agreed that the matter may proceed directly to an External Appeal.

Aetna will keep the records of your complaint for 3 years.

## **External Appeal**

### ***Right to an External Appeal***

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

### ***Right to Appeal a Determination that a Service is Not Necessary***

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

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

### ***Right to Appeal a Determination that a Service is Experimental or Investigational***

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

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

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

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

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

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

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

### ***The External Appeal Process***

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

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

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

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

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

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

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

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

### ***Responsibilities***

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

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

### ***Covered Services and Exclusions***

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

## General Information

### **Patient Management Program**

Aetna evaluates and determines the appropriateness of medical care resources utilized by our Covered Persons. To accomplish these goals, Aetna has developed a comprehensive Patient Management Program. Only medical directors make decisions denying coverage for services for reasons of medical necessity. Coverage denial letters delineate any unmet criteria, standards and guidelines, and inform the provider and Covered Person of the appeal process. Our patient management staff uses national guidelines and resources to guide the Pre-Certification, concurrent review and retrospective review process.

- **Pre-Certification**

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

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

- **Concurrent Review**

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

- **Discharge Planning**

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

- **Retrospective Record Review**

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

## **Provider Reimbursement**

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

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

Any charge for a service or supply furnished by a Participating Provider in excess of such provider's Negotiated Charge for that service or supply will not be a covered expense under the group contract. It will be the responsibility of Aetna and the Participating Provider to resolve the amount deemed to be excess.

## **Confidentiality**

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

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

## **Notice to Enrollees**

While the paper directory (available upon request) is believed to be accurate as of the print date, it is subject to change without notice. Consult Aetna's online provider directory on our website [\*www.aetna.com/docfind\*](http://www.aetna.com/docfind) for the most current provider listings. Participating Providers are independent contractors in private practice and are neither employees nor agents of Aetna, Stony Brook University, or Chickering Claims Administrators, Inc. The availability of any particular provider cannot be guaranteed for referred or in-network benefits, and provider network composition is subject to change without notice. Certain Primary Care Physicians may be affiliated with an Independent Practice Association (IPA), a Physician Medical Group (PMG), an integrated delivery system, or one of other provider groups.

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

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

All Covered Person care and related decisions are the sole responsibility of Participating Providers. Aetna does not provide health care services and, therefore, cannot guarantee any results or outcomes.

### **Accidental Death and Dismemberment Benefits**

This benefit provides Accidental Death and Dismemberment coverage of up to \$10,000.

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 Stony Brook University.

To file a claim for Accidental Death and Dismemberment, please contact Chickering Claims Administrators, Inc. at (877) 373-0741 for the appropriate claim forms.

### **Worldwide Emergency Travel Assistance Services**

These services are designed to protect Stony Brook students when traveling more than 100 miles from campus/home anywhere in the world and are offered up to an unlimited dollar amount.

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 the 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 Stony Brook Student Accident and Sickness 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**) **+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 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 and the Policy, the Master Policy will govern and control the payment of benefits.

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

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

This above disclosure is included as required by New York Insurance Regulation Section 52.10 and 52.59. Stony Brook University Student Accident and Sickness Insurance benefits are described in this Brochure.

### **Offered by:**



An Aetna Company

Chickering Benefit Planning Insurance Agency, Inc  
(877) 373-0741

### **Administered by:**

Chickering Claims Administrators, Inc.  
P.O. Box 15708  
Boston, MA 02215-0014  
[www.chickering.com](http://www.chickering.com)

### **Underwritten by:**



Aetna Life Insurance Company  
151 Farmington Avenue Hartford, CT 06156

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

**Policy No. 890444**

## **NOTICE**

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

By enrolling in the Plan, you permit us to use and disclose this information as described above on behalf of yourself and your dependents. To obtain a copy of our Notice of Privacy Practices describing in greater detail our practices concerning use and disclosure of personal information, please call the toll-free Customer Services number on your ID card or visit Chickering's "Student Connection" Link on the internet at: [www.chickering.com](http://www.chickering.com).