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NYU Health Center

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Graduate Student Health Insurance Plan Handbook

This handbook is for graduate assistants, teaching assistants and research assistants covered by the University's agreement with International Union UAW, AFL-CIO Local 2110, as well as specifically designated students who are fully funded by NYU for the cost of GSHIP.



www.nyu.edu/nyuhc

INSURANCE COMPANY

Aetna Insurance Company of Connecticut
151 Farmington Avenue
Hartford, CT 06156

GROUP POLICY NUMBER

711103

CLAIMS ADMINISTRATOR

Chickering Claims Administrators, Inc.
P.O. Box 15708
Boston, MA 02215-0014
800-466-4148
617-582-5000 (when outside the United States)
www.chickering.com

PLAN ADMINISTRATOR

NYU Health Center Student Health Insurance Services
726 Broadway, Suite 346
New York, NY 10003
212-443-1020

NEW YORK UNIVERSITY HEALTH CENTER

726 Broadway, 3rd & 4th Floors
New York, NY 10003
212-443-1000
www.nyu.edu/nyuhc

Hours of Operation*

Academic Year

Monday - Thursday • 8am - 6pm
Friday - Saturday • 10am - 6pm

Summer

(Memorial Day through Labor Day)

Monday - Thursday • 8am - 6pm
Friday • 10am - 6pm

NYUHC is closed on Sundays

* Hours of operation are subject to change. Please check our website at www.nyu.edu/nyuhc for up-to-date information.

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Graduate Student Health Insurance Program (GSHIP)

It is important that you **READ THIS BROCHURE CAREFULLY** since it discusses the details of this Plan. Please note that this brochure is intended to be a summary of the benefits afforded under this Plan. The Master Policy further explains benefits and any exclusions or limitations. Where a discrepancy exists between this brochure and other printed matter regarding this program and the Master Policy, the Master Policy will take precedence. The Master Policy, which is on file with the NYU Insurance Department, is available for review by appointment only. To make an appointment, please call the NYU Insurance Department at 212-998-2755. For additional details about benefits, call Chickering Claims Administrators, Inc. at 800-466-4148.

Periods of Coverage

The following chart shows the maximum period of coverage by term for students enrolled in the NYU Plans:

TERM	COVERAGE BEGINS	COVERAGE ENDS
Annual 2003-2004	12:01 a.m., August 21, 2003	12:01 a.m., August 21, 2004
Fall 2003	12:01 a.m., August 21, 2003	12:01 a.m., January 9, 2004
Spring/Summer 2004	12:01 a.m., January 9, 2004	12:01 a.m., August 21, 2004
Summer 2004	12:01 a.m., May 20, 2004	12:01 a.m., August 21, 2004

Mandatory Emergency Injury and Sickness Plan

Eligibility

All students enrolled in a degree-granting, advanced certificate, or postgraduate certificate program and registered for one (1) or more credits, or maintaining matriculation, are enrolled automatically in the Mandatory Emergency Injury and Sickness Plan. This plan cannot be waived. Students, spouses, same-sex domestic partners and dependents electing coverage under GSHIP will also be insured under this plan automatically.

Benefit Description

If an emergency results in an inpatient admission, notification to Chickering Claims Administrators, Inc. is required (see pages 19-20 for additional information).

Injury Benefit

LIMIT	\$2,500 maximum per condition per policy year
DEDUCTIBLE	\$25 per condition

Benefits are payable at 100% of **reasonable charges** for treatment in a hospital emergency room due to an emergency **injury**.

Sickness Benefit

LIMIT	\$2,500 maximum per condition per policy year
DEDUCTIBLE	\$25 per condition

Benefits are payable at 80% of **reasonable charges** for treatment in a hospital emergency room due to a sickness that constitutes an **emergency medical condition**.

An **emergency medical condition** is defined as 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.

Referral Requirement for Follow-up Medical Care after Emergency Room Treatment

After the covered person has received initial treatment for the emergency medical condition, he or she may be required to seek additional treatment or evaluation.

1. *Prior to this follow-up medical care*, the covered student must contact New York University Health Center (NYUHC) for treatment or evaluation required in Manhattan.
2. NYUHC may require that the covered student seek follow-up care through NYUHC.
3. Referrals cannot be granted after treatment has been rendered. (*IMPORTANT: see pages 21-23 for more details of the referral process*).
4. Covered dependents do not have access to NYUHC and therefore are not required to obtain a referral.
5. The Student Health Insurance Program will deny benefits to any covered student or to the provider if the covered student fails to receive proper authorization from NYUHC before receiving additional medical care.

Dental Injuries

The Mandatory Emergency Injury and Sickness Plan does not cover emergency treatment for dental injuries.

Emergency Medical Care

Life- or Limb-Threatening Emergency

Dial 911 to reach New York City Emergency Medical Services.

Other Emergencies

During New York University Health Center (NYUHC) Hours of Operation: Walk-in or call NYUHC Urgent Care Services at 726 Broadway, 3rd Floor, 212-443-1111. **Please note:** Expenses for emergency medical care provided at NYUHC is a covered benefit under GSHIP. Such expenses are not covered under the Mandatory Emergency Injury Sickness Plan.

After NYUHC Hours of Operation: Contact NYU Protection Services at 212-998-2222. You will be connected with a health care provider at Tisch Hospital's Emergency Room, which dedicates a phone line for NYU students in need of after hours medical care. A physician will provide advice over the telephone, and will determine if you need to come to the Emergency Room or can wait to see a health care provider. If you are seen in the Tisch Hospital's Emergency Room, NYUHC staff will be notified and may phone you after the visit to ensure that you are well and that you receive the necessary follow-up care.

During NYU Holiday Closings: If you are enrolled in GSHIP and you require medical care, you may visit a healthcare provider without an NYUHC referral. Seeking services from a preferred provider in the Aetna network will reduce your out-of-pocket expenses.

You will be responsible for any copays, deductibles, or coinsurance incurred outside NYUHC.

Graduate Student Health Insurance Plan

Except for medical emergencies or when seeking services outside of the Manhattan area, covered students are required first to seek treatment or be evaluated at NYUHC. (See pages 21-23 for details about the referral process.)

Eligibility/Enrollment of Students

The following students are automatically enrolled in the Graduate Student Health Insurance Plan (GSHIP) upon notification to the Student Health Insurance Services Office that their student status is in either the Class I or Class II category as defined below:

- Class I: Any teaching assistant, graduate assistant, and research assistant who is employed by New York University and is covered by the University's agreement with the International Union UAW, AFL-CIO Local 2110, Technical, Office and Professional Workers.
- Class II:
- a) Students who are not in Class I above and who are specifically designated by the Graduate School of Arts and Science (GSAS) to be enrolled in GSHIP. This determination is made each semester and requires that the student be fully funded by GSAS. Fully-funded GSAS students receive an award from GSAS that includes a minimum academic-year stipend of \$17,000 (\$8,500 for a single semester), tuition, registration and services fees, and full funding for the cost of this insurance plan.
 - b) Doctoral students who are not in Class I above and who are specifically designated by the Leonard N. Stern School of Business Doctoral Program to be enrolled in GSHIP and receive full funding for the cost of the plan.

