

# 2005 - 2006



## Nova Southeastern University

### Student Health Insurance Plan Brochure

**Offered by:**

Chickering Benefit Planning Insurance Agency, Inc.  
(800) 678-4561

**Administered by:**

Chickering Claims Administrators, Inc.

**Underwritten by:**

Aetna Life Insurance Company (ALIC)

Policy No. 724533

This Plan Contains a Deductible

GR-96137

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## ***The Nova Southeastern University Student Health Insurance Plan***

The Nova Southeastern University Student Health Insurance Plan has been developed especially for Nova Southeastern University students. The Plan provides coverage for illnesses and Injuries that occur on and off campus, and includes special cost-saving features to keep the coverage as affordable as possible. Nova Southeastern University is pleased to offer the Plan, as described in this Brochure, to students.

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

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

### ***Where to Find Help***

#### **By logging into Aetna Navigator, you can:**

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

#### **How do I register?**

- Go to ***www.chickering.com***
- Click on "Find Your School."
- Enter your school name and then click on "Search."
- Click on Aetna Navigator and then the "Access Navigator" link.
- Follow the instructions for First Time User by clicking on the "Register Now" link.
- Select a user name, password and security phrase.

Your registration is now complete, and you can begin accessing your personalized information!

#### **Need help with registration?**

Registration assistance is available toll free, Monday through Friday, from 7 a.m. to 9 p.m. Eastern Time at 1-800-225-3375.

## ***You Can Also Find Help***

### **For questions about:**

- Insurance Benefits
- Enrollment
- Enrollment Forms
- Waiver Process
- Claims Processing
- Inpatient Admission Pre-Certification

*Please contact:*

Chickering Claims Administrators, Inc.  
P.O. Box 15708  
Boston, MA 02215-0014  
**(800) 678-4561**

### **For questions about ID cards**

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

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

*For lost ID cards, contact:*

Chickering Claims Administrators, Inc.  
**(800) 678-4561**

Or visit [www.chickering.com](http://www.chickering.com), click on “Find Your School” and enter **724533** as your Policy Number.

### **For questions about:**

- Status of Pharmacy Claims
- Pharmacy Claim Forms
- Excluded Drugs and Pre-Authorization

*Please contact:*

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

### **For Provider Listings:**

*(Including Preferred Pharmacy Listings)*

A complete listing of Preferred Providers can be found through the internet by accessing Aetna's online **DocFind**<sup>®</sup> service located at [www.chickering.com](http://www.chickering.com). Click on “Find Your School” and enter **724533** as your Policy Number.

**For questions about:**

- Worldwide Emergency Travel Assistance Services

*Please contact:*

Assist America, Inc.

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

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

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

*Worldwide Web Access:*

- The Chickering Group - ***www.chickering.com***

## ***Nova Southeastern University Student Health Insurance Plan***

This is a brief description of the Accident and Sickness Medical Expense benefits available for Nova Southeastern University students and their eligible dependents. The Plan is underwritten by Aetna Life Insurance Company (Aetna). The exact provisions governing this insurance are contained in the Master Policy issued to the University, and may be viewed at the University during normal business hours.

The Plan is administered by Chickering Claims Administrators, Inc., P.O. Box 15708, Boston, MA 02215-0014.

### ***Eligibility Requirements***

*Student Eligibility Requirements*

All Nova Southeastern University Health Professions Division, Farquar Day, and on-campus residential students are required to maintain adequate health insurance. In addition, Federal Visa regulations require international J-1 students and their J-2 dependents to maintain adequate health insurance throughout their stay in the U.S.

If you are not currently insured, or your plan does not provide adequate coverage in South Florida, you are required to enroll in the Nova Southeastern University Student Health Insurance Plan. All students will automatically be enrolled in the Student Health Insurance Plan upon registration unless proof of other comparable coverage is presented prior to the waiver deadline. See the Waiver Process Section for more information.

All other registered degree seeking students enrolled in Nova Southeastern University taking credit hours are eligible to enroll in the Student Health Insurance Plan on a voluntary basis. To enroll please complete the Enrollment Form and mail to Chickering Benefit Planning Insurance Agency, Inc. by the appropriate deadline.

Students must actively attend classes for at least the first 31 days after the date for which coverage is purchased. If the eligibility requirements are not met, Aetna's only obligation is to refund the premium.

### *Dependent Eligibility Requirements*

Covered students may also enroll their lawful spouse and unmarried dependent children under age 19 (25 if in school) who reside with, and are fully supported by, the Covered Student for the same coverage. The Enrollment Form can be obtained at [www.chickering.com](http://www.chickering.com), or by contacting our Customer Service Department at (800) 678-4561.

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

All health insurance benefits applicable for children will be payable with respect to a newborn child from the moment of birth. The coverage for a newborn child consists of coverage for expenses incurred as a result of Injury or Sickness, including the necessary care or treatment of medically diagnosed congenital defects; birth abnormalities; or prematurity; and also includes transportation costs of the newborn to and from the nearest available facility appropriately staffed and equipped to treat the newborn's condition if the transportation is certified by the attending Physician as necessary, to protect the health and safety of the newborn child. The coverage of transportation costs may not exceed the Reasonable Charge allowance, up to \$1,000.

Notice must be given to Chickering Benefit Planning Insurance Agency, Inc. within 31 days of the date of the child's birth. If timely notice of the child's birth is given, no additional premium will be charged for the coverage of the newborn child for the duration of the notice period. If notice is not given within the 31-day period, an additional premium will be charged from the date of the child's birth. Coverage will not be denied for a child due to the failure of the covered student to provide a timely notice to Chickering Benefit Planning Insurance Agency, Inc. of the birth of the child.

### ***Enrollment Procedure***

#### *Students*

All Nova Southeastern University Health Professions Division, Farquar Day, and on-campus residential students will automatically be enrolled in the Nova Southeastern University Student Health Insurance Plan upon registration. Coverage can be waived if evidence of other comparable coverage is presented prior to the Waiver Deadline. See the Waiver Procedure section for more information.

Students who have previously waived participation in the Plan may enroll after the deadline only if there has been a significant life change (i.e. loss of prior coverage), and should contact Nova Southeastern University Office of Recreation and Wellness at (954)-262-7301.

All other students should contact Chickering Claims Administrators, Inc. at (800) 678-4561, or the Nova Southeastern University Office of Recreation and Wellness at (954)-262-7301 for more information.

### *Dependents*

All Nova students who wish to purchase coverage for their eligible dependents under Nova Southeastern University's Student Health Insurance Plan may do so by completing the Enrollment Form and remitting the appropriate premium to Chickering Benefit Planning Insurance Agency, Inc, prior to the applicable deadline. No Enrollment Forms will be accepted after deadline unless a qualifying life circumstance exists, such as involuntary loss of other coverage, marriage, or birth/adoption of a child.

**Annual/Fall Policy:** If the Enrollment Form is submitted before **October 1, 2005** (**August 1, 2005** for Dependents of PA and OT students), coverage will be backdated to the beginning of the Policy Period. If the Enrollment Form is submitted after **October 1, 2005**, it will not be accepted in the absence of a significant life change, and the student (or dependent) will have to wait until the next open enrollment period to apply. An Enrollment Form should be submitted directly to Chickering Benefit Planning Insurance Agency, Inc.

