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Welcome

Health Services at Columbia is part of the University’s Student Services division on the Morningside Campus. We provide integrated and accessible services and programs that support the well-being of the campus community and the personal and academic development of students.

Our on-campus programs and services are comprehensive; however, there may be circumstances in which you may need to fill a prescription or receive care from an off-campus clinician or hospital. To provide students with access to consistent, efficient care that complements the programs offered on campus, Columbia offers the Student Medical Insurance Plan in partnership with Chickering Benefit Planning Insurance Agency, Inc. Coverage is underwritten by Aetna Life Insurance Company.

Should you have any questions about Columbia’s policy on medical insurance coverage, the Columbia Student Medical Insurance Plan, or the Health Service Program, we encourage you to visit the Health Services website, www.health.columbia.edu.

An Important Note about Confidentiality

Columbia University, along with Chickering Claims Administrators, Inc., adheres to strict standards of confidentiality regarding information about health care services rendered, conditions, or any other privileged information to which Health Services at Columbia, Chickering, or Aetna have access. Furthermore, Aetna protects the privacy of confidential member medical information. *Participating Providers* are required to keep member information confidential in accordance with applicable laws. Aetna (including its affiliates and authorized agents, collectively "Aetna") and *Participating Providers* require access to member medical information for a number of important and appropriate purposes. Accordingly, for these purposes, members authorize the sharing of member medical information about themselves and their dependents between Aetna and *Participating Providers* and health delivery systems. You have the right, with some restrictions, to access your medical records by appointment from *Participating Providers*.

Special Notice

This guide is intended only to inform of services available under the Columbia Student Medical Insurance Plan. A complete listing and description of all benefits, limitations, and exclusions is found in the Master Policy. The Master Policy may be viewed by appointment at the Health Services Insurance Office. Copies are also available at the Office of the Vice President for Student Services and at the Student Affairs offices of Teachers College, Union Theological Seminary, and Jewish Theological Seminary of America.

If any discrepancy exists between information contained in the Master Policy, this guide, or online materials, the Master Policy will govern and control the payment of benefits.
Considering Your Options

Comparing Other Plans with the Columbia Student Medical Insurance Plan

Review the types of coverage included below, all of which are available through the Columbia Plan.

- Coverage in New York and worldwide
- Maximum aggregate lifetime benefit of $300,000 (Basic level of the Plan) or $1,000,000 (Comprehensive level of the Plan)
- Open Choice® PPO plan: option to see providers outside the plan’s network
- Adequate pharmacy benefits
- Coverage remains available as long as the student is registered or on an approved medical leave of absence
- Coverage for pre-existing conditions
- Benefits for inpatient and outpatient mental health care and treatment for chemical abuse
- Coverage for injuries resulting from the practice or play of athletics
- Payments made directly to hospitals for inpatient services
- Coverage for specialized therapeutic services, such as physical therapy
- Travel assistance services
- Option to enroll an eligible spouse or same-sex partner, as well as other eligible dependents

If you are unsure about how your current plan compares to the Columbia Plan, contact your insurance carrier’s administrator for details about available benefits. Other factors to consider when selecting a medical insurance plan:

- Will you "age-out" of your current insurance plan, carried by parents or legal guardians, at 19, 21, or 23 years of age?
- If you are hoping to extend coverage provided through a previous employer (through COBRA), what are the costs involved? Compare these with the premiums for the Columbia Student Medical Insurance Plan.
Why Our Plan Works for You

The Columbia Student Medical Insurance Plan provides coverage for a broad range of health care needs, both while students are in the United States and abroad:

- Benefits are designed to complement the services available on-campus
- On-campus clinicians serve as your primary care provider
- Access to services is streamlined and paperwork is limited
- Students pay only a modest copay for visits with consulting providers off campus (when referred by their on-campus clinician) and for prescription medications
- The Plan offers access to the nationwide Aetna network of specialists, representing clinicians in most areas of medical specialty. This can be of particular benefit while traveling or living away from campus for the summer
- Benefits are included for emergency assistance while traveling outside the United States
- The Plan covers a full year, starting September 1 and ending August 31 of the following year

The Columbia Student Medical Insurance Plan fulfills the definition of creditable coverage as explained in the Health Insurance Portability and Accountability Act (HIPAA) of 1996. If you choose to enroll in the Columbia Plan and wish to receive a certification of coverage, please call the Chickering Claims Administrators, Inc. Customer Service Line at 1-800-859-8471 or visit www.chickering.com/columbiadirect.html for online customer service.

The Student Medical Insurance Plan also meets and exceeds the requirements of USIA for International Students & Scholars.
2006-07 Columbia Plan Specifics

Two Levels of Coverage

Basic level of the Plan
The Basic level of the Student Medical Insurance Plan is designed to provide a level of coverage that is adequate for many people attending college or graduate programs. It is appropriate for students who:

• do not expect to need health care services frequently
• are looking for essential coverage at a reasonable cost
• are interested in utilizing a "pay-as-you-go" strategy: participants pay a lower insurance premium at the outset but a higher proportion of the cost of any services that may be utilized

The total maximum aggregate lifetime benefit available in the Basic level of the Plan is $300,000.

Comprehensive level of the Plan
The Comprehensive level of the Student Medical Insurance Plan includes all of the benefits provided by the Basic level of the Plan as well as more extensive benefits in certain areas:

• Additional coverage for off-campus psychotherapy ($500 per year). This is in addition to the $1,000 per year covered by the Health Service Fee.
• Enhanced benefits for prescription drugs, physical therapy, and other health care services.

The total maximum aggregate lifetime benefit available in the Comprehensive level of the Plan is $1,000,000.

For students who have chronic health conditions, take prescription drugs regularly, or anticipate utilizing mental health services in an ongoing way, this level of the Plan may be appropriate. Students will:

• pay a higher insurance premium up front
• pay less in out-of-pocket expenses as services are actually used
Period of Coverage

Policy Period


The coverage year is divided into two terms:

<table>
<thead>
<tr>
<th>Term</th>
<th>Dates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fall Term</td>
<td>September 1, 2006 – January 15, 2007</td>
</tr>
<tr>
<td>Spring Term</td>
<td>January 16, 2007 – August 31, 2007</td>
</tr>
</tbody>
</table>

*Please note that insurance coverage is officially established upon registration for the academic term associated with the period of coverage.

For students enrolling in the Fall Term and continuing as a registered student in the Spring Term, coverage becomes effective at 12:00 a.m. on September 1, 2006, and ends at 11:59 p.m. on August 31, 2007.

Students completing their programs in December in anticipation of a February graduation will have coverage through 11:59 p.m. on January 15, 2007. Students expecting to graduate in October 2006 are not eligible to enroll in the Student Medical Insurance Plan, but may enroll in the Continuation Plan offered by Chickering Claims Administrators, Inc.

For all students enrolling in their first term of classes for the Spring Term, coverage becomes effective at 12:00 a.m. on January 16, 2007, and ends at 11:59 p.m. on August 31, 2007.

For Journalism Masters Program students, the Plan is effective: August 1, 2006 - July 31, 2007.

Please note that for students who have not actively enrolled in the Plan, coverage is still retroactive to September 1, 2006. However, all expenses for prescriptions filled before September 30, 2006, will need to be submitted to Aetna Pharmacy Management for reimbursement. For full details about prescription coverage during this period, please contact Chickering Claims Administrators, Inc.

Enrollment for dates other than those above is allowed only upon the loss of other health insurance coverage. Documentation of loss of coverage is required. Chickering or the Insurance Office at Columbia Health Services must be contacted within 31 days of the loss of other coverage.
Continuation Privilege

An optional Continuation Plan is available for students whose registration at Columbia is ending. To be eligible to participate in the Continuation Plan, students must have been enrolled in the Columbia Plan in their final term as a registered student.

Chickering must receive applications and payment for the full premium within 30 days after the expiration of coverage under the student plan. Detailed information about the Continuation Plan and applications for enrollment are available at www.chickering.com/columbiadirect.html. You may enroll online by submitting your application and using a credit card for payment.

The maximum length of coverage under the Continuation Plan is 12 consecutive months. If eligible for additional coverage after August 31, 2007, the new Plan rates may apply.

What’s Covered

Physician Office Visits/Allergy Care

Benefits are available for the services specified as well as care by consulting specialists as described in the chart below.

<table>
<thead>
<tr>
<th>PHYSICIAN’S OFFICE VISITS</th>
<th>BASIC PLAN</th>
<th>COMPREHENSIVE PLAN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preferred Care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• 100% of the Negotiated Charge</td>
<td></td>
<td>• 100% of the Negotiated Charges</td>
</tr>
<tr>
<td>• $25 copay per visit</td>
<td></td>
<td>• $10 copay per visit</td>
</tr>
<tr>
<td>Non-Preferred Care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• 70% of Reasonable Charges up to $10,000</td>
<td></td>
<td>• 70% of Reasonable Charges up to $10,000</td>
</tr>
<tr>
<td>• 100% of Reasonable Charges thereafter</td>
<td></td>
<td>• 100% of Reasonable Charges thereafter</td>
</tr>
<tr>
<td>• $25 Deductible per visit</td>
<td></td>
<td>• $10 Deductible per visit</td>
</tr>
</tbody>
</table>

For allergy care, coverage of injections and serums is provided up to a maximum of $500 per condition.
Physical Therapy, Chiropractic Care, Radiation and Chemotherapies, Dialysis and Respiratory Therapy
These services are covered in the same manner as *Physician’s Office Visits*, with the following exception:

- For the Basic level of the Plan, coverage for physical therapy expenses is limited to a maximum of $250 per condition. This limitation does not apply to post-surgical therapy or accidental injuries. In these cases, benefits are available up to the plan maximum.
- For the Comprehensive level of the Plan, benefits are available up to the Plan maximum.

Acupuncture
Coverage for acupuncture may be available under very specific circumstances. Please contact Chickering Claims Administrators, Inc. for more information.

Hospital Outpatient Services
Benefits are available for the services specified as well as care by consulting specialists as described in the chart below.

<table>
<thead>
<tr>
<th>HOSPITAL OUTPATIENT SERVICES</th>
<th>BASIC PLAN</th>
<th>COMPREHENSIVE PLAN</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Preferred Care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• 80% of the Negotiated Charge up to $10,000</td>
<td></td>
<td>• 100% of the Negotiated Charges</td>
</tr>
<tr>
<td>• 100% of the Negotiated Charge thereafter</td>
<td></td>
<td>• $10 copay per visit</td>
</tr>
<tr>
<td>• $25 copay per visit</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Non-Preferred Care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• 50% of Reasonable Charges up to $10,000</td>
<td></td>
<td>• 70% of Reasonable Charges up to $10,000</td>
</tr>
<tr>
<td>• 100% of Reasonable Charges thereafter</td>
<td></td>
<td>• 100% of Reasonable Charges thereafter</td>
</tr>
<tr>
<td>• $25 Deductible per visit</td>
<td></td>
<td>• $10 Deductible per visit</td>
</tr>
</tbody>
</table>
X-Ray and Laboratory Services

Benefits are available for the services specified as well as care by consulting specialists as described in the chart below.