Special Eligibility/Enrollment

Extending Periods of Coverage

- Class I: Students whose appointments end, or are unexpectedly terminated, and their covered dependents, may extend coverage by
- a) enrolling in the Student Health Insurance Program, if meeting the eligibility requirement, or
 - b) extending coverage by election of continuing GSHIP coverage. (See NYU GSHIP Class I coverage insert for details.)
- Class II: Students may be eligible to purchase University-sponsored coverage to continue their current plan for a 3- or 6-month period through the Continuation Option. The Continuation Option Enrollment Form can be downloaded from www.nyu.edu/nyuhc/insurance or requested from the NYUHC Student Health Insurance Services Office (212-443-1020) or Chickering Claims Administrators, Inc. (800-466-4148). The student will be required to make payment directly to Chickering Benefit Planning Insurance Agency, Inc. before the

appropriate deadline in order to ensure continuity of coverage. Enrollment in the Continuation Option is available only to students and their dependents covered in the immediately preceding semester.

Insurance for Dependents

Enrollment

For an additional premium, **(to be paid for by the enrollee)**, covered students may also enroll their eligible **dependents** (see glossary on page 35 for a definition of eligible **dependent**).

1. **Dependents** are not eligible to use any services at NYUHC.
2. NYU students who are not insured under GSHIP may not enroll their **dependents**.

The GSHIP Dependent Enrollment Form can be requested from the NYUHC Student Health Insurance Services Office (212-443-1020) or Chickering Claims Administrators, Inc. (800-466-4148). The enrollment form, together with payment must be submitted directly to Chickering Benefit Planning Insurance Agency, Inc., P.O. Box 15706, Boston, MA 02215-0014. Payment must be made by check, money order, or credit card (MasterCard or Visa only). *Checks or money orders should be made payable to Chickering Benefit Planning Insurance Agency, Inc.* The form must be postmarked by the applicable enrollment deadline.

Periods of Coverage

When enrolling a dependent, the effective date of coverage is the date of the covered student's enrollment or the date of the dependent's enrollment, whichever is later. Dependent coverage terminates on the same date the covered student's coverage ends or the date such dependent ceases to meet the eligibility requirement, whichever occurs earlier.

Newborn Infant Coverage

All newborn children of a **covered student** or insured **dependent** spouse are covered automatically at birth for 31 days for an **injury** or **sickness**. Coverage may be continued after 31 days by providing notification of birth and forwarding the appropriate payment to Chickering Benefit Planning Insurance Agency, Inc. within 31 days from the date of the birth.

Newly Adopted Children

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 student** 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.

SUMMARY — of — BENEFITS

GRADUATE STUDENT HEALTH INSURANCE PLAN

The Graduate Student Health Insurance Plan provides limited benefits for health insurance ONLY. As defined by the New York State Insurance Department, 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, or nursing home and home health care insurance. The insurance policy itself sets forth the rights and obligations of both you and the insurance company.

The 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 Customer Service at Chickering Claims Administrators, Inc. 800-466-4148.

For a complete definition of **medically necessary**, please refer to the glossary on pages 36-37.

NYUHC On-Site Benefits

This benefit covers at 100% virtually all **medically necessary** services, as well as 80% of certain preventive care services, *when provided at NYU Health Center, 726 Broadway, New York, NY*, for all students enrolled in the Graduate Student Health Insurance Plan.

The NYUHC On-Site Benefit covers all expenses incurred at NYUHC by the **covered student** for the treatment of any covered medical condition where treatment is **medically necessary** and for which treatment is provided during the period of coverage, subject to the **lifetime aggregate maximum** benefit per condition and the plan limitations.

Covered services *when performed at NYUHC* and deemed **medically necessary** include, but are not limited to, the following:

- Primary and Specialty care examinations
- Physical Therapy
- Occupational Therapy
- Radiology
- Laboratory tests*
- Minor surgery
- Routine physical examination, covered at 80% [one (1) per policy year]
- Routine gynecological examinations, covered at 100%

* *Tests analyzed outside of NYUHC; e.g., certain blood tests, pap smears, biopsies, etc. are covered as described on page 11.*

BENEFIT	GSHIP
LIFETIME AGGREGATE MAXIMUM	\$150,000 per condition. This can be increased to \$500,000 through enrollment in the Catastrophic Option.
OUT-OF-POCKET MAXIMUMS	Preferred Care - \$2,000 per policy year. Non-Preferred Care - \$4,000 per policy year.
NYUHC ON-SITE BENEFIT	
ON-SITE SERVICES	Includes all of the benefits provided and described under the NYUHC On-Site Benefit at no additional cost per policy year. See description on pages 8-9.
INPATIENT BENEFITS	
ROOM AND BOARD	Preferred Care - 90% of the negotiated charge up to the Out-of-Pocket Maximum, 100% thereafter. Non-Preferred Care - 60% of reasonable charges up to the Out-of-Pocket Maximum, 100% thereafter.
OTHER HOSPITAL SERVICES	Preferred Care - 90% of the negotiated charge up to the Out-of-Pocket Maximum, 100% thereafter. Non-Preferred Care - 60% of reasonable charges up to the Out-of-Pocket Maximum, 100% thereafter.
PRE-ADMISSION TESTING	Preferred Care - 90% of the negotiated charge up to the Out-of-Pocket Maximum, 100% thereafter. Non-Preferred Care - 60% of reasonable charges up to the Out-of-Pocket Maximum, 100% thereafter.
INPATIENT NON-SURGICAL PHYSICIAN VISITS	Preferred Care - 90% of the negotiated charge up to the Out-of-Pocket Maximum, 100% thereafter. Non-Preferred Care - 60% of reasonable charges up to the Out-of-Pocket Maximum, 100% thereafter.

BENEFIT	GSHIP
SURGICAL BENEFITS Outpatient and Inpatient	
SURGEON'S FEES	Preferred Care - 90% of the negotiated charge up to the Out-of-Pocket Maximum, 100% thereafter. Non-Preferred Care - 60% of reasonable charges up to the Out-of-Pocket Maximum, 100% thereafter.
ANESTHESIA FEES	Preferred Care - 90% of the negotiated charge up to the out-of-pocket maximum, 100% thereafter. Non-Preferred Care - 60% of the reasonable charges up to the out-of-pocket maximum, 100% thereafter.
OUTPATIENT BENEFITS	
PER CONDITION COMBINED MAXIMUM	\$30,000 per policy year.
PHYSICIAN VISITS	At NYUHC: 100% of medically necessary treatment when performed at NYUHC only. Outside NYUHC: Preferred Care - 90% of the negotiated charge ; \$15 per visit copay . Non-Preferred Care - 60% of reasonable charges ; \$30 per visit deductible .
HOSPITAL OUTPATIENT	Preferred Care - 90% of the negotiated charge ; \$35 per visit copay . Non-Preferred Care - 60% of reasonable charges ; \$50 per visit deductible .
HOSPITAL EMERGENCY ROOM	Preferred Care - 90% of the negotiated charge ; \$50 per visit copay . Non-Preferred Care - 90% of reasonable charges ; \$50 per visit deductible .
LAB AND X-RAY	At NYUHC: 100% of medically necessary services when performed at NYUHC Outside NYUHC: Preferred Care - 90% of the negotiated charge up to the out-of-pocket maximum, 100% thereafter. Non-Preferred Care - 90% of reasonable charges up to the out-of-pocket maximum, 100% thereafter

