

2007 - 2008

**Student Accident and
Sickness Insurance Plan**



THE UNIVERSITY OF
CHICAGO



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

Policy No. 724543

Table of Contents

<u>Where to Find Help</u>	3
<u>Student Accident and Sickness Insurance Plan</u>	5
<u>Enrollment Policy</u>	5
<u>Insurance Premium/Policy Period</u>	6
<u>Basic Plan</u>	6
<u>Advantage Plan</u>	7
<u>Coverage Period</u>	7
<u>Enrollment Deadlines</u>	7
<u>Premium Refund Policy</u>	7
<u>Student Health Services Referral</u>	8
<u>Filing Claims Procedure</u>	8
<u>Assistance</u>	9
<u>Explanation of Benefits – EOB</u>	9
<u>Prescription Drug Claim Procedure</u>	9
<u>Preferred Provider Network</u>	10
<u>Inpatient Admission Pre-Certification Program</u>	10
<u>Description of Benefits</u>	11
<u>Basic Plan – Summary of Benefits Chart</u>	12
<u>Advantage Plan – Summary of Benefits Chart</u>	17
<u>Additional Services and Discounts</u>	22
<u>Accidental Death and Dismemberment</u>	24
<u>Emergency Travel Assistance Services</u>	24
<u>Medical Evacuation and Return of Mortal Remains Services</u>	24
<u>Optional Dental Coverage</u>	25
<u>General Provisions</u>	25
<u>State Mandated Benefits</u>	25
<u>Reimbursement</u>	25
<u>Subrogation</u>	26
<u>Subrogation Right of Recovery Provision</u>	26
<u>Coordination of Benefits</u>	27
<u>Definitions</u>	27
<u>Exclusions</u>	31
<u>Extension of Benefits</u>	36
<u>Termination of Insurance</u>	36
<u>Continuation Privilege</u>	37
<u>Appeals and Complaints Procedure</u>	37
<u>External Review</u>	38
<u>Important Note</u>	38

Where to Find Help

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

As a Chickering Student Health Insurance Plan member, you have access to Aetna Navigator™, your secure member website, packed with personalized benefits and health information. You can take full advantage of our interactive website to complete a variety of self-service transactions online. Please visit www.chickering.com, click on “Find Your School,” and enter your school name or Policy Number **724543**. Click on “Aetna Navigator.”

On-Campus Insurance Coordinators

(773) 834-4543, (773) 834-1554 or sasi@chickering.uchicago.edu

Chickering Claims Administrators, Inc. **(800) 294-9410**

Aetna Pharmacy Management (800) 238-6279 (Available 24 hours)

For Questions About ID Cards:

ID cards will be issued as soon as possible (typically 7-10 days from the time of your enrollment in the plan). If you need medical attention before the ID card is received, benefits will be payable according to the Policy. **You do not need an ID card to be eligible to receive benefits.** Once you have received your ID card, present it to the provider to facilitate prompt payment of your claims.

If you have lost your ID card or if you have not received it more than four weeks after you enroll, contact:

On-Campus Insurance Coordinator at **(773) 834-4543** or **(773) 834-1554**

Chickering Claims Administrators, Inc. **(800) 294-9410**

To request an ID card online, visit www.chickering.com, click on “Find Your School,” and enter your school name or Policy Number **724543**. Click on “Aetna Navigator.”

Chickering Claims Administrators, Inc.

P.O. Box 15708

Boston, MA 02215-0014

(800) 294-9410 or

(617) 218-8400 (collect if overseas), or visit www.chickering.com, click on “Find Your School,” and enter your school name or Policy Number **724543**.

Aetna Pharmacy Management:

- Status of Pharmacy Claim
- Pharmacy Claim Forms
- Excluded Drugs and Pre-Authorization
- Prescription drug benefit balance

(800) 238-6279 (Available 24 hours)

Chickering On-Campus Insurance Coordinators:

- Enrollment and Waiver Process

Visit: <http://studenthealth.uchicago.edu>

Contact: Chickering on-campus insurance coordinators

Administration Building 231-2

(773) 834-4543 or (773) 834-1554 or sasi@chickering.uchicago.edu

On-Campus Health Service:

Student Care Center

5841 South Maryland Avenue

Room R100

Chicago, IL 60637

Access to this clinic, as well as a variety of services, is covered by the quarterly Health and Wellness fee assessed on the student's Bursar bill. Among many services, the SCC provides annual physical examinations, women's health, lab testing, a travel and immunization clinic, along with health education material and outreach programming.

(773) 702-4156 for appointments and general information

(773) 702-6817 for billing questions or problems

(773) 834-5143 for health education questions

Student Counseling and Resource Service:

- On-Campus Counseling Center

Student Counseling and Resource Service

5737 South University Avenue

Chicago, IL 60637

Access to this clinic is covered by payment of the mandatory quarterly Health and Wellness fee assessed on the student's Bursar bill. Among many services, the SCRS provides psychological assessments, individual, couples, and/or group brief psychotherapy, medication management, academic skills counseling, emergency services, and crisis intervention.

(773) 702-9800 for appointments and general information

For Provider Listings (Including listing of Preferred Care Pharmacies):

You can use Aetna's online DocFind® service located at www.chickering.com. Click on "Find Your School," and enter **724543** as your Policy Number. You can use DocFind® to find out whether a specific doctor belongs to Aetna's network or to find preferred providers practicing in your area.

Emergency Travel Assistance Services:

Assist America, Inc.

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

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

E-mail address: *medservices@assistamerica.com*

Worldwide Web Access:

- The Chickering Group: *www.chickering.com*
- The University of Chicago: *http://studenthealth.uchicago.edu*

Aetna's online DocFind® service is located at *www.chickering.com*. Click on "Find Your School," and enter **724543** as your Policy Number. You can use DocFind® to find out whether a specific doctor belongs to Aetna's network or to find preferred providers practicing in your area.

<h2>Student Accident and Sickness Insurance Plan</h2>
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The Plan is underwritten by Aetna Life Insurance Company (Aetna). The exact provisions governing this insurance are contained in the Master Policy. The Plan is administered by Chickering Claims Administrators, Inc., P.O. Box 15708, Boston, MA 02215-0014.

Enrollment Policy

All students are required to carry adequate medical insurance to cover, among other costs, hospitalization, outpatient mental health, and outpatient diagnostic and surgical procedures. If the student is residing in Chicago, the insurance must cover medical care, other than emergency care, in the Chicago area. Each year, the insurance requirement must be satisfied in one of two ways:

1. Enroll in the Student Accident and Sickness Insurance plan; or
2. Complete the online insurance waiver application before the enrollment deadline.