<table>
<thead>
<tr>
<th>X-RAY AND LABORATORY SERVICES</th>
<th>BASIC PLAN</th>
<th>COMPREHENSIVE PLAN</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Preferred Care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>● 80% of the Negotiated</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Charge up to $10,000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>● 100% of the Negotiated</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Charge thereafter</td>
<td></td>
<td></td>
</tr>
<tr>
<td>● $25 copay per visit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>● For services rendered by</td>
<td></td>
<td></td>
</tr>
<tr>
<td>designated providers, after</td>
<td></td>
<td></td>
</tr>
<tr>
<td>referral by Health Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>clinician, coverage is</td>
<td></td>
<td></td>
</tr>
<tr>
<td>100% with no copay</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Non-Preferred Care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>● 60% of the Reasonable</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Charges up to $10,000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>● 100% of the Charge</td>
<td></td>
<td></td>
</tr>
<tr>
<td>thereafter</td>
<td></td>
<td></td>
</tr>
<tr>
<td>● $25 Deductible per visit</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| **Preferred Care**            | 100% of the Negotiated Charge |
|                               | $10 copay per visit           |
| ● For services rendered by    | attended by designated        |
| providers, after referral by   | Health Services clinician,    |
| Health Services clinician,    | the coverage is 100% with      |
| coverage is 100% with no       | no copay                     |
| copay                         |                               |
| **Non-Preferred Care**        | 70% of the Reasonable         |
| Charges up to $10,000         |                               |
| ● 100% of the Charge          |                               |
| thereafter                    |                               |
| ● $10 Deductible per visit    |                               |

Emergency Care

Emergency treatment is covered for severe injury or sudden, acute medical or psychiatric illness. If you are not sure whether emergency treatment is needed, Health Services providers are available to help assess your condition and determine the most appropriate course of action. Please be mindful of the following points regarding utilization of this benefit:

- It is not necessary to obtain a referral from your Health Services provider prior to receiving emergency care.
- Chickering does require that they be contacted within one business day following a hospital or emergency room inpatient admission—by the patient, the patient’s representative, or the hospital.
- In a true emergency situation, care received at an in-network hospital and out-of-network hospital would be reimbursed at the same rate. Examples of true emergencies include severe chest pain, appendicitis, and broken bone.
- Any follow-up care that is needed through a consulting specialist, following emergency care, will require a referral from your on-campus provider. Please see the Referral Requirements section for details.
Coverage is offered through the Health Service Fee, up to $500, for elective termination of pregnancy.

<table>
<thead>
<tr>
<th>ACCIDENTAL INJURY AND MEDICAL EMERGENCIES</th>
<th>EMERGENCY CARE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Enrolled in Basic level of the Student Medical insurance Plan or Carrying Alternative Coverage</strong></td>
<td><strong>Preferred Care</strong></td>
</tr>
<tr>
<td>• Maximum of $2000 per condition</td>
<td>• 80% of the Negotiated Charge up to $10,000</td>
</tr>
<tr>
<td><strong>Preferred Care</strong></td>
<td>• 100% of the Negotiated Charge thereafter</td>
</tr>
<tr>
<td>• 60% of the Negotiated Charges</td>
<td>• $25 copay per incident</td>
</tr>
<tr>
<td>• $25 copay per visit</td>
<td><strong>Non-Preferred Care</strong></td>
</tr>
<tr>
<td><strong>Non-Preferred Care</strong></td>
<td>• All emergency room care is covered as for Preferred Care</td>
</tr>
<tr>
<td>• 60% of the Reasonable Charges</td>
<td><strong>Preferred Care</strong></td>
</tr>
<tr>
<td>• $25 Deductible per visit</td>
<td>• 100% of the Negotiated Charge</td>
</tr>
<tr>
<td><strong>Preferred Care</strong></td>
<td>• $10 copay per incident</td>
</tr>
<tr>
<td>• 60% of the Negotiated Charges</td>
<td><strong>Non-Preferred Care</strong></td>
</tr>
<tr>
<td>• $10 Deductible per visit</td>
<td>• All emergency room care is covered as for Preferred Care</td>
</tr>
</tbody>
</table>
Surgical Services

Surgeons are included in the Aetna network of providers. Many services are now performed in an outpatient setting, in stand-alone clinics or providers’ offices. Please be mindful of the following points regarding utilization of this benefit:

- A referral is needed for non-emergency surgical care
- *Pre-certification by Chickering is required* for any inpatient hospital stay associated with surgical services. Please see the Inpatient Hospital Care section for more information.

### SURGICAL CARE

<table>
<thead>
<tr>
<th>Surgeon’s fees; Anesthetist Expense; OutPatient Day Surgery Facility Expense</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>BASIC PLAN</strong></td>
</tr>
<tr>
<td><strong>Preferred Care</strong></td>
</tr>
<tr>
<td>- 80% of the Negotiated Charge up to $10,000</td>
</tr>
<tr>
<td>- 100% of the Negotiated Charge thereafter</td>
</tr>
<tr>
<td>- $50 copay if surgical cost is less than $250;</td>
</tr>
<tr>
<td>- $125 copay if surgical cost is $250-$999;</td>
</tr>
<tr>
<td>- $300 copay if surgical cost is $1000 or more;</td>
</tr>
<tr>
<td><strong>Non-Preferred Care</strong></td>
</tr>
<tr>
<td>- 50% of Reasonable Charges up to $10,000</td>
</tr>
<tr>
<td>- 100% of Reasonable Charges thereafter</td>
</tr>
<tr>
<td>- $50 Deductible if surgical cost is less than $250;</td>
</tr>
<tr>
<td>- $125 Deductible if surgical cost is $250-$999;</td>
</tr>
<tr>
<td>- $300 Deductible if surgical cost is $1000 or more;</td>
</tr>
</tbody>
</table>

### SECOND SURGICAL CONSULT

| **BASIC PLAN** | **COMPREHENSIVE PLAN** |
| --- |
| **Preferred Care** |
| - 100% of the Negotiated Charge up to a maximum of $150 per consult |
| - $25 copay |
| **Non-Preferred Care** |
| - 70% of Reasonable Charges up to a maximum of $150 per consult |
| - $25 Deductible |
| **Preferred Care** |
| - 100% of the Negotiated Charges |
| - $10 copay |
| **Non-Preferred Care** |
| - 70% of Reasonable Charge |
| - $10 Deductible per visit |
Inpatient Hospitalization

Inpatient services are covered under the Student Medical Insurance Plan for both emergency medical and psychiatric treatment and non-emergency planned admissions. Please be mindful of the following points regarding utilization of this benefit:

- Chickering requires that they be contacted within 1 business day of an emergency inpatient hospital admission -- by the patient, the patient's representative, or the hospital.

- Chickering must be contacted for pre-certification at least 3 business days prior to a pre-planned admission. Contact should be made by the patient, patient's representative, health care provider, or hospital.

- The pre-certification process includes review of the anticipated length of stay. 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 Medical Insurance Plan.

- If pre-certification for a planned admission or notification of an emergency hospitalization is not secured, your hospital bill will be subject to a Deductible of $200 per admission, in addition to any other Deductible.

<table>
<thead>
<tr>
<th>INPATIENT HOSPITAL CARE</th>
<th>INPATIENT PHYSICIAN VISITS/CONSULTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternity Care; Newborn Nursery Care; Eating Disorder Treatment; Room &amp; Board; Other Covered Hospital Services</td>
<td>(coverage limited to one visit per day)</td>
</tr>
<tr>
<td><strong>BASIC PLAN</strong></td>
<td><strong>COMPREHENSIVE PLAN</strong></td>
</tr>
<tr>
<td><strong>Preferred Care</strong></td>
<td><strong>Preferred Care</strong></td>
</tr>
<tr>
<td>- 80% of the Negotiated Charge up to $10,000</td>
<td>- 100% of the Negotiated Charge</td>
</tr>
<tr>
<td>- 100% of the Negotiated Charge thereafter</td>
<td>- $10 copay per admission</td>
</tr>
<tr>
<td>- $25 copay per admission</td>
<td></td>
</tr>
<tr>
<td><strong>Non-Preferred Care</strong></td>
<td><strong>Non-Preferred Care</strong></td>
</tr>
<tr>
<td>- 50% of Reasonable Charges up to $10,000</td>
<td>- 70% of Reasonable Charges up to $10,000</td>
</tr>
<tr>
<td>- 100% of Reasonable Charges thereafter</td>
<td>- 100% of Reasonable Charges thereafter</td>
</tr>
<tr>
<td>- $25 Deductible per admission</td>
<td>- $10 Deductible per visit</td>
</tr>
</tbody>
</table>

**Note:** The table above outlines the benefits for inpatient hospitalization and outpatient physician visits/consultations under the Student Medical Insurance Plan. Each category includes separate plans with different coverage levels and copayments. The comprehensive plan typically offers more extensive coverage compared to the basic plan. The deducibles and copayments vary depending on the category and the type of service.
Pre-Natal and Maternity Care

Benefits are available for the following types of pre-natal and maternity care services:

- Physician’s Office Visits
- X-ray and Lab Services
- Emergency Care
- Surgical Services
- Inpatient Hospitalization
- Prescription Coverage (except pre-natal vitamins)

These services are covered in the same manner as described in the corresponding sections throughout this site. Please be mindful of the following points regarding utilization of this benefit:

- For inpatient hospitalization, pre-certification at least 3 days before the services are rendered is required, except in true emergencies.
- See the Coverage For Newborn or Newly Adopted Children section for information about coverage for newborn children.
- See the Coverage for Dependents section for information about enrolling children for further coverage under the Student Medical Insurance Plan.

Prescriptions

The prescription coverage included in the Student Medical Insurance Plan is designed to meet the basic needs of most college students. Your Aetna I.D. card functions as confirmation of your coverage through the Student Medical Insurance Plan. No separate prescription card is needed. You may contact Aetna Pharmacy Management at 1-800-AETNA Rx (238-6279) for assistance in determining your remaining available prescription benefit at any time.

The Aetna Preferred Drug List will be used as part of the prescription benefit coverage. The prescription copay will depend on whether your prescribed medication is a generic or brand name drug and for brand name drugs, whether the prescribed medication is listed on Aetna’s Preferred Drug List. The prescription copays are as follows:

- $30 for Tier Three (covered Brand Name medications not on the Preferred Drug List)
- $25 for Tier Two (covered Brand Name medications on the Preferred Drug List)
- $10 for Tier One (covered Generic medications)

You may find Aetna’s Brand Name Preferred Drug List by visiting the Columbia Health Services website or the Chickering website or by calling Chickering.
Prior authorization is required for the following medications:

- growth hormones
- drugs used for the treatment of malaria
- more than a 30-day supply per Prescription or refill

The following is a list of some medications not covered under the Plan. For a complete list of excluded medications or drugs available with prior authorization, please contact Aetna Pharmacy Management at 1-800-AETNA Rx (238-6279).

- allergy sera
- drugs whose sole purpose is to promote or stimulate hair growth
- appetite suppressants
- smoking deterrents
- immunization agents and vaccines
- non-self injectables

The plan does not currently cover mail-order prescriptions or those ordered over the Internet, for two main reasons:

1. Many students change their address multiple times. This can make it difficult to deliver prescriptions in a safe and secure manner.
2. Most mail-order prescription services provide medications in bulk. The majority of students utilize prescription medicines temporarily and/or are in the process of finding the correct dosage with the assistance of their health care provider. For this reason, ordering medications in large quantity is not of benefit to most students.

The least expensive approach to obtaining prescriptions is to fill them, when possible, as generics at Preferred Pharmacies. Aetna maintains a wide network of Preferred Pharmacies, where students will need to pay only a copay for each prescription, until they reach the Prescription Drug Policy Year maximum.