BENEFIT	GSHIP
WOMEN'S HEALTH BENEFITS	
WELL WOMAN CARE	
<i>Routine Gynecologic Exam</i>	100% at NYUHC Outside NYUHC, covered as any other outpatient non-NYUHC physician visit
<i>Pap Smear Screening</i>	Covered medical expenses include coverage for two pap smear screenings per policy year for women age 18 and older, payable on the same basis as any other outpatient laboratory expense. Coverage is provided more frequently upon a physician's recommendation.
<i>Mammography</i>	Preferred Care - 90% of the negotiated charge up to the out-of-pocket maximum, 100% thereafter Non-Preferred Care - 60% of reasonable charges up to the out-of-pocket maximum, 100% thereafter Payable as any other outpatient x-ray expense. The plan will cover one baseline mammogram for women between the ages of 35 and 40. Women age 40 and over have coverage for one mammogram per policy year thereafter. Coverage is provided more frequently upon a physician's recommendation.
MATERNITY	Pays the same benefits for maternity, as well as for the complications of pregnancy, as afforded any sickness. Well baby visits are not covered. In the event of an inpatient confinement, such benefits would be payable for inpatient care of the covered person , and any newborn child, as medically necessary . In the event of a hospital discharge earlier than 48 hours after a vaginal delivery, or 96 hours after a cesarean delivery, coverage is available for at least one home health care visit as medically necessary ; this visit will be payable at 100% and will not be subject to any plan copays or deductibles , if applicable. Coverage also includes parent education, assistance and training in breast or bottle feeding, and the performance of any necessary maternal and newborn clinical assessments.
CONTRACEPTIVES	
<i>Oral Contraceptive Pills</i>	Covered as a pharmacy benefit as outlined on page 13
<i>Prescription Contraceptive Services (other than oral contraceptives)</i>	100% coverage for services when performed at NYUHC Outside NYUHC, covered as any other outpatient expense
<i>Emergency Contraception</i>	100% coverage for services when performed at NYUHC
TERMINATION OF PREGNANCY	Covered medical expenses are payable as any other condition.

BENEFIT	GSHIP
ADDITIONAL BENEFITS	
AMBULANCE	100% coverage up to \$250 per transport to or from hospital.
PROSTATE CANCER SCREENING	Covered medical expenses include one annual (or more frequently if recommended by a physician) digital rectal exam and Prostate Antigen Specific (PSA) test. Covered medical expenses are payable on the same basis as any medical expense.
HOME HEALTH CARE	80% to maximum of \$75 per visit per policy year; 40 visits per policy year.
ORTHOPEDIC/PROSTHETIC APPLIANCES/BRACES	80% of reasonable charges not to exceed \$500 per policy year.
DURABLE MEDICAL EQUIPMENT	In addition to the NYUHC Only Plan benefit, 80% of allowable charges not to exceed \$500 per policy year.
PRESCRIPTION DRUG (SEE PAGE 32 FOR EXCLUSIONS)	Limit: \$750 per policy year maximum. Preferred Care: 100% after a \$20 copay for each brand name prescription drug or a \$10 copay for each generic prescription drug. Non-Preferred Care: 70% of reasonable charges after a \$20 deductible for each brand name prescription drug or a \$10 deductible for each generic prescription drug. Please note: You are required to pay in full at the time of service for all prescriptions dispensed at a Non-Preferred Pharmacy.
DIABETIC TREATMENT EXPENSE	Preferred Care: 90% of the negotiated charge up to the out-of-pocket maximum, 100% thereafter. Non-Preferred Care: 60% of reasonable charges up to the out-of-pocket maximum, 100% thereafter.
TRAVELER'S ASSISTANCE PROGRAM	See pages 16-17 for a description of this benefit.

BENEFIT	GSHIP
ADDITIONAL BENEFITS (cont'd)	
OPTICAL SERVICE AT NYUHC Note: Optical services are not an insured benefit and are not provided by Aetna Insurance Company of Connecticut. NYUHC has agreed to provide discounts as an added service to students covered under GSHIP.	Office Visits: No charge when medically necessary (i.e., conjunctivitis, corneal abrasions, etc.) Other Optical Services : (No benefit outside of NYUHC) <ul style="list-style-type: none"> Special discounts on: <ul style="list-style-type: none"> > New contact lens fittings (lenses not included) > Re-evaluation of current contact lens prescriptions > 10% discount on already discounted eyeglass frame and lenses package when prescribed by and purchased at NYUHC One free annual eye exam Supplies (contact lens solution, nose pads, sunglasses, etc.) available at competitive rates at NYUHC.
END OF LIFE CARE	Covered medical expenses include care provided at acute care facilities which specialize in the treatment of terminally ill patients for members diagnosed with advanced cancer. Reimbursement for services is provided at 100% of the negotiated charge. In the absence of a negotiated charge, reimbursement must be provided at 100% of the acute care facilities reimbursement rate under the Medicare program, after any applicable deductible.
RADIATION THERAPY, CHEMOTHERAPY AND INTRAVENOUS HOME THERAPY	Preferred Care - 90% of the negotiated charge up to the out-of-pocket maximum, 100% thereafter Non-Preferred Care - 60% of reasonable charges up to the out-of-pocket maximum, 100% thereafter Covered medical expenses do not count towards meeting the per condition outpatient maximum.

BENEFIT	GSHIP
MENTAL HEALTH BENEFITS	
INPATIENT MENTAL HEALTH	Preferred Care - 90% of the negotiated charge up to the out-of-pocket maximum, 100% thereafter up to \$150,000 Non-Preferred Care - 60% of reasonable charges up to the out-of-pocket maximum, 100% thereafter up to \$150,000
INPATIENT CHEMICAL ABUSE AND DEPENDENCE	Preferred Care - 90% of the negotiated charge up to the out-of-pocket maximum, 100% thereafter up to \$10,000 Non-Preferred Care - 60% of reasonable charges up to the out-of-pocket maximum, 100% thereafter up to \$10,000
PARTIAL HOSPITALIZATION	In exchange for full hospitalization
OUTPATIENT CHEMICAL ABUSE AND DEPENDENCE	Preferred Care - 100% of the negotiated charge Non-Preferred Care - 100% of reasonable charges Limit - 60 visits per policy year for outpatient treatment; and 20 of these outpatient visits must be available per policy year for counseling
OUTPATIENT MENTAL HEALTH	Preferred Care - 90% of the negotiated charge up to a policy year maximum of \$1,050 Non-Preferred Care - 90% of reasonable charges up to a policy year maximum of \$1,050 Note: Services at University Counseling Service (UCS) are free of charge to all matriculated students at NYU. Accessing UCS services has no impact on the \$1,050 maximum benefit.