To enroll or waive enrollment, go to the enrollment website at *https://registrar.uchicago.edu/health/*.

Students who fail to complete an insurance election or apply for a waiver by the enrollment deadline for the plan year will be automatically enrolled in the Basic plan and billed for that enrollment. The enrollment is binding for the entire plan year.

The waiver application requires the student to certify that his or her insurance coverage is comparable to the Student Accident and Sickness Insurance Plan.

Every student must complete the enrollment or waiver process **each year**.

Affiliated seminary students may enroll in the University of Chicago Student Accident and Sickness Insurance Basic Plan on a voluntary basis. To enroll you must complete a Seminary Enrollment Form. Enrollment Forms are available at the on-campus Insurance Coordinator's Office (Administration Building 231-2) or at your seminary administrator's office.

Eligible Dependents

You may enroll your eligible dependents online by the enrollment deadline at registrar.uchicago.edu/health/. If you are covered by The University of Chicago Student Accident and Sickness Insurance Plan, you may elect coverage for the following dependents:

- Your spouse;
- Your unmarried dependent children between the ages of 31 days and 19 years (23 if a full-time student) who live with you, and are fully supported by you; and
- Your University registered same-sex domestic partner. Registration forms are available online at: <http://hr.uchicago.edu/forms/benefits.html>.

Note: As a student you may enroll in either the Basic or Advantage Plan, while your dependents must enroll in the Basic Plan.

Newborn Infant Coverage and Adopted Child Coverage

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

If you plan on enrolling a newborn into the Student Accident and Sickness Insurance Plan, please contact the on-campus insurance coordinators at (773) 834-4543 or (773) 834-1554.

Coverage is provided for a child legally placed for adoption with a Covered Person for 31 days from the moment of placement, provided the child lives in the household of the Covered Person and is dependent upon the Covered Person for support. To extend coverage for an adopted child past the 31 days, the Covered Person must (1) enroll the child within 31 days of placement of such child and (2) pay any additional premium, if necessary, starting from the date of placement. You must enroll your newborn by contacting the on-campus insurance coordinators at (773) 834-4543 or (773) 834-1554.

Insurance Premium/Policy Period

Premiums are assessed in three installments during the academic year. These charges are added to Autumn, Winter, and Spring tuition bills. Students and dependents who are eligible to begin enrollment in the Winter or Spring quarters, or who are eligible only in Autumn and Spring quarters but not in Winter, will be charged a Summer quarter premium.

Basic Plan

	Annual	Autumn	Winter	Spring
Student Only	\$1,770	\$ 590	\$ 590	\$ 590
Dependent Spouse	\$3,120	\$1,040	\$1,040	\$1,040
Dependent Child(ren)	\$3,120	\$1,040	\$1,040	\$1,040
Seminary Students Only	\$3,120	\$1,040	\$1,040	\$1,040

Advantage Plan

	Annual	Autumn	Winter	Spring
Student Only	\$2,724	\$908	\$908	\$908

Coverage Period

Autumn Term	September 1, 2007 through January 6, 2008
Winter Term	January 7, 2008 through March 30, 2008
Spring Term	March 31, 2008 through June 22, 2008
Summer Term	June 23, 2008 through August 31, 2008

For most students, the enrollment period ends at 5:00 p.m. on the second Friday of the Autumn quarter. For students who are not registered for the Autumn quarter but register during the Winter, Spring or Summer quarter, the enrollment period ends at 5:00 p.m. on the second Friday of the first quarter in which they are registered at the University during the insurance plan year. Students who wish to enroll their eligible dependents must follow the same quarterly deadlines.

Enrollment Deadlines

Autumn	October 5, 2007
Winter	January 18, 2008
Spring	April 11, 2008
Summer	July 4, 2008

If you do not submit a waiver form by the deadline, you will be enrolled for the Basic Plan. The decision to waive or enroll is binding through the end of the Plan Year. Please contact the On-Campus Insurance Coordinators at **(773) 834-4543** or **(773) 834-1554** for mid-year enrollment and waiver information.

Premium Refund Policy

If you withdraw your course registration by the Friday of the third week of the Academic Quarter, and no claims have been filed, coverage will not be in effect and you will receive a full refund of the insurance premium. If you withdraw after the third Friday of the Academic Quarter, or have claims paid, your coverage will remain in effect until the end of the term and you will not receive a refund.

Insured students entering the armed forces of any country will not be covered under the Policy as of the date of such entry. A pro-rata refund of premium will be made for such person, including covered dependents, upon written request received by Chickering Claims Administrators, Inc., within 90 days of withdrawal from school.

Student Health Services Referral

When the Student Care Center (SCC) or the Student Counseling and Resource Service (SCRS) refers you to a specialist, you must get a referral form, completed by the SCC or SCRS provider. For each visit to a specialist without such referral, a \$25 per service penalty will be incurred. If the specialist recommends that you consult another specialist, you must return to the SCC or SCRS to obtain a different referral. Furthermore, if at some previous time you received treatment from a specialist for a medical condition and you think this condition is recurring, you must go to the SCC or SCRS first. The SCC or SCRS Physician will determine whether you need to be referred again to an outside specialist.

Note: The service penalty does not apply towards meeting the annual Out-of-Pocket Maximum.

Referrals must be obtained at the beginning of each academic year from the SCC, however, referrals from the SCRS only need to be obtained once per lifetime. This referral requirement applies to Covered Students and to their covered dependents age 14 and older. A referral is not required for Emergency Medical Conditions, for routine gynecological services, or if the Covered Person is 40 miles outside of the Campus area.

Filing Claims Procedure

In the event of an Injury or Sickness, report immediately to the Student Care Center or a qualified provider or hospital so that proper treatment can be prescribed or approved. It is to your advantage to utilize participating providers because of the savings for services and reduced out-of-pocket expenses. Most providers of service will file a claim for you.

In the event your provider of service does not file a claim on your behalf, it is your responsibility to initiate a claim in order to obtain reimbursement.

Please send all itemized medical bills as soon as possible after treatment is rendered to Chickering Claims Administrators, Inc. Your name, student ID number, and University name should be written clearly and attached to your medical bills. All information should be mailed to:

Chickering Claims Administrators, Inc.
P.O. Box 15708
Boston, MA 02215-0014
(800) 294-9410
(617) 218-8400 (outside United States)

Subsequent itemized medical bills should also be mailed promptly to the same address. Bills must be submitted within 12 months from the date of treatment.