A listing of Preferred Pharmacy locations can be obtained through Aetna Pharmacy Management at 1-800-AETNA Rx (238-6279) or on Chickering’s website. Once on the site, click on "DocFind®" and then "Find a Pharmacy." You will then enter your zip code and indicate that you are a member of an Open Choice PPO Plan. Students may also obtain a listing of Preferred Pharmacies in the Columbia area at the Health Services Insurance Office in John Jay Hall.

You will need to discuss with your health care provider whether use of a generic prescription is possible at the time the prescription is written.

The Student Medical Insurance Plan also allows you to fill prescriptions at Non-Preferred Pharmacies. However, you will be required to pay in full at the time of service for all prescriptions dispensed and submit a claim form to Aetna Pharmacy Management. Claims are reimbursed at the rates described in the following
chart. Reimbursement claim forms are available through Chickering Claims Administrators, Inc. or the Health Services Insurance Office in John Jay Hall. Please be aware that by New York State mandate, all contraceptive devices and medications, except those available over the counter, are covered under the Columbia Student Medical Insurance Plan.
### PRESCRIPTION MEDICATIONS
(See text above for medications excluded from coverage)

<table>
<thead>
<tr>
<th>BASIC PLAN</th>
<th>COMPREHENSIVE PLAN</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Preferred Pharmacy</strong></td>
<td><strong>Preferred Pharmacy</strong></td>
</tr>
<tr>
<td>Prescription benefits up to $1,000 per plan year.</td>
<td>Prescription benefits up to $1,250 per plan year.</td>
</tr>
<tr>
<td>• 100% of the Negotiated Charge</td>
<td>• 100% of the Negotiated Charge</td>
</tr>
<tr>
<td>• $10 for Tier One (Covered Generic medications)</td>
<td>• $10 for Tier One (Covered Generic medications)</td>
</tr>
<tr>
<td>• $25 for Tier Two (Covered Brand Name medications on the Preferred Drug List)</td>
<td>• $25 for Tier Two (Covered Brand Name medications on the Preferred Drug List)</td>
</tr>
<tr>
<td>• $30 for Tier Three (Covered Brand Name medications NOT on the Preferred Drug List)</td>
<td>• $30 for Tier Three (Covered Brand Name medications NOT on the Preferred Drug List)</td>
</tr>
</tbody>
</table>

**Note: Basic Plan**
Prescriptions for Insulin, syringes and diabetic testing supplies are covered at $10 Copay for Generic and $25 Copay for Brand up to plan maximum.

**Non-Preferred Pharmacy**
For all services by Non-Preferred Pharmacies, payment must be made in full to the pharmacy at time of service; claim for reimbursement of prescription benefit should then be submitted to Chickering.

Prescription benefits up to $1,000 per plan year:
• 70% of Reasonable Charge
• $10 for Tier One (Covered Generic medications)
• $25 for Tier Two (Covered Brand Name medications on the Preferred Drug List)
• $30 for Tier Three (Covered Brand Name medications NOT on the Preferred Drug List)

**Note: Basic Plan**
Prescriptions for Insulin, syringes and diabetic testing supplies are covered at $10 Copay for Generic and $25 Copay for Brand up to plan maximum.

**Non-Preferred Pharmacy**
For all services by Non-Preferred Pharmacies, payment must be made in full to the pharmacy at time of service; claim for reimbursement of prescription benefit should then be submitted to Chickering.

Prescription benefits up to $1,250 per plan year:
• 70% of the Reasonable Charge
• $10 for Tier One (Covered Brand Name medications on the Preferred Drug List)
• $30 for Tier Three (Covered Brand Name medications NOT on the Preferred Drug List)

**Note: Comprehensive Plan**
Prescriptions for Insulin, syringes and diabetic testing supplies are covered at $10 for Generic or Brand Name medications up to plan maximum.

After reaching $1,250 prescription benefit in plan year:
• 80% of Reasonable Charge
• No Copay
• Payment must be made in full to pharmacy at time of service; claim of reimbursement of prescription benefit should be submitted to Chickering.

**Note: Comprehensive Plan**
Prescriptions for Insulin, syringes and diabetic testing supplies are covered at $10 for Generic or Brand Name medications up to plan maximum.

After reaching $1,250 prescription benefit in plan year:
• 80% of Reasonable Charge
• No Deductible
Outpatient Mental Health Services
Mental health services, including a limited number of psychotherapy visits, are available on campus through Counseling and Psychological Services. These services are provided at no additional charge for all students who have paid the Health Service Fee.

Coverage for off-campus mental health services is also offered through the Health Service Fee. The Basic level of the Plan does not offer additional coverage to supplement the benefits provided through the Health Service Fee. The Comprehensive level of the Student Medical Insurance Plan does offer additional coverage.

A referral must be obtained through a CPS provider prior to receiving off-campus treatment by any specialist providers or institutional services. Services received off-campus prior to an evaluation at CPS will not be eligible for coverage.

Benefits are as follows:

<table>
<thead>
<tr>
<th>OUTPATIENT MENTAL HEALTH SERVICES</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>HEALTH SERVICE FEE OFF-CAMPUS SERVICES</strong></td>
</tr>
<tr>
<td>• 75% of each visit fee up to a maximum benefit per visit of $80</td>
</tr>
<tr>
<td>• A maximum of 1 visit per day</td>
</tr>
<tr>
<td>• A maximum benefit per year of $1,000</td>
</tr>
<tr>
<td>• A maximum lifetime benefit of $4,000</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>COMPREHENSIVE LEVEL OF THE STUDENT MEDICAL INSURANCE PLAN</th>
</tr>
</thead>
<tbody>
<tr>
<td>• 75% of each visit fee up to a maximum benefit per visit of $60</td>
</tr>
<tr>
<td>• A maximum of 1 visit per day</td>
</tr>
<tr>
<td>• Additional $500 maximum benefit per year over Health Service fee coverage, therefore</td>
</tr>
<tr>
<td>• Total maximum benefit per year: Health Service Fee + Comprehensive Plan = $1,500</td>
</tr>
<tr>
<td>Additional $2,300 lifetime benefit over Health Service Fee coverage; therefore</td>
</tr>
<tr>
<td>Total maximum lifetime benefit: Health Service Fee + Comprehensive Plan = $3,800</td>
</tr>
</tbody>
</table>
ADD/ADHD

ADD/ADHD Testing

Testing for Attention Deficit Disorder (ADD) and Attention Deficit Hyperactivity Disorder (ADHD) is covered as follows:

- Basic Plan: Following a $100 copay, 80% of remaining negotiated or reasonable charge up to $600 maximum benefit per policy year applies;
- Comprehensive Plan: Following a $50 copay, 100% of remaining negotiated or reasonable charge to $600 maximum benefit per policy year.

ADD/ADHD Medication Management Visits

Medication management will be covered as a physician’s office visit (see page 5) under the Basic or the Comprehensive Plan.

ADD/ADHD Cognitive Behavioral Therapies

Cognitive behavioral therapies will be covered as any other outpatient mental health visit (see previous page) under the Health Service Fee or the Comprehensive Plan.

Inpatient Mental Health Care

Students are encouraged to contact Counseling and Psychological Services for urgent or emergency mental health care needs. If, through consultation with an on-campus provider, inpatient services are deemed necessary, an appropriate referral will be made. Coverage is provided as follows, with a $25,000 per policy year maximum.

<table>
<thead>
<tr>
<th>INPATIENT HOSPITAL CARE</th>
<th>INPATIENT PHYSICIAN VISITS/CONSULTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternity Care; Newborn Nursery Care; Eating Disorder Treatment; Room &amp; Board; Other Covered Hospital Services</td>
<td>(coverage limited to one visit per day)</td>
</tr>
<tr>
<td><strong>BASIC PLAN</strong></td>
<td><strong>COMPREHENSIVE PLAN</strong></td>
</tr>
<tr>
<td><strong>Preferred Care</strong></td>
<td><strong>Preferred Care</strong></td>
</tr>
<tr>
<td>- 80% of the Negotiated Charge up to $10,000</td>
<td>- 100% of the Negotiated Charge</td>
</tr>
<tr>
<td>- 100% of the Negotiated Charge thereafter</td>
<td>- $10 copay per admission</td>
</tr>
<tr>
<td>- $25 copay per admission</td>
<td>- $25 copay per admission</td>
</tr>
<tr>
<td><strong>Non-Preferred Care</strong></td>
<td><strong>Non-Preferred Care</strong></td>
</tr>
<tr>
<td>- 50% of Reasonable Charges up to $10,000</td>
<td>- 70% of Reasonable Charges up to $10,000</td>
</tr>
<tr>
<td>- 100% of Reasonable Charges thereafter</td>
<td>- 100% of Reasonable Charges thereafter</td>
</tr>
<tr>
<td>- $25 Deductible per admission</td>
<td>- $10 Deductible per admission</td>
</tr>
<tr>
<td><strong>BASIC PLAN</strong></td>
<td><strong>COMPREHENSIVE PLAN</strong></td>
</tr>
<tr>
<td><strong>Preferred Care</strong></td>
<td><strong>Preferred Care</strong></td>
</tr>
<tr>
<td>- 100% of the Negotiated Charge up to $10,000</td>
<td></td>
</tr>
<tr>
<td>- $10 copay per visit</td>
<td></td>
</tr>
<tr>
<td><strong>Non-Preferred Care</strong></td>
<td><strong>Non-Preferred Care</strong></td>
</tr>
<tr>
<td>- 50% of Reasonable Charges up to $10,000</td>
<td></td>
</tr>
<tr>
<td>- 100% of Reasonable Charges thereafter</td>
<td></td>
</tr>
<tr>
<td>- $25 Deductible per visit</td>
<td></td>
</tr>
<tr>
<td><strong>Non-Preferred Care</strong></td>
<td><strong>Non-Preferred Care</strong></td>
</tr>
<tr>
<td>- 70% of Reasonable Charges up to $10,000</td>
<td></td>
</tr>
<tr>
<td>- 100% of Reasonable Charges thereafter</td>
<td></td>
</tr>
<tr>
<td>- $10 Deductible per visit</td>
<td></td>
</tr>
</tbody>
</table>
Inpatient treatment for an eating disorder is considered a medical admission, rather than a mental health admission, for the purpose of administration of the Student Medical Insurance Plan. Coverage is as above, with a per policy year maximum in accordance with the level of the Plan the student is enrolled in.

Urgent psychiatric hospitalization coverage is as follows:

<table>
<thead>
<tr>
<th>ACCIDENTAL INJURY AND MEDICAL EMERGENCIES</th>
<th>EMERGENCY CARE</th>
</tr>
</thead>
<tbody>
<tr>
<td>As Covered Through the Health Service Fee</td>
<td></td>
</tr>
<tr>
<td>Enrolled in Basic level of the Student Medical Insurance Plan or Carrying Alternative Coverage</td>
<td>Enrolled in Comprehensive level of the Student Medical Insurance Plan or Carrying Alternative Coverage</td>
</tr>
<tr>
<td>• Maximum of $2000 per condition</td>
<td>• Maximum of $2000 per condition</td>
</tr>
<tr>
<td>Preferred Care</td>
<td></td>
</tr>
<tr>
<td>• 80% of the Negotiated Charges</td>
<td></td>
</tr>
<tr>
<td>• $25 copay per visit</td>
<td></td>
</tr>
<tr>
<td>Non Preferred Care</td>
<td></td>
</tr>
<tr>
<td>• 60% of the Reasonable Charges</td>
<td></td>
</tr>
<tr>
<td>• $25 Deductible per visit</td>
<td></td>
</tr>
<tr>
<td>Preferred Care</td>
<td></td>
</tr>
<tr>
<td>• 80% of the Negotiated Charges</td>
<td></td>
</tr>
<tr>
<td>• $10 copay per visit</td>
<td></td>
</tr>
<tr>
<td>Non-Preferred Care</td>
<td></td>
</tr>
<tr>
<td>• All emergency room care is covered as for Preferred Care</td>
<td></td>
</tr>
</tbody>
</table>

Outpatient Chemical Abuse Treatment

Assessments for concerns about chemical abuse and/or dependency are available on campus at Counseling and Psychological Services. The Health Service Fee covers these services.

