

2008 - 2009

University of Pennsylvania



Penn Student Insurance Plan Brochure

Student Health Service

University of Pennsylvania
3535 Market Street, Suite 100
Philadelphia, PA 19104
Telephone: (215) 746-3535
E-mail: shsinsur@pobox.upenn.edu
Website: <http://www.vpul.upenn.edu/shs/shi.html>

Penn Student Insurance Plan (PSIP)

Aetna Student Health

Underwritten by:

Aetna Life Insurance Company (ALIC)

Policy No. **724535**

Dear Student,

Student wellness is essential to academic progress. In accordance with our institutional responsibility to safeguard the health and well-being of all students, the University maintains programs to ensure that students have access to health care along with health insurance to cover the costs of care. This Brochure describes the options for health insurance for students at the University of Pennsylvania. Please take a moment to review this information, so that you are familiar with our services.

The University provides outpatient medical care to students through the Student Health Service (SHS), a department of the Office of the Vice Provost for University Life. All full-time status students have coverage for care at the Student Health Service. The Student Health Service offers an array of clinical services, including initial and follow-up treatment of acute medical illness and Injury, management of chronic health problems, health screening and preventive care. We also coordinate referrals to specialists outside of Student Health. The Student Health Service Brochure describes the services that we offer; detailed information is available on the SHS website (<http://www.vpul.upenn.edu/shs/shi.html>). The focus of the Student Health Service is outpatient primary care; therefore, students also need medical insurance to cover the costs of care and services outside of SHS. All full-time students must have health insurance coverage for both inpatient and outpatient medical care and must provide information about their insurance coverage each year.

As a condition of enrollment in the University, full-time and dissertation-status students are automatically enrolled in the Penn Student Insurance Plan (PSIP) unless they provide proof of acceptable alternative coverage.

This Brochure describes the coverage available to you through the Penn Student Insurance Plan. If you are already covered through a health insurance plan, please take a few moments to review the provisions of that plan. Health insurance plans vary in the coverage they offer. Some provide excellent protection at home, but do not cover students while they are at school, studying abroad, or traveling. The Penn Student Insurance Plan has been developed to provide a comprehensive range of benefits for students whether they are here at Penn or traveling.

We have enclosed a guide that explains how to file your selection for coverage. All selections, whether enrollment in PSIP or waiver of coverage, must be submitted online, using the Penn Portal http://medley.isc-sec.upenn.edu/penn_portal/view.php. Insurance information submitted to other offices is not forwarded to the insurance workplace.

Our Insurance Office staff is available to answer any questions that you may have about PSIP; feel free to contact the Penn Student Insurance Office at (215) 746-3535, or send an email to: shsinsur@pobox.upenn.edu.



Evelyn Wiener, MD
Director

Table of Contents

	Page
<u>Information about the Penn Student Insurance Plan</u>	4
<u>Introduction</u>	4
<u>Description of Benefits</u>	4
<u>Student Health Service Referral Requirement</u>	5
<u>Summary of Benefits Chart</u>	6
<u>Preferred Provider Network</u>	13
<u>Inpatient Admission Pre-Certification Program</u>	14
<u>Additional Services and Discounts</u>	15
<u>Student Coverage</u>	17
<u>Waiver Process/Procedure</u>	19
<u>Dependent Coverage</u>	20
<u>Policy Period</u>	21
<u>Premium Rates</u>	22
<u>Premium Refund Policy</u>	22
<u>General Provisions</u>	23
<u>State Mandated Benefits</u>	23
<u>Reimbursement/Right of Recovery Provision</u>	23
<u>Subrogation/Right of Recovery Provision</u>	23
<u>Subrogation and Reimbursement/Right of Recovery Provisions</u>	24
<u>Non-Duplication of Benefits</u>	24
<u>Definitions</u>	25
<u>Exclusions</u>	29
<u>Extension of Benefits</u>	33
<u>Termination of Insurance</u>	33
<u>Claim Procedure</u>	34
<u>Prescription Drug Claim Procedure</u>	34
<u>On Call International</u>	35
<u>Accidental Death and Dismemberment (ADD) Benefits</u>	35
<u>Medical Evacuation and Repatriation (MER) Benefits</u>	35
<u>Worldwide Emergency Travel Assistance (WETA) Services</u>	35
<u>Where to Find Help</u>	37
<u>Important Note</u>	39

Information about the Penn Student Insurance Plan

Introduction

The Penn Student Insurance Plan (PSIP) has been developed especially for University of Pennsylvania students and their eligible dependents (Dependents include eligible spouses/domestic partners and children. Please see the Dependent Eligibility section for further information.). The Plan provides coverage for illnesses and Injuries that occur on and off campus, and includes special cost-saving features to keep the coverage as affordable as possible. The University of Pennsylvania is pleased to offer the Plan as described in this Brochure.

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

This Plan may not cover all your health care expenses. Read your Plan documents carefully to determine which health care services are covered. If you have any questions, please call the toll-free Customer Service number shown on your ID card. Emergency services are not subject to any referral or pre-certification requirements.

Description of Benefits

Payment will be made as allocated herein for Covered Medical Expenses incurred for any one Accident or any one Sickness incurred while insured under the Plan, not to exceed an Aggregate Lifetime Maximum per condition while continuously insured of \$2,000,000 for any one covered Accident or any one covered Sickness. In addition to the Plan's Aggregate Lifetime Maximum the Policy may contain benefit level maximums. Please review the Summary of Benefits section of this Brochure for any additional benefit level maximums.

The payment of any Copays, 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 savings may be achieved from these providers. Non-Preferred Care is subject to the Reasonable Charge. Any charges in excess of the Reasonable Charge are not covered under the Plan.

Student Health Service Referral Requirement

Student health care needs can best be satisfied and costs contained when an organized system of health care providers at the University of Pennsylvania Student Health Service manages the treatment. Students covered under the Penn Student Insurance Plan should first seek treatment at the SHS for each medical condition if within 25 miles of the University. The Student Health Service providers will refer you, if appropriate, to an outside provider. A new referral for each condition is required at the beginning of each Policy Year.

Any care received within 25 miles of the University without a prior SHS referral will be payable subject to the Non-Preferred Benefit, including the \$1,500 Deductible.

The referral requirement does not apply to the following services:

- Emergency Room Services (all follow-up treatment must be obtained through SHS)
- Inpatient and Outpatient Mental Health and Substance Abuse Services
- Women's Health Services
- Maternity
- Voluntary Termination of Pregnancy
- Annual Eye Examination
- Injury to Sound, Natural Teeth, or Removal of Impacted Wisdom Teeth

The referral requirement does not apply to covered dependents or when the SHS is closed.