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

Assistance

For assistance in filing a claim, or to inquire about the status of a claim, please contact an Insurance Coordinator on campus at 5801 South Ellis Avenue, Room 231 and 232, Chicago, IL 60637 at **(773) 834-4543** or **(773) 834-1554**. You may also contact the Customer Service Department at Chickering Claims Administrators, Inc., directly at **(800) 294-9410** between the hours of 8:30 a.m. and 5:30 p.m. (ET), Monday through Friday.

Explanation of Benefits – EOB

You will receive an “Explanation of Benefits” form after your claim is processed. The Explanation of Benefits will explain how your claim was processed according to the benefits of your Student Accident and Sickness Insurance Plan. This EOB is not a bill. If you owe something, your doctor will send a bill to you. This EOB is an explanation of how your claim was processed. If you have any questions regarding the Explanation of Benefits, please contact an on-campus coordinator at **(773) 834-4543**, **(773) 834-1554** or *sasi@chickering.uchicago.edu* Monday through Friday 8:30 a.m. to 5:00 p.m. You may also contact the Customer Service Department at Chickering Claims Administrators, Inc., at **(800) 294-9410**. Customer Service Representatives are available Monday through Friday, 8:30 a.m. to 5:30 p.m. (ET).

Prescription Drug Claim Procedure

When obtaining a covered Prescription, please present your Chickering ID card to an Aetna Preferred Pharmacy along with your applicable Copay. The Pharmacy will submit a claim to Aetna for the drug. Claim Forms, Pharmacy locations, and claims status information can be obtained by contacting Aetna Pharmacy Management at **(800) 238-6279**. Additionally, a listing of Pharmacy locations may be obtained by accessing Aetna’s online DocFind® service located at *www.chickering.com*. Click on “Find Your School” and enter **724543** as your Policy Number. You can use DocFind® to find out whether a specific pharmacy belongs to Aetna’s network or to find preferred providers practicing in your area.

When you need to fill a Prescription and do not have your ID card with you, you may obtain your Prescription from an Aetna Preferred Pharmacy and be reimbursed by submitting a completed Aetna Prescription Drug claim form. You will be reimbursed for covered medications directly by Aetna. Please note, in addition to your Copay, you may be required to pay the difference between the retail price you paid for the drug and the amount Aetna would have paid if you had presented your ID card and the Pharmacy had billed Aetna directly. When submitting a claim, please include all Prescription receipts; indicate that you attend The University of Chicago; and include your name, address, and student identification number.

Preferred Provider Network

The Chickering Group has arranged for you to access a Preferred Provider Network in your local community. Acute care facilities and mental health networks are available nationally if you require hospitalization outside the immediate area of The University of Chicago. 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. Students are responsible for determining whether or not their providers participate in the Preferred Provider Network.

You may contact Chickering Claims Administrators at **(800) 294-9410**. Additionally, you can obtain information regarding Preferred Providers through the Internet by accessing Aetna's online DocFind® service located at www.chickering.com. Click on "Find Your School" and enter **724543** as your Policy Number. You can use DocFind® to find out whether a specific doctor belongs to Aetna's network or to find preferred providers practicing in your area.

Preferred Providers are independent contractors and are neither employees nor agents of The University of Chicago, Chickering Claims Administrators, Inc., or Aetna. The University of Chicago Physicians Group and the University of Chicago Hospitals are considered Preferred Providers.

Note: All foreign claims incurred for Covered Medical Expenses under The University of Chicago Student Accident and Sickness Insurance Plan will be payable at the Preferred Care benefit level and should be submitted to Chickering Claim Administrators, Inc.

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. If you do not secure Pre-Certification for non-emergency inpatient admissions or provide notification for emergency admissions, your Covered Medical Expenses will be subject to a \$100 per admission Deductible.

Pre-Certification of Non-Emergency Inpatient Admissions

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

Notification of Emergency Admissions

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

Chickering Claims Administrators, Inc.
Attention: Managed Care Dept.
P.O. Box 15708
Boston, MA 02215-0014
(800) 294-9410

Description of Benefits

Payment will be made as allocated herein for Covered Medical Expenses incurred for any one Accident or any one Sickness while insured under the Plan, subject to stated maximums and other Policy limitation, for any one covered Accident or any one covered Sickness. The payment of any Copays, Deductibles, the balance above any Coinsurance amount, and any medical expenses not covered are the responsibility of the Covered Person.

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

Basic and Advantage Plan Comparison Chart

Basic Plan	Advantage Plan
\$200 Plan Deductible per Individual	\$100 Plan Deductible per Individual
\$1,500 Prescription Maximum per Policy Year	\$1,000,000 Prescription Maximum per Policy Year
Coinsurance Level: Preferred Care: 80% Non Preferred Care: 50%	Coinsurance Level: Preferred Care: 90% Non Preferred Care: 50%

Basic Plan – Summary of Benefits Chart

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

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

Please note the following:

- This is the only Plan Option available to dependents.
- This is the only Plan Option available to affiliated seminary students.
- A \$25 penalty, per service, will apply for non-emergency treatment/services obtained without first obtaining the appropriate referral from SCC or SCRS. Refer to The University of Chicago Student Health Services Referral section of this Brochure for details.

Aggregate Maximum	\$1,000,000 Lifetime Maximum
Annual Deductible <i>(Patient responsibility which must be satisfied before claim payment commences)</i>	\$200 (Prescription Drug Copays and other prescription claims do not apply towards meeting the annual deductible.)
Coinsurance Levels	Generally the Plan pays the following Insurance Levels: <i>Preferred Care:</i> 80% <i>Non-Preferred Care:</i> 50% For specific details see next page.
Annual Out-of-Pocket Maximum	\$1,700 Maximum <i>(Deductible and Coinsurance, combined, apply towards meeting the Out-of-Pocket Maximum; Copays, Prescription claims, service penalties, and excluded services do not apply towards meeting the Out-of-Pocket Maximum)</i>
Hospital Room and Board Expenses	Covered Medical Expenses are payable as follows: <i>Preferred Care:</i> 80% of the Negotiated Charge for an overnight stay. <i>Non-Preferred Care:</i> 50% of the Reasonable Charge for the semi-private room rate for an overnight stay.
Intensive Care Unit Expenses	Covered Medical Expenses are payable as follows: <i>Preferred Care:</i> 80% of the Negotiated Charge for an overnight stay. <i>Non-Preferred Care:</i> 50% of the intensive care room rate for an overnight stay.
Miscellaneous Hospital Expenses	Covered Medical Expenses are payable as follows: <i>Preferred Care:</i> 80% of the Negotiated Charge. <i>Non-Preferred Care:</i> 50% of the Reasonable Charge. Covered Medical Expenses include, but are not limited to: laboratory tests, X-rays, anesthesia, physiotherapy, use of special equipment, medicines, and use of operating room.