**Winter Policy:** If the Enrollment Form is submitted before **February 1, 2006**, coverage will be backdated to the beginning of the Policy Period. If the Enrollment Form is submitted after **February 1, 2006**, it will not be accepted in the absence of a significant life change, and the student (or dependent) will have to wait until the next open enrollment period to apply. An Enrollment Form should be submitted directly to Chickering Benefit Planning Insurance Agency, Inc. Winter Semester enrollment is available to dependents of new students only.

**Mid Year Enrollment:** Dependents of Covered Students may enroll after the deadline only if there has been a significant life change (i.e. loss of prior coverage). If the Enrollment Form is submitted within 30 days of qualifying event, coverage will be backdated to the date of qualifying event. If the Enrollment Form is submitted after the 30 days of qualifying event, it will not be accepted, and the dependent will have to wait until the next open enrollment period they are eligible for to enroll. The completed Enrollment Form should be submitted directly to Chickering Benefit Planning Insurance Agency, Inc.

### ***Waiver Procedure***

All Nova Southeastern University Health Professions Division, Farquar Day, and on-campus residential students who have other comparable coverage must file a waiver by the deadline below in order to waive participation in the Student Health Insurance Plan. Waivers can only be submitted online by visiting [www.chickering.com](http://www.chickering.com), and under "Find Your School" enter **724533** as your Policy Number. You may also link to this waiver site from [www.rec.nova.edu/insure\\_req.html](http://www.rec.nova.edu/insure_req.html).

If the waiver information has not been entered online by the indicated deadline, the student will remain enrolled in the University's Student Health Insurance Plan and the charge of \$1,594 for the Student Health Insurance Plan cannot be removed.

### ***Waiver Deadline***

Fall Semester: **October 1, 2005** (**August 1, 2005** for PA and OT Students)

Winter Semester: **February 1, 2006**

### ***Policy Period***

*All eligible students (excluding PA, and OT students)*

Coverage under Nova Southeastern University Student Health Insurance Plan is effective:

- **Annual Period:** 12:01 a.m. on **August 1, 2005**, through 12:01 a.m. on **August 1, 2006**.
- **Fall Semester Only:** 12:01 a.m. on **August 1, 2005** through 12:01 a.m. on **January 1, 2006**.
- **Winter Semester Only:** 12:01 a.m. on **January 1, 2006** through 12:01 a.m. on **August 1, 2006**.\*

**\*Please note:** Winter Semester enrollments available to new students only.

*Health Professions Division-Physician Assistant and Occupational Therapy Students*

Coverage under the Nova Southeastern University Student Health Insurance Plan for PA and OT programs is effective:

- **Annual Period:** 12:01 a.m. on **June 1, 2005**, through 12:01 a.m. on **June 1, 2006**.
- **Fall Semester Only:** 12:01 a.m. on **June 1, 2005**, through 12:01 a.m. on **January 1, 2006**.
- **Winter Semester Only:** 12:01 a.m. on **January 1, 2006**, through 12:01 a.m. on **June 1, 2006**.\*

**\*Please note:** Winter Semester enrollments available to new students only.

*Health Professions Division-Second Year Physician Assistant Students*

Coverage under the Nova Southeastern University Student Insurance Plan for PAII students is effective:

- **Annual Period:** 12:01 a.m. on **June 1, 2005**, through 12:01 a.m. on **September 1, 2006**.
- **Fall Semester Only:** 12:01 a.m. on **June 1, 2005**, through 12:01 a.m. on **January 1, 2006**.
- **Winter Semester Only:** 12:01 a.m. on **January 1, 2006**, through 12:01 a.m. on **September 1, 2006**.\*

**\*Please note:** Winter Semester enrollments available to new students only.

### ***Insured Dependents***

Coverage will become effective on the same date the Covered student's coverage becomes effective or one the date of a substantial life event when the completed Enrollment Form and premium are sent, if later. Coverage for covered dependents terminates in accordance with the Termination provisions described in the Master Policy. Examples include, but are not limited to, the date the dependent no longer meets the definition of a dependent.

### ***Premium Rates***

*All eligible students (excluding PA and OT students)*

	Annual 8/1/05-8/1/06	Fall 8/1/05-1/1/06	Winter 1/1/06-8/1/06
Student	\$1,594	\$639	\$955
Spouse	\$3,877	\$1,551	\$2,326
Per Child	\$2,586	\$1,033	\$1,553

*Physician Assistant and Occupational Therapy Students*

	Annual 6/1/05-6/1/06	Fall 6/1/05-1/1/06	Winter 1/1/06-6/1/06
Student	\$1,594	\$955	\$639
Spouse	\$3,877	\$2,326	\$1,551
Per Child	\$2,586	\$1,553	\$1,033

*Second Year Physician Assistant*

	Annual 6/1/05-9/1/06	Fall 6/1/05-1/1/06	Winter 1/1/06-9/1/06
Student	\$1,993	\$955	\$1,038
Spouse	\$4,848	\$2,326	\$2,522
Per Child	\$3,233	\$1,551	\$1,682

### ***Premium Refund Policy***

If you withdraw from Nova Southeastern University within the first 31 calendar days of the semester, you will receive a full refund of the insurance premium unless you or your covered dependent files a medical claim. If you withdraw from Nova Southeastern University after the first 31 calendar days of the semester, your coverage will remain in effect until the end of the term for which you have paid premium. No refunds will be granted after the first 31 calendar days of the semester.

The Policy also applies to students on leave of absence for medical or academic reasons, graduating students, and students choosing to enroll in a separate, comparable, or better plan during the Policy Period.

A Covered Person entering the armed forces of any country will not be covered under the Policy as of the date of such entry. A pro-rata refund of premium will be made for such person, and any of the student's covered dependents, upon written request received by Chickering Claims Administrators, Inc. within 90 days of withdrawal from the School.

### ***Pre-Existing Conditions***

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

Any Injury, Sickness, or condition that was diagnosed or treated, or would have caused a prudent person to seek diagnosis or treatment, within 12 months prior to the Covered Person's effective date of Insurance. Under the Policy, expenses incurred by a Covered Person for a Pre-Existing Condition will not be considered a Covered Medical Expense unless the Covered Person has been covered under the Policy for 12 consecutive months.

Routine follow up care to determine whether a breast cancer has recurred in a person who was previously determined to be free of breast cancer does not constitute medical advice, diagnosis, care or treatment for purposes of determining pre-existing conditions unless evidence of breast cancer is found during, or as a result of, the follow up care.

#### *Special Rules As To Pre-Existing Conditions*

If a Covered Person had creditable coverage and such coverage terminated within 30 days prior to the date he or she enrolled (or was enrolled) for coverage in the Policy, then any limitation as to a Pre-Existing Condition under this Policy will not apply for that person.