The Health Service Fee also includes coverage for outpatient chemical abuse treatment. Counseling and Psychological Services providers can help students determine the most appropriate form of treatment for their needs, and if necessary, connect them with off-campus providers familiar with the issues faced by university students. Students must obtain a referral for off-campus services. Benefits are provided as follows.

<table>
<thead>
<tr>
<th>OUTPATIENT CHEMICAL ABUSE</th>
</tr>
</thead>
<tbody>
<tr>
<td>HEALTH SERVICE FEE OFF-CAMPUS SERVICES</td>
</tr>
<tr>
<td>• 100% of Negotiated Charge or Reasonable Charges coverage up to a maximum of 60 visits per year</td>
</tr>
<tr>
<td>• Up to 20 of these visits can be used for family counseling of dependents</td>
</tr>
<tr>
<td>• Up to 5 family counseling sessions will be covered even if the treatment of the Covered Person has not begun</td>
</tr>
</tbody>
</table>
The Student Medical Insurance Plan (at the Basic or Comprehensive level) does not offer any additional coverage for students for Outpatient Chemical Abuse Treatment.

**Inpatient Chemical Abuse Treatment**

Students are encouraged to contact Counseling and Psychological Services for urgent or emergency mental health care needs. If, through consultation with an on-campus provider, inpatient treatment is deemed necessary, an appropriate referral will be made.

Coverage is provided as follows, for a maximum of 7 days per Policy Year for detoxification and 30 days per Policy Year for rehabilitation.

```
<table>
<thead>
<tr>
<th>INPATIENT HOSPITAL CARE</th>
<th>INPATIENT PHYSICIAN VISITS/CONSULTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternity Care; Newborn Nursery Care;</td>
<td>(coverage limited to one visit per day)</td>
</tr>
<tr>
<td>Eating Disorder Treatment; Room &amp; Board;</td>
<td></td>
</tr>
<tr>
<td>Other Covered Hospital Services</td>
<td></td>
</tr>
</tbody>
</table>

**BASIC PLAN**
- Preferred Care
  - 80% of the Negotiated Charge up to $10,000
  - 100% of the Negotiated Charge thereafter
  - $25 copay per admission

**COMPREHENSIVE PLAN**
- Preferred Care
  - 100% of the Negotiated Charge
  - $10 copay per admission

**Non-Preferred Care**
- 50% of Reasonable Charges up to $10,000
- 100% of Reasonable Charges thereafter
- $25 Deductible per admission

**BASIC PLAN**
- Preferred Care
  - 90% of the Negotiated Charge up to $10,000
  - 100% of the Negotiated Charge thereafter
  - $25 copay per visit

**COMPREHENSIVE PLAN**
- Preferred Care
  - 100% of the Negotiated Charge
  - $10 copay per visit

**Non-Preferred Care**
- 70% of Reasonable Charges up to $10,000
- 100% of Reasonable Charges thereafter
- $25 Deductible per visit

**Non-Preferred Care**
- 70% of Reasonable Charges up to $10,000
- 100% of Reasonable Charges thereafter
- $10 Deductible per visit
```
Urgent chemical abuse hospitalization coverage is as follows:

**Dental Services**

Coverage is available through the Student Medical Insurance Plan for the following types of accidental dental injury and for the treatment of certain serious dental conditions:

- emergency treatment of accidental injuries to sound, natural teeth
- non-emergency treatment of accidental injury to sound, natural teeth
- extraction of impacted wisdom teeth
- treatment of dental abscesses

These benefits are underwritten by Aetna and administered by Chickering. Coverage for true emergency treatment of accidental dental injury is the same when provided by Preferred and Non-Preferred Providers.
Options for Dental Services Not Covered By the Columbia Student Medical Insurance Plan

Health Services’ aim is to provide the Columbia community with access to convenient options for obtaining dental services covered by the Columbia Student Medical Insurance Plan as well as other necessary services at moderate cost.

Dental coverage is available through the Student Medical Insurance Plan only for accidental dental injury and for the treatment of certain serious dental conditions.

For those enrolled in the Columbia Student Medical Insurance Plan, Morningside Dental Associates (MDA), a program operated by the Columbia University School of Dental and Oral Surgery, offers specially discounted rates for a select group of services. These services are not underwritten by Aetna or administered by Chickering.

Care is provided by licensed dentists pursuing fellowship training under the supervision of faculty members of the School of Dental and Oral Surgery.

For participants in the Student Medical Insurance Plan, the following services are available with only a copay, which is required for each visit, as indicated in the chart below:

- One routine examination per year
- X-rays as needed, and with routine exam
- One dental cleaning (prophylaxis) per year
- Evaluation of emergency dental conditions, including relief of pain

Emergency services are provided by appointment during regular MDA office hours. Coverage does not include final treatment or restorations.

<table>
<thead>
<tr>
<th>COLUMBIA DENTAL ASSOCIATES SPECIFIED ROUTINE AND EMERGENCY SERVICES</th>
</tr>
</thead>
<tbody>
<tr>
<td>BASIC PLAN</td>
</tr>
<tr>
<td>$20 copay per visit</td>
</tr>
</tbody>
</table>

Those enrolled in the Student Medical Insurance Plan may also obtain the following dental services from MDA at the specially discounted rates specified in the chart below. Full payment is required for these services at the time they are rendered:

- Restorations (fillings, composites, crowns)
- Endodontics
- Periodontics
- Oral surgery
- Orthodontics
Morningside Dental Associates primary location is 1244 Amsterdam Avenue at 121st Street.

In special circumstances, students may be referred to the Morningside Dental Associates location at 622 West 168th Street, 8th Floor.

To learn more about MDA, their rates, and services available, please contact them directly at 212-865-8467.

**Additional Options**

**The Aetna Advantage Dental Plan** provides preventative dental care following a $5 per visit Co-pay. Annual premium is $228.00 per student, or $888.00 for the Student and Family Plan. Enrollment Deadlines are: Fall 9/30/06 and Spring 2/01/07.

For more information or to enroll in the Advantage Dental Plan please visit the Chickering website at [www.chickering.com/columbiadirect.html](http://www.chickering.com/columbiadirect.html). You do not need to be enrolled in the Columbia University Student Insurance Plan to enroll in the Advantage Dental Plan.

Please consult the Health Services website to see contact information for each of the programs described below and a full description of services provided.

Students and their partners and dependent children may access dental services through:
- Stu-Dent, a program offered by New York University’s College of Dentistry
- St. Luke’s-Roosevelt Hospital Dental and Oral Surgery Clinic

**Vision One® Discount Program**

Vision services and discounts are available through a discount program, Vision One®, which includes local providers as well as vendors throughout the United States. *This program is not underwritten by Aetna*. A listing of participating providers is available through the "DocFind™" feature at [www.chickering.com/columbiadirect.html](http://www.chickering.com/columbiadirect.html).
The Vision One® providers closest to the Morningside Campus are:

Columbia Opticians, Inc.
1246 Amsterdam (at 121st Street)
212-316-2020

The Spec Shop
2868 Broadway (between 111th and 112th Streets)
212-865-9825

Travel Assistance and Emergency Services

One of the most significant benefits available through the Columbia Plan is the Travel Assistance Services offered through Assist America and underwritten by Unum Provident Life Insurance Company of America. The program is offered at no additional charge in both the Basic and Comprehensive levels of the Plan. These benefits are designed to protect a person covered by the Student Medical Insurance Plan (both students and dependents) when they are over 100 miles from their permanent address and a medical or other travel-related emergency arises. These benefits apply throughout the United States and around the world.

Assist America Operations Centers have worldwide assistance capabilities and are known throughout the world as a premier Emergency Assistance Services provider. The Assist America Operations Center can be reached 24 hours a day, 365 days a year. Services included in the coverage are:

- access to a global network of over 600,000 pre-qualified doctors, hospitals, and pharmacies
- medical consultation, evaluation, and referral
- prescription assistance
- foreign hospital admission guarantee
- medical evacuation
- travel information and assistance for visa and passport requirements, travel advisories, legal concerns, interpreter needs, and lost luggage
- in the case of death of the Covered Person, return of mortal remains, available both when traveling as well as from the campus location

Assist America pays for all of the benefits and services it provides. All services must be arranged for and provided by Assist America in order to be covered. Any third party expenses incurred are the responsibility of the Covered Person or his or her family. The Assist America program meets and exceeds the requirements of USIA for International Students & Scholars.

An Assist America ID card will be supplied to you once you enroll in the Student Medical Insurance Plan. Please remember to carry your Assist America card with you.
Medical Evacuation and Return of Mortal Remains Services

In the event that an enrollee in the Student Medical Insurance Plan (student or dependent) becomes injured or ill and adequate medical facilities are not available locally, Assist America will use whatever mode of transport, equipment and personnel necessary to evacuate the Covered Person (and companion if necessary) to the nearest facility capable of providing required care. Once the Covered Person’s condition has been addressed, Assist America will arrange for transportation home or to their academic program.

In the event of death of a participant, Assist America will render every necessary type of assistance regarding the return of mortal remains. In such an event, contact should be made as soon as possible with Assist America. Medical Repatriation and Return of Mortal Remains services are available both while the Covered Person is traveling, as well as from the campus location.

Accidental Death and Dismemberment

The Student Medical Insurance Plan includes coverage for accidental death and dismemberment, underwritten by Unum Provident Life Insurance Company of America. Benefits are payable for the accidental death or dismemberment of the Covered Person up to a maximum of $10,000.

Exclusions and limitations may apply. For definitions of eligibility and a complete description of the benefits available for accidental death, dismemberment, loss of sight, speech, or hearing, please refer to the Master Policy, available for viewing by appointment only, through the Health Services Insurance Office in John Jay Hall.

To file a claim for Accidental Death and Dismemberment benefits, please contact Chickering Claims Administrators, Inc. for the appropriate claim forms.
**Dependent Coverage**

Students who enroll in the Columbia Student Medical Insurance Plan may also choose to insure their eligible dependents, which include:

- The student's lawful spouse or same-sex partner residing with the student
- The student's unmarried children, including stepchildren and foster children who are under the age of 19, are not self-supporting, and reside with the student, or for whom the student is court-ordered to provide insurance
- Newborn or newly adopted children

New dependents (due to marriage, birth, adoption, and approval of government issued travel documentation to the US.) may be added to the Policy only within 31 days of their addition to the family. Other than newborns, a dependent’s premium will not be pro-rated.

*Only a modified version of the Basic level of the Plan is available for coverage of eligible dependents. Please note that there are some differences between the Basic level of the Plan for students and the coverage for eligible dependents. These differences are explained below.*

Students who wish to obtain insurance coverage for their eligible dependents must be enrolled themselves in the Student Medical Insurance Plan and must, therefore, also be enrolled in Health Services at Columbia and pay the Health Service Fee.