Basic Plan – Summary of Benefits (continued)	
Pre-Admission Testing Expenses	Covered Medical Expenses are payable as follows: Preferred Care: 80% of the Negotiated Charge. Non-Preferred Care: 50% of the Reasonable Charge.
Physician’s Hospital Visit Expenses	Covered Medical Expenses for charges for the non-surgical services of the attending Physician or a consulting Physician are payable as follows: Preferred Care: 80% of the Negotiated Charge. Non-Preferred Care: 50% of the Reasonable Charge.
Surgical Expenses	Covered Medical Expenses for charges for surgical services performed by a Physician are payable as follows: Preferred Care: 80% of the Negotiated Charge. Non-Preferred Care: 50% of the Reasonable Charge.
Anesthetist and Assistant Surgeon Expenses	Covered Medical Expenses for the charges of an anesthetist and an assistant surgeon during a surgical procedure for surgical services performed during a surgical operation are payable as follows: Preferred Care: 80% of the Negotiated Charge. Non-Preferred Care: 50% of the Reasonable Charge. Covered Medical Expenses include, but are not limited to: Physician’s office visits, hospital or outpatient department or emergency room visits, physical therapy, clinical lab, radiological facility, or other similar facility licensed by the state.
Primary and Preventative Care Expenses for Insured Dependent Children	Covered Medical Expenses are payable on the same basis as any other illness or Injury for the primary and preventative care of insured dependent children under the age of 14. Coverage includes the initial well child exams, unlimited routine Physician’s office visits, including routine tests and immunizations.
Physician’s Office Visit/Consult Expenses	Covered Medical Expenses are payable as follows: Preferred Care: 80% of the Negotiated Charge. Non-Preferred Care: 50% of the Reasonable Charge.
Lab and X-ray Expenses (Non-Hospital)	Covered Medical Expenses are payable as follows: Preferred Care: 80% of the Negotiated Charge. Non-Preferred Care: 50% of the Reasonable Charge.
Mammography Expenses	Coverage will be provided for one baseline mammogram for women between ages 35 and 40, one annual mammogram for women aged 40 and older and at the age and intervals considered medically necessary by the woman’s health care provider for women under 40 years of age and having a family history of breast cancer or other risk factors. Covered Medical Expenses are payable as follows: Preferred Care: 80% of the Negotiated Charge. Non-Preferred Care: 50% of the Reasonable Charge.

Basic Plan – Summary of Benefits (continued)	
Routine Pap Smear Screening Expenses	Coverage will be provided for one annual routine Pap smear screening for women age 18 and older. Covered Medical Expenses are payable as follows: Preferred Care: 80% of the Negotiated Charge. Non-Preferred Care: 50% of the Reasonable Charge.
Allergy Shot and Injection Expenses	Covered Medical Expenses are payable as follows: Preferred Care: 80% of the Negotiated Charge. Non-Preferred Care: 50% of the Reasonable Charge.
Day Surgery Facility Expenses	Covered Medical Expenses are payable as follows: Preferred Care: 80% of the Negotiated Charge. Non-Preferred Care: 50% of the Reasonable Charge.
Radiation Therapy/ Chemotherapy Expenses	Covered Medical Expenses are payable as follows: Preferred Care: 80% of the Negotiated Charge. Non-Preferred Care: 50% of the Reasonable Charge.
Physiotherapy Expenses	Covered Medical Expenses are payable as follows: Preferred Care: 80% of the Negotiated Charge. Non-Preferred Care: 50% of the Reasonable Charge.
Emergency Room Expenses	Covered Medical Expenses for treatment of a Medically Necessary Emergency Medical Condition are payable as follows: Preferred Care: 80% of the Negotiated Charge. Non-Preferred Care: 80% of the Reasonable Charge.
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 follows: Preferred Care: 80% of Negotiated Charge for inpatient mental health. Non-Preferred Care: 50% of the Reasonable Charge. Inpatient treatment is limited to a maximum of 30 days per Policy Year/60 days per Lifetime per condition for any one or related mental health conditions. 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 two days of partial hospitalization may be exchanged for one day of full hospitalization.

Basic Plan – Summary of Benefits (continued)

<p>Outpatient Expenses – Mental Health</p>	<p>Covered Medical Expenses for the care or treatment of a mental health condition by a licensed or accredited health service organization or hospital or by a licensed practitioner are payable as follows: Preferred Care: 80% of the Negotiated Charge. Non-Preferred Care: 80% of the Reasonable Charge.</p> <p>Outpatient treatment is payable up to a maximum of \$70 per visit and to a maximum of 25 visits per Policy Year.</p> <p>Please note: Office visits scheduled solely for the Mental Health purpose of medicine management are not a Covered Medical Expense under the outpatient mental health benefit. Instead, these visits are payable on the same basis as any Sickness under the Outpatient portion of the Plan.</p>
<p>Inpatient Expenses – Drug Abuse and Alcoholism</p>	<p>Covered as any other Accident or Sickness.</p>
<p>Outpatient Expenses – Drug Abuse and Alcoholism</p>	<p>Covered Medical Expenses for outpatient drug abuse or alcoholism treatment is limited to a maximum of \$90 per visit, and to a maximum of 25 visits per Policy Year, and to a Lifetime Maximum Benefit of \$6,500: Preferred Care: 80% of the Negotiated Charge. Non-Preferred Care: 50% of the Reasonable Charge.</p>
<p>Maternity Expenses</p>	<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 maximum of 48 hours after a vaginal delivery and for a minimum of 96 hours after a Cesarean delivery. The plan does not cover planned home deliveries. Upon discharge, benefits will be payable for one post-delivery home visit by a health care provider, if the visit is prescribed by the attending Physician. If a Covered Person is discharged earlier, benefits will be payable for one post-delivery home visit by a health care provider within 24 hours of discharge and, if prescribed by the attending Physician, one additional home visit.</p>
<p>Voluntary Termination of Pregnancy Expenses</p>	<p>Covered Medical Expenses for voluntary termination of pregnancy are payable on the same basis as any other Condition.</p>
<p>High Cost Procedure Expenses</p>	<p>Covered Medical Expenses are payable as follows: Preferred Care: 80% of the Negotiated Charge. Non-Preferred Care: 50% of the Reasonable Charge.</p>