Worldwide Emergency Travel Assistance Services

This benefit is designed to protect New York University students and their eligible **dependents** at home or while traveling. The benefit provides accidental death and dismemberment coverage up to \$10,000 underwritten by Unum Provident. It also includes medical evacuation and repatriation coverage with a medical assistance program designed to help locate medical care while traveling worldwide.

Insurance Company: Unum Provident Life Insurance Company of America

Group Policy Number: 01-AA-UNM-CHK

Plan Administrator: Chickering Claims Administrators, Inc.
P.O. Box 15708
Boston, MA 02215-0014

800-466-4148 (within the United States)

If outside the U.S., call collect by dialing the U.S. access code plus 617-582-5000.

Traveler's Assistance Services Provided by:

Assist America, Inc.
800-872-1414 (within the United States)
If outside the U.S., call collect by dialing the U.S. access code plus 301-656-4152.
medservices@assistamerica.com

An Assist America ID card will be supplied to you upon request once you enroll in GSHIP. 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 U.S. Department of State requirements for international students and scholars.

Travel Assistance Services

These services are designed to protect NYU students and their eligible dependents when traveling more than 100 miles from home anywhere in the world.

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.*

Accidental Death and Dismemberment Benefit

This insurance coverage provides accidental death and dismemberment coverage underwritten by Unum Provident Life Insurance Company of America.

Benefits are payable for the accidental death and dismemberment of the eligible insureds 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 by appointment at the NYU Insurance Department, 7 East 12 Street, 8th Floor, 212-998-2755.)

To file a claim for Accidental Death and Dismemberment, please contact Chickering Claims Administrators, Inc. at 800-466-4148 for the appropriate claim forms.

Catastrophic Option

Eligibility

Any student and his or her **dependents** already enrolled in GSHIP are eligible to add the Catastrophic Option. Spring coverage under the Catastrophic Option is available only to students who were not insured under GSHIP during the preceding fall term. The Catastrophic Option Enrollment Form may be downloaded from www.nyu.edu/nyuhc/insurance or requested from the NYUHC Student Health Insurance Services Office (212-443-1020) or Chickering Claims Administrators, Inc. (800-466-4148).

Period of Coverage

Coverage under the Catastrophic Option becomes effective in accordance with the following:

- (a) If the eligible student's Catastrophic Option Enrollment Form and premium are received by Chickering Claims Administrators, Inc. on or before August 21, 2003, for annual coverage, coverage becomes effective on August 21, 2003. If the eligible student's Catastrophic Option Enrollment Form and premium are received on or before January 9, 2004, for spring coverage, coverage becomes effective on January 9, 2004.
- (b) If the eligible student's Catastrophic Option Enrollment Form and premium are received after August 21, 2003, for annual coverage, or after January 9, 2004, for spring coverage, coverage becomes effective on the postmarked date of the Catastrophic Option Enrollment Form, but will not be accepted after the appropriate deadline (Fall - Sept. 30; Spring - Feb 10). Note: the period of coverage for this plan may differ from that of the Comprehensive Plan.
- (c) Those students enrolling only for Summer Term are not eligible for this benefit.

Maximum Injury and Sickness Benefit

Limit: Covered students: \$500,000 lifetime aggregate maximum
Covered dependents: \$250,000 lifetime aggregate maximum

Deductible: \$150,000 per condition (see below)

When the covered person incurs **covered medical expenses** as the result of an **injury** or **sickness**, this plan will pay 100% of the covered charges of a **preferred care, designated care, or non-preferred** care provider to a combined maximum benefit of \$500,000 for each covered student and \$250,000 for each covered dependent subject to a \$150,000 deductible (satisfied by GSHIP).

The maximum benefit is payable for those **covered medical expenses** incurred within the period of coverage. This plan is subject to the definitions, inpatient admission pre-certification requirement, **Preferred Provider Network** referral requirements, general terms and conditions, and exclusions applicable to the Student Health Insurance Program.

GENERAL TERMS AND CONDITIONS

COORDINATION OF BENEFITS

Benefits will be coordinated with any other group medical surgical or hospital plan so that combined payments under all programs will not exceed 100% of charges incurred for covered services and supplies.

BENEFIT PERIOD

Reasonable charges for medical expenses incurred by **covered students** or their insured **dependents** are covered if they are incurred within the period of coverage

up to the **aggregate maximum** benefit for each **injury** or for each **sickness**. Any expenses incurred beyond the period of coverage are not covered by this program.

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 Master Policy, but only while they are incurred during the ninety (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

For a Covered Student:

Insurance for a **covered student** will end on the date that the **covered student** withdraws from NYU to enter the armed forces of any country. Premiums will be refunded on a pro-rata basis when application is made within 90 days from withdrawal. If withdrawal from NYU is for a reason other than entering the armed forces, no premium refund will be made. Students will be covered for the policy term during which they are enrolled and for which the premium has been paid.

For a Covered Dependent:

Insurance for a covered **dependent** will end when insurance for the **covered student** ends. Before then, coverage will end:

For a Child

1. upon the next premium due date after the date of the child's marriage; or
2. upon the next premium due date after the child's 19th birthday (23rd birthday if in school).

However, if at the time at which insurance would otherwise cease the child is then incapable of self-sustaining employment due to mental or physical disability, coverage will end on the date the incapacity ends.

For a Spouse or Same Sex Partner

upon the next premium date after the date the marriage ends in divorce or annulment.

Termination will not prejudice any claim for a charge that is incurred prior to the date coverage ends.

INPATIENT HOSPITAL ADMISSION

Pre-certification will be coordinated by the Program's Plan Administrator:

Chickering Claims Administrators, Inc.
P.O. Box 15708
Boston, MA 02215-0014
Telephone: 800-466-4148
617-582-5000 (when outside of the United States)

Pre-Certification of Non-Emergency Inpatient Admissions

Inpatient Admission Pre-Certification is required by all NYU-sponsored Student Health Insurance Plans. If you do not secure pre-certification for non-emergency **hospital** admissions or do not provide notification for emergency hospital admissions, your covered expenses will be subject to a \$200 per admission deductible. The patient, doctor, or **hospital** must telephone Chickering Claims Administrators, Inc., the plan administrator, at least three (3) business days prior to the planned admission. You are responsible for advising your **physician** of the pre-admission certification requirement of this program. 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 Master Policy, as well as a review of eligibility, adherence to notification guidelines, and benefit coverage under the Program.

Notification of Emergency Hospital Admissions

The patient, patient's representative, doctor, or **hospital** must telephone Chickering Claims Administrators, Inc. within one (1) business day following admission. All inpatient admissions will be monitored by Chickering Claims Administrators, Inc.

NEW YORK STATE-MANDATED BENEFITS

This Program will pay benefits in accordance with any applicable New York State Insurance Law(s).