**Period of Coverage for Eligible Dependents**

Coverage will become effective on the same date the insured student's coverage becomes effective; if dependents are enrolled prior to the deadline, coverage begins September 1, 2006.

A new enrollment request for Dependent Coverage must be provided by September 30\textsuperscript{th} in each Plan Year. Covered students may also request enrollment of their dependents beginning with the Spring term if the request and applicable premiums are submitted by February 1. Unlike the student plan, dependents' Fall Term enrollment is not automatically continued for the Spring Term. Dependents have the option to remain insured for the period from January 16, 2007 through August 31, 2007 (July 31, 2007 for dependents of Journalism Masters Program students) by completing a new application form and submitting the Spring Term premium. The deadline for enrolling for the Spring Term is February 1, 2007. Previously insured dependents and students must re-enroll before the deadline in order to avoid a break in coverage for conditions that existed in prior Policy Years. Once a break in continuous coverage occurs, the definition of Pre-Existing Condition will apply in determining coverage of any condition that existed during the break.
Coverage for insured dependents terminates in accordance with the Termination provisions described in the Master Policy. Termination of benefits may be affected by the following factors, among others: the date the student's coverage terminates and the date the dependent no longer meets the definition of a dependent.

**Enrollment of Eligible Dependents**

Dependents are not automatically enrolled. Application forms for dependent enrollment are available online at the Chickering website.

A new application for dependent coverage must be submitted each term by the deadlines below:

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Fall</strong></td>
<td>September 30, 2006</td>
</tr>
<tr>
<td><strong>Spring</strong></td>
<td>February 1, 2007</td>
</tr>
</tbody>
</table>

**Newborn or Newly Adopted Children**

Children born to a covered person during the Plan term will 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 unless the newborn is enrolled in the Plan.

Coverage is also provided for a child legally placed for adoption with a covered person, for 31 days from the moment of placement, provided that the child lives in the household of the covered person and is dependent upon him or her for support. At the end of this 31-day period, coverage will cease unless the adopted child is enrolled in the Plan.

All benefits available for newborn and newly adopted children, within 31 days of birth or placement, are equal to those available for individuals covered under the Plan.
Benefits for Eligible Dependents

Coverage for dependents is provided in the same manner as for enrolled students, with the following exceptions:

- **Aggregate Lifetime Maximum**: $300,000
- **Physician’s Office Expenses for Well-Child Care** (children from birth through age 19) are covered in the same manner as *Physicians Office Visits* for enrolled students in the Basic level of the Plan.
- **Covered Medical Expenses** for the administration of an immunization or a vaccine, as well as the cost of the immunization agent itself, are covered up 100% for children from birth through age 19.
- **Physician’s Office Visit expenses** for emergency care of a sick child are covered in the same manner as *Physician's Office Visits* coverage for enrolled students under the Basic level of the Plan.
- **Outpatient Chemical Abuse Treatment coverage** is available up to a maximum of 60 visits per policy year. Up to 20 of these visits must be available for family counseling visits. Coverage for each visit is provided in the same manner as *Hospital Outpatient Services* for students enrolled in the Basic level of the Plan.
- **Dependent coverage does not include benefits for Outpatient Mental Health Services or Elective Termination of Pregnancy**. These benefits are available to students only through the Health Service Fee.

### Premiums for Eligible Dependents

<table>
<thead>
<tr>
<th>Type of Coverage</th>
<th>Fall Premium</th>
<th>Spring/Summer Premium</th>
<th>Total annual Premium</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Spouse or Same-Sex Domestic Partner Only:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All except JNMS</td>
<td>$1,768</td>
<td>$2,744</td>
<td>$4,512</td>
</tr>
<tr>
<td>JNMS</td>
<td>$1,768</td>
<td>$2,744</td>
<td>$4,512</td>
</tr>
<tr>
<td><strong>Dependent Children Only</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All except JNMS</td>
<td>$883</td>
<td>$1,371</td>
<td>$2,254</td>
</tr>
<tr>
<td>JNMS</td>
<td>$883</td>
<td>$1,371</td>
<td>$2,254</td>
</tr>
<tr>
<td><strong>Spouse or Same-Sex Partner &amp; Children</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All except JNMS</td>
<td>$2,651</td>
<td>$4,115</td>
<td>$6,766</td>
</tr>
<tr>
<td>JNMS</td>
<td>$2,651</td>
<td>$4,115</td>
<td>$6,766</td>
</tr>
</tbody>
</table>
**Dependents of Funded Graduate Students**

Funded graduate students should contact their departmental administrator, financial aid or fellowship offices to determine if their program will pay for a portion of the cost for insuring their dependents prior to enrolling them. If the funding is approved, the students are provided with a confirmation stamp from their department. To enroll their dependents, funded students should download and complete the application and send the stamped copy with their portion of the premium directly to Chickering at the address provided on the application. Online enrollment is not available for funded graduate students because of the additional documentation requirement.

**Coverage for Specific Off-Campus Services Provided through the Health Service Fee**

This coverage is arranged through the Chickering Benefit Planning Insurance Agency, Inc. and is underwritten by Aetna Life Insurance Company, but it is separate from the Columbia Student Medical Insurance Plan. It is available to all students enrolled in the Health Service Program regardless of the type of health insurance plan a student carries. There are limits and restrictions on this special coverage. Please review the full coverage descriptions and procedures for utilizing the benefits at the Health Services website.

For questions about any of these benefits, please contact the Insurance Office at 212-854-7210 or hs-enrollment@columbia.edu.

Coverage is provided for:

- treatment of accidental injury or medical emergencies
  - emergency room care
  - emergency inpatient hospital care
  - physician services related to the treatment of accidental injury or medical emergencies
- elective termination of pregnancy, up to $500
- off-campus mental health services*
- outpatient treatment for chemical abuse*

*Coverage is available only after a referral has been provided by a Counseling and Psychological Services clinician.*
Please see the *Periods of Coverage* section for definitions of the Fall and Spring terms.

**For Students Only**

<table>
<thead>
<tr>
<th>Type of Coverage</th>
<th>Fall Premium</th>
<th>Spring/Summer Premium</th>
<th>Total annual Premium</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic Level of Plan</td>
<td>$553</td>
<td>$848</td>
<td>$1,401</td>
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<tr>
<td>Comprehensive Level of Plan</td>
<td>$790</td>
<td>$1,218</td>
<td>$2,008</td>
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**Changes from 2005-06**

There are improvements in dependent coverage for the 2006-07 policy year. Every year Health Services reevaluates the health insurance being offered, making adjustments and negotiating changes as necessary so as to offer the most cost-effective, appropriate coverage possible.

- **Improved coverage for children from birth through age 19:**
  - Removal of the $50 maximum on coverage for office visits so that 100% of the visits to in-network providers is covered (other than a $25 Copay)
  - Expanded well-child coverage to children ages 2 through 19 (formerly coverage provided up to age 2 only)
  - Inclusion of routine immunizations in coverage for well-child visits. A separate charge will no longer be assessed.

- **Increased plan maximum coverage for all dependents**
  - $300,000 lifetime maximum instead of $60,000 Policy Year maximum
Referral Guidelines

Except in emergencies, a referral from an on-campus Primary Care Medical Services (PCMS) or Counseling and Psychological Services (CPS) clinician is **required** in order to utilize the benefits available under the Columbia Student Medical Insurance Plan for off-campus services. Clinicians at PCMS and CPS provide referrals after evaluation and treatment on-campus has been completed and as the need for outside services is clinically indicated.

- You must obtain the referral from a Health Services provider **prior** to receiving any off-campus medical services, counseling, or psychiatric services. Services rendered without an appropriate referral will not be covered under the Student Medical Insurance Plan.
- You do not need separate referrals each time you see the same provider for an on-going condition.
- If you are injured or become ill while traveling or spending an extended time away from Columbia, you will need to call and speak with your Health Services clinician, who will help you determine what kind of treatment is appropriate.
- When you are not in New York City during semester breaks, holidays, or the summer, you will be covered for primary care, as well as other services, from the Aetna network of providers, as long as you get a referral from your on-campus provider in advance.
- Even with a referral, you will be responsible for a copay and possible additional charges when seeing an off-campus consulting provider.
- Advance consultation with a Health Services clinician is **not** required in a medical emergency.

A referral is **not** required under the following conditions, though your Health Services clinician can assist you in finding appropriate services.

- **Emergency Medical Conditions**, as described in this Brochure. The student must return to Health Services for necessary follow-up care
- Pre-natal and obstetrical care
- Elective termination of pregnancy
- For women age 35-40, one baseline mammogram; one per year thereafter for women age 40 and older. Coverage will be provided more frequently if recommended by a **Physician** for a **Covered Person** who has a prior history of breast cancer or who has a first degree relative with a prior history of breast cancer
- Continuing treatment for a condition established in a prior year under the Columbia Student Medical Insurance Plan
- One annual routine Pap smear screening and office visit; Pap smear screenings are available on campus, where a student pays no copay or deductible. One annual routine Pap smear screening and office visit will also
be covered off-campus without a referral. If additional appropriate testing is performed as part of an off-campus annual Pap smear screening office visit, benefits for the testing will be payable in accordance with the Policy and no referral will be needed.

**The Aetna Network**

After obtaining a referral from a Health Services provider to see a consulting off-campus clinician, you may want to select a *Preferred Provider* from the Aetna network in order to maximize your savings and reduce out-of-pocket expenses. It is to your advantage to utilize a *Preferred Provider* because significant savings can be achieved due to their agreement with Aetna regarding rates of payment for their services. If you elect to receive care from a *Non-Preferred Provider*, any charges in excess of the *Reasonable Charge* allowance will not be covered.

The Student Medical Insurance Plan provides students access to a provider network throughout the country. A partial listing of *Preferred Providers* is available at Health Services, where providers are available to provide suggestions about consulting specialists in Manhattan who understand the needs of Columbia students and are often conveniently located.

Ultimately, however, it is the student's responsibility to make sure the off-campus provider is a *Preferred Provider* in the Aetna network to be eligible for the highest level of benefits. You can visit the Chickering website for a full listing of providers nationwide. Click on "DocFind® ", enter your zip code, and indicate that you belong to an "Open Choice" PPO Plan.

Students can access healthcare for chronic conditions while traveling outside the United States. As Aetna does not maintain a network of providers outside the U.S., services are covered at the *Preferred Provider* rate. Please contact Chickering Claims Administrators, Inc. for more detailed information.

*Preferred Providers* are independent contractors and are neither employees nor agents of Columbia University, Chickering Claims Administrators, Inc., or Aetna.
**General Policy Provisions**

The following provides information regarding General Policy Provisions. Additionally, it should be noted that the Plan will always pay benefits in accordance with any applicable New York State Insurance Laws. Any questions regarding this content should be addressed to Chickering Benefit Planning Insurance Agency, Inc.

**Submitting Claims To Chickering Claims Administrators, Inc.**

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

1. Bills must be submitted to the following address within 90 days from the date of treatment.
2. Payment for *Covered Medical Expenses* will be made directly to the hospital or *Physician* concerned unless bill receipts and proof of payment are submitted.
3. In the event of a disagreement over the payment of a claim, a written request to review the claim must be mailed to Chickering Claims Administrators, Inc. within 60 days from the date appearing on the Explanation of Benefits.

**Appealing a Claim**

**Complaint and Appeals Procedure**

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

The complaints and appeals process is designed to address coverage issues, complaints and problems. If you have a coverage issue or other problem, call Chickering Customer Services at 1-800-859-8471. A representative will address your concern. If you are dissatisfied with the outcome of the initial contact, the decision may be appealed.