Basic Plan – Summary of Benefits (continued)	
Ambulance Expenses	<p>Covered Medical Expenses are payable as follows for the services of a professional ambulance to or from a hospital when required due to the emergency nature of a covered Accident or Sickness:</p> <p>Preferred Care: 80% of the Negotiated Charge. Non-Preferred Care: 80% of the Reasonable Charge.</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, Seasonale, Depo-Provera, Patch and Ring are provided under the Prescription Drug Benefit portion of the Plan.</p>
Prescription Drug Benefit Expenses	<p>\$25 Copay for each Brand Name Prescription. \$10 Copay for each Generic Prescription Drug.</p> <p>A 90-day supply will be filled at two times the Copay cost for Chronic Medications filled at The University of Chicago Medical Center Pharmacy (DCAM).</p> <p>Covered Medical Expenses are payable up to a maximum of \$1,500 per Policy Year. Benefits are paid only when Prescriptions are filled at a Pharmacy which is a Preferred Care Provider. Please use your Chickering ID card when obtaining your Prescriptions.</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, as well as preventative medication.</p> <p>Covered medications include oral contraceptives, Lunelle, Depo-Provera, Patch and Ring. Expenses incurred for office visits in conjunction with the administration of a covered prescription contraceptive are provided under the Medical portion of the Plan.</p> <p>Prior authorization is required for growth hormones and drugs which are for treatment of malaria. For assistance, or for information on excluded medications and drugs available with prior authorization, please contact (800) 238-6279.</p>
Durable Medical Equipment Expenses	<p>Covered Medical Expenses are payable as follows:</p> <p>Preferred Care: 80% of the Negotiated Charge. Non-Preferred Care: 50% of the Reasonable Charge.</p>

Basic Plan – Summary of Benefits (continued)

Home Health Care Expenses	Covered Medical Expenses are payable as follows: Preferred Care: 80% of the Negotiated Charge. Non-Preferred Care: 50% of the Reasonable Charge. Covered Medical Expenses are incurred within 12 months from the date of the first home health care visit. Four hours of home health aide service shall be considered as one home care visit.
Dental Expenses	Covered Medical Expenses for removal of impacted wisdom teeth and the treatment of an Injury to sound natural teeth are payable at 80% of the Actual Charge.

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

Advantage Plan – Summary of Benefits Chart

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

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

Please note the following:

- This Plan Option is not available for dependents.
- This Plan Option is not available for affiliated seminary students.
- A \$25 per service penalty will apply for non-emergency treatment/services obtained without first obtaining the appropriate referral from SCC or SCRS. Refer to The University of Chicago Student Health Services Referral section of this brochure for details.

Aggregate Maximum	\$1,000,000 Lifetime Maximum
Annual Deductible <i>(Patient responsibility which must be satisfied before claim payment commences)</i>	\$100 <i>(Prescription Drug Copays do not apply towards meeting the annual deductible.)</i>
Coinsurance Levels	Generally the Plan pays the following Insurance Levels: Preferred Care: 90% Non-Preferred Care: 50% For specific details, please see below.
Annual Out-of-Pocket Maximum	\$1,700 <i>(Deductible and coinsurance, combined, apply towards meeting the Out-of-Pocket Maximum; Copays, prescription claims, service penalties and excluded services do not apply towards meeting the Out-of-Pocket Maximum)</i>

Advantage Plan – Summary of Benefits (continued)

Hospital Room and Board Expenses	Covered Medical Expenses are payable as follows: Preferred Care: 90% of the Negotiated Charge for an overnight stay. Non-Preferred Care: 50% of the Reasonable Charge for the semi-private room rate for an overnight stay.
Intensive Care Unit Expenses	Covered Medical Expenses are payable as follows: Preferred Care: 90% of the Negotiated Charge for an overnight stay. Non-Preferred Care: 50% of the intensive care room rate for an overnight stay.
Miscellaneous Hospital Expenses	Covered Medical Expenses are payable as follows: Preferred Care: 90% of the Negotiated Charge. Non-Preferred Care: 50% of the Reasonable Charge. Covered Medical Expenses include, but are not limited to: laboratory tests, X-rays, anesthesia, physiotherapy, use of special equipment, medicines, and use of operating room.
Pre-Admission Testing Expenses	Covered Medical Expenses are payable as follows: Preferred Care: 90% of the Negotiated Charge. Non-Preferred Care: 50% of the Reasonable Charge.
Physician's Hospital Visit Expenses	Covered Medical Expenses for charges for the non-surgical services of the attending Physician or a consulting Physician are payable as follows: Preferred Care: 90% of the Negotiated Charge. Non-Preferred Care: 50% of the Reasonable Charge.
Surgical Expenses	Covered Medical Expenses for charges for surgical services performed by a Physician are payable as follows: Preferred Care: 90% of the Negotiated Charge. Non-Preferred Care: 50% of the Reasonable Charge.
Anesthetist and Assistant Surgeon Expenses	Covered Medical Expenses for the charges of an anesthetist and an assistant surgeon during a surgical procedure for surgical services performed during a surgical operation are payable as follows: Preferred Care: 90% of the Negotiated Charge. Non-Preferred Care: 50% of the Reasonable Charge. Covered Medical Expenses include, but are not limited to: Physician's office visits, hospital or outpatient department or emergency room visits, physical therapy, clinical lab, radiological facility, or other similar facility licensed by the state.
Physician's Office Visit/Consult Expenses	Covered Medical Expenses are payable as follows: Preferred Care: 90% of the Negotiated Charge. Non-Preferred Care: 50% of the Reasonable Charge.
Lab and X-ray Expenses (Non-Hospital)	Covered Medical Expenses are payable as follows: Preferred Care: 90% of the Negotiated Charge. Non-Preferred Care: 50% of the Reasonable Charge.