PRE-EXISTING CONDITIONS

Expenses incurred by a **covered person** as a result of a **pre-existing condition** will not be considered covered medical expenses unless no charges are incurred or treatment rendered for the condition for a period of 6 months while covered under this Program, or the **covered person** has been covered under this Program for 12 consecutive months, whichever happens first.

If a person has creditable coverage and such coverage terminated within 63 days prior to the date enrolled in this Program, then any limitation as to a **pre-existing condition** under this Program will apply to only the extent that the limitation would have applied if the **covered person** had remained covered under the prior creditable coverage.

Creditable coverage means a **covered person's** prior medical coverage as defined in the Federal Health Insurance Portability and Accountability Act (HIPAA) of 1996. Such coverage includes: coverage issued on a group or individual basis, Medicare, Medicaid, military-sponsored health care, a program of the Indian Health Service, a state health benefits risk pool, the Federal Employees' Health Benefits Plan (FEHBP), a public health plan as defined in the regulations, and any health benefit plan under Section 5(e) of Peace Corps Act.

Please note:

- Any student or dependent that enrolls during the open enrollment period is not subject to the rules governing pre-existing conditions.
- Any student or dependent that enrolls after the open enrollment period is considered a **late enrollee**, subject to the rules governing pre-existing conditions.

PREFERRED/DESIGNATED PROVIDER NETWORK

The Chickering Group has arranged for you to access a **Preferred Provider Network** and certain designated providers in your local community. Acute care facilities and mental health networks are available nationally if you require hospitalization outside the immediate area of the New York University campus. To maximize your savings and reduce your out-of-pocket expenses, select a **preferred provider** or **designated provider**. It is to your advantage to utilize a preferred provider or designated provider because significant savings can be achieved from the substantially lower rates these providers have agreed to accept as payment for their services. **Preferred providers/designate providers** are independent contractors and are neither employees nor agents of Chickering Claims Administrators Inc. or Aetna Insurance Company of Connecticut. You may contact Chickering Claims Administrators, Inc. at 800-466-4148 to locate preferred providers in your area.

REFERRAL REQUIREMENTS*

Students Seeking Medical Services IN Manhattan

Initial NYUHC Referral

Except for the situations listed below, all **covered students** in need of medical care **in Manhattan** are required, except in the case of a medical emergency, to first seek treatment and be evaluated at NYU Health Center (NYUHC) at 726 Broadway, New York, NY 10003. If evaluation by an NYUHC provider determines that you need services unavailable at NYUHC, you will be given a written off-site referral. If you receive non-emergency medical care anywhere in Manhattan without first being evaluated and referred by NYUHC, you will be denied benefits under this Student Health Insurance Program. *Referrals cannot be granted retroactively after treatment has been rendered.*

Referral Limitations

The referral is only valid for treatment of a specific condition, for the period of time stated on the referral. The referral may also limit the number of visits allowed within that time frame. **Your condition must be re-evaluated by your healthcare provider at NYUHC, 726 Broadway, before you seek additional outside treatment that exceeds these limits.**

Summer NYUHC Referrals

Whether or not a student is enrolled in summer courses at NYU, he or she must obtain authorization from NYUHC for outpatient medical benefits that take place in Manhattan and begin during the summer months (see referral sections above).

Referrals for Follow Up After Medical Emergency - (see page 4)

Referrals are not required for:

- Emergency Medical Conditions
- Gynecological Care
- Maternity Care

** Referral requirements are applicable to covered students only. Since covered dependents do not have access to NYUHC services, they do not need referrals to be covered for services outside NYUHC.*

Students Seeking Medical Services OUTSIDE Manhattan

Although there is no referral requirement for covered services received outside Manhattan, we encourage students to first seek services by an NYUHC provider who will be able to supervise and coordinate care with **no out-of-pocket expense** for medically necessary treatment at NYUHC.

If that is not possible, seek care from providers who participate in the Aetna network to ensure maximum benefits and minimal out-of-pocket expenses. To find an Aetna Network Provider go to www.aetna.com/docfind. Be sure to enter your zip code and select **Open Choice PPO Plan** as your health plan type. You may also call Chickering Claims Administrators, Inc. at 800-466-4148 and a representative will assist you.

Students may, however, use any provider outside the borough of Manhattan without an off-site referral from NYUHC. In all cases, students will be responsible for any copayments or coinsurance fees incurred.

Mental Health Services and Chemical Abuse and Dependence Services

Referrals are not required for mental health services and chemical abuse and dependence services.

University Counseling Service (UCS) provides services to matriculated students free of charge, with no impact on the maximum \$1,050 outpatient mental health benefit. Call 212-998-4780 for information about UCS services, or for information about services and clinicians in the community.

Frequently Asked Questions About Referrals

What if the off-site provider tells me that I need additional procedures or services?

The health care provider to whom you are referred may determine that additional tests or procedures outside of his/her office are medically necessary to properly treat your condition.

1. You should contact NYUHC to find out if the necessary services are available at NYUHC. If the services are available, you should make an appointment at NYUHC for these services.
2. If the requested services are unavailable at NYUHC, you may make an appointment with the provider who is recommended by the requesting physician. *An additional off-site referral is not required as long as the services are received within the period of time stated on the referral and are related to the same diagnosed condition.* (However, the health care provider or facility you are referred to may ask for a referral to ensure that they will get payment from the insurance company).

I have been referred to an off-site specialist before, but I now have a new medical condition. Do I need another referral authorization to see the same specialist?

A referral indicates services requested for a specific condition. So, if a new or different medical condition arises, you will need to be evaluated by your NYUHC health care provider again in order to obtain a referral authorization for this new condition.

Does a referral guarantee payment of medical services rendered?

Even though a referral may be required for payment of benefits, it does not necessarily guarantee payment. Benefits are subject to all provisions and limitations as outlined in this handbook including, but not limited to: deductibles, co-payments, maximum policy limits, determination of medical necessity, reasonable charges, etc.

OTHER AETNA PROGRAMS

As a participant in GSHIP, you have access to the following additional Aetna Programs:

Vision One® Discount Program

In addition to services available at NYUHC Optometry Services, this Program allows you to purchase certain vision services and supplies, including Lasik surgery, at discounted rates. You can obtain more detailed information regarding services, supplies, and discounts, as well as a list of providers who provide services, supplies, and discounts at www.aetna.com/docfind.

Fitness Program

Through the Fitness Program, you have access to special membership rates at participating health clubs nationwide and discounts on certain home exercise equipment. Members can also try out many participating clubs before joining by using a free trial workout certificate. Contact Chickering Claims Administrators, Inc. at 800-466-4148 for more information.

Alternative Health Care Programs

- Natural Alternatives: Offers members special rates on alternative therapies, including visits to acupuncturists, chiropractors, massage therapists and nutritional counselors.
- Vitamin Advantage™: Members can save on over-the-counter vitamins and nutritional supplements.
- Natural Products: Offers members savings on many health-related products, including aromatherapy, foot care and natural body care products.