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

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

For purposes of the following section, the term “you” pertains to the *Covered Person*, including students as well as covered dependents.

**Internal Appeals Procedure**

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

Aetna has established a procedure for resolving appeals. If you have an appeal, please follow this procedure:
First Level Appeals Procedure

- An Appeal must be submitted to Aetna within 180 days of the date Aetna provides notice of denial. The address is on your ID Card. The Appeal may be submitted by you, or by a representative as designated by you.
- You may submit an oral grievance in connection with:
  - A denial of, or failure to pay for, a referral; or
  - A determination as to whether a benefit is covered under this Plan.

You may do this by calling Customer Services. The Customer Services telephone number is on your ID Card. If you are required to leave a recorded message, your message will be acknowledged within one business day after the call was recorded.

Aetna will summarize the nature of the grievance in writing. You will be required to sign a written acknowledgement of the grievance. Such acknowledgement will be mailed promptly to you. You must sign and return the acknowledgement, with any amendments, in order to initiate the grievance. Upon receipt of the signed acknowledgement, the process below will be followed:
- An acknowledgment letter will be sent to you within 1 day of Aetna’s receipt of an oral Appeal and within 5 days of Aetna’s receipt of a written Appeal. This letter may request additional information. If so, the additional information must be submitted to Aetna within 15 days of the date of the letter.
- You will be sent a response within 30 days of Aetna’s receipt of the Appeal. The response will be based on the information provided with, or subsequent to, the Appeal.
- If the Appeal concerns an eligibility issue, and if additional information is not submitted to Aetna after receipt of Aetna’s response, the decision is considered Aetna’s final response 45 days after receipt of the Appeal. For all other Appeals, if additional information is to be submitted to Aetna after receipt of Aetna’s response, it must be submitted within 15 days of the date of Aetna’s response letter.
- Aetna’s response will be sent within 30 days from the date of Aetna’s first response letter.

In any urgent or emergency situation, the Expedited Appeal procedure may be initiated by a telephone call to Customer Services. The Customer Services telephone number is on your ID Card. A verbal response to the Appeal will be given to you and to your provider within 2 days provided that all necessary information is available. Written notice of the decision will be sent within 2 business days of Aetna’s verbal response.
Second Level Appeals Procedure
If you are dissatisfied with Aetna’s grievance determination, you or a representative designated by you may submit a written appeal within 60 business days after receipt of such determination.

- An acknowledgement letter will be sent to you within 15 days of Aetna’s receipt of the written appeal. This letter may request additional information. If so, the additional information must be submitted to Aetna within 15 days of the date of the letter.
- Aetna’s final response for an urgent or emergency situation will be sent within 2 business days. For all other situations, a response will be sent within 30 business days from the date of Aetna’s receipt of all necessary information.

If additional time is needed to resolve an Appeal, except in an urgent or emergency situation, Aetna will provide a written notification indicating that additional time is needed, explaining why such time is needed and setting a new date for a response. The additional time will not be extended beyond another 30 days.

You must exhaust the Internal Appeals Procedure before requesting an External Appeal. However, you are not required to exhaust the Internal Appeals Procedure prior to requesting an External Appeal, if you and Aetna have agreed that the matter may proceed directly to an External Appeal.

Aetna will keep the records of your complaint for 3 years.

External Appeal
Right to an External Appeal
Under certain circumstances you have a right to an external appeal of a denial of coverage. Specifically, if Aetna has denied coverage on the basis that the service is not necessary or is an experimental or investigational treatment, you may appeal that decision to an External Appeal Agent, an independent entity certified by the State, to conduct such appeals.

Right to Appeal a Determination That a Service is Not Necessary
If Aetna has denied coverage on the basis that the service is not necessary you may appeal to an External Appeal Agent if you satisfy the criteria listed below:

- The service, procedure, or treatment must otherwise be a Covered Medical Expense under this Plan; and
- You must have received a final adverse determination through the first level of the internal review process and Aetna must have upheld the denial or you and Aetna must agree in writing to waive any internal appeal.
Right to Appeal Determination That a Service is Experimental or Investigational

If you have been denied coverage on the basis that the service is an experimental or investigational treatment, you must satisfy the following criteria:

- The service must otherwise be a Covered Medical Expense under this Plan; and
- You must have received a final adverse determination through the first level of the internal appeal process and Aetna must have upheld the denial or you and Aetna must agree in writing to waive any internal appeal.

In addition, your attending Physician must certify that you have a life-threatening or disabling condition or disease. A “life-threatening condition or disease” is one which, according to the current diagnosis of the attending Physician, has a high probability of death. A “disabling condition or disease” is any medically determinable physical or medical impairment that can be expected to result in death or that has lasted, or can be expected to last, for a continuous period of not less than 12 months which renders you unable to engage in any substantial gainful activities. In the case of a dependent child under the age of 18, a “disabling condition or disease” is any medically determinable physical or mental impairment of comparable severity.

Your attending Physician must also certify that the life-threatening or disabling condition or disease is one for which standard health services are ineffective, or medically inappropriate, or one for which there does not exist a more beneficial standard service or procedure covered under this Plan, or one for which there exists a clinical trial (as defined by law).

In addition, your attending Physician must have recommended at least one of the following:

- A service, procedure, or treatment that two documents from available medical and scientific evidence indicate is likely to be more beneficial to you than any standard Covered Medical Expense (only certain documents will be considered in support of this recommendation—your attending physician should contact the State in order to obtain current information as to what documents will be considered acceptable); or
- A clinical trial for which you are eligible (only certain clinical trials can be considered).

For the purposes of this section, your attending Physician must be a licensed, board certified, or board eligible Physician, qualified to practice in the area appropriate to treat your life-threatening or disabling condition or disease.
The External Appeal Process

If, through Aetna’s internal appeal process, you have received a final adverse determination upholding a denial of coverage on the basis that the service is not necessary or is an experimental or investigational treatment, you have 45 days from receipt of such notice to file a written request for an external appeal. If you and Aetna have agreed to waive any internal appeal, you have 45 days from the receipt of such waiver to file a written request for an external appeal. Aetna will provide an external appeal application with the final adverse determination issued through Aetna’s internal appeal process or its written waiver of an internal appeal.

You may also request an external appeal application from the New York State Department of Insurance at 1-800-400-8882. The completed application must be submitted to the New York State Department of Insurance at the address listed in the application. If you satisfy the criteria for an external appeal, the State will forward the request to a certified External Appeal Agent.

You will have the opportunity to submit additional documentation with the request. If the External Appeal Agent determines that the information you submit represents a material change from the information on which Aetna based its denial, the External Appeal Agent will share this information with Aetna in order for it to exercise its right to reconsider its decision. If Aetna chooses to exercise this right, Aetna will have 3 business days to amend or confirm its decision. Please note that in the case of an expedited appeal (described below), Aetna does not have a right to reconsider its decision.

In general, the External Appeal Agent must make a decision within 30 days of receipt of the completed application. The External Appeal Agent may request additional information from you, your physician, or Aetna. If the External Appeal Agent requests additional information, it will have 5 additional business days to make its decision. The External Appeal Agent must notify you in writing of its decision within 2 business days.

If your attending Physician certifies that a delay in providing the service that has been denied poses an imminent or serious threat to your health, you may request an expedited external appeal. In that case, the External Appeal Agent must make a decision within 3 days of receipt of the completed application. Immediately after reaching a decision, the External Appeal Agent must try to notify you and Aetna by telephone or facsimile of that decision. The External Appeal Agent must also notify you in writing of its decision.

If the External Appeal Agent overturns Aetna’s decision that a service is not necessary, or approves coverage of an experimental or investigational treatment, Aetna will provide coverage subject to the other terms and conditions of this Plan. If the External Appeal Agent approves coverage of an experimental or investigational treatment that is part of a clinical trial, Aetna will only cover the
costs of services required to provide treatment to you according to the design of the trial. Aetna shall not be responsible for the costs of investigational drugs or devices, the costs of non-health care services, the costs of managing research, or costs which would not be covered under this Plan for non-experimental or non-investigational treatments provided in such clinical trial.

The External Appeal Agent’s decision is binding on both you and Aetna. The External Appeal Agent’s decision is admissible in any court proceeding.

You will be charged a fee of $50 for an external appeal. The external appeal application will instruct you on the manner in which you must submit the fee. Aetna will also waive the fee if Aetna determines that paying the fee would pose a hardship to you. If the External Appeal Agent overturns the denial of coverage, the fee shall be refunded to you.

Responsibilities
It is your responsibility to initiate the external appeals process. You may initiate the external appeal process by filing a completed application with the New York State Department of Insurance. If the requested service has already been provided to you, your attending Physician may file an expedited appeal application on your behalf, but only if you have consented to this in writing.

Under New York State law your completed request for appeal must be filed within 45 days of either the date upon which you receive written notification from Aetna that it has upheld a denial of coverage or the date upon which you receive a written waiver of any internal appeal. Aetna has no authority to grant an extension of this deadline.

Covered Services and Exclusions
In general, this Plan does not cover experimental or investigational treatments. However, this Plan shall cover an experimental or investigational treatment approved by an External Appeal Agent in accordance with this section. If the External Appeal Agent approves coverage of an experimental or investigational treatment that is part of a clinical trial, Aetna will only cover the costs of services required to provide treatment to you, according to the design of the trial. Aetna shall not be responsible for the costs of investigational drugs or devices, the costs of non-health care services, the costs of managing research, or costs which would not be covered under this Plan for non-experimental or non-investigational treatments provided in such clinical trial.
Prescription Drug Claim Procedure

Preferred Care

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

When you need to fill a prescription and do not have your ID card with you, you may obtain your Prescription from an Aetna Preferred Pharmacy and be reimbursed by submitting a completed Aetna Prescription Drug claim form. A claim form is available at Chickering’s website, Health Services or by calling Aetna Pharmacy Management at (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.chickering.com/columbiadirect.html.

Non-Preferred Pharmacy

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-Preferred Pharmacy.

Claim forms, pharmacy locations, and claims status information can be obtained by contacting Aetna Pharmacy Management at (800)-238-6279. Additionally, a listing of pharmacy locations can be obtained online at: www.chickering.com/columbiadirect.html.

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

Patient Management Program

Aetna evaluates and determines the appropriateness of medical care resources utilized by our members. To accomplish these goals, Aetna has developed a comprehensive Patient Management Program. 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. Aetna’s patient management staff uses national guidelines and resources to guide the pre-certification, concurrent review, and retrospective review processes.
**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 Chickering.

Such Pre-Certification must be obtained before care is received, or in the case of an emergency admission, procedure, or treatment, within 1 business day after the start of a confinement as a full-time inpatient or the performance of the procedure or treatment, or as soon as reasonably possible.

**Concurrent Review**

The concurrent review process assesses the necessity for continued stay, level of care, and quality of care for members 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 member 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 members includes the retrospective review of claims submitted for payment, and medical records submitted for potential quality and utilization concerns.

**Coordination of Benefits**

If a student who enrolls in the Student Medical Insurance Plan is insured under more than one group health plan, the benefits provided through the Student Medical Insurance Plan will be used before those of a plan that provides coverage to the student as a dependent.

When both parents have group health plans that provide coverage to the student as a dependent, the benefits of the plan of the parent whose birth date falls earlier in the year will be used first. The benefits available under the Student Medical Insurance Plan may be coordinated with other benefits available to the student and/or dependents (if enrolled) under any auto insurance, Workers' Compensation, Medicare, or other coverage. The Plan pays in accordance with the rules set forth in the Policy.
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.