Advantage Plan – Summary of Benefits (continued)

Mammography Expenses	<p>Coverage will be provided for one baseline mammogram for women between ages 35 and 40 and one annual mammogram for women aged 40 and older.</p> <p>Covered Medical Expenses are payable as follows: Preferred Care: 90% of the Negotiated Charge. Non-Preferred Care: 50% of the Reasonable Charge.</p>
Routine Pap Smear Screening Expenses	<p>Coverage will be provided for one annual routine Pap smear screening for women age 18 and older.</p> <p>Covered Medical Expenses are payable as follows: Preferred Care: 90% of the Negotiated Charge. Non-Preferred Care: 50% of the Reasonable Charge.</p>
Allergy Shot and Injection Expenses	<p>Covered Medical Expenses are payable as follows: Preferred Care: 90% of the Negotiated Charge. Non-Preferred Care: 50% of the Reasonable Charge.</p>
Surgery Expenses (includes assistant surgery)	<p>Covered Medical Expenses are payable as follows: Preferred Care: 90% of the Negotiated Charge. Non-Preferred Care: 50% of the Reasonable Charge.</p>
Day Surgery Facility Expenses	<p>Covered Medical Expenses are payable as follows: Preferred Care: 90% of the Negotiated Charge. Non-Preferred Care: 50% of the Reasonable Charge.</p>
Radiation Therapy/Chemotherapy Expenses	<p>Covered Medical Expenses are payable as follows: Preferred Care: 90% of the Negotiated Charge. Non-Preferred Care: 50% of the Reasonable Charge.</p>
Physiotherapy Expenses	<p>Covered Medical Expenses are payable as follows: Preferred Care: 90% of the Negotiated Charge. Non-Preferred Care: 50% of the Reasonable Charge.</p>
Emergency Room Expenses	<p>Covered Medical Expenses for a Medically Necessary Emergency Medical Condition are payable as follows: Preferred Care: 90% of the Negotiated Charge. Non-Preferred Care: 90% of the Reasonable Charge.</p>
Inpatient Expenses – Mental Health	<p>Covered Medical Expenses for the treatment of a mental health condition while confined as an inpatient in a hospital or facility licensed for such treatment are payable as follows: Preferred Care: 90% of the Negotiated Charge for inpatient mental health. Non-Preferred Care: 50% of the Reasonable Charge.</p> <p>Inpatient treatment is limited to a maximum of 30 days per Policy Year/60 days per Lifetime, per condition for any one or related mental health condition.</p>

Advantage Plan – Summary of Benefits (continued)

<p>Inpatient Expenses – Mental Health <i>(continued)</i></p>	<p>Covered Medical Expenses also include the charges made for treatment received during partial hospitalization in a hospital or treatment facility. Prior review and approval must be obtained on a case-by-case basis by contacting Chickering Claims Administrators, Inc. When approved, benefits will be payable in place of an inpatient admission, whereby two days of partial hospitalization may be exchanged for one day of full hospitalization.</p>
<p>Outpatient Expenses – Mental Health</p>	<p>Covered Medical Expenses for the care or treatment of a mental health condition by a licensed or accredited health service organization or hospital or by a licensed practitioner are payable as follows: Preferred Care: 80% of the Negotiated Charge. Non-Preferred Care: 80% of the Reasonable Charge.</p> <p>Outpatient treatment is payable up to a maximum of \$70 per visit and to a maximum of 25 visits per Policy Year.</p> <p>Please note: Office visits scheduled solely for the purpose of medicine management are not a Covered Medical Expense under the outpatient mental health benefit. Instead, these visits are payable on the same basis as any Sickness under the Outpatient portion of the Plan.</p>
<p>Inpatient Expenses – Drug Abuse and Alcoholism</p>	<p>Covered as any other Accident or Sickness.</p>
<p>Outpatient Expenses – Drug Abuse and Alcoholism</p>	<p>Covered Medical Expenses for outpatient drug abuse or alcoholism treatment is limited to a maximum of \$90 per visit, and to a maximum of 25 visits per Policy Year, and to a Lifetime Maximum Benefit of \$6,500: Preferred Care: 90% of the Negotiated Charge. Non-Preferred Care: 50% of the Reasonable Charge.</p>
<p>Maternity Expenses</p>	<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 maximum of 48 hours after a vaginal delivery and for a minimum of 96 hours after a Cesarean delivery. The plan does not cover planned home deliveries. Upon discharge, benefits will be payable for one post-delivery home visit by a health care provider, if the visit is prescribed by the attending Physician. If a Covered Person is discharged earlier, benefits will be payable for one post-delivery home visit by a health care provider within 24 hours of discharge and, if prescribed by the attending Physician, one additional home visit.</p>

Advantage Plan – Summary of Benefits (continued)	
Voluntary Termination of Pregnancy Expenses	<p>Covered Medical Expenses for voluntary termination of pregnancy are payable on the same basis as any other Condition.</p> <p>Covered Medical Expenses are payable a follows: Preferred Care: 90% of the Negotiated Charge. Non-Preferred Care: 50% of the Reasonable Charge.</p>
Ambulance Expenses	<p>Covered Medical Expenses are payable as follows for the services of a professional ambulance to or from a hospital when required due to the emergency nature of a covered Accident or Sickness: Preferred Care: 90% of the Negotiated Charge. Non-Preferred Care: 90% of Reasonable Charge.</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, Seasonale, Depo-Provera, Patch and Ring are provided under the Prescription Drug Benefit portion of the Plan.</p>
Prescription Drug Expenses	<p>\$25 Copay for each Brand Name Prescription Drug \$10 Copay for each Generic Prescription Drug</p> <p>A 90-day supply will be filled at two times the Copay cost for Chronic Medications filled at The University of Chicago Medical Center Pharmacy (DCAM).</p> <p>Covered Medical Expenses are payable up to \$1,000,000 maximum per Policy Year. Benefits are paid only when Prescriptions are filled at a Pharmacy which is a Preferred Care Provider. Please use your Chickering ID card when obtaining your Prescription.</p> <p>Medications not covered by this benefit include, but are not limited to: allergy sera, drugs whose sole purpose is to promote or to stimulate hair growth, appetite suppressants, smoking deterrents, immunization agents and vaccines, and non-self injectables.</p> <p>Covered medications include oral contraceptives, Lunelle, Depo-Provera, Patch and Ring. Expenses incurred for office visits in conjunction with the administration of a covered prescription contraceptive are provided under the Medical portion of the Plan.</p> <p>Prior authorization is required for growth hormones and drugs which are for treatment of malaria. For assistance, or for information on excluded medications and drugs available with prior authorization, please contact (800) 238-6279.</p>

Advantage Plan – Summary of Benefits (continued)

Durable Medical Equipment Expenses	<p>Preferred Care: 90% of the Negotiated Charge. Non-Preferred Care: 50% of the Reasonable Charge.</p>
Home Health Care Expenses	<p>Covered Medical Expenses are payable as follows: Preferred Care: 90% of the Negotiated Charge. Non-Preferred Care: 50% of the Reasonable Charge.</p> <p>Covered Medical Expenses are incurred within 12 months from the date of the first home health care visit. Four hours of home health aide service shall be considered as one home care visit.</p>
Dental Expenses	<p>Covered Medical Expenses are payable as follows: Dental Expenses Covered Medical Expenses for removal of impacted wisdom teeth and treatment of an Injury to sound natural teeth are payable at 90% of the Actual Charge.</p>

Additional Services and Discounts

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

Vision One® Discount Program	<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).</p> <p>To learn more about medical procedures and possible treatment options, call (800) 793-8616 for additional program information and provider locations, or simply visit www.chickering.com, click on “Find Your School,” and enter your school name or Policy Number 724543.</p>
Aetna Natural Products and Services Program SM	<p>Discounts are offered on alternative therapies and savings on vitamins and other health-related products.</p>
Fitness Program	<p>Aetna’s Fitness Program, offered in conjunction with GlobalFit™, offers discounted membership rates at more than 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>

Additional Services and Discounts (continued)

Informed Health® Line Service

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).