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

#### *Limitation:*

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

### ***Continuously Insured***

Persons who have remained Continuously Insured under the Policy and other prior health insurance policies will be covered for any Pre-Existing Condition that manifests itself while Continuously Insured, except for expenses payable under prior policies in the absence of the Policy. Previously Covered Persons must re-enroll for coverage by the indicated enrollment deadlines in order to avoid a break in coverage for conditions that existed in the prior Policy Year. Once a break in continuous coverage occurs for more than 30 days, the definition of Pre-Existing Conditions will apply.

### ***Nova Southeastern University Health Care Centers***

Students' and dependents health care needs can best be satisfied when an organized system of health care providers at the Nova Southeastern University Health Care Centers manages the treatment. Coverage for Non-Prescription services rendered at the Health Care Centers are payable at 100% with waiver of the annual Deductible. (Please note that while some services (i.e. lab tests, X-rays, and certain subspecialty care) may be ordered by NSU Health Care Center providers, the services may actually be performed by outside of the NSU Health Care Center, and will be subject to the provisions of the Plan, including the annual deductible and coinsurance.)

Prescription Drug charges are payable at 100% after a per prescription Copay up to the annual Prescription Drug maximum. See page 21 for more information on Prescription Drug Coverage.

When necessary, referrals will be issued to Preferred Providers (please note that, unless specifically noted, a referral is required when you are within the service area for benefits to be payable). Please see page 13 for more information, and for circumstances in which referrals are not required.

***If you are enrolled in the Student Health Insurance Plan, you must initiate care at one of the following NSU Health Care Centers (when appropriate) in order for benefits to be payable.***

Nova Southeastern University Student Health Center  
Address: 3200 S. University Drive  
Phone #: (954) 262-1262  
Hours of Operation:  
Monday - Friday: 12:00 p.m. - 7:00 p.m.

Sanford L. Ziff Health Care Center

Address: 3200 S. University Drive

Phone #: **(954) 262-4100**

*Hours of Operation:*

Monday - Friday: 9:00 am - 12:00 p.m. and 1:30 p.m. - 5:00 p.m.

Saturday: 9:00 a.m.- 1:00 p.m.

Nova Southeastern University Health Center at North Miami Beach

Address: 1750 167th St.

Phone: **(305) 949-4000**

*Hours of Operation:*

Monday - Friday: 9:00 a.m. - 12:00 p.m. and 1:30 p.m. - 5:00 p.m.

Saturday: 9:00 a.m. - 1:00 p.m.

These facilities provide primary care, women's health services, routine services, as well as a variety of other health care services. In addition, the Health Care Center can provide off-campus referrals to Preferred Providers for services not available at NSU.

***If you are enrolled in the Student Health Insurance Plan, and unless noted otherwise, a referral from the Nova Southeastern University Health Care Center is required for most services in order for benefits to be payable.***

Services provided at the NSU Health Care Centers are subject to all Policy limits and exclusions as they relate to health care services (including Pharmacy). Lab tests, X-rays, and certain subspecialty care may be performed by non-NSU Health Care Center providers, and will be subject to the annual Deductible and Coinsurance.

### ***Preferred Provider Network***

The Chickering Group has arranged for you to access a Preferred Provider Network in your local community. Acute care facilities and mental health networks are available nationally. To maximize your savings and reduce your out-of-pocket expenses, select a Preferred Provider. It is to your advantage to use a Preferred Provider because significant savings may be achieved from the substantially lower rates these providers have agreed to accept as payment for their services.

Preferred Providers are independent contractors and are neither employees nor agents of, Chickering Claims Administrators, Inc., Aetna, or with the exception of the NSU Health Care Center, Nova Southeastern University.

You can obtain a complete listing of Preferred Providers through the internet by accessing Aetna's online **DocFind**<sup>®</sup> service located at [www.chickering.com](http://www.chickering.com). Click on "Find Your School" enter **724533** as your Policy Number. You can use **DocFind**<sup>®</sup> to find out whether a specific provider belongs to Aetna's network or to find preferred providers practicing in your area. You may also contact Chickering Claims Administrators, Inc. at **(800) 678-4561**.

### ***Inpatient Admission Pre-Certification Program***

Pre-Admission Certification is designed to help you receive quality, cost-effective medical care.

- All inpatient admissions, including length of stay, must be certified by contacting Chickering Claims Administrators, Inc.
- Pre-Certification does not guarantee the payment of benefits for your inpatient admission. Each claim is subject to medical policy review in accordance with the exclusions and limitations contained in the Policy, as well as a review of eligibility, adherence to notification guidelines, and benefit coverage under the Student Accident and Sickness Plan.
- If you do not secure Pre-Certification for non-emergency inpatient admissions or provide notification for emergency admissions, your Covered Medical Expenses will be subject to an additional \$200 per admission Deductible.

#### *Pre-Certification of Non-Emergency Inpatient Admissions*

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

#### *Notification of Emergency Admissions*

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

Chickering Claims Administrators, Inc.  
Attention: Managed Care Dept.  
P.O. Box 15708  
Boston, MA 02215-0014  
**(800) 678-4561**

### ***Referral Requirements***

***A referral from the Nova Southeastern University Health Care Center is required for all Covered Persons (including covered dependents) prior to receiving outpatient services from providers other than the University Health Care Center.*** Expenses incurred for services for which no prior referral has been obtained are excluded from coverage. Referrals are required on a per Accident or illness basis, and must be renewed each Policy Year. A referral is not necessary under the following conditions:

1. Treatment of an Emergency Medical Condition. The student must return to the Nova Southeastern University Health Care Center for necessary follow-up care or a referral.

2. Medical care received when the student is outside the service area. The Service area is defined as from 163rd St. in Miami/Dade County up to and including all of Broward County.
3. When the Nova Southeastern University Health Care Center is closed. When care is initiated at another treatment facility, the student must return to the Nova Southeastern University Health Care Center for necessary follow-up care, or for a referral.
4. Gynecological services.
5. Chiropractic, Dermatological, and Podiatry Services, and other mandated benefits for which referrals are not required.

If you are enrolled in the Student Health Insurance Plan, you **must** initiate care at one of the NSU Health Care Centers listed on page 12 (when appropriate) in order for benefits to be payable. **If a referral is not received (when appropriate), no benefits are payable.**

### ***Description of Benefits***

Payment will be made as allocated herein for Covered Medical Expenses for an Accident or Sickness. Benefits will be payable up to an Aggregate Maximum of \$200,000 for any one Accident or any one Sickness.

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

To maximize your savings and reduce out-of-pocket expenses, select a Preferred Provider. It is to your advantage to utilize a Preferred Provider because significant savings can be achieved from the substantially lower rates these providers have agreed to accept as payment for their services. Non-Preferred Care is subject to the Reasonable Charge allowance maximums. Any charges in excess of the reasonable allowance are not covered under the Plan.

A complete listing of Preferred Providers is available by contacting Chickering Claims Administrators, Inc. at (800) 678-4561 for specific provider information. You can also obtain a complete listing of Preferred Providers through the internet by accessing Aetna's online DocFind<sup>®</sup> service located at [www.chickering.com](http://www.chickering.com). Click on "Find Your School" enter 724533 as your Policy Number.