Summary of Benefits Chart

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

<p>Annual Plan Deductible</p>	<p>Preferred Care: \$250 per Policy Year. Non-Preferred Care: \$1,500 per Policy Year. Note: The Deductible does not apply to:</p> <ul style="list-style-type: none"> • Treatment received at Student Health Services (with the exception of labs sent to a third party for processing) • Emergency Room Care (Facility and Physician) • Prescription Drugs • Inpatient and Outpatient Mental Health or Substance Abuse Treatment • Immunizations • Annual Eye Examinations
<p>Referral Requirements</p>	<p>Students seeking services to a specialist must obtain a referral (consultation form/request for consultation) from a Student Health Service provider, prior to a visit with the specialist that is outside of SHS, but within 25 miles of the university.</p>
<p>Maximum Benefit per Lifetime per Condition</p>	<p>After any applicable Copays or Deductible have been satisfied, Covered Medical Expenses are payable up to an Aggregate Lifetime Maximum of \$2,000,000 per condition.</p> <p>It should be noted that expenses incurred for emergency services are not subject to the Plan's lifetime per condition maximum. In addition, emergency services are not subject to Pre-Certification and/or referral requirements.</p>
<p>Out-of-Pocket Maximum Expenses <i>(includes the Annual Plan Deductible)</i></p>	<p>The maximum dollar amount an insured is required to pay out during a Policy Year (subject to the limitations listed below): Once an insured individual has reached the applicable Out-of-Pocket Maximum within a Policy Year for Covered Medical Expenses (not including Prescription Drugs), the Plan will pay 100% of the Negotiated Charge or the Reasonable Charge up to the overall Plan Maximum.</p> <p>Any applicable Preferred Care Copays, Non-Preferred Care per visit Deductibles, Prescription Drug expenses, or expenses in excess of the Reasonable Charge do not apply towards meeting the Out-of-Pocket Maximum. Any penalty that results due to failure to secure Pre-Certification, does not apply to meeting the Out-of-Pocket Maximum of Coinsurance and Deductibles.</p> <p>Charges in excess of any specified maximum, and non-covered services are not applied toward meeting the Out-of-Pocket Maximum and are the responsibility of the insured.</p> <p>Preferred Care: \$1,500 per insured; \$3,000 per family per Policy Year. Non-Preferred Care: \$4,000 per insured; \$8,000 per family per Policy Year.</p>

Inpatient Hospitalization Benefits	
Hospital Room and Board Expenses <i>(Plan Deductible applies)</i>	Covered Medical Expenses are payable as follows after a \$100 Copay for Hospital Room and Board: <i>Preferred Care:</i> 100% of the Negotiated Charge for an overnight stay. <i>Non-Preferred Care:</i> 70% of the Reasonable Charge for the semi-private room rate for an overnight stay.
Intensive Care Expenses <i>(Plan Deductible applies)</i>	Covered Medical Expenses are payable as follows: <i>Preferred Care:</i> 100% of the Negotiated Charge for an overnight stay. <i>Non-Preferred Care:</i> 70% of the Reasonable Charge of the intensive care room rate for an overnight stay.
Miscellaneous Hospital Expenses <i>(Plan Deductible applies)</i>	Covered Medical Expenses are payable as follows: <i>Preferred Care:</i> 100% of the Negotiated Charge for an overnight stay. <i>Non-Preferred Care:</i> 70% of the Reasonable Charge. Covered Medical Expenses include, but are not limited to: laboratory tests, X-rays, anesthesia, use of special equipment, medicines, and use of operating room.
Physician Hospital Visit Expenses <i>(Plan Deductible applies)</i>	Covered Medical Expenses for charges for the non-surgical services of the attending Physician or a consulting Physician are payable as follows: <i>Preferred Care:</i> 100% of the Negotiated Charge. <i>Non-Preferred Care:</i> 70% of the Reasonable Charge.
Surgical Expenses <i>(Plan Deductible applies)</i>	Covered Medical Expenses for charges for surgical services performed by a Physician are payable as follows: <i>Preferred Care:</i> 100% of the Negotiated Charge after \$150 Copay per surgery. <i>Non-Preferred Care:</i> 70% of the Reasonable Charge. Surgical expenses include, but are not limited to: child birth (vaginal or c-section), endoscopy, mole removal, and biopsies. Some injection procedures are considered as invasive surgery and therefore may be billed as a surgical procedure.
Anesthetist and Assistant Surgeon Expenses <i>(Plan Deductible applies)</i>	Covered Medical Expenses for the charges of an anesthetist and an assistant surgeon during a surgical procedure for surgical services performed during a surgical operation are payable as follows: <i>Preferred Care:</i> 100% of the Negotiated Charge. <i>Non-Preferred Care:</i> 70% of the Reasonable Charge.

Outpatient Benefit Expenses (Plan Deductible Applies)

Covered Medical Expenses include, but are not limited to: Physician’s office visits, specialist expenses, hospital or outpatient department or emergency room visits, physical therapy, clinical lab, radiological facility, or other similar facility licensed by the state.

Physician’s Office Visit Expenses <i>(including an annual routine physical)</i> <i>(Plan Deductible applies)</i>	Covered Medical Expenses are payable as follows: <i>Preferred Care:</i> 100% of the Negotiated Charge after a \$25 Copay per visit. (The per-visit Copay is waived if services are obtained at SHS and for Pre-Natal/Maternity Care.) <i>Non-Preferred Care:</i> 70% of the Reasonable Charge.
--	--

Surgical Expenses <i>(Plan Deductible applies)</i>	Covered Medical Expenses are payable as follows after a \$150 Copay per Surgery: <i>Preferred Care:</i> 100% of the Negotiated Charge. <i>Non-Preferred Care:</i> 70% of the Reasonable Charge.
---	---

Lab and X-ray Expenses <i>(Non-Hospitalization)</i> <i>(Plan Deductible applies)</i>	Covered Medical Expenses are payable as follows: <i>Preferred Care:</i> 100% of the Negotiated Charge after a \$35 Copay per visit. (Lab and X-ray Copay is waived for Pre-Natal/Maternity Care.) <i>Non-Preferred Care:</i> 70% of the Reasonable Charge.
--	--

Treatment Expenses for an Emergency Medical Condition <i>(including psychiatric conditions – Referral/pre-certification not required)</i>	Covered Medical Expenses are payable as follows: <i>Preferred Care:</i> 100% of the Negotiated Charge after a \$75 Copay per visit, with waiver of the Deductible. <i>Non-Preferred Care:</i> 100% of the Reasonable Charge after a \$75 Deductible per visit, with waiver of the Deductible.
--	---

**Mental Health and Substance Abuse Benefit Expenses
(Referral Not Required but Pre-Certification May be Required)**

(If an emergency service, any maximum benefit and referral/Pre-Certification requirement will not apply and covered expenses incurred on a Non-Preferred basis will be paid at the Preferred level of coverage and will be treated like any emergency medical condition. Pre-Certification is required for non-emergency inpatient services.)

