

2008-2009

**University of Michigan
International Plan**



**Student/Scholar
Health Insurance Plan Brochure**

Revised: October 22, 2008

Aetna Student Health

Underwritten by:

Aetna Life Insurance Company
(ALIC)

Policy No. 711146

Dear International Students and Scholars:

Your health is your most precious possession. One serious illness or Injury can mean financial disaster and can end your educational dreams. That is why we are pleased to present the University of Michigan International Student/Scholar Health Insurance Plan for the academic year 2008-2009.

A detailed description of the Student/Scholar Health Insurance Plan is outlined in the following pages. Although this protection is liberal, there are specific exclusions and limitations in coverage, which should be carefully noted as you read the provisions of the Plan.

All University of Michigan F-1 international students whose Forms I-20 were issued by the University of Michigan, and their accompanying F-2 dependents are eligible for this plan and must remain enrolled in the plan throughout their stay as U-M F-1 students or F-2 dependents unless, in the judgment of the University, comparable coverage is in effect under another insurance policy.

All University of Michigan J-1 international students and scholars whose Forms DS-2019 were issued by the University of Michigan and their accompanying J-2 dependents are eligible for this plan and must remain enrolled in the plan throughout their stay as J-1 students or scholars or J-2 dependents unless, in the judgment of the University, comparable coverage is in effect under another insurance policy.

If you have insurance that is comparable to the U-M Health Insurance Plan, you can request a waiver of the health insurance requirement. Please consult the health insurance section of the International Center's website for more information about requirements for comparable coverage and waiver request procedures. Insurance waivers must be renewed every academic year.

We hope you enjoy your stay at the University of Michigan.

Sincerely,

The University of Michigan International Center

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This Summary of Coverage is not Medicare supplement coverage.

If you are eligible for Medicare, review the Medicare Supplement Buyer's Guide available from the Plan Administrator.

The University of Michigan International Student/Scholar Health Insurance Plan

The University of Michigan International Student/Scholar Health Insurance Plan has been developed especially for University of Michigan F-1 and J-1 International Students/Scholars and their accompanying dependents. The Plan, which is underwritten by Aetna Life Insurance Company (Aetna), provides coverage for illnesses and Injuries that occur on and off campus (worldwide), and includes special cost-saving features to keep the coverage as affordable as possible. The University of Michigan 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, which may be viewed at the University during business hours. If any discrepancy exists between this Brochure and the Policy, the Master Policy will govern and control the payment of benefits. The Plan is administered by Aetna Student Health P.O. Box 15708, Boston, MA 02215-0014.

U.S. Government requirements for J1/J2 Visa policyholders are satisfied under the University of Michigan International Plan.

Where to Find Help

For Questions About:

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

Please contact:

Aetna Student Health
P.O. Box 15708 Boston, MA 02215-0014
(800) 239-9697
(617) 218-8400

For Questions About:

- Enrollment
- Waiver Process
- Referral Process

Please contact:

University of Michigan International Center
603 East Madison Street
Ann Arbor, MI 48109-1370
(734) 647-2303
E-mail: **ihi@umich.edu**

For Questions About:

- On Call International 24/7 Emergency Travel Assistance Services

Please contact:

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

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

For Questions About Prescriptions:

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

Please contact:

Aetna Pharmacy Management

(800) 238-6279 (Available 24 hours)

For Questions About ID Cards:

You will be issued a permanent ID card as soon as possible. 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.

For lost ID cards, contact:

Aetna Student Health **(800) 239-9697** or visit www.aetnastudenthealth.com, click on “**Student Connection**” and enter **711146** as your Policy Number.

Provider Listings:

A complete list of providers (including Preferred Pharmacies) can be obtained

- By calling Aetna Student Health
- By using Aetna’s DocFind® Service at: www.aetnastudenthealth.com, click on “**Find Your School**” and enter **711146** as your Policy Number.

Worldwide Web Access:

- Aetna Student Health
www.aetnastudenthealth.com
- Aetna’s DocFind Service
www.aetnastudenthealth.com/stu_conn/
- University of Michigan International Center
www.internationalcenter.umich.edu

Got Questions? Get Answers with Aetna's Navigator®

As an Aetna Student Health insurance 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 registering onto Aetna Navigator?

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

Policy Period

1. Student/Scholar: Coverage under the 2008/2009 Student/Scholar Health Insurance Plan will become effective at 12:01 a.m. on September 1, 2008. Coverage becomes effective on that date or on the effective date printed on the “Temporary Insurance Certificate” received at the Mandatory Check-In program, whichever is later, each Policy Year. Your coverage is effective through the end date of your I-20 or DS-2019 form, or for F-1 students on post-completion Optional Practical Training (OPT), through the end of the OPT period.
2. Insured Dependents: Coverage will become effective on the same date the insured student’s coverage becomes effective. 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 dependent no longer meets the definition of a dependent

Premium Rates

Students and scholars will be billed once each month. Note: Students and scholars enrolled in the Plan for part or all of a calendar month will be billed for the entire calendar month, since the monthly premium cannot be pro-rated.

Monthly Rate*	
Student/Scholar	\$ 89
Student/Scholar and One Dependent	\$368
Student/Scholar and Two or More Dependents	\$647

* *The monthly rates include a University Administrative Fee.*

Premium Refund Policy/Cancellation of Insurance

Leaving U-M or not enrolling in classes does not automatically cancel your participation in the Student/Scholar Health Insurance Plan.

U-M F-1 or J-1 students or scholars who leave the University **permanently** earlier than they anticipated, should be sure to fill out the appropriate departure form so that the International Center can make appropriate adjustments to their SEVIS (Student Exchange Visitor Information System) records. Once this form is processed, the end date of your insurance coverage will also be adjusted if necessary. Departure forms are available at <http://internationalcenter.umich.edu/immig/forms/>. Please follow the instructions on the form that describe when and how to fill out the form and where to submit the form.

There are some situations in which you may need to visit the International Center Insurance Office to fill out and sign a Cancellation Form instead of or in addition to a departure form in order to change the end date of your insurance coverage. All Cancellation Forms must be approved by the Health Insurance Advisor. Please contact the Insurance Advisor at ihi@umich.edu for more information.

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

Student/ Scholar Coverage

Eligibility

Eligibility for this plan is limited to University of Michigan F-1 international students or J-1 international students or scholars whose Forms I-20 or DS-2019 were issued by the University of Michigan. The accompanying dependents of these students and scholars are also eligible for this Plan.