## Summary of Benefits Chart

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

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

<p><i>Deductible</i> (waived for services rendered at Nova Southeastern Health Care Centers)</p>	<p>\$250 per Person, Per Policy Year (Lab tests and services by providers within the NSU Health Care Centers that are exclusive of NSU (such as Imaging and certain subspecialty areas), will be subject to this annual Deductible).</p>
<p><i>Benefit Allocation</i></p>	<p>Covered Medical Expenses listed below are payable in accordance with the following reimbursement levels unless noted otherwise:  <b>Preferred Care:</b> 80% of the Negotiated Charges for the first \$12,500 of Covered Medical Expenses, and 100% of the Negotiated Charge thereafter up to the Plan maximum.  <b>Non-Preferred Care:</b> 60% of the Reasonable Charge allowance up to the Plan maximum.</p>
<p><b>Inpatient Hospitalization Benefits (not subject to referral requirement)</b></p>	
<p><i>Hospital Room and Board Expenses</i></p>	<p>Covered Medical Expenses are payable as follows:  <b>Preferred Care:</b> the Negotiated Charge for an overnight stay.  <b>Non-Preferred Care:</b> the Reasonable Charge for an overnight stay.</p>
<p><i>Intensive Care Unit Expenses</i></p>	<p>Covered Medical Expenses are payable as follows:  <b>Preferred Care:</b> the Negotiated Charge for an overnight stay.  <b>Non-Preferred Care:</b> the Reasonable Charge for an overnight stay.</p>
<p><i>Miscellaneous Hospital Expenses</i></p>	<p>Covered Medical Expenses are payable as follows:  <b>Preferred Care:</b> the Negotiated Charge.  <b>Non-Preferred Care:</b> the Reasonable Charge.            Covered Medical Expenses include, but are not limited to: laboratory tests, X-rays, surgical dressings, anesthesia, supplies and equipment use, and medicines.</p>

<i>Physician Hospital Visit Expenses</i>	Covered Medical Expenses for charges for the non-surgical services of the attending Physician or a consulting Physician are payable as follows: <b>Preferred Care:</b> the Negotiated Charge. <b>Non-Preferred Care:</b> the Reasonable Charge.
<b>Surgical Benefits (Inpatient and Outpatient)</b>	
<i>Surgical Expenses</i>	Covered Medical Expenses for charges for surgical services performed by a Physician are payable as follows: <b>Preferred Care:</b> the Negotiated Charge. <b>Non-Preferred Care:</b> the Reasonable Charge.
<i>Day Surgical Expenses</i>	Covered Medical Expenses for charges for day surgical services are payable as follows: <b>Preferred Care:</b> the Negotiated Charge after a \$100 Copay per surgical procedure. <b>Non-Preferred Care:</b> the Reasonable Charge after a \$100 Copay per surgical procedure.
<i>Anesthetist Expenses</i>	Covered Medical Expenses for the charges of an anesthetist during a surgical procedure are payable as follows: <b>Preferred Care:</b> 25% of the Surgical Allowance. <b>Non-Preferred Care:</b> 25% of the Surgical Allowance.
<i>Assistant Surgeon Expenses</i>	Covered Medical Expenses for the charges of assistant surgeon during a surgical procedure are payable as follows: <b>Preferred Care:</b> the Negotiated Charge. <b>Non-Preferred Care:</b> the Reasonable Charge.
<i>Outpatient Hospital Services for Surgery Expenses</i>	Covered Medical Expenses are payable as follows: <b>Preferred Care:</b> the Negotiated Charge. <b>Non-Preferred Care:</b> the Reasonable Charge.

<b>Outpatient Benefit Expenses</b>	
<p>Covered Medical Expense, are payable up to a combined maximum of \$5,000 per Accident or Sickness per Policy Year.</p> <p>Covered Medical Expenses include, but are not limited to: Physician's office visits, hospital or outpatient department or emergency room visits, durable medical equipment, chemotherapy, radiation therapy, tests and procedures, physical therapy, clinical lab, radiological facility, or other similar facility licensed by the state. Except as previously noted, students and dependents must obtain a referral from one of the Nova Southeastern Health Care Centers prior to obtaining care outside of the Health Care Center in order for benefits to be payable.</p>	
<p><i>Primary Care Physician Office Visit Expenses</i></p>	<p>Covered Medical Expenses are payable as follows:  <b>Preferred Care:</b> the Negotiated Charge after a \$10 Copay per visit (benefits are payable at 100%, with waiver of the Copay for services rendered at any of the NSU Health Care Centers).  <b>Non-Preferred Care:</b> the Reasonable Charge.</p>
<p><i>Routine Physical Expenses for Covered Students, spouses and dependent children age 17 and older (includes routine annual OB Gyn, lab fees for Pap smears, and immunizations)</i></p>	<p>Covered Medical Expenses are payable as follows:  <b>Preferred Care:</b> the Negotiated Charge after a \$10 Copay per visit (benefits are payable at 100%, with waiver of the Copay, for services rendered at any of the NSU Health Care Centers).  <b>Non-Preferred Care:</b> the Reasonable Charge.</p>
<p><i>Well Child Care Visit Expenses</i></p>	<p>Covered Medical Expenses are payable as follows:  <b>Preferred Care:</b> the Negotiated Charge after a \$10 Copay per visit (benefits are payable at 100%, with waiver of the Copay, for services rendered at any of the NSU Health Care Centers).  <b>Non-Preferred Care:</b> the Reasonable Charge.</p> <p>Covered Medical Expenses include the following services for a covered dependent under age 17:</p> <ul style="list-style-type: none"> <li>• a review and written record of the child's complete medical history,</li> <li>• physical examination,</li> <li>• developmental assessment,</li> <li>• anticipatory guidance,</li> <li>• appropriate immunizations, and</li> <li>• laboratory test</li> </ul>

	The above listed services and periodic visits shall be provided in accordance with prevailing medical standards consistent with the Recommendations for Preventive Pediatric Health Care of the American Academy of Pediatrics.
<i>Specialty Care Office Visit Expenses</i>	Covered Medical Expenses are payable as follows: <b>Preferred Care:</b> the Negotiated Charge after a \$15 Copay per visit (benefits are payable at 100%, with waiver of the Copay, for services rendered at any of the NSU Health Care Centers). <b>Non-Preferred Care:</b> the Reasonable Charge.
<i>Laboratory and X-ray Expenses</i>	Covered Medical Expenses are payable as follows: <b>Preferred Care:</b> the Negotiated Charge. <b>Non-Preferred Care:</b> the Reasonable Charge.
<i>Durable Medical Equipment Expenses</i>	Covered Medical Expenses are payable as follows: <b>Preferred Care:</b> the Negotiated Charge. <b>Non-Preferred Care:</b> the Reasonable Charge.
<i>Mammogram Expenses (referral not required)</i>	Covered Medical Expenses for one baseline mammogram for women age 35-40, one annual mammogram for women age 40 and older, or more frequently based on the recommendation of a Physician for women who are at risk for breast cancer are payable on the same basis as any other X-ray expense.
<i>Emergency Room Expenses (referral not required. Must return to NSU Health Care center for follow up care).</i>	Covered Medical Expenses for an Emergency Medical Condition are -payable as follows: <b>Preferred Care:</b> 80% of the Negotiated Charge after a \$50 Copay per visit (waived if admitted). <b>Non-Preferred Care:</b> 80% of the Reasonable Charge after a \$50 Deductible per visit (waived if admitted).