Inpatient Mental Health Expenses	Covered Medical Expenses for the treatment of a mental health condition while confined as an inpatient in a hospital or facility licensed for such treatment are payable as follows: <i>Preferred Care:</i> 100% of the Negotiated Charge with waiver of the Deductible. <i>Non-Preferred Care:</i> 70% of the Reasonable Charge with waiver of the Deductible.
----------------------------------	---

Mental Health and Substance Abuse Benefit Expenses (continued)

<p>Inpatient Mental Health Expenses <i>(continued)</i></p>	<p>Treatment is limited to a maximum of 30 days per Policy Year per condition for any one or related mental health condition.</p> <p>Covered Medical Expenses also include the charges made for treatment received during partial hospitalization in a hospital or treatment facility. With the exception of emergency services, prior review and approval must be obtained on a case-by-case basis by contacting Aetna Student Health. When approved, benefits will be payable in place of an inpatient admission, whereby two days of partial hospitalization may be exchanged for one day of full hospitalization.</p>
<p>Outpatient Mental Health Expenses</p>	<p>Covered Medical Expenses for the care or treatment of a mental health condition by a licensed or accredited health service organization or hospital or by a licensed practitioner are payable as follows:</p> <p><i>Preferred Care:</i> 100% of the Negotiated Charge after \$25 Copay, with waiver of the Deductible.</p> <p><i>Non-Preferred Care:</i> 70% of the Reasonable Charge, with waiver of the Deductible, up to a maximum of \$80 per visit.</p> <p>Outpatient treatment is subject to a maximum of 50 visits per condition, per Policy Year.</p>
<p>Inpatient Substance Abuse Expenses</p>	<p>Covered Medical Expenses for the treatment of substance abuse while confined as an inpatient in a hospital or facility licensed for such treatment are payable as follows:</p> <p><i>Preferred Care:</i> 100% of the Negotiated Charge with waiver of the Deductible.</p> <p><i>Non-Preferred Care:</i> 70% of the Reasonable Charge with waiver of the Deductible.</p> <p>Treatment is limited to a maximum of 30 days per Policy Year.</p> <p>Covered Medical Expenses for the treatment of substance abuse while confined as an inpatient in a non-hospital treatment facility licensed for such treatment are payable as follows:</p> <p><i>Preferred Care:</i> 100% of the Negotiated Charge with waiver of the Deductible.</p> <p><i>Non-Preferred Care:</i> 70% of the Reasonable Charge with waiver of the Deductible.</p> <p>Treatment is limited to a maximum of 30 days per Policy Year.</p> <p>The above maximums do not apply for confinements due to detoxification. Charges incurred solely for detoxification are payable on the same basis as any other inpatient expense up to a maximum of seven days of any one confinement for the first four such confinements over the Covered Person's lifetime.</p>

Mental Health and Substance Abuse Benefit Expenses (continued)	
Inpatient Substance Abuse Expenses <i>(continued)</i>	Covered Medical Expenses also include the charges made for treatment received during partial hospitalization in a hospital or treatment facility. With the exception of emergency services, prior review and approval must be obtained on a case-by-case basis by contacting Aetna Student Health. When approved, benefits will be payable in place of an inpatient admission up to a maximum of 30 days per Policy Year.
Outpatient Substance Abuse Expenses	Covered Medical Expenses for the care or treatment of substance abuse by a licensed or accredited health service organization or hospital or by a licensed practitioner are payable as follows: Preferred Care: 100% of the Negotiated Charge after \$25 Copay, with waiver of the Deductible. Non-Preferred Care: 70% of the Reasonable Charge, with waiver of the Deductible, up to a maximum of \$80 per visit. Outpatient treatment is subject to a maximum of 50 visits per Policy Year and to a maximum of 120 visits per lifetime.
Maternity Benefits	
Maternity Expenses – Office Visits and Lab/X-ray Copays are waived for Pre-Natal/Maternity Care. <i>(Plan Deductible applies/Referral not required)</i>	Covered as any other Sickness. Covered Medical Expenses for pregnancy, childbirth, and complications of pregnancy are payable on the same basis as any other Sickness. In the event of an inpatient confinement, such benefits would be payable for inpatient care of the Covered Person, and any newborn child, for a minimum of 48 hours after a vaginal delivery and for a minimum of 96 hours after a cesarean delivery. Any decision to shorten such minimum coverages shall be made by the attending Physician in consultation with the mother and done in accordance with the rules and regulations promulgated by the Department of Public Health. In such cases, Covered Medical Expenses may include home visits, parent education, and assistance and training in breast- or bottle-feeding.
Voluntary Termination of Pregnancy Expenses <i>(Plan Deductible applies/Referral not required)</i>	Covered Medical Expenses for voluntary termination of pregnancy are payable on the same basis as any other Sickness.
Additional Benefits	
High Cost Procedure Expenses <i>(Plan Deductible applies)</i>	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: Preferred Care: 100% of the Negotiated Charge after a \$50 Copay per visit. Non-Preferred Care: 70% of the Reasonable Charge.

Additional Benefits (continued)	
Diagnostic Testing and Treatment For Learning Disabilities Expenses (<i>Plan Deductible applies</i>)	<p>Covered Medical expenses include charges incurred for diagnostic testing and treatment of attention deficit disorder or for attention deficit hyperactive disorder.</p> <p>Covered Medical Expenses are payable on the same basis as any other condition.</p>
Durable Medical Equipment Expenses (<i>replacements are not covered</i>) (<i>Plan Deductible applies</i>)	<p>Covered Medical Expenses are payable as follows: Preferred Care: 90% of the Negotiated Charge. Non-Preferred Care: 60% of the Reasonable Charge.</p> <p>Covered Medical Expenses include, but are not limited to, coverage for orthopedic shoes, foot orthotics or other devices to support the feet if they are Medically Necessary to prevent the complications of diabetes.</p>
Ambulance Expenses (<i>Plan Deductible applies</i>)	<p>Covered Medical Expenses are payable at 100% of the Reasonable Charge for the services of a professional ambulance to or from a hospital when required due to the emergency nature of a covered Accident or Sickness.</p>
Prescription Drug Benefit Expenses	<p>Covered Medical Expenses for outpatient Prescription Drugs associated with a covered Sickness or Accident which occurs during a Policy Year are payable as follows: Preferred Care: Covered Medical Expenses are payable at 100% of the Negotiated Charge after a \$15 Copay for Generic Prescription Drugs and \$30 Copay for Brand-Name Prescription Drugs. Non-Preferred Care: Covered Medical Expenses are payable at 100% of the Reasonable Charge after a \$15 Deductible for Generic Prescription Drugs and \$30 Deductible for Brand-Name Prescription Drugs.</p> <p>Benefits are not payable for more than a 30 day supply per Prescription or refill without prior authorization.</p> <p>Coverage includes contraceptive jellies, foams, devices, patch, ring, implants and injections.</p> <p>Coverage of diabetic supplies (other than testing supplies, needles and syringes) and education are covered under the medical portion of the Plan. Coverage of drugs prescribed for the treatment of diabetes, testing supplies, lancets, needles and syringes are a Covered Medical Expense under the Prescription Drug portion of the Plan.</p> <p>Mail Order Prescriptions are covered at 2x the Copay per 90 day supply.</p> <p>Medications not covered by this benefit include, but are not limited to: drugs to promote or to stimulate hair growth, appetite suppressants, smoking deterrents, and non self-injectables. Prior authorization is required for growth hormones.</p> <p>For assistance, or for a complete list of excluded medications and drugs available with prior authorization, please contact (800) 238-6279.</p>