1. 24-Hour Nurse Line

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 improve the way you communicate with your health care providers. Find out how to describe health symptoms more effectively, ask the right questions and provide a clear history of your eating, exercise and lifestyle habits.

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

2. Audio Health Library

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

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

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

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

3. Healthwise® Knowledgebase

If you prefer to view health information online, simply 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.

**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.*

Accidental Death and Dismemberment Benefit

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

To file a claim for Accidental Death and Dismemberment, please contact Chickering Claims Administrators, Inc., at **(800) 294-9410** for the appropriate claim forms.

Emergency Travel Assistance Services

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

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

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

Medical Evacuation and Return of Mortal Remains Services

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

Please note: Any third party expenses incurred are the responsibility of the Participant. An Assist America ID card will be supplied to you once you enroll in The Chickering Student 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**) **plus (301) 656-4152**, in the event of an emergency when you are traveling. With one phone call, you will be connected to a global network of more than 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 the U.S. Department of State for International Students & Scholars.

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

Optional Dental Coverage

Two options are available for students desiring dental coverage. Coverage runs from **September 1, 2007** through **August 31, 2008**. Students may contact Chickering directly online to enroll in these plans.

Option #1

Aetna Advantage™ Dental Plan provides preventative dental care following a \$5.00 per visit Copay. Annual premium is \$160.41 per student, or \$515.00 for the Student and Family Plan. Enrollment Deadlines are:

Fall 9/30/07

Spring 2/17/08

Option #2

Vital Savings by Aetna® is a discount program that lets you save money on dental services through one of the largest dental discount networks, Aetna Dental Access. The University of Chicago Dental Clinic is an in-network provider under this program. Enrollment costs \$25 per student, \$44 for a Student and one Dependent, or \$63 for a Student and more than one Dependent. Enrollment Deadline is 5/31/08.

NOTE: You may enroll in one or both of these Dental Plans regardless of your enrollment in the SASI plan.

General Provisions

State Mandated Benefits

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

Reimbursement

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

- a) To repay Aetna for such benefits to the extent they are responsible for losses for which compensation is paid to the Covered Person by or on behalf of the person at fault;

- b) To allow Aetna a lien on such compensation and to hold such compensation in trust for Aetna; and
- c) To execute and give to Aetna any instruments needed to secure the rights under (a) and (b).

Subrogation

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

Subrogation Right of Recovery Provision

Immediately upon paying or providing any benefit under this Plan, Aetna shall be subrogated to all rights of recovery a Covered Person has against any party potentially responsible for making any payment to a Covered Person, due to a Covered Person's injuries or illness, to the full extent of benefits provided, or to be provided by Aetna. A "Covered Person" includes, for the purposes of this provision, anyone on whose behalf this Plan pays or provides any benefit, including but not limited to the minor child or Dependent of any Covered Person, entitled to receive any benefits from this Plan.

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

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

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

The Covered Person acknowledges that this Plan's subrogation rights are a first priority claim against all potential responsible parties and are to be paid to Aetna before any other claim for the Covered Person's damages. This Plan shall be entitled to full reimbursement first from any potential responsible party payments even if such payment to the Plan will result in a recovery to the Covered Person, which is insufficient to make the Covered Person whole or to compensate the

Covered Person in part or in whole for the damages sustained. This Plan is not required to participate in or pay attorney fees to the attorney hired by the Covered Person to pursue the Covered Person's damage claim. In addition, this Plan shall be responsible for the payment of attorney fees for any attorney hired or retained by this Plan. The Covered Person shall be responsible for the payment of all attorney fees for any attorney hired or retained by the Covered Person or for the benefit of the Covered Person.

The terms of this entire subrogation provision shall apply. This Plan is entitled to full recovery regardless of whether any liability for payment is admitted by any potentially responsible party and regardless of whether the settlement or 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 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.

Intercollegiate Sports Limitation: Expenses incurred for Injuries resulting from the play or practice of collegiate or intercollegiate sports (including collegiate and intercollegiate club sports and intramurals) are considered Covered Medical Expenses up to a maximum of \$25,000 per Policy Year.

Definitions

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

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

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

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

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

Copay: The amount that must be paid by the Covered Person at the time services are rendered by a Preferred Provider. Copay amounts are the responsibility of the Covered Person. (**Please note:** Copays do not apply towards meeting the Plan's Out-of-Pocket Maximum.)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- Those furnished solely because of the setting if the service or supply could safely and adequately be furnished in a Physician's or a dentist's office or other less costly setting.

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

Non-Preferred Care (out-of-network): 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 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.

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

Pharmacy: An establishment where Prescription Drugs are legally dispensed.

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

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

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

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

- The provider's usual charge for furnishing it; and
- The charge Aetna determines to be appropriate, based on factors such as the cost of providing the same or a similar service or supply and the manner in which charges for the service or supply are made; and
- The charge Aetna determines to be the prevailing charge level made for it in the geographic area where it is furnished.
- In some circumstances Aetna may have an agreement, either directly or indirectly through a third party, with a provider which sets the rate that Aetna will pay for a service or supply. In these instances, in spite of the methodology described above, the Reasonable Charge is the rate established in such agreement.

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

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

Aetna may take into account factors, such as:

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

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

Exclusions

The Plan neither covers nor provides benefits for the following:

1. Expenses incurred for services normally provided without charge by the Student Care Center or the Student Counseling and Resource Service.
2. 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.
3. Expenses incurred as a result of commission of a felony.
4. 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.
5. Expenses incurred as a result of dental treatment, except for Injury to sound, natural teeth or for the removal of impacted wisdom teeth as provided elsewhere in the Policy.
6. Expenses incurred for Injury resulting from the play or practice of intercollegiate sports, in excess of \$25,000 per Policy Year. (Please note that participation in sports clubs or intramural athletic activities is not excluded.)

