The Portland State University student health insurance plan is underwritten by Aetna Life Insurance Company (Aetna) and administered by Chickering Claims Administrators, Inc. (CCA). Aetna Student HealthSM is the brand name for products and services provided by Aetna and CCA and their applicable affiliated companies.
Your student health insurance coverage, offered by Aetna Student Health*, may not meet the minimum standards required by the health care reform law for the restrictions on annual dollar limits. The annual dollar limits ensure that consumers have sufficient access to medical benefits throughout the annual term of the policy. Restrictions for annual dollar limits for group and individual health insurance coverage are $2 million for policy years beginning on or after September 23, 2012 but before January 1, 2014. Restrictions for annual dollar limits for student health insurance coverage are $500,000 for policy years beginning on or after September 23, 2012, but before January 1, 2014. Your student health insurance coverage includes an annual limit of $500,000 on all covered services including Essential Health Benefits. Other internal maximums (on Essential Health Benefits and certain other services) are described more fully in the benefits chart included inside this Plan summary. If you have any questions or concerns about this notice, contact (877) 850-6062. Be advised that you may be eligible for coverage under a group health plan of a parent’s employer or under a parent’s individual health insurance policy if you are under the age of 26. Contact the plan administrator of the parent’s employer plan or the parent’s individual health insurance issuer for more information.

The Portland State University sponsored Student Health Insurance plan has met all minimum standards for the 2013-2014 plan year as required by Health and Human Services and is fully compliant with health care reform for plans beginning prior to 9/23/2013.

**WHEN COVERAGE BEGINS**

Insurance under the Policy will become effective at 12:01 a.m. on the later of:

✓ The Policy effective date;
✓ The beginning date of the term for which premium has been paid;

**IMPORTANT NOTICE - Premiums will not be pro-rated if the Insured enrolls past the first date of coverage for which he or she is applying. Final decisions regarding coverage effective dates are made by Aetna Student Health.**

The below enrollments will be allowed a 14 day grace period from the term start date to enroll whereby the effective date will be backdated a maximum of 14 days. No policy shall ever start prior to the term start date:

1. All hard-waiver mandatory (insurance is required as a condition of enrollment on campus) enrollments received prior to the Drop Deadline given on p. 3 of this Brochure. Any enrollments received thereafter will not be backdated.
2. All direct enrollments into the same exact policy if re-enrollment occurs within 14 days of the prior policy termination date.

**WHEN COVERAGE ENDS**

Insurance of all Insured Persons terminates at 12:01 a.m. on the earlier of:

✓ Date the policy terminates for all Insured Persons; or
✓ End of the period of coverage for which premium has been paid; or
✓ Date the Insured Person ceases to be eligible for the insurance; or
✓ Date the Insured Person enters military service.

Dependent coverage will not be effective prior to that of the Insured Student or extend beyond that of the Insured Student.

**COVERAGE IS NOT AUTOMATICALLY RENEWED. Eligible Persons must re-enroll when coverage terminates to maintain coverage. NO notification of plan expiration or renewal will be sent.**

**IMPORTANT**

This is just a brief description of your benefits. For a full summary of the plan including refund requests, how to file a claim, mandated benefits and other important information, please visit [wfis.wellsfargo.com/psu](http://wfis.wellsfargo.com/psu) to view the complete PSU Student Health Insurance Brochure underwritten by Aetna Life Insurance Company.
HEALTH INSURANCE REQUIREMENT AND ELIGIBILITY

DOMESTIC STUDENTS - All registered domestic students taking 5 or more in-load, non-self-support* Portland State University (PSU) credit hours or more during Fall, Winter and Spring/Summer combined terms are automatically enrolled in the PSU-sponsored Student Health Insurance Plan unless they choose to submit an online insurance waiver of comparable coverage. Eligible students will be charged a Health Insurance Fee of $594 for each of the following terms by the posted Drop Deadlines of each term. Students only need one approved waiver per academic year. All students who have the student health insurance plan during Spring term 2014, will be covered until 12:01 am of September 20, 2014, regardless of summer credit hours. This means that if you have paid the Spring/Summer combined charge, you will have continuous coverage throughout the Summer term, regardless of taking classes, traveling, or graduating. Please check the website for updates on the summer insurance charges if Summer 2014 is the domestic student’s first term at PSU: www.pdx.edu/shac.

If you are not enrolled in five or more in-load, non-self-support credit hours by the Drop Deadline listed above, you will not be eligible for the PSU-sponsored Student Health Insurance Plan.

INTERNATIONAL STUDENTS - Oregon law requires that all international students and scholars at Portland State University (PSU) in F-1 and J-1 visa status and each dependent that accompanies them to the United States in F-2 and J-2 visa status have adequate medical insurance coverage. It is the policy of PSU that these students purchase year-round health insurance coverage through the University even during vacation terms or while out of the country.