Additional Benefits (continued)	
Home Health Care Expenses <i>(Plan Deductible applies)</i>	Covered Medical Expenses are payable at 100% of the Reasonable Charge incurred within 12 months from the date of the first home health care visit. The maximum number of covered visits is limited to 40. Four hours of home health aide service shall be considered as one home care visit.
Diabetic Treatment Expenses <i>(Plan Deductible applies)</i> <i>(Please note: Diabetic testing supplies and insulin are covered under the Prescription Drug Program.)</i>	Covered Medical Expenses for diabetic self-management education programs or for supplies not covered by the Prescription Drug Program are payable as follows: Preferred Care: 100% of the Negotiated Charge. Non-Preferred Care: 70% of the Reasonable Charge.
Women's Health Benefit Expenses <i>(Referral not required)</i>	The Plan will pay for one baseline mammogram for women between the ages of 35 and 40. (Women under age 40 have coverage for mammograms when recommended by the woman's Physician.) Women ages 40 and over have coverage for one routine annual mammogram per Policy Year thereafter. Benefits are payable on the same basis as any X-ray expenses and the Plan Deductible applies. Covered Medical Expenses include coverage for one routine gynecological exam and an annual routine Pap smear screening for women ages 18 and older. Covered Medical Expenses are payable on the same basis as any other outpatient expense with waiver of the Plan Deductible.
Mastectomy and Reconstructive Breast Surgery Expenses	Covered Medical Expenses include charges incurred for mastectomy and/or reconstructive surgery for a covered female student or dependent who has undergone a mastectomy. This includes all stages of reconstructive breast surgery on the non-diseased breast to establish symmetry with the diseased breast when reconstructive surgery has been performed on the diseased breast, prostheses, and treatment of physical complications of all stages of mastectomy, including lymphedemas. Covered Medical Expenses are payable on the same basis as any other Sickness.
Immunization Benefit Expenses <i>(For covered students and covered dependents)</i>	Covered Medical Expenses includes coverage of charges made by a provider for child immunizations, including immunization agents under age 21 and which, as determined by the Department of Health, conform with standards of the Advisory Committee on immunization practices of the Center for Disease Control, U.S. Department of Health and Human Services. Covered Medical Expenses are payable on the same basis as any expenses, with waiver of the Deductible.

Additional Benefits (continued)	
Immunization Benefit Expenses (continued)	<p>Please note: This Plan also covers Penn required pre-matriculation immunizations. Covered immunization expenses do not apply towards meeting the Plan's Aggregate Maximum per condition.</p> <p>Preferred Care: 90% of the Negotiated Charge.</p> <p>Non-Preferred Care: 60% of the Reasonable Charge. (Covered 100% at SHS)</p> <p>Gardasil (HPV vaccine) is covered at \$40 Copay per injection at Penn Student Health Services only.</p>
Vision Expenses (Referral not required)	<p>Covered Medical Expenses for one routine eye examination per Policy Year are payable as follows:</p> <p>Preferred Care: 90% of the Negotiated Charge.</p> <p>Non-Preferred Care: 60% of the Reasonable Charge.</p>
Physical Therapy Expenses (Plan Deductible applies)	<p>Covered Medical Expenses are payable as follows:</p> <p>Preferred Care: 90% of the Negotiated Charge.</p> <p>Non-Preferred Care: 60% of the Reasonable Charge.</p>
Dental Expenses (Plan Deductible applies/Referral not required)	<p>Covered Medical Expenses are payable at 90% of the Actual Charge for the treatment of an Injury to sound, natural teeth.</p> <p>Covered Medical Expenses are payable at 90% of the Actual Charge for the removal of impacted wisdom teeth.</p>

Preferred Provider Network

Aetna Student Health has arranged for you to access a Preferred Provider Network in your local community. Acute care facilities and mental health networks are available nationally if you require hospitalization outside the immediate area of the University of Pennsylvania campus.

To maximize your savings and reduce your out-of-pocket expenses, select a Preferred Provider. It is to your advantage to use a Preferred Provider because savings may be achieved from the Negotiated Charges these providers have agreed to accept for their services. Preferred Providers are independent contractors and are neither employees nor agents of University of Pennsylvania, Aetna Student Health, or Aetna. A complete listing of participating Preferred Providers and Pharmacies are available through the Internet by accessing Aetna's online DocFind® service located at www.aetnastudenthealth.com. Click on "Find Your School," enter **724535** as your Policy Number. You can use DocFind® to find out whether a specific provider belongs to Aetna's network or to find Preferred Providers practicing in your area. You may also contact Aetna Student Health at **(800) 841-5374**.

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 Aetna Student Health.
- 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 a \$200 per admission Deductible.

Pre-Certification of Non-Emergency Inpatient Admissions:

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

Notification of Emergency Admissions:

The emergency health care provider, patient's representative, Physician, hospital or facility must telephone within 48 hours, or the next business day, whichever is later, following admission.

Aetna Student Health

Attention: Managed Care Dept.

P.O. Box 15708

Boston, MA 02215-0014

(800) 841-5374

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

Additional Services and Discounts

As a member of the Plan, you can also take advantage of the following services, discounts, and programs. These are not underwritten by Aetna. To learn more about these additional services and search for providers, visit www.aetnastudenthealth.com.

<p>Aetna VisionSM Discount Program¹</p>	<p>Aetna VisionSM Discount Program: The Aetna Vision 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 15% discount on LASIK surgery (the laser vision correction procedure).</p>
<p>Aetna FitnessSM Discount Program¹</p>	<p>Aetna FitnessSM Discount Program: Aetna's Fitness Program provides members with access to preferred membership rates at nearly 10,000 fitness clubs nationwide in the GlobalFitTM network, as well as discounts on home fitness equipment, exercise videos and more!</p>
<p>Aetna's Informed Health[®] Line²</p>	<p>Aetna's Informed Health[®] Line*: Get credible health information 24 hours a day from Informed Health Line. Call us toll free, anytime day or night, 365 days a year.</p> <p>You never know when a health question might come up. Informed Health Line connects you to a team of registered nurses experienced in providing information on a variety of health topics – 24 hours a day, 7 days a week.</p> <p>You also have access to our Audio Health Library, a recorded collection of thousands of health topics that's available in English or Spanish. Transfer easily to an Informed Health Line registered nurse at any time during your call.</p> <p>Or, to get credible health information online, register for Aetna Navigator (visit www.aetnastudenthealth.com to register), our password-protected member website. After logging in, click on <i>Take Action on Your Health</i>, <i>Treating Illness</i> and then <i>Health A-Z</i>.</p> <p>To reach an Informed Health Line Nurse, please call (800) 556-1555. For TDD (hearing and speech impaired only), please call (800) 270-2386.</p> <p><i>*Health information programs provide general health information and are not a substitute for diagnosis or treatment by a physician or other health care professional. Also, the topics discussed by the nurses, on the audio tapes or online may not necessarily be covered by your health Plan.</i></p>
<p>Aetna Natural Products and ServicesSM Discount Program^{1,2,3}</p>	<p>Aetna Natural Products and ServicesSM Discount Program: Offers members access to reduced rates from natural therapy professionals, including acupuncturists, chiropractors, massage therapists and diet counselors, and access to discounts on health-related products, such as over-the-counter vitamins, supplements and more!</p>

Additional Benefits (continued)

<p>Vital SavingsSM on Dental⁴</p>	<p>Vital SavingsSM on Dental is a dental discount program helping you save an average of 15% to 50%* on a wide array of dental services – with one low annual fee of \$25 per person. Enroll online at www.aetnastudenthealth.com.</p> <p><i>*Actual costs and savings vary by provider and geographic area.</i></p>
<p>Aetna Dental[®] Advantage Plan⁵</p>	<p>With our Aetna Dental[®] Advantage Plan, you select a primary care dentist (PCD) and have most of your preventive and restorative services covered by a copayment or reduced fee for each visit. Enroll online at www.aetnastudenthealth.com.</p>

<p>Aetna Dental[®] Advantage Plan</p>	<p>Annual 9/1/08-8/31/09 Deadline: 9/15/08</p>	<p>Spring 1/1/09-8/31/09 Deadline: 1/31/09</p>	<p>Summer 5/1/09-8/31/09 Deadline: 5/31/09</p>
<p>Student</p>	<p>\$205.00</p>	<p>\$137.00</p>	<p>\$ 68.00</p>
<p>Student plus One Dependent</p>	<p>\$402.00</p>	<p>\$268.00</p>	<p>\$134.00</p>
<p>Student plus Two or More Dependents</p>	<p>\$768.00</p>	<p>\$512.00</p>	<p>\$256.00</p>

¹Discount programs provide access to discounted prices and are NOT insured benefits.