Termination of Insurance

Benefits are payable under the Policy only for those Covered Medical Expenses incurred while the Policy is in effect for the Covered Person. No benefits are payable for any expenses incurred after the date the insurance terminates for the Covered Person, except as may be provided under the extension of benefits or for a pregnancy which commenced during the term insured. (See the Extension of Benefits After Termination section.)

Extension of Benefits After Termination

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

Benefits will continue to be available for a Covered Person who incurs medical expenses directly relating to a pregnancy that began before coverage under the Policy ceased. This benefit will be covered only for the period of the pregnancy.

Refund Policy

Except for a medical withdrawal from Columbia due to an Accident or Sickness that would be covered by the Student Medical Insurance Plan, any student withdrawing from school during the first 31 days of the period for which coverage is purchased shall not be covered under the policy, and a full refund of the value of the premium will be applied to the student's Student Account Statement.

Students withdrawing after 31 days will remain covered under the Policy for the full period for which the premium has been paid. Under these circumstances, no refund will be allowed.

A Covered Person entering the armed forces of any country will not be covered under the Student Medical Insurance Plan as of the date of such entry. A pro rata refund of the premium will be made for such person and any covered dependents, upon receipt of a written request by Chickering Claims Administrators, Inc., within 90 days of withdrawal.
Withdrawal from Classes Due to Medical Leave

If a student qualifies for a medical leave of absence within 30 days of the official start of the semester, charges on their Student Account Statement for the Health Services Fee and Student Medical Insurance Plan premium will be reversed.

Those who wish to maintain Student Medical Insurance Plan coverage must first obtain a letter from the appropriate Dean indicating that they are on an approved medical leave of absence. The student must then visit the Health Services Insurance Office in John Jay Hall and provide two separate payments: one for the Health Service Fee and one for the Student Medical Insurance Plan premium.

Students who withdraw from classes due to an approved medical leave of absence after 30 days of the official start of the semester will continue to be covered under the Student Medical Insurance Plan for the remainder of that semester only. In order to continue coverage for the next semester, the student will need to proceed as described above.

Limitations on Coverage

Pre-Existing Conditions

Limitations on coverage of Pre-Existing Conditions will apply to students, and their covered dependents, who elect coverage more than 30 days after the date they become eligible for coverage under the Columbia Student Medical Insurance Plan. For these late applicants, expenses incurred as a result of a pre-existing condition will not be considered covered expenses unless no charges are incurred for treatment of the condition for a period of 6 months while covered under the Plan.

Special Rules Regarding Pre-Existing Conditions

If a person had alternative insurance coverage which terminated within 63 days prior to the date he or she enrolled (or was enrolled) in the Columbia Student Medical Insurance Plan, then any limitation as to a Pre-Existing Condition under this Plan will apply for that person only to the extent that such limitation would have applied if he or she had remained covered under the prior Creditable Coverage. Please see definition of Creditable Coverage in the Terms to Know section.

Also, if a person enrolls (or is enrolled) in this Plan immediately after any applicable probationary period has been served, and that person had Creditable Coverage which terminated within 63 days prior to the first day of such probationary period, then any limitation as to a Pre-Existing Condition will apply for that person only to the extent that such limitation would have applied if he or she had remained covered under the prior Creditable Coverage. The waiting period for Pre-Existing Conditions will have been met if the individual has been continuously insured under the Columbia Student Medical Insurance Plan or another comparable plan for at least 12 consecutive months.
Example:
If a student enrolls as a late applicant in the Plan effective October 1, 2006 and seeks treatment for diabetes after that date, treatment would not be covered if the student were diagnosed and/or had treatment between March 31, 2006 and September 30, 2006 of that year.

Covered claims related to the diabetes condition would be covered after October 1, 2007 provided the insured maintains continuous coverage.

Treatment for Pre-Existing Conditions is provided on-campus through Health Services. If additional treatment off-campus is needed for a Pre-Existing Condition, the additional treatment would not be covered until the established waiting period has elapsed. Treatment for a new, covered illness connected with a Pre Existing Condition will be covered, within Policy maximums.

Example:
If you have a Pre-Existing Condition of hypertension, but suffer an allergic reaction to drugs prescribed for hypertension after enrollment in the Plan, treatment of the allergic reaction would be covered.

Continuously Insured
A person is considered continuously insured if they were insured under prior Creditable Coverage, including the Columbia Student Medical Insurance Plan, and are now insured under the Plan. Persons who have remained continuously insured will be covered for conditions first manifesting themselves while continuously insured except as specified in the Pre-Existing Conditions provision.

Previously insured dependents and students must re-enroll for coverage for the Fall Term by September 30, 2006 and for the Spring Term by February 1, 2007 in order to avoid a break in coverage for conditions that existed in prior Policy Years. Once a break in continuous coverage occurs, the definition of Injury or Sickness will apply in determining coverage of any condition that existed during the break.

Policy Exclusions
The Plan neither covers nor provides benefits for the following:

1. Pre-Existing Conditions under the Basic Accident and Sickness Benefit for dependents; and under the Comprehensive Accident and Sickness Benefit for students and dependents, until the individual has been continuously insured under the Columbia Student Medical Insurance Plan or comparable coverage for more than 12 months.

2. Expenses incurred as a result of dental treatment, except for:
   (a) Injury to sound, natural teeth
   (b) Extraction of impacted wisdom teeth as provided elsewhere in the Policy
3. Expenses incurred for services normally provided without charge by the Policyholder’s health service, infirmary, hospital, or by health care providers employed by the Policyholder.

4. Expenses incurred for eye refractions, vision therapy, radial keratotomy (except as medically necessary), eyeglasses, contact lenses (except when required after cataract surgery) or other vision or hearing aides, or prescriptions or examinations except as required for repair caused by a covered Injury.

5. Expense incurred for cosmetic surgery; reconstructive surgery; or other services and supplies which improve; alter; or enhance appearance; whether or not for psychological or emotional reasons.
   
   *This exclusion does not apply to reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered dependent child which has resulted in a functional defect.*

6. 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.

7. 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.

8. 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.

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

10. Expenses incurred for treatment provided in a governmental hospital unless there is legal obligation to pay such charges in the absence of insurance.

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

12. Expenses incurred for preventative medicines, sera, vaccines, or oral contraceptives, unless otherwise provided in the Policy.

13. Expense for contraceptive methods; devices or aids; and charges for services and supplies for or related to gamete intrafallopian transfer; artificial insemination; in-vitro fertilization (except as required by the state law); or embryo transfer procedures; elective sterilization or its reversal; or elective abortion; unless specifically provided for in this Policy.

14. 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.

15. Expenses incurred 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 are specifically provided in the Policy.

16. Expenses incurred for any services rendered by a member of the *Covered Person's* immediate family.

17. Expenses incurred for services normally provided without charge by the school and covered by the school fee for services.
18. Expenses incurred for custodial care. Custodial care means services and supplies furnished to a person mainly to help him or her in the activities of daily life. This includes room and board and other institutional care. The person does not have to be disabled. Such services and supplies are custodial care without regard to:
   - By whom they are prescribed;
   - By whom they are recommended, or;
   - By whom or by which they are performed.

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

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

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

   • The disease can be expected to cause death within one year; in the absence of effective treatment; and
   • The care or treatment is effective for that disease; or shows promise of being effective for that disease; as demonstrated by scientific data. In making this determination; Aetna will take into account the results of a review by a panel of independent medical professionals. They will be selected by Aetna. This panel will include professionals who treat the type of disease involved.

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

   • Have been granted treatment investigational new drug (IND); or Group c/treatment IND status; or
   • Are being studied at the Phase III level in a national clinical trial; sponsored by the National Cancer Institute; or
Are recognized for treatment of the specific type of cancer for which the drug has been prescribed in one of the following reference compendia:

- The American Medical Association Drug Evaluations;
- The American Hospital Formulary Service Drug Information; or
- The United States Pharmacopeia Drug Information; or
- Recommended by review article or editorial comment in a major peer reviewed professional journal; or

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

20. 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).

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

22. Expense for charges that are not Reasonable Charges, as determined by Aetna.

23. 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.

24. 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.

25. Expense for services or supplies provided for the treatment of obesity and/or weight control.

26. Expense for injuries sustained as the result of a motor vehicle accident; to the extent that benefits are payable under other valid and collectible insurance; whether or not claim is made for such benefits. The Policy will only pay for those losses; which are not payable under the automobile medical payment insurance Policy.

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

While the paper directory of providers (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 for the most current provider listings.

Participating Providers are independent contractors in private practice and are neither employees nor agents of Aetna, Columbia University, or Chickering Claims Administrators, Inc. The availability of any particular provider cannot be guaranteed for referred or in-network benefits, and provider network composition is subject to change without notice.

Certain primary care physicians may be affiliated with an Independent Practice Association (IPA), a Physician Medical Group (PMG), an integrated delivery system, or one of other provider groups.

Not every provider listed in the directory will be accepting new patients. Although Aetna has identified providers who were 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 Chickering.

In the event of a problem with coverage, members should contact Chickering on how to utilize the complaint and appeal procedure when appropriate. All member 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.

Provider Reimbursement

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

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

Aetna Pharmacy Management negotiates discounts from independent pharmacies, chain pharmacies that participate in the Aetna network. The reimbursement formula is based on Average Wholesale Price (AWP) less a negotiated discount, plus a dispensing fee. The dispensing fee is a contractual fee negotiated between Aetna Pharmacy Management and the network pharmacy.

You can conduct an on-line search for Participating Pharmacies through DocFind®, which is available through www.chickering.com/columbiadirect.html. A paper directory is also available to members.
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.

**Notice Regarding Type of Coverage Offered**

The Student Medical Insurance Plan provides limited benefits for health insurance ONLY. It does NOT provide basic hospital, basic medical, major medical insurance, Medicare supplement, long-term care insurance, nursing home insurance only, home health care insurance only, or nursing home and home health care insurance as defined by the New York State Insurance Department.

The insurance policy itself sets forth the rights and obligations of both you and the insurance company. It is therefore important that you READ ALL INFORMATION carefully. Please refer to this site as it outlines the provisions of the Master Policy. No individual policies will be issued.

**Notice Regarding Nonpublic Personal Information**

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, Aetna uses personal information internally, shares it with affiliates, and discloses 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 Aetna to use and disclose this information as described above on behalf of yourself and your dependents. To obtain a copy of Aetna's Notice of Privacy Practices describing in greater detail practices concerning use and disclosure of personal information, please call the toll-free Customer Services number on your ID card or visit Chickering's website at [www.chickering.com](http://www.chickering.com).
**Terms to Know**

The following terms are used throughout this Brochure. These will assist in your understanding of the Columbia Student Medical Insurance Plan and the application of the benefits available.

**Accident**
An occurrence which is:
- Unforeseen; and,
- Is not due to, or contributed to by, a Sickness or disease of any kind; and,
- Causes Injury.

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

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

**Brand Name Prescription Drug or Medicine**
A **Prescription Drug** that is protected by trademark registration.

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

**Copay**
The amount that must be paid by the **Covered Person** at the time services are rendered by a **Preferred Provider**. Copay amounts are the responsibility of the **Covered Person**. (Please note that the copay amount will not be reimbursed by Chickering Claims Administrators, Inc.)