University of Michigan (Ann Arbor) Insurance Requirement

All University of Michigan (Ann Arbor) F-1 international students whose Forms I-20 were issued by the University of Michigan (Ann Arbor), and their accompanying F-2 dependents are eligible for this Plan and must remain enrolled in the Plan throughout their stay as U-M F-1 students or F-2 dependents unless, in the judgment of the University, comparable coverage is in effect under another insurance policy.

All University of Michigan (Ann Arbor) J-1 international students and scholars whose Forms DS-2019 were issued by the University of Michigan (Ann Arbor) and their accompanying J-2 dependents are eligible for this plan and must remain enrolled in the plan throughout their stay as U-M J-1 students or scholars or J-2 dependents unless, in the judgment of the University, comparable coverage is in effect under another insurance policy.

University of Michigan (Flint) Insurance Requirement

All University of Michigan (Flint) F-1 international students whose Forms I-20 were issued by the University of Michigan (Flint), and their accompanying F-2 dependents are eligible for this Plan and must remain enrolled in the Plan throughout their stay as U-M/Flint F-1 students or F-2 dependents unless, in the judgment of the University, comparable coverage is in effect under another insurance policy.

Information regarding the enrollment, billing or waiver procedures is contained within the University of Michigan Flint International Student Health Insurance Plan Notice. A copy of this Notice accompanies this brochure or can be obtained from the Flint International Student Center at 219 UCEN 303 E. Kearsley St.

University of Michigan (Dearborn) Insurance Requirement

All University of Michigan (Dearborn) F-1 international students whose Forms I-20 were issued by the University of Michigan (Dearborn), and their accompanying F-2 dependents are eligible for this Plan and must remain enrolled in the Plan throughout their stay as U-M/ Dearborn F-1 students or F-2 dependents unless, in the judgment of the University, comparable coverage is in effect under another insurance policy.

All University of Michigan (Dearborn) J-1 international students and scholars whose Forms DS-2019 were issued by the University of Michigan (Dearborn) and their accompanying J-2 dependents are eligible for this plan and must remain enrolled in the plan throughout their stay as U-M J-1 students or scholars or J-2 dependents unless, in the judgment of the University, comparable coverage is in effect under another insurance policy.

Information regarding the enrollment, billing or waiver procedures is contained within the University of Michigan Dearborn International Student Health Insurance Plan Notice. A copy of this Notice accompanies this brochure or can be obtained from the Dearborn Counseling and Support Services at 4901 Evergreen Road, 2157 University Center. For more information visit http://www.umd.umich.edu/css_health_int_obtain_waiver/

Enrollment

All new University of Michigan F-1 international students or J-1 international students or scholars whose Forms I-20 or DS-2019 were issued by the University of Michigan and their accompanying F-2 and J-2 dependents will be enrolled in the International Student/Scholar Health Insurance Plan as soon as the student or scholar has completed the mandatory check-in process, and coverage will become effective on the check-in date.

Waivers

If you are eligible for health insurance benefits administered by the University of Michigan Benefits office because you are or will be a University of Michigan employee or a U-M fellowship-holder whose fellowship includes GradCare, please enroll yourself and any eligible dependents in that coverage as soon as possible by following the procedures described at <http://www.umich.edu/~benefits/enrollment/index.htm>. Please also review the information available at <http://www.umich.edu/~benefits/jobgroups/index.htm> carefully, or ask your department administrator for assistance, since specific procedures may be different depending on your “benefit group.” Once you and any accompanying F-2 or J-2 dependents are enrolled in these benefits, your international student/scholar insurance plan coverage will be cancelled and any needed adjustments (credits) will be made to your insurance account. The cancellation date will depend on the effective date of your University of Michigan benefits. No waiver request form is required since this is an automated process.

International students and J-1 Exchange Visitors who would like to substitute private insurance or insurance provided by a sponsor for the International Student/Scholar Insurance Plan should fill out and submit the International Health Insurance Waiver Request Form, available on the International Center website, to request approval of an insurance waiver and cancellation of International Student/Scholar Insurance Plan coverage. More information about requesting a waiver and about the coverage an insurance plan must have in order for a waiver to be approved is available on the International Center website.

Coverage End Date

Your coverage under the International Student/Scholar Insurance Plan will extend through the end date of your I-20 or DS-2019, or through the end of your F-1 post-completion Optional Practical Training for students who are recommended for post-completion OPT. If the end date of your I-20 or DS-2019 changes, the end date of your health insurance coverage will also change.

Automatic Re-enrollment in the International Student/Scholar Insurance Plan

If your alternative coverage ends before the end of your stay as an F-1 or J-1 student or scholar, you will be re-enrolled in the International Student/Scholar insurance plan. Also, if a waiver request form has been approved for private insurance or insurance provided by a sponsor, and the time period for which the waiver has been approved has ended, and the waiver is not renewed or is not re-approved, you will be re-enrolled in the International Student/Scholar insurance plan if you have not yet completed your stay as an F-1 student or J-1 student or scholar.

If you leave the University **permanently** before the end date of your I-20 or DS-2019, or leave the United States because you have decided not to complete your post-completion Optional Practical Training (OPT), please be sure to fill out the appropriate departure form. Forms are available at <http://internationalcenter.umich.edu/immig/forms/>. Please follow the instructions on the form that describe when and how to fill out the form and where to submit the form.

If you do not submit a departure form, the International Center will not know that you have ended your F-1 or J-1 stay, and you may be billed for health insurance, either because your enrollment in the International Student/Scholar Insurance Plan will be continued or because you will be automatically re-enrolled in the International Student/Scholar Insurance Plan if your alternative coverage and/or your insurance waiver ends before your I-20, DS-2019 or (for F-1 students on Optional Practical Training) your OPT end date.

Dependent Coverage

Eligibility

Covered students may also enroll their lawful spouse/same-sex domestic partner and unmarried dependent children under age 19 (23 if in school or on medical leave from school for up to 12 months. Proof of illness is required) who are fully supported by the student. (1) A covered dependent who will lose coverage due to his/her age (e.g. over 19) may stay on the plan if the dependent is incapable of self support due to a mental or physical disability and is dependent on subscriber for support. Proof of dependency must be presented within 31 days of loss of coverage. (2) A covered dependent who is a covered dependent due to full or part-time student status must be allowed to continue coverage on the plan while taking a leave of absence from school due to an illness or injury. The coverage for the dependent on a leave of absence shall continue for at least 12 months or until the dependent reaches the age which he or she would normally terminate from the plan, i.e. age 19. Proof of illness or injury can be required.