²Health information programs provide general health information and are not a substitute for diagnosis or treatment by a physician or other health care professionals.

³These services, programs or benefits are offered by vendors who are independent contractors and not employees or agents of Aetna.

⁴The Vital Savings by Aetna[®] program (the “Program”) is not insurance. The Program provides Members with access to discounted fees pursuant to schedules negotiated by Aetna Life Insurance Company for the Vital Savings by Aetna[®] discount program. The Program does not make payments directly to the providers participating in the Program. Each Member is obligated to pay for all services or products but will receive a discount from the providers who have contracted with the Discount Medical Plan Organization to participate in the Program. Aetna Life Insurance Company, 151 Farmington Avenue, Hartford, CT 06156, 1-877-698-4825, is the Discount Medical Plan Organization.

⁵Aetna Dental Advantage Plan is provided or administered by Aetna Dental Inc. and/or Aetna Health Inc.

Got Questions? Get Answers with Aetna Student Health's Aetna Navigator®

As an Aetna Student Health Insurance Plan member, you have access to Aetna Navigator®, your secure member website, packed with personalized claims and health information. You can take full advantage of our interactive website to complete a variety of self-service transactions online.

By logging into Aetna Navigator, you can:

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

How do I register?

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

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

Need help with registration?

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

Student Coverage

Eligibility

All students of the University who are registered and are actively participating in credit courses leading to a degree or a certificate are eligible to participate in the Penn Student Insurance Plan (PSIP).

NOTE: English Language Program (ELP) students are not eligible for PSIP and should contact their Program Director for other options.

Students must actively attend classes within the first 31 days after the date for which coverage is purchased. Internet classes and television (TV) courses may not fulfill the eligibility requirements that the covered student actively attends classes. If the eligibility requirements are not met, Aetna's only obligation is to refund the premium.

Enrollment

(Your PennKey and password authentication is required, for details, please go to <http://www.upenn.edu/computing/pennkey/>).

Each school year, all full-time and dissertation-status students must either enroll in PSIP or waive coverage with proof of comparable coverage by the stated deadline. Selections from previous years are not rolled forward or renewed. Students who do not enroll or waive participation in the Plan by the stated deadline will be subject to automatic enrollment in PSIP with student coverage only. Dependents are not automatically enrolled.

Part-time students are eligible to purchase this coverage as well; however, they are not default enrolled in the Plan.

Students who want PSIP coverage should enroll online to ensure continuation of insurance benefits without disruption and to guarantee coverage in the event that their student registration status changes. Eligible students can enroll online through the PennPortal links, first to Health & Welfare and from there to Appointments (417-WELL), immunizations, health insurance, clinical fee and more.

Approved Leave of Absence (LOA)

Students on an approved medical or academic leave of absence may voluntarily continue their coverage for up to 12 months following the termination of their regular student coverage and for no more than 24 months of cumulative coverage.

Students should contact Penn Student Insurance Office for the appropriate approval forms and Enrollment Forms. Payment must be made directly to Aetna Student Health.

Please note:

- 1) The Carrier reserves the right to make the final determination regarding eligibility for initial and continued enrollment in this Plan, and
- 2) Students on a judicial or dropped status are not eligible for Leave of Absence coverage through PSIP and should contact the Student Health Insurance Office to determine if other options for insurance coverage are available.
- 3) Students applying for Annual Leave of Absence coverage must have been insured under the PSIP for the previous semester.
- 4) LOA students are not eligible for care at SHS and therefore are not subject to the referral requirement.

Study Abroad Students

If you are in a Study Abroad program in the fall you will not be automatically enrolled in PSIP. To enroll, you must submit your request prior to the September 15th deadline.

If you choose not to enroll, and return to Penn in the Spring semester you will be automatically enrolled in PSIP effective **January 1, 2009** and billed the \$1,667 premium unless a waiver is filed before the **January 31, 2009** deadline.

Waiver Process/Procedure

Students who are covered under a health insurance plan that meets the criteria for alternative coverage may choose to waive participation in the (PSIP) Plan by going to Penn's main webpage at www.upenn.edu and following the link to PennPortal. Under "Health & Welfare," follow the link to "Appointments (417-WELL), immunizations, health insurance, clinical fees and more," and provide proof of alternative coverage by the specified deadline date(s). Students whose plans do not meet the minimum standards will be alerted and must bring their coverage up to an acceptable level prior to the waiver deadline date in order to waive participation in the Plan.

Full-time and dissertation students whose plans do not meet the minimum standards will be required to document acceptable coverage by **September 15, 2008** or they will be automatically enrolled in PSIP. Students who matriculate in July, August, or September 2008 must submit their Waiver no later than **September 15, 2008**. Students who matriculate in January 2009 must submit their Waiver no later than **January 31, 2009**, and students who matriculate in the Summer 2009 must submit their Waiver by **May 29, 2009**. The University reserves the right to audit all waivers to ensure compliance with University insurance standards and to enroll students into PSIP if their insurance plan does not meet the criteria for alternative coverage.

After the waiver deadline, students cannot cancel their PSIP coverage. This provision includes, but is not limited to, the following situations:

- 1) The Covered Person obtains health insurance coverage from an employer.
- 2) The Covered Person leaves school after the waiver deadline date.

Your waiver of previous plan years for PSIP will not forward to a new academic year. Students must provide a waiver each academic year. Students who fail to provide information about their insurance coverage will be billed for and enrolled in PSIP.

Non-Responders to Waiver Process/Procedure

All full-time and dissertation-status students are required to show proof of coverage or enroll in PSIP.

Student who do not respond by the following response due dates will be automatically enrolled with student coverage only in PSIP: New full-time students beginning studies in July, August, or September and returning full-time and dissertation-status students who do not enroll or waive by **September 15, 2008** will be enrolled in the PSIP effective **September 1, 2008**. The 2008-2009 PSIP is an annual plan, with a premium of \$2,560. The premium is billed in two installments directly to student accounts and is subject to the payment guidelines of Student Financial Services.

The deadline to make changes, including changes in enrollment or full waiver, will be **September 21, 2008**. **Please note: Changes to enrollment effective dates will not be permitted.** Between September 22nd and October 13th, student may only withdraw from the Plan with proof of acceptable alternative coverage. Between October 14th and November 3rd, students who submit proof of alternative coverage will be assessed an administrative fee of \$100. All requests for termination between September 22nd and November 3rd are subject to approval from the insurance carrier.

The changes that may be requested between September 16th and September 21st are:

- Cancel an enrollment with a valid waiver.
- Remove a waiver with a valid enrollment selection.

Changes to enrollment effective dates will not be allowed. Between September 22nd and October 13th only waivers will be considered. An administrative fee of \$100 will be assessed for waivers submitted between October 14th and November 3rd.