Students may place orders by mail, telephone, fax or Internet to receive savings on health-related products offered through Vitamin Advantage and Natural Products. Students may visit Aetna's website (www.aetna.com) for the latest additions to the Vitamin Advantage and Natural Products lists and vendors, and a listing of Natural Alternatives participating providers. These participating providers and vendors are independent contractors and are neither agents nor employees of the University, Chickering or Aetna.

EXCLUSIONS

The following is a partial summary of the expenses neither provided for nor covered by the NYU-sponsored Student Health Insurance Plans. Additional exclusions may apply. Please refer to the Master Policy on file at the NYU Insurance Department, 7 East 12th Street, 7th Floor or contact Chickering Claims Administrators, Inc. at 800-466-4148.

1. Expense incurred as a result of dental treatment, except for treatment resulting from **injury to sound, natural teeth** as provided elsewhere in the Program
2. Expense incurred for services normally provided without charge by NYUHC or University Counseling Service
3. Expense incurred for eye refractions, vision therapy, 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. Expense 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. Expense 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. Expense incurred as a result of an **injury** or **sickness** due to working for wage or profit or for which benefits are payable under any Workers' Compensation or Occupational Disease Law
7. Expense incurred as a result of an **injury** sustained or **sickness** contracted while in the service of the Armed Forces of any country Upon the covered person entering the Armed Forces of any country, the unearned pro-rata premium will be refunded to the policyholder.
8. Expense incurred for treatment provided in a governmental **hospital** unless there is a legal obligation to pay such charges in the absence of insurance
9. Expense incurred for **elective treatment** or elective surgery except as specifically provided elsewhere in the Program and performed while the Program is in effect (*refer to definition shown on page 35 of this handbook*)
10. Expense incurred for cosmetic surgery, reconstructive surgery, or other services and supplies which improve, alter, or enhance appearance, whether or not for psychological or emotional reasons; except to the extent needed to:
 - 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 severe birth defect; including harelip, webbed fingers, or toes; or
 - as direct result of
 - disease; or
 - surgery performed to treat a disease or injury
 - 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 this Program. Surgery must be performed:
 - in the calendar year of the accident which causes the **injury**; or
 - in the next calendar year.
11. Expenses for injuries sustained as the result of a motor vehicle accident to the extent that mandatory automobile no-fault benefits are recovered or recoverable whether or not the claim is made for such benefit
 12. Expense incurred as a result of allergy shots and injections, preventive medicines, serums, or vaccines unless otherwise provided in the policy
 13. Expense incurred as a result of commission of a felony
 14. Expense incurred after the date insurance terminates for a **covered person** except as may be specifically provided in the Extension of Benefits Provision
 15. Expense incurred for any services rendered by a member of the **covered person's** immediate family
 16. Expense incurred for treatment, service, or supply that is not **medically necessary** (*see pages 36-37 for definition*) 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.)
 17. Expense incurred for **injury** resulting from the play or practice of interscholastic sports officially sanctioned by NYU's Department of Athletics, Intramural, and Recreation
 18. Expense for over-the-counter contraceptive methods and charges for or related to artificial insemination, in-vitro fertilization, or embryo transfer procedures, elective sterilization or its reversal unless otherwise provided for in the policy
 19. Expenses for treatment of injury or sickness to the extent that payment is made, as a judgment or settlement, by any person deemed responsible for injury or sickness (or their insurers)
 20. Expenses incurred for or in connection with: procedures; services; or supplies that are, as determined by Aetna, to be experimental or investigational.
 21. Expense incurred for which no member of the covered person's immediate family has any legal obligation for payment
 22. Any exclusion above will not apply to the extent that coverage of the charges is required under any law that applies to the coverage

FILING CLAIMS

It is the student's responsibility to obtain and complete the appropriate claim form for any medical treatment provided outside of NYUHC or for services not covered under our plans. If you are eligible for benefits from a private health insurance carrier you must follow your carrier's instructions for filing a claim.

Many health care providers will bill Chickering Claims Administrators Inc. directly. Some health care providers may not accept the NYU-sponsored Student Health Insurance Plans and require either full or partial payment at the time service is rendered. This is most common when traveling abroad. Therefore, you should always be prepared to make such payment. After you have made payment, you then may submit a claim to Chickering Claims Administrators, Inc. for reimbursement.

Follow these Steps to File a Claim:

1. Obtain a claim form

- Download claim form from www.nyu.edu/nyuhc/insurance,
- Pick up a claim form at:
NYUHC Student Health Insurance Services Office
726 Broadway, Suite 346; or
- Request that a claim form be mailed to you by contacting:
NYUHC Student Health Insurance Services Office at 212-443-1020, or
Chickering Claims Administrators, Inc. at 800-466-4148.

2. Complete the claim form

- attach any itemized bills related to your treatment
- indicate that you attend NYU
- include your name, address and student identification number

If you paid for any services, in full or in part, attach evidence of such payment (e.g., cash or credit card receipt, copy of canceled check, etc.) to the claim form. Without such evidence, you will not be reimbursed. All documentation must be in English.

(Please note: You need to submit only one claim form for each condition, even if you have multiple bills, receipts, etc. related to that condition.)

3. Keep a copy

For your records, keep a copy of your completed claim form, medical bills, and any other documentation submitted with your claim.

4. **Mail the completed claim form** and any attached itemized bills, receipts, etc. to:

Chickering Claims Administrators, Inc.
P.O. Box 15708
Boston, MA 02215-0014

If after filing your claim form you receive additional bills, submit them directly to Chickering Claims Administrators, Inc. Make certain that all your medical bills

correctly show your name and social security number (make changes on the medical bills, if necessary). Claim forms, medical bills, and all other claim-related correspondence should be directed to Chickering Claims Administrators, Inc. within 30 days of treatment.

If you have any problems in filing a claim and need assistance, please contact Chickering Claims Administrators, Inc. at 800-466-4148. If you need further assistance, contact the NYUHC Student Health Insurance Services Office at 212-443-1020 or health.insurance@nyu.edu.

If Your Claim is Denied

If your claim has been denied, the reason will be included in the "Explanation of Benefits" that you will receive. Claims can be denied for several reasons. For example:

- You did not complete the appropriate claim form.
- You are not insured under the program.
- You failed to seek treatment at NYUHC when required (except for prescriptions).
- The medical services performed were not covered under the program (except for prescriptions).
- The maximum benefits under your plan have been paid to you already.

Complaint and Appeals Procedure

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

The complaints and appeals process is designed to address coverage issues, complaints and problems. If you or your covered dependent have a coverage issue or other problem, call Chickering Customer Services at (800) 466-4148. 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

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

Internal Appeals Procedure

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

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

First Level Appeals Procedure

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

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

- An acknowledgment letter will be sent to you within 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 **1-800-400-8882**. 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.

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**. For your convenience, NYUHC has a full-service preferred Pharmacy on-site.

If you need to fill a prescription and do not have your ID card with you, you may obtain and pay for your prescription from an Aetna **preferred pharmacy** and be reimbursed by submitting a completed Aetna Prescription Drug Claim Form to the address on the form.

You will be reimbursed for covered medications directly by Aetna Pharmacy Management Network.