Enrollment

Accompanying F-2 and J-2 dependents of F-1/J-1 International Students and International Visiting Scholars will be enrolled in the International Student/Scholar Health Insurance Plan as soon as the student or scholar has completed the mandatory check-in process, and coverage will become effective on the check-in date. For information or general questions on dependent enrollment, contact the University of Michigan International Center, **(734) 647-2303**.

Newborn Infant Coverage and Adopted Child Coverage

A child born to a Covered Person shall be covered for Accident, Sickness, and congenital defects for 31 days from the date of birth. At the end of this 31-day period, coverage will cease under the University of Michigan International Student/Scholar Health Insurance Plan. To extend coverage for a newborn past the 31 days, the Covered Person must (1) enroll the child within 31 days of birth and (2) pay the additional premium starting from the date of birth. Coverage is provided for a child legally placed for adoption with a covered student/scholar for 31 days from the moment of placement for a child who is legally placed for adoption with a covered student/scholar and is dependent upon the covered student/scholar for support. To extend coverage for an adopted child past the 31 days, the Covered Person must (1) enroll the child within 31 days of placement of such child and (2) pay any additional premium, if necessary, starting from the date of placement.

For further assistance and premium information, please contact The University of Michigan International Center, **(734) 647-2303** or ihi@umich.edu.

Continuously Insured

Persons who have remained Continuously Insured under the University of Michigan International Policy, prior University of Michigan International Student/Scholar Insurance policies or University of Michigan sponsored health insurance programs for Graduate Student Assistants, Fellowship-holders, or University faculty and staff will be covered for any Pre-Existing Condition that manifests itself while Continuously Insured, except for expenses payable under prior policies in the absence of the Policy. Once a break in continuous coverage occurs, the definition of Pre-Existing Conditions will apply.

Preferred Provider Network

The University of Michigan International Student/Scholar Health Insurance Plan for the 2008-2009 Policy Year has a Preferred Provider Organization Network through Aetna. To maximize your savings and reduce your out-of-pocket expenses, select a Preferred Provider. It is to your advantage to utilize a Preferred Provider because significant savings can be achieved from the substantially lower rates these providers have agreed to accept as payment for their services. Preferred Providers are independent contractors and are neither employees nor agents of University of Michigan, Aetna Student Health or Aetna.

A complete listing of participating providers is available at:

- Aetna Student Health at **(800) 239-9697**.
- Aetna's online **DocFind**[®] service located online at **www.aetnastudenthealth.com**. Click on "**Find Your School**" enter **711146** as your Policy Number.

Referral Requirements

Students' health care needs can best be satisfied when an organized system of health care providers at the University of Michigan Health Service manages the treatment. If you are enrolled in the Student/Scholar Health Insurance Plan, it is to your advantage to first seek treatment at the University Health Service in order to reduce your out-of-pocket expenses. The health care providers will then refer you, if appropriate, to an outside provider. For specific information about referral requirements for students, scholars, spouses and children, please refer to the Summary of Benefits charts under "Deductible".

Please note:

- Covered students/scholars and their dependents who continue treatment of a condition from one Policy Year to the next do not need to obtain a new referral from the University Health Service. Refer to the Summary of Benefits Chart for details.
- No referral is necessary for behavioral/mental health services. Copays still apply. Refer to the Summary of Benefits Chart for details.

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/Scholar Health Insurance Plan.

If you do not secure Pre-Certification for non-emergency inpatient admissions or provide notification for emergency admissions, your Covered Medical Expenses will be subject to a \$200 per admission Deductible.

Pre-Certification of Non-Emergency Inpatient Admissions

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

Notification of Emergency Admissions

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

Aetna Student Health
Attention: Managed Care Dept.
P.O. Box 15708 Boston, MA 02215-0014
(800) 239-9697

Description of Benefits

Payment will be made as allocated herein for Covered Medical Expenses incurred for any one Accident or any one Sickness while insured under the Plan, not to exceed an Aggregate Maximum while continuously insured of \$250,000 for any one covered Accident or any one covered Sickness. In addition to the Plan's Aggregate Maximum the Policy may contain benefit level maximums. Please review the Summary of Benefits section of this brochure for any additional benefit level maximums.

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 significant savings can be achieved from the substantially lower rates these providers have agreed to accept as payment for their services. Non-Preferred Care is subject to the Reasonable Charge allowance maximums. Any charges in excess of the Reasonable Charge allowance are not covered under the Plan.

A complete listing of Preferred Providers can be obtained by accessing Aetna's DocFind Service on the web at: www.aetnastudenthealth.com/stu_conn. You can also contact Aetna Student Health at **(800) 239-9697** for specific provider information.

Summary of Benefits Chart

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

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

<p>Deductible</p> <p><i>Please Note: North Campus Family Health Service and Community Family Health Center are both part of the Nurse Managed Care Centers of Ann Arbor</i></p>	<p>\$50 per covered Injury or Sickness. The Deductible is waived, or reduced, if following conditions are met:</p> <ul style="list-style-type: none"> • If a student, dependent spouse, same-sex domestic partner, dependent child (age 10 or older) or visiting scholar is first treated at, or referred by, the University Health Service, the Deductible will be waived; • If a dependent spouse, same-sex domestic partner or visiting scholar is first treated at, or referred by, North Campus Family Health Service or Community Family Health Center, the Deductible will be \$10 per Injury or Sickness; • If a dependent child is first treated at, or referred by, North Campus Family Health Service, Community Family Health Center or Pediatric Primary Care at the East Arbor Health Center (under 18 years of age), the Deductible will be \$10 per Injury or Sickness.
<p>Benefit Allocation</p>	<p>Covered Medical Expenses listed below are payable in accordance with the following reimbursement levels:</p> <ul style="list-style-type: none"> • 100% Coverage for first \$5,000; • 80% Coverage for \$5,001 to \$40,000; • 100% Coverage for \$40,001 to \$250,000. <p>Note: When confined in a Preferred hospital, all covered facility expenses will be covered at 100%.</p>
<p>Inpatient Hospitalization Benefits</p>	
<p>Hospital Room and Board Expenses</p>	<p>Covered Medical Expenses are payable as follows: Preferred Care: the Negotiated Charge for an overnight stay. Non-Preferred Care: the Reasonable Charge for an overnight stay.</p>
<p>Intensive Care Unit Expenses</p>	<p>Covered Medical Expenses are payable as follows: Preferred Care: the Negotiated Charge for an overnight stay. Non-Preferred Care: the Reasonable Charge for an overnight stay.</p>
<p>Miscellaneous Hospital Expenses</p>	<p>Covered Medical Expenses are payable at Actual Charge up to the Aggregate Maximum.</p> <p>Covered Medical Expenses include, but are not limited to: laboratory tests, X-rays, nurses, anesthesia supplies, equipment use, and medicines.</p>
<p>Physician Hospital Visit Expenses</p>	<p>Covered Medical Expenses for charges for the non-surgical services of the attending Physician or a consulting Physician are payable as follows: Preferred Care: the Negotiated Charge. Non-Preferred Care: the Reasonable Charge.</p>