After November 3rd, students may not terminate coverage.

New full-time and dissertation-status students beginning studies in the Spring Semester who do not enroll or submit a waiver of alternative coverage by **January 31, 2009** will be enrolled in the PSIP effective **January 1, 2009** and billed the Spring Semester premium of \$1,667. Students may not withdraw or cancel coverage in the Plan once the waiver deadline has passed.

Late Enrollment

Coverage for late enrollees may be possible only under certain conditions. After the enrollment deadline, only those students who have involuntarily lost health insurance coverage through a “Qualifying Life Event” such as (1) removal from a parent’s health insurance plan after achieving a landmark birthday that disqualifies them from a parent’s health insurance plan or (2) losing private insurance through loss of employment or divorce, may apply for late enrollment.

A certificate of credible coverage stating the date of the involuntary loss of health coverage and a signed application must be submitted to the Student Health Insurance Office within 31 days of the qualifying life event. Please contact the Student Health Insurance Office for details.

Dependent Coverage

Eligibility

Covered students may enroll their lawful spouse/domestic partner and unmarried dependent children under age 19 who reside with, and are fully supported by, the covered student for the same coverage.

Enrollment

All spouses and domestic partners must have a Penn Guest Card at the time of application and enrollment. Covered students may enroll their eligible dependents online by the specified deadline(s) by visiting www.aetnastudenthealth.com, click on “Find your School” and enter “724535” as your Policy Number. Students will need to submit an online Dependent Enrollment Application with an electronic check or MasterCard/Visa payment.

The dependent enrollment deadline date for the Fall Semester is **September 15, 2008**. The enrollment deadline date for the Spring/Summer Semester is **January 31, 2009**. The enrollment deadline date for the Summer Semester is **May 29, 2009**. The Dependent Enrollment Application and premium will not be accepted after the deadline. Please contact Aetna Student Health at **(800) 841-5374** with any questions regarding dependent enrollment.

Spouse/Domestic Partners

Students may add a spouse or a domestic partner within 31 days of the marriage or establishment of a domestic partnership. Proof may be requested by Aetna Student Health or the University of Pennsylvania's Student Health Service and may include the procurement of a Guest Card from the Penn Card Center.

Newborn Infant Coverage and Adopted Child Coverage

All newborn children of a covered student or insured dependent spouse are covered automatically at birth for 31 days for an Injury or Sickness, premature birth and medically diagnosed congenital defects. Students should contact the Penn Student Insurance Office for a newborn Enrollment Form within this 31 day period. Students will receive a separate bill for newborns.

Coverage can also be provided for a child legally placed with a covered student from the moment of placement. Extended coverage beyond the first 31 days is available through Aetna Student Health provided the Covered Person enrolls the child within the first 31 days of placement of such child.

Policy Period

1. For early start students who want to begin their coverage on **July 1** or **August 1 2008**, please contact the Student Health Insurance Office for an application. New undergraduates and returning graduate students may begin their coverage on **September 1, 2008** only. The deadline to enroll in or waive PSIP is **September 15, 2008**. All plans will expire at 11:59 p.m. on **August 14, 2009**, except for students who graduate in December whose plans will expire on **February 28, 2009**.
2. **Spring 2009 Semester Students:** Enrollment prior to 5:00 p.m. **January 31, 2009** for the Spring Semester will become effective at 12:01 a.m. on **January 1, 2009**, and will terminate at 11:59 p.m. on **August 14, 2009**.
3. **New Summer 2009 Semester Students:** Enrollment prior to 5:00 p.m. on **May 31, 2009** for the Summer Semester will become effective at 12:01 a.m. on **May 1, 2009**, and will terminate at 11:59 p.m. on **August 14, 2009**.
4. **Insured Dependents:** Coverage will become effective on the same date the insured student's coverage becomes effective, or the day after the completed Enrollment Form is received, if later. Coverage for insured dependents terminates in accordance with the Termination provisions described in the Master Policy. Examples include, but are not limited to, the date the student's coverage terminates and the date the dependent no longer meets the definition of a dependent.
5. **December Graduates:** If you are a December Graduate, your coverage will terminate on **February 28, 2009**. If you have enrolled dependents, their coverage will terminate in conjunction with your own.

After enrollment, students may only add a spouse, child, or domestic partner according to the Domestic Partner and Newborn and Adopted Children Enrollment guidelines.

The Carrier reserves the right to make the final determination regarding eligibility for initial and continued enrollment in this Plan.

PSIP is an annual Plan with coverage through **August 14, 2009**. Students enrolled in PSIP who graduate in December have coverage until **February 28, 2009** and are entitled to the full benefits of the Plan. Students enrolled in the PSIP who graduate in May have coverage until **August 14, 2009** and are entitled to the full benefits of the Plan. Full benefits include continued access to care at the Penn Student Health Service.

Premium Rates

	Annual Rate 9/1/08-8/14/09	Spring Rate 1/1/09-8/14/09	Summer Rate 5/1/09-8/14/09
Student Only	\$2,560.00	\$1,667.00	\$ 788.00
Spouse	\$3,234.00	\$2,100.00	\$ 985.00
One Child	\$3,234.00	\$2,100.00	\$ 985.00
Two or more Children	\$3,781.00	\$2,455.00	\$1,152.00

Annual premiums are billed in two installments (Fall and Spring). An administrative fee is included in the student rate.

**Student premiums are posted directly to student SFS accounts and are payable to the University. All premiums for dependents are billed by and paid directly to Aetna Student Health.*

For early start students who want to begin coverage on 7/1 or 8/1, please contact the Student Insurance Office for an application.

Please note:

- Regardless of the point in time during the open enrollment period in which the Enrollment is submitted, the student premium is not pro-rated. Premiums are billed in two installments (fall and spring).
- At any time after the open enrollment period, when a student, spouse, child, or domestic partner is added to the Plan due to a qualifying life event, the applicable monthly pro-rated premium will be charged for the period they are being added.

Premium Refund Policy

Except for medical withdrawal due to a covered Accident or Sickness, any student withdrawing from school during the first 31 days of the period for which coverage is purchased shall not be covered under the Policy and a full refund of premium will be made unless a claim has been filed. Students withdrawing after 31 days will remain covered under the Policy for the full period for which they enrolled and full premium for that period must be paid. Students withdrawing after 31 days will remain covered under the Policy for the full period for which they enrolled and full premium for that period must be paid. **No refunds will be allowed.**

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 covered dependents, upon written request received by Aetna Student Health within 90 days of withdrawal from school.

General Provisions

State Mandated Benefits

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

Reimbursement/Right of Recovery Provision

If a loss or Injury sustained by a Covered Person is caused by the act or omission of a third party, benefits otherwise payable under this Policy for Covered Medical Expenses under the Plan for such loss or Injury will be paid only on the condition that the Covered Person (or his or her legally authorized representative if the person is legally incapable) shall agree in writing:

- To pay Aetna to the extent that a third party settlement or judgment includes an amount (or portion thereof) previously paid by Aetna for the same medical services or benefits as incurred by the Covered Person.
- To provide Aetna a lien, to the extent of such benefits paid. The lien may be filed with the person whose act caused the Injuries, his agent, or a court jurisdiction in the matter.

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.

Aetna shall exercise such reimbursement rights to the extent permitted by law.

The Covered Person shall do nothing to prejudice Aetna’s 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.