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

**Covered Person**
A covered student or dependent whose coverage is in effect under the Policy. See the **Eligibility** sections of this Brochure for additional information.
Creditable Coverage
A person's prior medical coverage as defined in the Federal Health Insurance Portability and Accountability Act (HIPAA) of 1996. Such coverage includes the following:

- Coverage issued on a group or individual basis
- Medicare
- Medicaid
- Military-sponsored health care
- A program of the Indian Health Service
- A state health benefits risk pool
- The Federal Employees' Health Benefit Plan (FEHBP)
- A public health plan as defined in the regulations
- Any health benefit plan under Section 5(e) of the Peace Corps Act

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

Emergency Medical Condition
A medical or behavioral condition, the onset of which is sudden, and manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the person afflicted with such a condition in severe jeopardy, or, in the case of a behavioral condition, placing the health of such person or others in serious jeopardy.
- Serious impairment to such person's bodily functions
- Serious dysfunction of any bodily organ or part of such person
- Serious disfigurement of such person

It does not include elective care, routine care, or care for a non-emergency Sickness.
Generic Prescription Drug or Medicine
A Prescription Drug that is not protected by trademark registration but is produced and sold under the chemical formulation name.

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

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

• Be care or treatment which is likely to produce as significant positive outcome as any alternative service or supply, both as to the Sickness or Injury involved and the person’s overall health condition. It must be no more likely to produce a negative outcome than any alternative service or supply, both as to the Sickness or Injury involved and the person's overall health condition.

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

• As to diagnosis, care, and treatment, be no more costly (taking into account all health expenses incurred in connection with the treatment, service, or supply) than any alternative service or supply to meet the above tests.

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

• Information relating to the affected person's health status
• Reports in peer reviewed medical literature
• Reports and guidelines published by nationally recognized health care organizations that include supporting scientific data
• Generally recognized professional standards of safety and effectiveness in the United States for diagnosis, care, or treatment
• The opinion of health professionals in the generally recognized health specialty involved; and
• Any other relevant information brought to Aetna's attention.
In no event will the following services or supplies be considered to be *Medically Necessary*:

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

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

**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:

- The service or supply could have been provided by a *Preferred Care Provider*, and
- The provider is of a type that falls into one or more of the categories of providers 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* with Aetna.

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

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

**Physician**
A legally qualified Physician licensed by the state in which he/she practices, and any other practitioner who must by law be recognized as a doctor legally qualified to render treatment.
Pre-Existing Condition
Any Injury, Sickness, or condition for which medical advice, diagnosis, or treatment was recommended or received within 6 months prior to the Covered Person’s effective date of insurance. If a student has continuous coverage under the Columbia University Student Medical Insurance Plan from one year to the next, an Accident or Sickness that first manifests itself during a prior year’s coverage shall not be considered a Pre-Existing Condition.

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

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

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

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

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

- The provider’s usual charge for furnishing it
- 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
- 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, 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:

- complexity
- degree of skill needed
- type of specialty of the provider
- range of services or supplies provided by a facility
- 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.
Enrollment in the Columbia Student Medical Insurance Plan

Enrollment Deadlines for the Plan

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<tr>
<th>Semester</th>
<th>Deadline</th>
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<tr>
<td>Fall</td>
<td>September 30, 2006</td>
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<td>Spring (new students only)</td>
<td>February 1, 2007</td>
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<tr>
<td>Summer (new trimester students only)</td>
<td>June 14, 2007</td>
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Students have the opportunity to enroll in the Columbia Student Medical Insurance Plan at the beginning of the first semester of their academic career and at the start of each academic year thereafter.

Full-Time and Residential Students
All registered full-time and residential students are automatically enrolled in the Basic level of the Plan if no valid waiver request is submitted. Full-time students must confirm any specific insurance selection every year by actively enrolling in the Basic or Comprehensive level of the Plan or by requesting a waiver of automatic enrollment in the Columbia Student Medical Insurance Plan and demonstrating coverage under another comparable policy.

Students may choose to upgrade to the Comprehensive level of the Plan by indicating their choice through the insurance selection website accessible from the Health Services website by the specified deadline. Students at Columbia’s affiliates (Jewish Theological Seminary, Teachers College, and Union Theological Seminary) must follow their school’s enrollment process.

Enrollment in the Columbia Student Medical Insurance Plan, either by automatic enrollment or online selection, is effective only upon the student's registration for the term for which coverage will be active.

Once the student's insurance coverage decision has been determined for the Fall term, either by automatic enrollment, online selection, or waiver request, that decision will automatically be continued in the following Spring term as long as the student remains registered at the University. It is not possible to upgrade or downgrade the level of coverage in the Spring.

Part-Time Students
Part-time students may choose to enroll in the Columbia Student Medical Insurance Plan. Enrolling in the plan will automatically initiate enrollment in the Health Service Program, which is required. Please visit the Health Services website for more information about on-campus services and the Health Services Fee. Part-time students who have been insured under the Plan in previous years and wish to enroll again must re-enroll by September 30, 2006 in order to avoid a break in coverage for conditions that existed in the prior policy years. Please visit the Health Services or Chickering websites’ Limitations on Coverage sections for more information about breaks in coverage and pre-existing conditions.
**Funded Graduate Students**

Please contact your departmental administrator, Financial Aid Office, or Fellowship Office for information about whether your school provides funding to cover any portion of the Student Medical Insurance Plan premium.

**Students Studying Abroad**

Students expecting to participate in any Study Abroad program should consult with an Insurance Specialist at Health Services about the type of insurance coverage the student will rely on while traveling. All registered full time students are automatically enrolled in the Basic Level of the Plan if no valid waiver request is submitted and approved. Full time students must confirm their insurance selection each year by actively enrolling the Basic or Comprehensive Level of the Plan or by requesting a waiver of automatic enrollment in the Columbia Student Medical Insurance Plan and demonstrating coverage under another comparable policy.

**How to Enroll**

To confirm automatic enrollment in the Basic level of the Plan (full-time students), to request enrollment in the Basic level (part-time students), or to enroll in the Comprehensive level of the Plan (all students), a student must enter the confirmation or request by indicating their choice through the insurance selection website accessible from the Health Services website by the specified deadline. Students at Columbia’s affiliates (Jewish Theological Seminary, Teachers College, and Union Theological Seminary) must follow their schools’ procedures.

**Insurance ID Cards**

Coverage for most students begins on September 1, 2006. (For specific dates applicable to your academic program and registration term, see page 6 of this brochure entitled “Periods of Coverage.”)

Most services are available to students enrolled in the Columbia Student Medical Insurance Plan without the use of an ID card. The card provides proof that you are enrolled in an insurance plan and may make accessing certain services easier. You can expedite receipt of your card by actively confirming your automatic enrollment in the Basic level of the Plan or by enrolling in the Comprehensive level of the Plan prior to the deadline. After your online selection has been entered, a card is normally issued within 14 days. Students who are automatically enrolled in the plan will receive an identification card from Aetna in the third week of October.

Please be sure to note that if you utilize the Columbia Student Medical Insurance Plan benefits (for prescription coverage, specialist services, etc.) before the enrollment/waiver period has ended, it will no longer be possible to change your mind about being enrolled in the Columbia Student Medical Insurance Plan.

Replacement insurance ID cards may be ordered by selecting the “Aetna Navigator” option on the Chickering website.
Requesting a Waiver of Automatic Enrollment in the Columbia Student Medical Insurance Plan

Waiver Request Submission Deadlines

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Criteria for comparable Alternate Health Insurance Coverage

Students interested in requesting a waiver of automatic enrollment in the Columbia Student Medical Insurance Plan must document comparable coverage in another insurance plan. Please review your alternate coverage carefully to determine if it is appropriate. Your alternate coverage must meet at least the following six criteria:

1. My plan provides coverage for medically necessary care while I am in New York City or traveling or studying in the United States or abroad.

2. The maximum benefit for my coverage is at least $300,000 per lifetime.

3. My coverage will remain in force as long as I am a registered student, including approved leave of absence for medical reasons and non-degree status at Columbia University.

4. As of September 1, 2006 (January 16, 2007 for new Spring enrollees and June 1, 2007 for new summer enrollees) my plan will cover me for any pre-existing condition.

5. My plan covers the following types of care: treatment for injuries resulting from the practice or play of athletics, inpatient psychiatric care, and treatment for inpatient chemical dependency.

6. My coverage is provided by a company licensed to do business in the United States, with a U.S. based claims payment office and U.S. telephone number.

Students requesting a waiver of automatic enrollment in the Columbia Student Medical Insurance Plan must also provide specific information identifying the insurance carrier and primary subscriber for the proposed alternate coverage. The specific information required is described at the Health Services website and can be found on the insurance ID card for the alternate plan or in other policy documents provided by the carrier of the entity sponsoring the plan.

The University reserves the right to verify the insurance information you have provided. If you have not provided sufficient information to allow verification of your coverage, or if your plan does not meet the stated requirements, you are under insured and you may be automatically enrolled in the Basic Level of the insurance plan and charged for the premium.
Graduate Students in Special Categories

For graduate students in the following categories only, a waiver of participation in the Plan automatically generates a waiver of the Health Service Fee:

- Registering solely to defend a dissertation
- Registering for Matriculation and Facilities (M&F), Extended Residence (ER), or MFA Research
- Registering for the Journalism full-time research or full-time special research programs

To preserve enrollment in Health Services at Columbia only, the student must complete an enrollment form available in the Insurance Office in addition to making the online waiver request.

How to Submit a Waiver Request

To request a waiver of automatic enrollment in the Columbia Student Medical Insurance Plan, the student must submit an online request at the insurance selection website accessible from the Health Services website by the specified deadline. **All online requests are considered but are not guaranteed approval.** It's recommended that you print a copy of your confirmation for your records. The confirmation documents the date and time of your request and a transaction number.

If enrollment in the Columbia Student Medical Insurance Plan has been waived for the Fall term the waiver will automatically be extended to the Spring term unless a significant life change occurs which warrants enrollment. Some examples of significant life changes are termination of insurance coverage under a partner's or employer's benefit plan, or surpassing the maximum age for coverage as a dependent under a parent's plan. Late requests for enrollment will be reviewed upon receipt of documentation of such a change.

Because students' alternate insurance coverage may change, students wishing to request a waiver of automatic enrollment in the Columbia Student Medical Insurance Plan must submit a new waiver request by September 30 of each year in which the student is registered.

Students at Columbia's affiliates (Jewish Theological Seminary, Teachers College, and Union Theological Seminary) must follow their schools' procedures.
Member Information Website

Questions? Get Answers with Chickering’s Aetna Navigator™
As a member of the Columbia Student Medical Insurance Plan, you have access to Aetna Navigator™, your secure member website, providing personalized benefits and health information. You can take full advantage of this interactive website to complete a variety of self-service transactions online.

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

How do I access the Aetna Navigator™?
• Go to www.chickering.com
• Click on "Find Your School."
• Enter your school name and then click on "Search."
• Click on Aetna Navigator and then the "Access Navigator" link.
• Follow the instructions for First Time User by clicking on the “Register Now” link.
• Select a user name, password and security phrase.

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

Need help with access to Aetna Navigator™?
Setup assistance is available toll free, Monday through Friday, from 7 a.m. to 9 p.m. Eastern Time at 1-800-225-3375.
Columbia University’s Student Medical Insurance Plan is offered by:

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

Administered by:

Chickering Claims Administrators, Inc.
P.O. Box 15708
Boston, MA 02215-0014
(800) 859-8471

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