Inpatient Hospitalization Benefits <i>(continued)</i>	
Pre-Admission Testing Expenses	Covered Medical Expenses for any pre-admission testing are payable as follows: Preferred Care: the Negotiated Charge. Non-Preferred Care: the Reasonable Charge.
Surgical Expenses	Covered Medical Expenses for charges for surgical services performed by a Physician are payable as follows: Preferred Care: the Negotiated Charge. Non-Preferred Care: the Reasonable Charge.
Anesthetist and Assistant Surgeon Expenses	Covered Medical Expenses for the charges of an anesthetist and an assistant surgeon during a surgical procedure are payable as follows: Preferred Care: the Negotiated Charge. Non-Preferred Care: the Reasonable Charge.
Facility Expenses	Covered Medical Expenses are payable at the Actual Charge for the use of the operating and recovery rooms and any miscellaneous supplies necessary during a surgical operation.
Outpatient Benefits	
Outpatient Expenses	Covered Medical Expenses for the use of the outpatient facilities of a licensed hospital, walk-in clinic, or Physician's office are payable as follows: Preferred Care: the Negotiated Charge. Non-Preferred Care: the Reasonable Charge.
Outpatient Day Surgery Expenses	Covered Medical Expenses for charges related to surgery performed on an outpatient basis are payable as follows: Preferred Care: the Negotiated Charge. Non-Preferred Care: the Reasonable Charge.
Physician's Expenses	Covered Medical Expenses for the non-surgical services of a Physician are payable as follows: Preferred Care: the Negotiated Charge. Non-Preferred Care: the Reasonable Charge.
Laboratory and X-Ray Expenses <i>(Included: Chlamydia and Gonorrhea screenings)</i>	Covered Medical Expenses are payable as follows: Preferred Care: the Negotiated Charge. Non-Preferred Care: the Reasonable Charge.
Consultant's Physician Expenses	Covered Medical Expenses for the services of a consulting physician when deemed Medically Necessary and ordered by the Attending Physician for the purpose of confirming or determining a diagnosis, but not for the purpose of treatment, are payable as follows: Preferred Care: the Negotiated Charge. Non-Preferred Care: the Reasonable Charge.

Mental Health and Substance Abuse Benefits	
Inpatient Expenses	<p>Covered Medical Expenses for the treatment of a mental health condition or for substance abuse while confined as an inpatient in a hospital or facility licensed for such treatment are payable on the same basis as for any other Sickness.</p> <p>Inpatient mental health treatment is limited to a maximum of 30 days per Policy Year per condition for any one or related mental health condition.</p>
Outpatient Expenses	<p>Covered Medical Expenses for the treatment of a mental health condition are payable as follows up to a maximum of 25 visits per Policy Year:</p> <p>Preferred Care: 100% of the Negotiated Charge after a \$25 per visit Copay.</p> <p>Non-Preferred Care: 100% of the Reasonable Charge after a \$50 per visit Copay.</p> <p>The Plan provides the benefits for substance abuse as mandated by Michigan Public Act 429 of 1980. The current benefit mandate is \$3,774. This figure will be increased by the Consumer Price Index on April 1, 2009. These benefits are paid under the Sickness Expense Benefit.</p> <p>“Intermediate care” means the use of covered therapeutic techniques in:</p> <ol style="list-style-type: none"> (1) a full 24-hour residential setting; or (2) a partial, less than 24-hour residential setting; for individuals physiologically or psychologically dependent upon alcohol and drugs. <p>“Outpatient Care” means the use, on both a scheduled and nonscheduled basis, of covered therapeutic techniques for individuals physiologically or psychologically dependent on alcohol or drugs.</p> <p>Covered therapeutic techniques include psychotherapy, counseling, detoxification services, and other ancillary services, such as medical testing, diagnostic evaluation, and referral to other services identified in a treatment plan.</p>
Maternity Benefits	<p>Covered Medical Expense for pregnancy, childbirth, and complications of pregnancy are payable on the same basis as any other Sickness. Hospital charges for a newborn infant are covered and are payable on the same basis as any other Sickness.</p>
Voluntary Termination of Pregnancy Expenses	<p>Covered Medical Expenses for voluntary termination of pregnancy are payable on the same basis as any other Sickness up to a maximum of \$350 per Policy Year.</p>

Additional Benefits	
Prescription Drug Benefit Expenses	<p>Covered Medical Expenses for outpatient Prescription Drugs associated with a covered Sickness or a covered Accident are payable as follows:</p> <p>Preferred Care: 90% of the Negotiated Charge. Non-Preferred Care: 90% of the Reasonable Charge.</p> <p>Please note that you are required to pay in full at the time of service for all Prescriptions dispensed at a Non-Participating Pharmacy. (Please refer to the Prescription Drug Claim Procedures Section of this Brochure for information regarding the claim submission and reimbursement process.)</p> <p>Medications covered by this benefit include drugs resulting from psychotherapy. Medications not covered by this benefit include, but are not limited to: oral contraceptives, allergy sera, all acne medications, drugs whose sole purpose is to promote or to stimulate hair growth, appetite suppressants, smoking deterrents, immunization agents and vaccines, and non-self injectables.</p> <p>Prior authorization is required for more than a 30-day supply per Prescription or refill, growth hormones, and drugs used for treatment of Malaria.</p> <p>For a complete listing of excluded medications or drugs available with prior authorization, please contact (800) 238-6279.</p>
Physiotherapy and Chiropractic Service Expenses	<p>Covered Medical Expenses are payable at the Reasonable Charge not to exceed one visit per day for the services of a licensed physiotherapist.</p> <p>Covered Medical Expenses are payable at the Reasonable Charge for the services of a licensed chiropractor.</p>
Ambulance Expenses	<p>Covered Medical Expenses are payable at 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>
Dental Expenses	<p>Covered Medical Expenses are payable at the Reasonable Charge for dental treatment not to exceed \$250 maximum per Policy Year as a result of accidental Injury to sound natural teeth. This maximum includes expenses for the removal of one or more impacted wisdom teeth.</p>
Home Health Care Expenses	<p>Covered Medical Expenses are payable at the Actual Charge for home health care services made by a home health care agency pursuant to a home health care plan.</p>
Mastectomy and Prosthetic Devices Expenses	<p>Covered Medical Expenses are payable on the same basis as any expense.</p>