<b>Mental Health and Substance Abuse</b>	
<i>Inpatient Mental Health Expenses</i>	Covered Medical Expenses for the treatment of a mental health condition while confined as an inpatient in a hospital or facility licensed for such treatment are payable on a per condition, per Policy Year basis on the same basis as for any other Sickness for the first 30 days of confinement and up to a separate maximum of \$5,000 for the 31st through the 60th day of confinement. Inpatient mental health treatment is limited to a maximum of 60 days per Policy Year per condition for any one or related mental health condition.
<i>Partial Mental Health and Substance Abuse Hospitalization Expenses</i>	Covered Medical Expenses also include the charges made for treatment received during partial hospitalization in a hospital or treatment facility. Prior review and approval must be obtained on a case-by-case basis by contacting Chickering Claims Administrators, Inc. When approved, benefits will be payable in place of an inpatient admission, whereby two days of partial hospitalization may be exchanged for one day of full hospitalization.
<i>Outpatient Mental Health Expenses</i>	Covered Medical Expenses for the care or treatment of a mental health condition by a licensed or accredited health service organization or hospital or by a licensed practitioner are payable as follows: <b>Preferred Care:</b> the Negotiated Charge. <b>Non-Preferred Care:</b> the Reasonable Charge.  Outpatient treatment is payable up to a maximum of \$1,000 per Policy Year.
<i>Inpatient Substance Abuse Expenses</i>	<b>Drug Abuse:</b> Covered Medical Expenses for the treatment of a drug abuse condition while confined as an inpatient in a hospital or facility licensed for such treatment are payable on the same basis as for any other Sickness up to a separate maximum of \$5,000 per condition.  <b>Alcoholism:</b> Covered Medical Expenses for the treatment of an alcoholism condition while confined as an inpatient in a hospital or facility licensed for such treatment are payable on the same basis as for any other Sickness.

<p><i>Outpatient Substance Abuse Expenses</i></p>	<p><b>Drug Abuse:</b>  Covered Medical Expenses are payable as follows:  <b>Preferred Care:</b> the Negotiated Charge.  <b>Non-Preferred Care:</b> the Reasonable Charge.  Outpatient treatment of drug abuse is payable up to a maximum of \$60 per visit and to an overall maximum of \$600 per Policy Year.  <b>Alcoholism:</b>  Covered Medical Expenses for the outpatient care or treatment of alcoholism by a licensed or accredited health service organization or hospital or by a fully licensed practitioner are payable on the same basis as any other condition.</p>
<p><b>Maternity Benefits</b></p>	
<p><i>Maternity Expenses</i></p>	<p>Covered Medical Expenses for pregnancy, childbirth, and complications of pregnancy are payable on the same basis as any other Sickness. For inpatient confinements, benefits will be payable for inpatient care of the Covered Person and any newborn child (including newborn hearing screening) for a minimum of 48 hours following a vaginal delivery and a minimum of 96 hours following a cesarean delivery.</p> <p>Covered Medical Expenses include benefits for services of a certified nurse midwife provided that expenses for such services are reimbursed when such services are performed by any other duly licensed practitioner.</p>
<p><b>Additional Benefits</b></p>	
<p><i>High Cost Procedure Expenses</i></p>	<p>Covered Medical Expenses for high cost procedures in excess of \$200, such as, but not limited to, outpatient diagnostic C.A.T. Scans, Magnetic Resonance Imaging, and Laser treatments are payable as follows:  <b>Preferred Care:</b> the Negotiated Charge.  <b>Non-Preferred Care:</b> the Reasonable Charge.</p> <p>Covered Medical Expenses are payable up to a maximum of \$1,000 per Accident or Sickness.</p>
<p><i>Dental Injury Expenses</i></p>	<p>Covered Medical Expenses are payable at 80% of the Actual Charge to a maximum of \$200 per tooth for Injury to sound, natural teeth.</p>

<i>Ambulance Expenses</i>	<p>Covered Medical Expenses are payable as follows for the services of a professional ambulance to or from a hospital when required due to the emergency nature of a covered Accident or Sickness.</p> <p><b>Preferred Care:</b> 80% of the Negotiated Charge.  <b>Non-Preferred Care:</b> 80% of the Reasonable Charge.</p>
<i>Mastectomy Reconstruction and Prosthetic Expenses</i>	<p>Benefits for Covered Medical Expenses are payable on the same basis as any other Sickness for charges incurred incident to a mastectomy for the initial prosthetic device and for reconstructive surgery. If a mastectomy is performed and there is no evidence of malignancy, coverage is limited to the provision of an initial prosthetic device and reconstructive surgery performed within two years of the mastectomy.</p>
<i>Osteoporosis Expenses</i>	<p>Benefits for Covered Medical Expenses are payable on the same basis as any other Sickness for the Medically Necessary diagnosis and treatment of osteoporosis for high risk Covered Persons.</p>
<i>Diabetes Expenses</i>	<p>Coverage is provided, on the same basis as any other Sickness, for medically appropriate and necessary equipment, supplies, and self-management education. Coverage for insulin, including syringes, and diabetic testing supplies are a covered expense under the Prescription Drug portion of the Plan.</p>
<i>Anesthesia and Hospitalization Expenses For Dental Services</i>	<p>Covered Medical Expenses include charges for general anesthesia and hospitalization performed in connection with non-covered dental services for:</p> <ul style="list-style-type: none"> <li>• Children who are under 8 years of age; and</li> <li>• Persons with medical conditions what would create an undue medical risk if the dental service or surgery is not rendered in a hospital or in a surgery center.</li> </ul> <p>Covered Medical Expenses are payable on the same basis as any other expense.</p>
<i>Bones and Joints of The Facial Region Expenses</i>	<p>Covered Medical Expenses include charges incurred for diagnostic an surgical procedures involving bones or joints of the facial region when the service is medically necessary to treat conditions caused by congenital or developmental deformity, disease or injury.</p> <p>Covered Medical Expenses are payable on the same basis as any expense.</p>