Subrogation/Right of Recovery Provision

As a condition to payment of benefits under this Plan for expenses incurred by a Covered Person due to Injury or illness for which a third party may be liable:

- Aetna shall, to the extent of benefits it has paid, be subrogated to (has the right to pursue) all rights of recovery of Covered Persons against such third party to the extent permitted by law.
- Aetna shall have the right to recover from the Covered Person amounts received by judgment, settlement, or otherwise from such third party or his or her insurance carrier.
- The Covered Person (or person authorized by law to represent the Covered Person if he or she is not legally capable) shall:
 - Execute and deliver any documents that are required; and
 - Do whatever else is necessary to secure such rights as determined by Aetna.

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

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.

Aetna shall exercise such subrogation rights to the extent permitted by law.

Subrogation and Reimbursement/Right of Recovery Provisions

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 the entire subrogation and reimbursement provisions 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 only" or "non-economic damages only" to the extent permitted by law.

In the event any claim is made that any part of these subrogation and reimbursement provisions are ambiguous or questions arise concerning the meaning or intent of any of their 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 these provisions.

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, as a result, receive Medical Expense 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 this Policy for all Covered Medical Expenses incurred by a Covered Person from one Policy Year to the next.

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

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

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

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

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

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

- Placing the health of the enrollee 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 woman or her unborn child.

A medical condition will be considered an Emergency Medical Condition based upon whichever one of the following is most favorable to the Covered Person:

- The presenting of symptoms; or
- The final diagnosis of the medical condition;

As they are reported to Aetna by the hospital emergency room provider.

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.

Emergency Services: This means any health care service or supply to a Covered Person to treat an Emergency Medical Condition. Coverage for such services is available 24 hours per day.

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, any person who is part of his or her family, or any health care provider, or health care facility; or
- Those furnished solely because the person is an inpatient on any day on which the person's Sickness or Injury could safely and adequately be diagnosed or treated while not confined; or
- Those furnished solely because of the setting if the service or supply could safely and adequately be furnished, in a Physician's or a dentist's office, or other less costly setting.

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

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

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

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

Pharmacy: An establishment where Prescription Drugs are legally dispensed.

Physician: A legally qualified Physician. Also, to the extent required by law, a practitioner who performs a service for which coverage is provided when it is performed by a Physician.

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

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

Preferred Health Care: A health care service or supply that is furnished by a hospital or Physician that is a Preferred Care Provider. It also includes a health care service or supply furnished by a hospital or Physician that is not a Preferred Care Provider:

- For an Emergency Medical Condition when travel to a Preferred Care Provider is not feasible.
- For treatment or services furnished by a Physician that has a type of practice that is not listed in the Directory but whose services are required to be covered by law.
- For treatment or services furnished by a Physician within the geographic area covered in the Directory, but only if a Preferred Care Provider is not reasonably available, provided you contact Aetna and Aetna confirms that a Preferred Care Provider is not reasonably available.

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

This list is only a partial list. Please refer to the School's Master Policy on file at the school for a complete list of exclusions.

The Plan neither covers nor provides benefits for the following:

1. Expenses incurred as a result of dental treatment, except for treatment resulting from Injury to sound, natural teeth, or the removal of impacted wisdom teeth as provided elsewhere in the Policy.
2. Expenses incurred for services normally provided without charge by the Policyholder's Health Service, infirmary or hospital, or by health care providers employed by the Policyholder.
3. Expenses incurred for eye refractions, vision therapy, radial keratotomy, eyeglasses, contact lenses (except when required after cataract surgery), or other vision or hearing aids, or Prescriptions or examinations except as required for repair caused by a covered Injury.
4. Expenses incurred as a result of Injury due to participation in a riot. "Participation in a riot" means taking part in a riot in any way, including inciting the riot or conspiring to incite it. It does not include actions taken in self-defense, so long as they are not taken against persons who are trying to restore law and order.
5. Expenses incurred as a result of an Accident occurring in consequence of riding as a passenger or otherwise in any vehicle or device for aerial navigation, except as a fare-paying passenger in an aircraft operated by a scheduled airline maintaining regular, published schedules on a regularly established route.
6. Expenses incurred as a result of an Injury or Sickness due to working for wage or profit for which benefits are payable under any Workers' Compensation Act, Occupational Disease Laws, or by the United States Longshoremen's and Harbor Workers' Compensation Act.
7. Expenses incurred as a result of Injury sustained or Sickness contracted while in the service of the armed forces of any country. Upon the Covered Person entering the armed forces of any country, the unearned pro-rata premium will be refunded to the Policyholder.
8. Expenses incurred for treatment provided in a governmental hospital unless there is a legal obligation to pay such charges in the absence of insurance.
9. Expenses incurred for, or related to, services, treatment, education testing, or training related to learning disabilities or developmental delays unless otherwise provided in the Policy.
10. Expenses incurred for plastic surgery, cosmetic surgery, reconstructive surgery, or other services and supplies that improve, alter, or enhance appearance, whether or not for psychological or emotional reasons. This exclusion will not apply to the extent needed to:

- a) Improve the function of a part of the body that is not a tooth or structure that supports the teeth, and is malformed as a result of a severe birth defect (including harelip and webbed fingers or toes), or as direct result of disease, or surgery performed to treat a Sickness or Injury.
- b) Repair an Injury which occurs while the Covered Person is covered under the Plan. Surgery must be performed in the Policy Year of the Accident which causes the Injury, or in the next Policy Year.

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

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

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

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

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

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

- Those that do not require the technical skills of a medical, 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.

13. Expenses incurred for any services rendered by a family member of a Covered Person's immediate family or a person who lives in the Covered Person's home.

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

15. Expenses incurred for the treatment of temporomandibular joint (TMJ) dysfunction and associated myofascial pain unless otherwise provided in the Policy.

16. 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.

17. Expenses incurred after the date insurance terminates for a Covered Person except as may be specifically provided in the Extension of Benefits provision.

18. Expenses incurred for Injury resulting from the play or practice of intercollegiate sports (participation in sports clubs or intramural athletic activities are not excluded).

19. Expenses covered by any other valid and collectible medical, health, or accident insurance to the extent that benefits are payable under other valid and collectible insurance whether or not a claim is made for such benefits.

20. Expenses incurred for services normally provided without charge by the school and covered by the school fee for services.

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

22. Expenses incurred as a result of commission of a felony.

23. Expenses incurred for treatment of mental or nervous disorders unless otherwise provided in the Policy.

24. Expenses incurred for voluntary or elective abortions unless otherwise provided in the Policy.

25. Expense incurred for which no member of the Covered Person's immediate family has any legal obligation for payment.

26. Expenses incurred for, or in connection with, procedures, services, or supplies that are, as determined by Aetna, to be experimental or investigational. A drug, 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 shows promise of being effective for that disease, as demonstrated by scientific data. In making this determination, Aetna will take into account the results of a review by a panel of independent medical professionals. They will be selected by Aetna. This panel will include professionals who treat the type of disease involved.

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

- Have been granted treatment investigational new drug (IND), or Group c/treatment IND status; or
- Are being studied at the Phase III level in a national clinical trial, sponsored by the National Cancer Institute;

If Aetna determines that available, scientific evidence demonstrates that the drug is effective, or shows promise of being effective, for the disease.