Additional Benefits <i>(continued)</i>	
Intractable Pain Evaluation and Treatment Expenses	Covered Medical Expenses are payable on the same basis as any expense.
Women's Health Benefit Expenses	<p>Covered Medical Expenses are payable at the Reasonable Charge for breast cancer diagnostic services, including mammography screening for women age 35 or above.</p> <p>Covered Medical Expenses incurred for services related to breast cancer include, but are not limited to, breast cancer diagnostic services; breast cancer rehabilitation services; and breast cancer outpatient services.</p>
Pap Smear Screening Expenses	<p>Covered Medical Expenses include coverage for one annual Pap smear screening.</p> <p>Covered Medical Expenses are payable on the same basis as any other outpatient expense.</p>
Diabetic Equipment and Self-Management Education Expenses	Covered Medical Expenses for diabetic equipment (including insulin, syringes, and diabetic testing equipment) and self-management education programs are payable on the same basis as any expense.
Well Child Care and Immunization Expenses	<p>Benefits will be provided for covered services provided by a Physician to covered children age five and under, even though they are not ill.</p> <p>Covered Medical Expenses will be limited to physical examinations and childhood immunizations.</p>
HPV Vaccine	Covered Medical Expenses are reimbursed at 50% of the Negotiated or Reasonable Charge. (Female Members Only)
Durable Medical Equipment Expenses	<p>Covered Medical Expenses will be payable on the same basis as any condition.</p> <p>Covered Medical Expenses are payable at the Reasonable Charge for the lesser of either the Actual Charge to purchase or the Actual Charge to lease durable medical equipment.</p>
Hospice Care Expenses	Covered Medical Expenses are payable at the Actual Charge for hospice care services provided for a terminally ill Covered Person during a hospice benefit period.
TB Testing Benefit	Covered Medical Expenses will be payable on the same basis as any condition.

International Student/Scholar Health Insurance Vision Plan

University Health Service (UHS) will manage the vision benefit for those insured by the International Student/Scholar Health Insurance Plan. This service is not underwritten by Aetna.

The UHS Eye Care Clinic will provide one (1) routine eye exam per Policy Year/per enrollee with a \$15 Copay per exam as long as the individual is enrolled in the International Student/Scholar Health Insurance Plan at the time of service.

The routine eye exam will include:

- Refraction and dilation of the eyes
- Health history
- Check of the interior and exterior eye as well as surrounding area for defects, disease, and clarity of vision
- Eye coordination
- Color vision
- Depth perception
- Refractive error and field of vision

Not Included: Contact Lenses evaluation or fitting. Additional fees will be charged if these services are performed and will be the patient's financial responsibility.

Vision Care Provider of Your Choice

In some instances you may need to use a Vision Care Provider other than UHS. UHS will reimburse the Policyholder when a routine eye exam is received outside of UHS at a Vision Care Provider of your choice. UHS will reimburse for one (1) routine eye exam per Policy Year /per enrollee not to exceed a benefit maximum of \$30, after applying the \$15 Copay per exam, and subject to UHS guidelines.

The reimbursement option is limited to:

- Infant/toddlers under three years of age
- Students/Scholars studying out of the Ann Arbor area

The University Health Service Eye Care Clinic is located at:

207 Fletcher Street
Ann Arbor, MI 48109-1050
http://www.uhs.umich.edu/depts/eye_clinic.html
For an appointment call: (734) 764-8325
Toll free (866) 386-0002

For eligible reimbursement of eligible services provided by a Vision Care Provider of your choice, send your original paid receipt to:

University of Michigan/University Health Service
Managed Care/Student Insurance Office
207 Fletcher Street
Ann Arbor, MI 48109-1050
www.uhs.umich.edu
mancare-stuins@umich.edu

Please remember to make a copy of your receipt for your own records.

Vital SavingsSM on Dental by Aetna

Vital Savings on DentalSM by Aetna is a dental discount program helping you and your dependents save on a wide array of dental services – with one low annual fee of \$25 for students. Enroll online at www.aetnastudenthealth.com; click on “**Find Your School**”.

Student: \$25

Student + 1 Dependent: \$44

Student + 2 or more Dependents: \$63

The 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.

General Provisions

State Mandated Benefits

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

Subrogation/Reimbursement Right of Recovery Provision

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

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

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

The Covered Person shall do nothing to prejudice Aetna’s subrogation and reimbursement rights.

The Covered Person shall, when requested, fully cooperate with Aetna's efforts to recover its benefits paid. It is the duty of the Covered Person to notify Aetna within 45 days of the date when any notice is given to any party, including an attorney, of the intention to pursue or investigate a claim, to recover damages, due to injuries sustained by the Covered Person. The Covered Person acknowledges that this Plan's subrogation and reimbursement rights are a first priority claim against all potential responsible parties, and are to be paid to Aetna before any other claim for the Covered Person's damages. This Plan shall be entitled to full reimbursement first from any potential responsible party payments, even if such payment to the Plan will result in a recovery to the Covered Person, which is insufficient to make the Covered Person whole, or to compensate the Covered Person in part or in whole for the damages sustained. This Plan is not required to participate in or pay attorney fees to the attorney hired by the Covered Person to pursue the Covered Person's damage claim. In addition, this Plan shall be responsible for the payment of attorney fees for any attorney hired or retained by this Plan. The Covered Person shall be responsible for the payment of all attorney fees for any attorney hired or retained by the Covered Person or for the benefit of the Covered Person. The terms of this entire subrogation and reimbursement provision shall apply. This Plan is entitled to full recovery regardless of whether any liability for payment is admitted by any potentially responsible party, and regardless of whether the settlement or judgment received by the Covered Person identifies the medical benefits this Plan provided. This Plan is entitled to recover from any and all settlements or judgments, even those designated as "pain and suffering" or "non-economic damages" only.

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

Non-Duplication of Benefits

This provision applies if a covered student:

- (a) Is covered by any other group or blanket health care plan; and
- (b) Would, 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.