7. Expense incurred for a treatment, service, or supply, which is not Medically Necessary, as determined by Aetna, for the diagnosis, care, or treatment of the Sickness or Injury involved. This applies even if they are prescribed, recommended, or approved, by the person's attending Physician, or dentist.

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

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

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

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

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

8. Expenses incurred for, or related to, services, treatment, education testing, or training related to learning disabilities or developmental delays.

9. Expenses incurred as a result of an Injury or Sickness for which benefits are payable under a Workers' Compensation or Occupational Disease Law.

10. Expenses incurred as a result of preventive medicines, serums, or vaccines unless otherwise provided in the Policy.
11. Expenses incurred for any services rendered by a member of the Covered Person's immediate family or a person who lives in the Covered Person's home.
12. Expenses incurred for treatment provided in a governmental hospital unless there is a legal obligation to pay such charges in the absence of insurance.
13. Expenses incurred for plastic surgery, cosmetic surgery, reconstructive surgery, or other services and supplies which improve, alter, or enhance appearance, whether or not for psychological or emotional reasons. This exclusion 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, webbed fingers, or toes), or as direct result of disease or from surgery performed to treat a Sickness or Injury.
 - b) Repair an Injury (including reconstructive surgery for a prosthetic device for a Covered Person who has undergone a mastectomy) which occurs while the Covered Person is covered under the Plan. Surgery must be performed in the Policy Year of the Accident which causes the Injury, or in the next Policy Year.
14. Expenses incurred for the repair or replacement of existing artificial limbs, orthopedic braces, or orthotic devices.
15. Expenses incurred for which no member of the Covered Person's immediate family has any legal obligation for payment.
16. Expenses for artificial or related to artificial insemination, in vitro fertilization, or embryo transfer procedures, elective sterilization or its reversal, or elective abortion unless otherwise provided in the Policy.
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 for: (a) care of flat feet; (b) supportive devices for the foot; and (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 insured is diabetic or suffers from circulatory problems.

20. 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.
21. 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.
22. Expenses incurred as a result of Injury sustained or Sickness contracted while in the service of the armed forces of any country. Upon the Covered Person entering the armed forces of any country, the unearned pro-rata premium will be refunded by the Policyholder.
23. 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.
24. Expenses incurred for, or in connection with, speech therapy. This exclusion does not apply for charges for speech therapy that is expected to restore speech to a person who has lost existing function (the ability to express thoughts, speak words, and form sentences) as a result of an Accident or Sickness.
25. Expenses incurred for massage therapy.
26. 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.
27. Expenses for Injuries sustained as the result of a motor vehicle accident to the extent that benefits are payable under other valid and collectible insurance whether or not a claim is made for such benefits.
28. Expenses incurred for treatment of temporomandibular joint (TMJ) dysfunction and associated myofascial pain unless otherwise provided in the Policy.
29. Expenses incurred beyond the end of the Policy Year in which the Injury or initial medical treatment of the Sickness or Injury took place.
30. Expenses for treatment of Injury or Sickness to the extent that payment is made, as judgment or settlement, by any person deemed responsible for the Injury or Sickness (or their insurers).

31. Expenses incurred for the removal of an organ from a Covered Person for the purpose of donating or selling the organ to any person or organization. This limitation does not apply to a donation by a Covered Person to a spouse, child, brother, sister, or parent.

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

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

However, this exclusion will not apply with respect to services or supplies (other than drugs) received in connection with a disease if Aetna determines that:

- The disease can be expected to cause death within one year, in the absence of effective treatment; and
- The care or treatment is effective for that disease, or shows promise of being effective for that disease, as demonstrated by scientific data.

In making this determination Aetna will take into account the results of a review by a panel of independent medical professionals. They will be selected by Aetna. This panel will include professionals who treat the type of disease involved.

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

- Have been granted treatment investigational new drug (IND) or Group c/treatment IND status; or
- Are being studied at the Phase III level in a national clinical trial sponsored by the National Cancer Institute; or
- If Aetna determines that available, scientific evidence demonstrates that the drug is effective or shows promise of being effective for the disease.

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

34. Expenses incurred for, or related to, sex change surgery or to any surgical treatment of gender identity disorders. (**Please note:** Covered Medical Expenses do include charges incurred for non-surgical therapy provided for treatment of gender identity disorders.)

35. Those for routine physical exams, routine vision exams, routine dental exams, routine hearing exams, immunizations, or other preventive services and supplies except to the extent coverage for such exams, immunizations, services, or supplies is specifically provided in the Policy or through the on-campus Student Care Center.

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

37. Expenses incurred for breast reduction/mammoplasty.

38. Expenses incurred for gynecomastia (male breasts).

39. Expenses incurred for sinus surgery except for acute purulent sinusitis.

40. Expenses for charges that are not reasonable charges.

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

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

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

Extension of Benefits

If a Covered Person is confined to a hospital on the date his or her insurance terminates, expenses incurred after the termination date and during the continuance of that hospital confinement shall be payable in accordance with the Policy. Benefits will be provided until you are discharged, your hospital days are exhausted, or until the end of your benefit period, whichever occurs first.

Termination of Insurance

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

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

4. Day before the start of the coverage period.
5. First day of coverage period or First day of covered enrollment.

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

Continuation Privilege

Students and their eligible covered dependents, who have been continuously insured under the school's Student Accident and Sickness Insurance Plan and have graduated or are otherwise ineligible under that policy, may continue their coverage for a period of not more than 12 months. Enrollment forms will confirm eligibility, deadlines dates and premium rates.

Enrollment applications for continued coverage are available by contacting:

- The Chickering Group either by phone, **(800) 294-9410** or
- Via the web at: www.chickering.com, click on "Find Your School," and enter your school name or Policy Number **724543**
- Insurance Coordinators on campus at: 5801 South Ellis Avenue, Room 231 or 232, Chicago, IL 60637 (**Note:** *The maximum length of coverage under the Continuation Plan is 12 consecutive months*). Coverage dates are not to exceed beyond **August 31, 2008**, at the rates listed. If eligible for additional coverage, new rates may apply.

Appeals and Complaints Procedure

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

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

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

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

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

External Review

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

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

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

Important Note

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

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

Offered by:



Chickering Benefit Planning Insurance Agency, Inc.
1 Charles Park
Cambridge, MA 02142

Administered by:

Chickering Claims Administrators, Inc.
P.O. Box 15708
Boston, MA 02215-0014
(800) 294-9410
www.chickering.com

Underwritten by:



Aetna Life Insurance Company (ALIC)
151 Farmington Avenue
Hartford, CT 06156
Policy No. 724543

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

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.