<p><i>Cleft Lip/Cleft Palate Expenses (Applies for Covered Dependent Children under Age 18)</i></p>	<p>Covered Medical Expenses for charges incurred for the treatment of cleft lip/cleft palate on an inpatient or an outpatient basis are payable on the same basis as any other expense. Refer to the Master Policy for details.</p>
<p><i>Prescription Drug Benefit Expenses</i></p>	<p>Covered Medical Expenses for outpatient Prescription Drug Expenses associated with a covered Sickness or covered Accident occurring during the Policy Year are payable as follows:</p> <p><b>Preferred Pharmacy:</b> 100% of the Negotiated Charge after a \$30 Copay for each Brand-Name Prescription Drug or a \$15 Copay for each Generic Drug</p> <p><b>Non-Preferred Pharmacy:</b> 80% of the Reasonable Charge after a \$30 Deductible for each Brand-Name Prescription Drug or a \$15 Deductible for each Generic Drug.</p> <p><b>Please note:</b> You are required to pay in full at the time of service for all Prescriptions dispensed at a Non-Preferred Pharmacy. (Please refer to the Prescription Drug Claim Procedure section of this Brochure for information regarding the claim submission and reimbursement process.)</p> <p>Covered Medical Expenses are payable up to a maximum of \$750 per Policy Year.</p> <p>Medications not covered by this benefit include, but are not limited to: oral contraceptives prescribed for contraceptive purposes, allergy sera, drugs whose sole purpose is to promote or to stimulate hair growth, appetite suppressants, smoking deterrents, and non-self injectables.</p> <p>Prior authorization is required for oral contraceptives (prescribed for purposes other than contraception), growth hormones and for drugs, which are used for the treatment of malaria.</p> <p>Students are invited to have their Prescriptions filled at the NSU Pharmacy.</p> <p>Nova Southeastern University Pharmacy  Address: 3200 S. University Drive  Phone: (954) 262-4550  Hours of Operation: Monday - Friday: 9 am - 5 pm  Saturday: 9 am - 1 pm</p>

## **Additional Services and Discounts**

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

### *Vision One*<sup>®</sup>

The Vision One Discount Program helps you save on many eye care products, including sunglasses, contact lenses, non-prescription sunglasses, contact lens solutions and other eye care accessories. Plus, you can receive up to a 25% discount on LASIK surgery (the laser vision correction procedure). Call (800) 793-8616 for additional Program information and provider locations, or simply log onto [www.chickering.com](http://www.chickering.com). Click on "Find Your School" enter 724533 as your Policy Number to find a Vision One provider near you.

Students are invited to utilize the NSU Eye Institutes for Optometry Services.

## **Informed Health Line**

Aetna's Informed Health<sup>®</sup> Line gives you easy access credible health information. All Informed Health Line services are available 24 hours a day, 365 days a year on demand from any touch-tone phone or computer within the United States (including Alaska and Hawaii).

### **1. 24-Hour Nurse Line**

Call our toll free number to access registered nurses who are experienced in providing information on a variety of health topics.\* The nurses can help you:

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

To reach an Informed Health<sup>®</sup> Line Nurse, please call 1-800-556-1555

For TDD (hearing and speech impaired only): 1-800-270-2386

### **2. Audio Health Library**

The Informed Health<sup>®</sup> Line audio health library contains information on thousands of health topics such as common conditions and diseases, gender- and age-specific health issues, dental care, mental health and substance abuse, weight loss and much more. Each health topic in the audio health library has a corresponding topic code. View a complete list of topic codes by clicking on one of the PDF files below.

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

To access the Informed Health Line audio health library, please call 1-800-556-1555  
For TDD (hearing and speech impaired only): 1-800-270-2386

### 3. Healthwise® Knowledgebase



If you prefer to view health information online, simply click on this link to the Healthwise® Knowledgebase, one of the most advanced health databases available. The Healthwise Knowledgebase contains detailed information about health conditions, medical tests and procedures, medications and treatment options. It also features illustrations and decision-focused tools to help you make more informed health care decisions.

*\* Informed Health Line nurses cannot diagnose, prescribe or give medical advice. Contact your physician with any questions or concerns regarding your health care needs.*

*Also, the topics discussed by the nurses, on the audio tapes or online may not necessarily be covered by your health plan.*

## **General Provisions**

### **State Mandated Benefits**

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

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

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

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

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

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

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

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

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

### ***Non-Duplication of Benefits***

This provision applies if a Covered Student:

- a) is covered by any other group or blanket health care plan; and
- b) would, therefore, receive medical expenses or service benefits in excess of the actual expenses incurred.

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

### ***Definitions***

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

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

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

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

*Coinsurance:* The percentage of Covered Medical Expenses payable by Aetna under the Accident and Sickness Insurance Plan.

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

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

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

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

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

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

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

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

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

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

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

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

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

- and the person's overall health condition. It must be no more likely to produce a negative outcome than any alternative service or supply, both as to the Sickness or Injury involved and the person's overall health condition; and
- As to diagnosis, care, and treatment, be no more costly (taking into account all health expenses incurred in connection with the treatment, service, or supply,) than any alternative service or supply to meet the above tests.

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

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

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

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

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

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

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

*Pharmacy:* An establishment where Prescription Drugs are legally dispensed.

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

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

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

*Pre-Existing Condition:* Any Injury, Sickness, or condition that was diagnosed or treated, or would have caused a prudent person to seek diagnosis or treatment, within 12 months prior to the Covered Person's effective date of Insurance. Under the Policy, expenses incurred by a Covered Person for a Pre-Existing Condition will not be considered a covered expense unless the Covered Person has been covered under the Policy for 12 consecutive months.

Routine follow up care to determine whether a breast cancer has recurred in a person who was previously determined to be free of breast cancer does not constitute medical advice, diagnosis, care or treatment for purposes of determining pre-existing conditions unless evidence of breast cancer is found during, or as a result of, the follow up care.

If a Covered Person has continuous coverage under the Nova Southeastern University Student Health Insurance Plan from one year to the next, an Accident or Sickness that first manifests itself during a prior year's coverage shall not be considered a Pre-Existing Condition.

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

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

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

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

- The charge Aetna determines to be the prevailing charge level made for it in the geographic area where it is furnished.

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

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

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

Aetna may take into account factors, such as:

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

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

### ***Exclusions***

The Plan neither covers nor provides benefits for the following:

1. Expenses incurred as a result of dental treatment, except for Injury to sound, natural teeth.
2. Expenses incurred for services normally provided without charge by the Policyholder's School Health Service, infirmary or hospital, or by health care providers employed by the Policyholder.
3. Expenses incurred for services normally provided without charge by the school and covered by the school fee.
4. Expenses incurred for eye refractions, vision therapy, radial keratotomy, eyeglasses, contact lenses (except when required after cataract surgery), or other vision or hearing aids, Prescriptions, or examinations, except as required for repair caused by a covered Injury.

5. Expenses incurred as a result of Injury due to participation in a riot. "Participation in a riot" means taking part in a riot in any way, including inciting the riot or conspiring to incite it. It does not include actions taken in self-defense, so long as they are not taken against persons who are trying to restore law and order.
6. Expenses incurred as a result of commission of a felony.
7. Expenses incurred as a result of an accident occurring in consequence of riding as a passenger or otherwise in any vehicle or device for aerial navigation, except as a fare-paying passenger in an aircraft operated by a scheduled airline maintaining regular published schedules on a regularly established route.
8. Expenses incurred as a result of an Injury or Sickness due to working for wage or profit and for which benefits are paid under a Workers' Compensation or Occupational Disease Law.
9. Expenses incurred as a result of Injury sustained or Sickness contracted while in the service of the armed forces of any country. Upon the Covered Person entering the armed forces of any country, the unearned pro-rata premium will be refunded to the Policyholder.
10. Expenses incurred for treatment provided in a government hospital unless there is a legal obligation to pay such charges in the absence of insurance.
11. Expenses incurred for plastic surgery, cosmetic surgery, reconstructive surgery, or other services and supplies that improve, alter, or enhance appearance, whether or not for psychological or emotional reasons. This exclusion will not apply to the extent needed to:
  - a) Improve the function of a part of the body that is not a tooth or structure that supports the teeth and is malformed as a result of a severe birth defect (including harelip and webbed fingers or toes), a direct result of disease, or surgery performed to treat a Sickness or Injury.
  - b) Repair an Injury (including reconstructive surgery for a prosthetic device for a Covered Person who has undergone a mastectomy) which occurs while the Covered Person is covered under the Plan. Surgery must be performed in the Policy Year of the Accident, which causes the Injury, or in the next Policy Year.
12. Expenses incurred after the date insurance terminates for a Covered Person except as may be specifically provided in the Extension of Benefits provision.
13. Expenses incurred for any services rendered by a family member of the Covered Person's immediate family or a person who lives in the Covered Person's home.