Limitations

Pre-Existing Condition Limitation

Covered Medical Expenses are payable on the same basis as any other condition for a Pre-Existing Condition up to a maximum of \$1,000 per Accident or Sickness for Covered Persons. This limitation will no longer apply when the Covered Person has been continuously insured for six consecutive months. This benefit is subject to all other Policy conditions and limitations. See Pre-Existing Condition in the Definition Section.

Definitions

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

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

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

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

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

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

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

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

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

- Placing the person's health in serious jeopardy; or
- Serious impairment to bodily function; or
- Serious dysfunction of a body part or organ; or
- In the case of a pregnant woman, serious jeopardy to the health of the fetus. It does include an Accident or serious illness such as heart attack, stroke, poisoning, loss of consciousness or respiration, and convulsions. It does not include elective care, routine care, or care for non-emergency illness.

Hospital Confinement: A stay of 18 or more hours in a row as a resident bed patient in a hospital.

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

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

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

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

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

Negotiated Charge: The maximum charge a Preferred Care Provider 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.

Pharmacy: An establishment where Prescription Drugs are legally dispensed.

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

Pre-Existing Condition: An Injury, Sickness, or condition for which medical advice, diagnosis, care, or treatment was recommended or received by the Covered Person within the six months immediately preceding the effective date of their coverage, or, up to 6 months after the effective date of coverage.

If a Covered Person has continuous coverage under the University of Michigan Student/Scholar Health Insurance Plan from prior University of Michigan International Student/Scholar Insurance policies or University of Michigan-sponsored health insurance programs for graduate student assistants, fellowship-holders, or University faculty and staff, an Accident or Sickness that first manifests itself during a prior year's coverage shall not be considered a Pre-Existing Condition.

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 included in the Directory as a Preferred Care Provider for the service or supply involved, and the class of which the Covered Person is a member.

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

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

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

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

- Unusual; or
- Not often provided in the area; or

- Provided by only a small number of providers in the area. Aetna may take into account factors, such as:
- The complexity;
- The degree of skill needed;
- The type of specialty of the provider;
- The range of services or supplies provided by a facility; and
- The prevailing charge in other areas.

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

Exclusions

The Plan neither covers nor provides benefits for the following:

1. Expenses incurred as a result of dental treatment, except for treatment resulting from Injury to sound, natural teeth or for the removal of one or more 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 for which benefits are payable under any Workers' Compensation or Occupational Disease Law.
7. Expenses incurred as a result of Injury sustained or Sickness contracted while in the service of the armed forces of any country. Upon the Covered Person 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.

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 (including reconstructive surgery for a prosthetic device for a Covered Person who has undergone a mastectomy) which occurs while the Covered Person is covered under the Plan. Surgery must be performed in the Policy Year of the Accident which causes the Injury, or in the next Policy Year.
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. Expenses incurred for allergy shots and injections, preventive medicines, serums, vaccines, or oral contraceptives unless otherwise provided in the Policy.
13. Expense incurred for a treatment, service, or supply, which is not Medically Necessary, as determined by Aetna, for the diagnosis care or treatment of the Sickness or Injury involved. This applies even if they are prescribed, recommended, or approved, by the person's attending Physician, or dentist.

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

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

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

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

- Those that do not require the technical skills of a medical, a mental health, or a dental professional; or

- Those furnished mainly for the personal comfort or convenience of the person, any person who cares for him or her, or any persons who is part of his or her family, any healthcare provider, or healthcare facility; or
 - Those furnished solely because the person is an inpatient on any day on which the person's Sickness or Injury could safely, and adequately, be diagnosed, or treated, while not confined, or those furnished solely because of the setting, if the service or supply could safely and adequately be furnished in a Physician's or a dentist's office, or other less costly setting.
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 the repair or replacement of existing artificial limbs, orthopedic braces, or orthotic devices.
 17. Expenses incurred for custodial care. Custodial care means services and supplies furnished to a person to help them 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 to by whom or by which they are performed.
 18. Expenses incurred after the date insurance terminates for a Covered Person except as may be specifically provided in the Extension of Benefits provision.
 19. Expenses covered by any other valid and collectible medical, health, or accident insurance to the extent that benefits are payable under other valid and collectible insurance whether or not a claim is made for such benefits.
 20. Expenses incurred for services normally provided without charge by the school and covered by the school fee for services.
 21. Expenses for treatment for Injury to the extent benefits are payable under any state no-fault automobile coverage, or any first-party medical benefits payable under any other mandatory no-fault law.
 22. Expenses for contraceptive methods, devices, or aids, charges for or related to artificial insemination, in vitro fertilization, or embryo transfer procedures, elective sterilization or its reversal, or elective abortion unless otherwise provided in the Policy.
 23. Expenses incurred as a result of commission of a felony.
 24. Expenses incurred for treatment of mental or nervous disorders unless otherwise provided in the Policy.
 25. Expenses incurred for the treatment of alcoholism or drug addiction unless otherwise provided in the Policy.
 26. Expenses incurred for Injury resulting from the play or practice of intercollegiate sports.

27. Expenses incurred for any services rendered by a member of the Covered Person's immediate family or a person who lives in the Covered Person's home.
28. Expenses incurred for or in connection with procedures, services, or supplies that are, as determined by Aetna, to be experimental or investigational. A drug, a device, a procedure, or treatment will be determined to be experimental or investigational if:
- There are insufficient outcomes data available from controlled clinical trials published in the peer reviewed literature, to substantiate its safety and effectiveness, for the disease or Injury involved; or
 - If required by the FDA, approval has not been granted for marketing; or
 - A recognized national medical or dental society or regulatory agency has determined, in writing, that it is experimental, investigational, or for research purposes; or
 - The written protocol or protocols used by the treating facility, or the protocol or protocols of any other facility studying substantially the same drug, device, procedure, or treatment, or the written informed consent used by the treating facility, or by another facility studying the same drug, device, procedure, or treatment, states that it is experimental, investigational, or for research purposes.

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

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

29. 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).
30. Expenses incurred for, or related to, sex change surgery or to any treatment of gender identity disorders.
31. Those for routine physical exams, routine vision exams, routine dental exams, routine hearing exams, immunizations, or other preventive services and supplies, except to the extent coverage for such exams, immunizations, services, or supplies is specifically provided in the Policy.
32. Expenses incurred for breast reduction/mammoplasty.
33. Expenses incurred for gynecomastia (male breasts).