You may obtain your prescription from a **non-preferred pharmacy** and be reimbursed by submitting a completed Aetna Pharmacy Management Prescription Drug Claim Form. You may obtain a prescription drug claim form from Chickering Claims Administrators, Inc. or the NYUHC Student Health Insurance Services Office. You will be reimbursed for covered medications based on the **reasonable charge**, less any applicable deductible and coinsurance, directly by Aetna. Please note: You will be required to pay in full at the time of services for all prescriptions dispensed at a non-participating pharmacy.

To obtain a listing of preferred pharmacies, contact Chickering Claims Administrators, Inc. at 800-466-4148.

Medications Not Covered by the Aetna Pharmacy Management Network

Medications not covered by this benefit include, but are not limited to:

- Over-the-counter medications
- Drugs whose sole purpose is to promote or stimulate hair growth
- Renova
- Allergy Sera
- Smoking cessation medications

- Appetite suppressants
- Fertility medications
- Preventative medicines or vaccines, except when medically necessary (i.e., rabies, Hepatitis B immunoglobulin)
- Non-self injectables (i.e., Depo-Provera)

Prior authorization is required for growth hormones and drugs for treatment of malaria. For assistance, or a complete list of excluded medications and drugs available with prior authorization, please contact Aetna Pharmacy Management Network at 800-238-6279.

Covered pharmaceutical expenses include coverage for oral contraceptives. Coverage for prescription contraceptive devices or for covered Depoprovera or Lunelle injections is provided under the medical portion of the Plan.

If Your Claim is Denied/How to Appeal a Claim

(See FILING CLAIMS section on pages 26-27.)

RIGHT TO RECOVERY

Aetna reserves the right to receive reimbursement from a **covered person** for benefits it paid for a **covered person** because all or some covered expenses either were not paid by the **covered person**, or exceeded the benefits provided under this plan. If a **covered person** receives reimbursement from a third party for covered expenses as a result of legal action taken to recover the loss which was due to negligence, wrongful acts, or omissions, Aetna reserves the right to repayment of benefits paid for the same covered expenses.

In addition, if a **covered person** suffers an injury or sickness as a result of a negligent or wrongful act or omission, Aetna reserves the right to seek reimbursement (where permitted by law) from that third-party for benefits it paid for covered expenses. In such a case the **covered person** is obligated to provide Aetna with any information necessary to enforce its rights under this provision.

GLOSSARY

Actual Charge

The charge made for a covered service by the provider who furnishes it

Complications of Pregnancy

Conditions that require hospital stays before the pregnancy ends and whose diagnoses are distinct from but are caused or affected by pregnancy.

These conditions are:

- acute nephritis or nephrosis; or
- cardiac decompensation or missed abortion; or
- similar conditions as severe as these

Not included are:

- a) false labor, occasional spotting, or physician prescribed rest during the period of pregnancy;
- b) morning sickness;
- c) hyperemesis gravidarum and preclampsia; and
- d) similar conditions not medically distinct from a difficult pregnancy

Complications of pregnancy also include:

- nonelective cesarean section; and
- termination of an ectopic pregnancy; and
- spontaneous termination when a live birth is not possible
(This does not include voluntary abortion)

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

Coinsurance

The percentage of covered medical expenses payable by Aetna under this Accident and Sickness plan

Covered Dependent

A **covered student's dependent** who is insured under this Program

Covered Medical Expense

Those charges for any treatment, service, or supplies covered by this Program that are:

- not in excess of the **reasonable charges**; or
- not in excess of the charges that would have been made in the absence of this coverage; and
- incurred while the Program 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** and any **covered dependent** while coverage under the Program is in effect.

Covered Student

A student of New York University who is insured under this Program

Deductible

The specific amount of **covered medical expenses** that must be incurred by, and paid for by, the **covered person** before benefits are payable under the Program (Deductible amounts are the responsibility of the **covered person**.)

Dependent

(A) the **covered student's** spouse residing with the **covered student**; or
(B) the person identified as a domestic partner in the "Declaration of Domestic Partnership," which is completed and signed by the **covered student**; and
(C) the **covered student's** unmarried child under the age of 19 years (or 23 if a student)

The child must reside with, and be fully supported by, the covered student.

The term "**child**" includes a **covered student's** stepchild, adopted child, and a child for whom a petition for adoption is pending and who is residing with the **covered student** and who is chiefly dependent on the **covered student** for his or her full support.

The term "**dependent**" does not include a person who is (a) an eligible student or (b) a member of the armed forces.

Designated Care

Care provided by a **designated care provider** upon referral from NYUHC

Designated Care Provider

A health care provider who is affiliated and has an agreement with NYUHC to furnish services and supplies at a **negotiated charge**

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;
- treatment of infertility;
- routine physical examinations; and
- well baby visits.

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

Hospital

A facility that meets all of these tests:

- it provides in-patient services for the care and treatment of injured and sick people;
- it provides room and board services and nursing services 24 hours a day;
- it has established facilities for diagnosis and major surgery;
- it is run as a hospital under the laws of the jurisdiction in 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 a substance abuse treatment facility during any period in which it provides effective treatment of substance abuse to the covered person.

Hospital Confinement

A documented inpatient stay in a hospital as a resident bed patient

Injury

Bodily injury caused by an accident (this includes related conditions and recurrent symptoms of such injury)

Late Enrollee

Any student or dependent that enrolls after the open enrollment period

Lifetime Aggregate Maximum

The maximum benefit that will be paid under this Program for all **covered medical expenses** incurred by a **covered person** that accumulate from one Program year to the next

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 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 a **designated care provider**, has agreed to make as to any service or supply for the purpose of benefits under this Program

Non-Preferred Care

A health care service or supply furnished by a health care provider that is not a **designated care provider**; or that is not a **preferred care provider**; if, as determined by Aetna:

- the service or supply could have been provided by a **preferred care provider**; and
- the provider is of a type that falls into one or more of the categories of providers; or a **designated care provider**

Non-Preferred Care Provider

A non-preferred care provider is:

- a health care provider that has not contracted to furnish services or supplies at a **negotiated charge**; or
- a **preferred care provider** that is furnishing services or supplies without the referral of NYUHC; or
- a health care provider that is not a **designated care provider**

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

Out-of-Pocket Maximum Expenses

The maximum dollar amount an insured is required to pay out during a policy year (subject to the limitations listed below):

Once an insured individual has reached the applicable Out-of-Pocket Maximum (as stated above) within a Policy Year for covered medical expenses (not including prescription drugs), the Plan will pay 100% up to the overall Plan Maximum.

Any applicable Preferred Care Copays, Non-Preferred Care Deductibles, or expenses in excess of the Reasonable Charge do not apply towards meeting the Out-of-Pocket Maximum. Any amount payable as a result of failure to secure Pre-Certification for inpatient admissions also does not apply towards meeting the Out-of-Pocket Maximum. Charges in excess of any specified maximum, and non-covered services are not applied toward meeting the Out-of-Pocket Maximum and are the responsibility of the insured.