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

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

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

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

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

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

15. Expenses incurred by a Covered Person not a United States Citizen for services performed within the Covered Person's home country.

16. Expenses incurred for non-surgical treatment of temporomandibular joint (TMJ) dysfunction and associated myofascial pain. This limitation does not apply to diagnostic or surgical procedure involving bones or joints of the jaw or facial region if Medically Necessary to treat conditions caused by congenital or developmental deformity, disease, or Injury. This exclusion applies equally to all Physicians and other practitioners.

17. Expenses for treatment of Injury or Sickness to the extent payment is made, as a judgment or settlement, by any person deemed responsible for the Injury or Sickness (or their insurers).

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

- By whom they are prescribed; or
- By whom they are recommended; or
- By whom or by which they are performed.

19. Expenses incurred or treatment rendered unless the Covered Person is under a legal obligation to pay for such treatment or expense, or expenses which are in excess of the Reasonable Charge.

20. Expenses incurred as a result of allergy shots and injections, preventive medicines, serums, vaccines, or oral contraceptives (i.e., birth control pills) unless otherwise provided in the Policy.

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

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

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

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

25. Expenses incurred for the repair or replacement of existing artificial limbs, orthopedic braces, or orthotic devices, or other devices to support the feet unless Medically Necessary to prevent complications of diabetes.

26. Expenses covered by any other valid and collectible medical, health, or accident insurance to the extent that benefits are payable under other valid and collectible insurance whether or not a claim is made for such benefits.
27. Expenses incurred for voluntary or elective abortions unless otherwise provided in the Policy.
28. Expenses incurred as a result of suicide, attempted suicide, or intentionally self-inflicted Injury whether sane or not.
29. Expenses incurred for Injury resulting from the play or practice of collegiate or intercollegiate sports, including collegiate club sports and intramurals (the University has purchased a separate Sports Policy to cover these services).
30. 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 the Injury or Sickness (or their insurers).
31. Expenses incurred for experimental or investigative procedures.
- As determined by Aetna, a drug, device, procedure, or treatment will be determined to be experimental or investigational if: there are insufficient outcomes data available from controlled clinical trials published in the peer reviewed literature to substantiate: its safety, and effectiveness, for the disease or Injury involved; or if required by the FDA, approval has not been granted for marketing; or a recognized national medical or dental society, or regulatory agency has determined, in writing, that it is experimental, investigational, or for research purposes; or the written protocol or protocols used by the treating facility; or the protocol or protocols of any other facility studying substantially the same drug, device, procedure, or treatment; or the written informed consent used by the treating facility; or by another facility studying the same drug, device, procedure, or treatment states that it is experimental, investigational, or for research purposes.
  - However, this exclusion will not apply with respect to services or supplies (other than drugs) received in connection with a disease, if Aetna determines that: the disease can be expected to cause death within one year in the absence of effective treatment; and the care or treatment is effective for that disease or shown promise of being effective for that disease; as demonstrated by scientific data. In making this determination Aetna will take into account the results of review by a panel of independent medical professionals. They will be selected by Aetna. This panel will include professionals who treat the type of disease involved.

In the event, charges for or related to both autologous bone marrow transplants and high dose chemotherapy when used in the same course of treatment, are excluded from coverage; except when such charges are for the care or the treatment of the following:

- Acute Leukemia
- Hodgkin's disease (relapsed)
- Neuroblastoma, Stages III and IV
- Non-Hodgkin's lymphoma
- State II/III Breast Cancer
- Metastatic (State IV) Breast Cancer
- Myelodysplastic Syndrome
- Chronic Myelogenous Leukemia
- High Risk Neuroblastoma

Also, this exclusion will not apply with respect to drugs that: have been granted treatment investigational new drug (IND) group c/treatment IND status or are being studied at the Phase III level in a national clinical trial sponsored by the National Cancer Institute; if Aetna determines that available scientific evidence demonstrates that the drug is effective, or shows promise of being effective for the disease.

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

33. Expenses incurred for care furnished mainly to provide a surrounding free from exposure that can worsen the person's disease or Injury.

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

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

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

37. Those for routine physical exams, routine vision exams, routine dental exams, routine hearing exams, immunizations, or other preventive services and supplies, except to the extent coverage for such exams, immunizations, services, or supplies is specifically provided in the Policy. (Refer to the Summary of Benefits Chart for details regarding Covered Medical Expenses.)

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

39. Expenses incurred for breast reduction/mammoplasty.

40. Expenses incurred for gynecomastia (male breasts).

41. Expenses incurred for sinus surgery, except for acute purulent sinusitis.
42. Expenses for charges that are not Reasonable Charges, as determined by Aetna.
43. Expenses for treatment of covered students who specialize in the mental health care field, and who receive treatment as part of their training in that field.
44. Expense for: (a) care of flat feet; (b) supportive devices for the foot; (c) care of corns, bunions, or calluses; (d) care of toenails; and (e) care of fallen arches; weak feet; or chronic foot strain; except that (c) and (d) are not excluded when Medically Necessary; because the Covered Person is diabetic; or suffers from circulatory problems.
45. Expenses incurred for elective treatment or elective surgery except as specifically provided elsewhere in the Policy and performed while the Policy is in effect.
46. Expenses arising as a result of a Pre-Existing Condition.

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

### ***Extension of Benefits***

If a Covered Person is confined to a hospital on the date his or her insurance terminates, expenses incurred after the termination date and during the continuance of that hospital confinement shall be payable in accordance with the Policy, but only while they are incurred during the 12-month 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. Such benefits will be covered only for the period of that pregnancy.

Dental expenses incurred after the date of coverage under the Policy ceases will be covered as stated below:

If a Covered Person is not totally disabled when his or her dental coverage ceases because the Policy discontinues as to the class of which he or she is a member:

- Dental benefits will be available for up to 90 days from the date the Policy discontinues, but only for services and supplies needed for treatment of any dental condition diagnosed prior to the date coverage ceases and while coverage was in force for such person.

- These include services and supplies which have been rendered and received, including delivered and installed, if these apply, prior to the end of the 90-day period. Not included are routine services and services and supplies for orthodontic treatment.