34. Expenses incurred for sinus surgery, except for acute purulent sinusitis.
35. Expenses for charges that are not reasonable charges, as determined by Aetna.
36. 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.
37. Expenses for: (a) care of flat feet; (b) supportive devices for the foot; (c) care of corns, bunions, or calluses; (d) care of toenails; and (e) care of fallen arches; weak feet; or chronic foot strain; except that (c) and (d) are not excluded when medically necessary, because the Covered Person is diabetic; or suffers from circulatory problems.
38. Expenses incurred for elective treatment or elective surgery except as specifically provided elsewhere in the Policy and performed while the Policy is in effect.
39. Expenses arising as a result of a Pre-Existing Condition, unless otherwise provided in the Policy.
40. Expenses incurred for gastric bypass or any restrictive procedures for weight loss.

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

Extension of Benefits

If a Covered Person is confined to a hospital on the date his or her insurance terminates, expenses incurred after the termination date and during the continuance of that hospital confinement shall be payable in accordance with the Policy, but only while they are incurred during the 31-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.

Continuation Privilege

Once an International Student or International Visiting Scholar's status as a University of Michigan F-1 or J-1 visa holder ends, the International Student or International Visiting Scholar may be eligible to continue coverage in this Plan up to nine months. The cost of this continuation plan will be two times that of the current (active) Plan. Questions relating to this provision should be directed to Aetna Student Health at **(800) 239-9697**.

Claim Procedure

How to File a Claim

In the event of an Accident or Sickness, the Student should report to the University Health Service, or a qualified provider or hospital health care provider to secure treatment. As described in the Preferred Provider Network section of the Brochure, it is to your advantage to utilize participating Preferred Providers because of the savings for services and reduced out-of-pocket expenses.

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

Please send all itemized medical bills within 90 days after treatment is rendered to Aetna Student Health. Your name, eight-digit UMID number, name of the country where treatment was provided (if not in the U.S.), and University of Michigan International Plan should be written clearly and attached to your medical bills.

All information should be mailed to:

Aetna Student Health
P.O. Box 15708
Boston, MA 02215-0014
(800) 239-9697
(617) 218-8400 (outside the United States)

Subsequent itemized medical bills should also be mailed promptly to the above address. Payment for covered expenses will be made directly to the hospital or Physician unless you submit paid receipts attached to the itemized bills.

For assistance in filing a claim, or inquiring about the status of a claim, please contact the Customer Service Department at Aetna Student Health directly at **(800) 239-9697** between the hours of 8:30 AM and 8:30 PM Eastern Standard Time, Monday through Friday.

General coverage questions and claims questions should also be directed to the Customer Service Department at Aetna Student Health at **(800) 239-9697**.

You will receive an “Explanation of Benefits” form after your claims are processed. The Explanation of Benefits will explain how your claim was processed according to the benefits of your Student Health Insurance Plan. If you have any questions regarding the Explanation of Benefits, please contact the Customer Service Department at Aetna Student Health at **(800) 239-9697**.

On occasion, the claims investigation process will require additional information in order to properly adjudicate the claim. This investigation will be handled directly by The Aetna Student Health Claims Department.

Prescription Drug Claim Procedure

Prescription Drug Claim Procedure

Preferred Care: When obtaining a covered Prescription, please present your Aetna 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 University Health Service, at <http://www.aetnastudenthealth.com/schools/aetnaDrug.pdf> 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.aetna.com/docfind.

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 Michigan and include your name, address, and student identification number.

Grievance, Appeals and External Review

Aetna has established a procedure for resolving grievances and appeals by Covered Persons. If a Covered Person's claim is denied in whole or in part, the Covered Person will receive a written notice of the denial from Aetna. The notice will explain the reason for the denial, and the procedures to follow for filing a grievance or appeal. To file a grievance or appeal, the Covered Person, or health care provider, on behalf of the Covered Person, may request a review of any coverage decision by contacting:

Aetna Student Health
P.O. Box 15717
Boston, MA 02215-0014
Phone: **(800) 859-8452**

If, after exhausting the internal appeals procedures, the Covered Person, the Covered Person's Physician or the Hospital is still dissatisfied with Aetna's response, the Covered Person may be eligible to file a request for an External Review with the Michigan Insurance Commissioner. Information about filing a request for an External Review may be obtained by contacting:

Michigan Insurance Commissioner
(877) 999-6442

When filing for an External Review, the Covered Person will be required to authorize the release of any medical records that may be required to be reviewed for the purpose of reaching a decision on the External Review.

General Information

Contact the Michigan Department of Consumer and Industry Services at **(517) 373-0220** to verify participating providers' licenses or to access information on formal complaints and disciplinary actions filed or taken against participating providers.

Continuation of Care

If participation between a Preferred Care Provider and Aetna terminates, and the Covered Person is undergoing an active course of treatment, Aetna shall continue to permit the Covered Person to continue an ongoing course of treatment that is Medically Necessary with that Preferred Care Provider as follows:

- For up to 90 days from the date of notice to the Covered Person by the Preferred Care Provider, or until Aetna can assist the Covered Person to make an orderly transition to another Preferred Care Provider, whichever is less; or
- If the Covered Person is in the second or third trimester of pregnancy at the time of the Preferred Care Provider's termination, through postpartum care directly related to the pregnancy; or
- If the Covered Person is determined to be terminally ill prior to a Preferred Care Provider's termination, and the Preferred Care Provider was treating the terminal illness before the date of termination or knowledge of the termination, for the remainder of the Covered Person's life for care directly related to the terminal illness.

This provision applies only if the Preferred Care provider agrees to all of the following:

- To continue to accept as payment in full reimbursement from Aetna at the rates applicable prior to the termination;
- To adhere to the Aetna's standards for maintaining quality health care and to provide to Aetna necessary medical information related to the care; and
- To otherwise adhere to the Aetna's policies and procedures, including, but not limited to, those concerning utilization review, referrals, pre-authorization, and treatment plans.

As used above, "Preferred Care Provider" includes an allopathic physician, osteopathic physician, or podiatric physician. "Terminates" or "termination" includes the nonrenewal expiration, or ending for any reason of a participation agreement or contract between a Physician and Aetna, but does not include a termination by Aetna for failure to meet applicable quality standards for fraud.

Notification to Covered Persons of Provider Termination

Covered Persons are notified of PCP termination or change of contract status by a system-generated letter, advising Covered Persons following receipt of the PCP's intent to terminate the provider agreement. Covered Person Services Representatives are available to assist Covered Persons with provider changes. They can be reached by dialing the toll-free number identified on the Covered Person ID card.