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

28. Expenses incurred for, or related to, sex change surgery or to any treatment of gender identity disorders.
29. Expenses for routine physical exams, routine vision exams, routine dental exams, routine hearing exams, immunizations for Covered Persons ages 21 and older, or other preventive services and supplies, except to the extent coverage for such exams, immunizations, services, or supplies is specifically provided in the Policy.
30. Expenses incurred for breast reduction/mammoplasty unless they are incurred in connection with a mastectomy and breast reconstruction.
31. Expenses incurred for gynecomastia (male breasts).
32. Expenses for charges that are not Reasonable Charges, as determined by Aetna.
33. 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.

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

Extension of Benefits

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

Termination of Insurance

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

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:

Aetna Student Health
P.O. Box 15708
Boston, MA 02215- 0014
(800) 841-5374
(617) 218-8400 (outside United States)

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

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

Prescription Drug Claim Procedure

Preferred Care: When obtaining a covered Prescription, please present your Aetna Student Health 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 the Internet at: www.aetnastudenthealth.com. Click on "Find Your School" enter **724535** 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 the University of Pennsylvania and include your name, address, and student identification number.

On Call International

Aetna Student Health has contracted with On Call International (On Call) to provide Covered Persons with access to certain accidental death and dismemberment benefits, worldwide emergency travel assistance services and other benefits.

A brief description of these benefits is outlined below.

Accidental Death and Dismemberment (ADD) Benefits¹

These benefits are underwritten by United States Fire Insurance Company (USFIC) and include the following:

Benefits are payable for the Accidental Death and Dismemberment of Covered Persons, up to a maximum of \$10,000.

Medical Evacuation and Repatriation (MER) Benefits¹

The following benefits are underwritten by Virginia Surety Company (VSC), with medical and travel assistance services provided by On Call. These benefits are designed to assist Covered Persons when traveling more than 100 miles from home, anywhere in the world.

- Unlimited Emergency Medical Evacuation
- Unlimited Medically Supervised Repatriation (while traveling or on campus)
- Unlimited Return of Mortal Remains (while traveling or on campus)
- \$2,500 Joining of Ill Family Member Accommodations
- Return of Traveling Companion

Worldwide Emergency Travel Assistance (WETA) Services¹

On Call provides the following travel assistance services:

- 24/7 Emergency Travel Arrangements
- Translation Assistance
- Emergency Travel Funds Assistance
- Lost Luggage and Travel Documents Assistance
- Assistance with Replacement of Credit Card/Travelers Checks
- 24/7 U.S. Nurse Help Line
- Medical/Dental/Pharmacy Referral Service
- Hospital Deposit Arrangements
- Dispatch of Physician
- Emergency Medical Record Assistance

The On Call International Operations Center can be reached 24 hours a day, 365 days a year.

The information contained above is a just summary of the ADD, MER and WETA benefits and services available through On Call, USFIC and VSC. For a copy of the plan documents applicable to the ADD, MER and WETA coverage, including a full description of coverage, exclusions and limitations, please contact Aetna Student Health at www.aetnastudenthealth.com or 800-966-7772.

NOTE: In order to obtain coverage, all MER and WETA services must be provided and arranged through On Call. Reimbursement will not be provided for any services not provided and arranged through On Call. Although certain emergency medical services may be covered under the terms of the Covered Person's student health insurance plan (the "Plan"), neither On Call, USFIC nor WETA provides coverage for emergency medical treatment rendered by doctors, hospitals, pharmacies or other health care providers. Coverage for such services will be provided in accordance with the terms of the Plan and exclusions and limitations may apply.

To file a claim for ADD benefits, or to obtain MER and WETA benefits/services, or for any questions related to those benefits/services, please call On Call International at the following numbers listed on the On Call ID card provided to Covered Persons when they enroll in the Plan: Toll Free 1-866-525-1956 or collect 1-603-328-1956. All Covered Persons should carry their On Call ID card when traveling.

Aetna Student Health is the brand name for products and services provided by Aetna Life Insurance Company and Chickering Claims Administrators, Inc, (CCA). CCA and On Call are independent contractors and not employees or agents of the other. CCA provides access to ADD, MER and WETA benefits/services through a contractual arrangement with On Call. However, neither CCA nor any of its affiliates provides or administers ADD, MER or WETA benefits/services and neither CCA nor any of its affiliates is responsible in any way for the benefits/services provided by or through On Call, USFIC or VSC. Premiums/fees for benefits/services provided through On Call, USFIC and VSC are included in the Rates outlined in this brochure.

¹These services, programs or benefits are offered by vendors who are independent contractors and not employees or agents of Aetna.

Where to Find Help

For Questions About:

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

Please contact:

Aetna Student Health
P.O. Box 15708
Boston, MA 02215-0014
(800) 841-5374

For Questions About ID Cards:

A permanent ID card will be issued as soon as possible. This card is for identification only. It is not a guarantee of eligibility or benefits. This card will be mailed to the address you have on file with the University of Pennsylvania Registrar. Please be sure to notify PENN-in-Touch or the Registrar of any address changes. If you need medical attention before the ID card is received, benefits will be payable according to the Policy. **You do not need an ID card to be eligible to receive benefits.** Once you have received your permanent ID card, present it to the provider to facilitate prompt payment of your claims. **Note:** Please be advised you will receive a unique Aetna member ID number on your membership card. For lost ID cards, contact: Aetna Student Health, **(800) 841-5374** or visit www.aetnastudenthealth.com. Click on “Find Your School” and enter **724535** as your Policy Number.

For Questions About:

- Benefits
- Enrollment Forms
- Late Enrollment Guidelines (for spouse, dependents, life-change, and newborns)
- Waiver Process
- Penn Authentication
- Student Health Service

Please contact:

Student Health Service
University of Pennsylvania
3535 Market Street, Suite 100
Philadelphia, PA 19104
(215) 746-3535 or E-mail: shsinsur@pobox.upenn.edu

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 a listing of Preferred Care Pharmacies):

Use Aetna's online DocFind® service located at www.aetnastudenthealth.com. Click on "Find Your School" and enter **724535** as your Policy Number. You can use DocFind® to find out whether a specific provider belongs to Aetna's network or to find Preferred Providers practicing in your area.

For Questions About:

- On Call International 24/7 Emergency Travel Assistance Services

Please contact:

On Call International at **1- (866) 525-1956** (within U.S.).

If outside the U.S., call collect **by dialing the U.S. access code plus 1- (603) 328-1956**. Please also visit www.aetnastudenthealth.com and visit your school-specific site for further information.

Worldwide Web Access:

- Aetna Student Health: www.aetnastudenthealth.com
- University of Pennsylvania: www.vpul.upenn.edu/shs

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.

Administered by:

Aetna Student Health
P.O. Box 15708
Boston, MA 02215-0014
(800) 841-5374
www.aetnastudenthealth.com

Underwritten by:



Aetna Life Insurance Company (ALIC)
151 Farmington Avenue
Hartford, CT 06156
(860) 273-0123
Policy No. 724535

The Penn Student Insurance Plan (the “Plan”) is underwritten by Aetna Life Insurance Company (ALIC). The Plan is administered by Chickering Claims Administrators, Inc. **Aetna Student Health is the brand name for products and services provided by these companies.**

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 Aetna Student Health's Student Connection Link on the Internet at *www.aetnastudenthealth.com*.

Notes

Notes