This Extension of Benefits for dental coverage will cease on the earlier of:

- a) the end of the 90-day period after the Covered Person's coverage ceases under the Policy; and
- b) the date the person covered under the Policy becomes covered under the succeeding policy providing coverage or services for similar dental procedures.

However, during any time that an elimination period in the succeeding Policy excludes either the patient or the services rendered as a result of any dental condition diagnosed prior to the date coverage ceases, and while coverage was in force for such person, this Extension of Benefits will be deemed to continue until the end of the 90-day period.

### ***Termination of Insurance***

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

### ***Claim Procedure***

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

Chickering Claims Administrators, Inc.

P.O. Box 15708

Boston, MA 02215-0014

**(800) 678-4561**

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

1. Bills must be submitted within 90 days from the date of treatment.
2. Payment for Covered Medical Expenses will be made directly to the hospital or Physician concerned unless bill receipts and proof of payment are submitted.
3. If itemized medical bills are available at the time the claim form is submitted, attach them to the claim form. Subsequent medical bills should be mailed promptly to the above address.

4. In the event of a disagreement over the payment of a claim, a written request to review the claim must be mailed to Chickering Claims Administrators, Inc. within 60 days from the date appearing on the Explanation of Benefits (EOB).

### ***Complaint and Appeals Procedure***

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

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

In the event a Covered Person disagrees with how a claim was processed, they may request a review of the decision. The Covered Person's request must be made in writing within 60 days of receipt of the EOB. The Covered Person's request must include why they disagree with the way the claim was processed. The request must also include any additional information that supports the claim (e.g., medical records, Physician's office notes, operative reports, a Physician's letter of medical necessity, etc.). Please submit all requests to:

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

### ***Prescription Drug Claim Procedure***

***Preferred Care:*** When obtaining a covered Prescription, please present your Chickering ID card to an Aetna Preferred Pharmacy along with your applicable Copay. The Pharmacy will submit a claim to Aetna for the drug.

When you need to fill a Prescription and do not have your ID card with you, you may obtain your prescription from an Aetna Preferred Pharmacy and be reimbursed by submitting a completed Aetna Prescription Drug claim form. A claim form is available at Student Health Services or by calling (800) 238-6279.

You will be reimbursed for covered medications directly by Aetna. Please note, in addition to your Copay, you may be required to pay the difference between the retail price you paid for the prescription drug and the amount Aetna would have paid if you had presented your ID card and the Pharmacy had billed Aetna directly.

Information regarding Preferred Care Pharmacy locations is available by accessing Aetna's online **DocFind**<sup>®</sup> service located at [www.chickering.com](http://www.chickering.com). Click on "Find Your School" enter **724533** as your Policy Number.

**Non-Preferred Care:** You may obtain your Prescription from a Non-Preferred Pharmacy and be reimbursed by submitting a completed Aetna Prescription Drug claim form. You will be reimbursed for covered medications at the Reasonable Charge allowance, less any applicable Deductible, directly by Aetna. You will be responsible for any amount in excess of the Reasonable Charge.

*Please note:* You will be required to pay in full at the time of service for all Prescriptions dispensed at a Non-Participating Pharmacy.

Claim forms, Pharmacy locations, and claims status information can be obtained by contacting Aetna Pharmacy Management at **(800) 238-6279**.

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

## ***General Information***

### ***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 Covered Persons in receiving appropriate health care and maximizing coverage for those health care services.

Our Patient Management staff use national guidelines and resources to guide the Pre-Certification, concurrent review, and retrospective review processes. On the basis of information collected from providers, Patient Management staff apply Milliman & Robertson Health Care Management Guidelines when conducting concurrent review. If there is no applicable Milliman & Robertson Guideline, Patient Management staff apply 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-reviewed medical literature, the recommendations of leading medical organizations, and, where appropriate, the Health Care Financing Administration's Medicare coverage policies. Aetna has placed its CPBs on its website [www.aetna.com](http://www.aetna.com). Since CPBs can be highly technical and are designed to be used by our professional staff in making coverage determinations, Covered Persons may want to review the CPBs of interest with their physician so they may fully understand them. CPBs do not constitute medical advice and

treating providers are solely responsible for medical advice and treatment of Covered Persons. CPBs are a tool to be interpreted in conjunction with the Covered Person's specific benefit plan and after consultation with the treating Physician; they contain only a partial, general description of benefits 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 Covered Person 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 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 follow-up action based on quality or utilization issues, and review all appeals of inpatient concurrent review decisions. Aetna's effort to manage the services provided to Covered Persons includes the retrospective review of claims submitted for payment, and medical records submitted for potential quality and utilization concerns.

### ***Direct Access Chiropractic, Dermatologic, and Podiatric Services***

Covered Persons have direct access to the participating chiropractic, dermatologic, and podiatric providers of their choice and do not need a referral to access these benefits covered under their health benefits plans.

### ***Provider Reimbursement***

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

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

Aetna Pharmacy Management negotiates discounts from independent pharmacies, and 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 online search for participating pharmacies through **DocFind**<sup>®</sup>, which is available on our website.

A paper directory is also available to Covered Persons upon request.

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

### ***Confidentiality***

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

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

### ***Notice to Enrollees***

While the paper directory (available upon request) is believed to be accurate as of the print date, it is subject to change without notice. Consult Aetna's online provider directory on our website for the most current provider listings. Participating providers are independent contractors in private practice and are neither employees nor agents of Aetna, the School, 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 the toll-free number on your ID card.

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

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

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

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

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

To file a claim for Accidental Death and Dismemberment, please contact Chickering Claims Administrators, Inc. at **(800) 678-4561** for the appropriate claim forms.

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

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

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

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

## ***Medical Evacuation and Return of Mortal Remains Services***

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

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

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

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

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

## ***Important Note***

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

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

### **Offered by:**

Chickering Benefit Planning Insurance Agency, Inc.

### **Administered by:**

Chickering Claims Administrators, Inc.  
P.O. Box 15708  
Boston, MA 02215-0014  
(800) 678-4561  
[www.chickering.com](http://www.chickering.com)



### **Underwritten by:**

Aetna Life Insurance Company (ALIC)  
151 Farmington Avenue  
Hartford, CT 06156  
Policy No. 724533

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

## NOTICE

Aetna considers nonpublic personal member information confidential and has policies and procedures in place to protect the information against unlawful use and disclosure. When necessary for your care or treatment, the operation of your health Plan, or other related activities, we use personal information internally, share it with our affiliates, and disclose it to health care providers (doctors, dentists, pharmacies, hospitals, and other caregivers), vendors, consultants, government authorities, and their respective agents. These parties are required to keep personal information confidential as provided by applicable law. Participating Network/Preferred Providers are also required to give you access to your medical records within a reasonable amount of time after you make a request. By enrolling in the Plan, you permit us to use and disclose this information as described above on behalf of yourself and your dependents. To obtain a copy of our Notice of Privacy Practices describing in greater detail our practices concerning use and disclosure of personal information, please call the toll-free Customer Services number on your ID card or visit Chickering's Student Connection Link on the internet at [www.chickering.com](http://www.chickering.com).