Aetna has in place a process of monitoring significant participating provider activity. Provider agreements provide for 90 days notification of either party of intent to terminate the agreement. Marketing is notified and notifies its customers of participating provider additions and terminations.

Intractable Pain Coverage

Aetna provides benefits for the evaluation and treatment of intractable pain when it is determined to be Medically Necessary and otherwise eligible by Aetna. Intractable pain means "a pain state in which the cause of the pain cannot be removed or otherwise treated and which, in the generally accepted practice of allopathic or osteopathic medicine, no relief of the cause of the pain or cure of the cause of the pain is possible or none has been found after reasonable efforts, including, but not limited to, evaluation by the attending Physician and by one or more other Physicians specializing in the treatment of the area, system, or organ of the body perceived as the source of the pain." Upon request, pursuant to Michigan law, the following information can be supplied to you:

1. Date of provider certification by applicable nationally recognized Board or other organization;
2. Names of licensed facilities where providers have privileges;
3. Prior authorization requirements and limitations including medication formulary restrictions;
4. Information about financial relationships between providers and the health Plan. To obtain this and further information on the health Plan you may call Member Services at **(800) 208-8755** or write to Aetna, 26957 Northwestern Highway, Suite 140, Southfield, MI 43034-4728.

Patient Management Program

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

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

Pre-Certification

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

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

For more information, please refer to the Inpatient Admission Pre-Certification Program section on page 12.

Concurrent Review

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

Discharge Planning

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

Retrospective Record Review

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

Provider Reimbursement

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

Non-participating providers, providing covered services, are compensated on a fee-for-service basis. Any charge for a service or supply furnished by a participating provider in excess of such provider's Negotiated Charge for that service or supply will not be a covered expense under the group contract. It will be the responsibility of Aetna and the participating provider to resolve the amount deemed to be excess.

Confidentiality

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

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

Notice to Enrollees

While this directory (available upon request) is believed to be accurate as of the print date, it is subject to change without notice. Consult Aetna's online provider directory on our website: www.aetna.com/docfind for the most current provider listings. Participating Providers are independent contractors in private practice and are neither employees nor agents of Aetna, the School, or Aetna Student Health. The availability of any particular provider cannot be guaranteed for referred or in-network benefits, and provider network composition is subject to change without notice. Certain Primary Care Physicians may be affiliated with an Independent Practice Association (IPA), a Physician Medical Group (PMG), an Integrated Delivery System or one of other provider groups. Not every provider listed in the directory will be accepting new patients. Although Aetna has identified providers who were not accepting patients as known to Aetna at the time this provider directory was created, the status of a provider's practice may have changed. For the most current information, please contact the selected Physician or Customer Services at the toll-free number on your ID card.

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

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

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.

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,(or crossing an international border,) 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 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.

The On Call International program meets and exceeds the U.S. Government requirements for International Students & Scholars.

Supplemental repatriation and medical evacuation insurance is available for purchase by the International Students and Scholars who have prior qualifying coverage for medical care as outlined in this Brochure and require only coverage for the medical evacuation and repatriation benefits. Coverage may be purchased for the student/scholar or for the student/scholar and all dependents. The cost of this stand-alone medical evacuation and repatriation coverage is \$30 per Policy Year per insured and cannot be pro-rated.

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 ADDMER 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.

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

Where to go for Health Care:

If you have a life-threatening emergency, call 911 or go directly to the nearest hospital emergency room. Options include University Hospital, 1500 E. Medical Center Drive, Ann Arbor, MI 48109. <http://www.med.umich.edu/em/patientinfo/index.htm>. A deductible will apply; for details see the **Deductible Section of the Summary of Benefits Chart on Page 13.**

If you need medical care, but it is not an emergency, you can avoid or reduce the deductible by seeing the following health care providers first. **For more specific information about referral requirements, please refer to the Deductible Section of the Summary of Benefits Chart on Page 13.**

- **University Health Service (students, spouses, scholars, same sex domestic partners, children 10 or above)**

University Health Service (UHS)

www.uhs.umich.edu

207 Fletcher Street

Ann Arbor, MI 48109

(734) 764-8320

Access to After Hours Care **(734) 662-5674**

- **North Campus Family Health Service or Community Family Health Center (scholars, spouses, same sex domestic partners, children)**

North Campus Family Health Service

<http://www.nursing.umich.edu/ncfhs/>

2364 Bishop

Ann Arbor, MI 48109

(734) 647-1636

Community Family Health Center

<http://www.nursing.umich.edu/cfhc/>

1230 North Maple Road

Ann Arbor, MI 48103

(734) 998-6117

- **East Ann Arbor Health Center (children under age 18)**

East Ann Arbor Health Center

4260 Plymouth Road

Ann Arbor, MI 48109-2700

(734) 647-5715

Regents of the University of Michigan

Julia Donovan Darlow
Ann Arbor

Laurence B. Deitch
Bingham Farms

Olivia P. Maynard
Goodrich

Rebecca McGowan
Ann Arbor

Andrea Fischer Newman
Ann Arbor

Andrew C. Richner
Grosse Pointe Park

S. Martin Taylor
Grosse Pointe Farms

Katherine E. White
Ann Arbor

Mary Sue Coleman (ex officio)

Important Note

University of Michigan Non-Discrimination Policy Notice

The University of Michigan, as an equal opportunity/affirmative action employer, complies with all applicable federal and state laws regarding nondiscrimination and affirmative action, including Title IX of the Education Amendments of 1972 and Section 504 of the Rehabilitation Act of 1973. The University of Michigan is committed to a policy of nondiscrimination and equal opportunity for all persons regardless of race, sex, color, religion, creed, national origin or ancestry, age, marital status, sexual orientation, gender identity, gender expression, disability, or Vietnam-era veteran status in employment, educational programs and activities, and admissions. Inquiries or complaints may be addressed to the Senior Director for Institutional Equity and Title IX/Section 504 Coordinator, Office of Institutional Equity, 2072 Administrative Services Building, Ann Arbor, Michigan 48109-1432, **734-763-0235**, TTY **734-647-1388**. For other University of Michigan information call **734-764-1817**.

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) 239-9697
www.aetnastudenthealth.com

Underwritten by:

Aetna Life Insurance Company (ALIC)
151 Farmington Avenue
Hartford, CT 06156
Policy No. **711146**

The University of Michigan Student Health 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**.