Physician

A legally qualified physician licensed by the state in which he or she practices, 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** following the referral by NYUHC; or
- a **non-preferred care provider** on the referral of NYUHC and if approved by Aetna; or
- any health care provider for an emergency condition when travel to a **preferred care provider** or referral by NYUHC prior to treatment is not feasible

Preferred Care Provider (or Preferred Provider)

A health care provider who has contracted with Aetna to furnish services or supplies for a **negotiated charge** but only if the provider is, with Aetna's consent, listed as a **preferred care provider** for:

- the service or supply involved; and
- the class of **covered persons** of which you are member

Preferred Pharmacy

A pharmacy which is party to a contract with Aetna Pharmacy Management Network to dispense drugs to persons covered under the program, but only while the contract remains in effect; and when the pharmacy dispenses a prescription drug under the terms of its contract with Aetna

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

Disease or illness including related conditions and recurrent symptoms of the sickness. Sickness also includes pregnancy and complications of pregnancy. All injuries or sickness due to the same or a related cause are considered one **injury** or **sickness**.

Sound, Natural Teeth

Natural teeth, the major portion of the individual tooth that is present regardless of fillings and is not carious, abscessed, or defective. Sound, natural teeth shall not include capped teeth.

GENERAL INFORMATION

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

Patient Management Program

Aetna has developed a Patient Management Program to assist in the determining what health care services are covered under the health plan and the extent of such coverage. The program assists members in receiving appropriate health care and maximizing coverage for those health care services.

Patient Management staff use national guidelines and resources to guide the precertification, concurrent review, and retrospective review processes. On the basis of information collected from providers, Patient Management staff applies Millman and Robertson Health Care Management Guidelines when conducting concurrent U.C. review. If there is no applicable Millman & Robertson Guideline, Patient Management staff applies InterQual ISD criteria. Aetna's Coverage Policy Bulletins (CPBs) are also used as a guide in making coverage determinations. CPBs do not cover every aspect of medicine, and may not apply to your specific Plan, but have been developed to address new approaches to care, including new technologies, new treatment approaches, and procedures. CPBs are based on peer-review medical literature, the recommendations of leading medical organizations, and, where appropriate, the Health Care Financing Administration's Medicare coverage policies. You can view CPBs at www.aetna.com. Since CPBs can be highly technical and are designed to be used by our professional staff in making coverage determinations, you may want to review the CPBs of interest with your physician. CPBs do not constitute medical advice and treating providers are solely responsible for medical advice and treatment of members. CPBs are a tool to be interpreted in conjunction with the member's specific benefit plan and after consultation with the treating physician; CPBs contain only a partial, general description of benefit and do not constitute a contract. CPBs are regularly updated and are, therefore, subject to change.

Only Medical Directors make decisions denying coverage for services for reasons of medical necessity. Coverage denial letters delineate any unmet criteria standards and guidelines, and inform the provider and member of the appeal process.

The Aetna Patient Management plan includes the following components:

- **Pre-certification**

You must obtain pre-certification for certain types of care rendered by preferred or 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 pre-certification 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 followup action based on quality or utilization issues, and review all 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 student 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.

Aetna Pharmacy Management negotiates discounts from independent Pharmacies, chain pharmacies that participate in the Aetna network. The reimbursement formula is based on Average Wholesale Price (AWP) less a negotiated discount, plus a dispensing fee. The dispensing fee is a contractual fee negotiated between Aetna Pharmacy Management and the network pharmacy. With Internet access, you can conduct an on-line search for participating pharmacies through DocFind, which is available at www.aetna.com/docfind. A paper directory is also available to covered students.

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 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 student 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 student medical information about themselves and their dependents between Aetna and participating providers and health delivery systems.

Notice to Enrollees

While the paper provider directory (available upon request) is believed to be accurate as of the print date, it is subject to change without notice. Participating providers are independent contractors in private practice and are neither employees nor agents of Aetna, NYU, 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 this provider directory was created, the status of a provider's practice may have changed.

For the most current information, please contact the selected physician or Customer Services at 800-466-4148.

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.

Notice of Information Disclosure

Aetna considers nonpublic personal member information ("NPI") 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 NPI 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 NPI 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 describing in greater detail our practices concerning use and disclosure of NPI, please call the toll-free Customer Services number on your ID card or visit Chickering Student Connection Link at www.chickering.com.

QUICK REFERENCE GUIDE

Contact Information		
CHICKERING CLAIMS ADMINISTRATORS, INC.	P.O. Box 15708 Boston, MA 02215-0014 800-466-4148, or 617-582-5000 when outside of the United States www.chickering.com	Student health insurance claims, enrollment, and information about benefits.
AETNA PHARMACY MANAGEMENT NETWORK	800-238-6279	Information about the Aetna Pharmacy Management Network.
ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS AND WORLDWIDE TRAVEL ASSISTANCE	Assist America, Inc. 800-872-1414 When outside of the U.S. access code + 301-656-4152 (You may call collect.)	Provides Accidental Death and Dismemberment Benefits and Traveler's Assistance Services
NEW YORK UNIVERSITY	726 Broadway, 3rd and 4th Floors New York, NY 10003-9580	Appointments or information about services at NYUHC; Student Health Insurance Selection/Waiver Form; inquiries pertaining to charges for services rendered at the NYUHC; information pertaining to NYUHC Pharmacy Services
NEW YORK UNIVERSITY HEALTH CENTER	General Information: 212-443-1000 Student Health Insurance: 212-443-1020 Patient Accounts: 212-443-1010 Pharmacy Services: 212-443-1050 www.nyu.edu/nyuhc	
UNIVERSITY COUNSELING SERVICE	726 Broadway, 4th Floor New York, NY 10003-9580 212-998-4780 www.nyu.edu/counseling	Appointments or information about services
DENTAL FACULTY PRACTICE	418 Lafayette Street, 3rd Floor New York, NY 10003-6947 212-443-1313 www.nyu.edu/dental	Stu-Dent Plan/Urgent Dental Service
OFFICE FOR INTERNATIONAL STUDENTS AND SCHOLARS	561 La Guardia Place New York, NY 10012-1402 212-998-4720 www.nyu.edu/osl/oiss	General information for international students and scholars
PROTECTION AND TRANSPORTATION SERVICE	14 Washington Place, 1st Floor New York, NY 10003-6696 212-998-2222 www.nyu.edu/pages/protection/	Emergencies/General Information
HENRY & LUCY MOSES CENTER FOR STUDENTS WITH DISABILITIES	240 Greene Street, 4th Floor New York, NY 10012-9873 212-998-4980 (Voice/TTY) www.nyu.edu/oslcsd	Services for students with qualified hearing and visual impairments, mobility impairments, learning disabilities and attention deficit disorders, chronic illnesses, and psychological impairments.

New York University is fully committed to the principle of equal opportunity and to the goal of assuring the greatest possible diversity in faculty and staff. In keeping with this policy, NYUHC will recruit, hire, train, and promote to all job levels the most qualified persons without regard to race, color, religion, sex, sexual orientation, marital or parental status, citizenship status, national origin, age or disability.

New York University is an affirmative action/equal opportunity institution.