All International students taking 1 or more credit are automatically enrolled in the PSU-sponsored Student Health Insurance Plan unless they are eligible and choose to submit an online insurance waiver of comparable coverage. International students will be charged a Health Insurance Fee of $594 for each of the following terms: Fall, Winter, Spring/Summer Combined. All students who have the student health insurance plan during Spring term 2014, will be covered until 12:01 am of September 20, 2014 regardless of summer credit hours. This means that if you have paid the Spring/Summer combined charge, you will have continuous coverage throughout the Summer term, regardless of taking classes, traveling, or graduating.

International Dependents, Scholars or those on Optional Practical Training (OPT), must be recovered within 30 days after the coverage expiration date. It is the student’s responsibility to make timely renewal payment to avoid a lapse in coverage.

Eligible students who involuntarily lose coverage under another group insurance plan are also eligible to purchase the Portland State University Student Health Insurance Plan. These students must provide the PSU Health Insurance Coordinator, located at SHAC, with proof that they have lost insurance through another group (certificate and letter of ineligibility) within 30 days of the qualifying event. The effective date would be the later of: a) term effective date, or b) the day after prior coverage ends if enrollment request is received by the PSU Health Insurance Coordinator within 30 days of loss of prior coverage.

To be an Insured under the Policy, the student must have paid the required premium and his/her name, student number and date of birth must have been included in the declaration made by the School or the Administrative Agent to the Insurer. All students must actively attend classes for the first 14 consecutive days following their effective date for the term purchased, and/or pursuant to their visa requirements for the period for which coverage is purchased, except in the case of medical withdrawal or during school authorized breaks.

Withdrawal From School

If you leave Portland State University for reason of a covered accident or sickness resulting in a University approved Medical Leave of Absence, you will be eligible for continued coverage under this Plan for only the first term immediately following your leave, provided you were enrolled in this Plan for the term previous to your leave. Enrollment must be initiated by the student and is not automatic. All applicable enrollment deadline dates apply. You must pay the applicable insurance premium. A maximum of one term of medical leave will be granted by Portland State University during your academic career.

For international dependent enrollment eligibility and rates please contact Wells Fargo Insurance at (800) 853-5899.

<table>
<thead>
<tr>
<th>Coverage Period</th>
<th>FALL 9/20/13 - 1/6/14</th>
<th>WINTER 1/6/14 -3/31/14</th>
<th>SPRING/SUMMER 3/31/14 - 9/20/14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drop and Waiver Deadline</td>
<td>10/13/13</td>
<td>1/19/14</td>
<td>4/13/14</td>
</tr>
<tr>
<td>Students</td>
<td>$ 594</td>
<td>$ 594</td>
<td>$ 594</td>
</tr>
</tbody>
</table>

For international dependent enrollment eligibility and rates please contact Wells Fargo Insurance at (800) 853-5899.

*NOTE: Most self-support, continuing education and course credits received from TV, Internet, Video or Satellite are not eligible for the Health Fee, which gives access to the Center for Student Health & Counseling (SHAC), and are also not eligible for this insurance. If you have questions about the types of credits you are taking, visit: www.pdx.edu/financial-services/tuition-fees-self-support-courses.

Please make sure you understand your school’s credit hour and other requirements for enrollment in this plan. Aetna Student Health reserves the right to review, at any time, your eligibility to enroll in this plan. If it is determined that you did not meet the school’s eligibility requirements for enrollment, your participation in the plan may be terminated or rescinded in accordance with its terms and applicable law.

Eligibility Requirement

You must meet the Eligibility requirements each time you pay a premium to continue insurance coverage. To avoid a lapse in coverage, your premium must be recovered within 30 days after the coverage expiration date. It is the student’s responsibility to make timely renewal payment to avoid a lapse in coverage.

Eligible students who involuntarily lose coverage under another group insurance plan are also eligible to purchase the Portland State University Student Health Insurance Plan. These students must provide the PSU Health Insurance Coordinator, located at SHAC, with proof that they have lost insurance through another group (certificate and letter of ineligibility) within 30 days of the qualifying event. The effective date would be the later of: a) term effective date, or b) the day after prior coverage ends if enrollment request is received by the PSU Health Insurance Coordinator within 30 days of loss of prior coverage.

To be an Insured under the Policy, the student must have paid the required premium and his/her name, student number and date of birth must have been included in the declaration made by the School or the Administrative Agent to the Insurer. All students must actively attend classes for the first 14 consecutive days following their effective date for the term purchased, and/or pursuant to their visa requirements for the period for which coverage is purchased, except in the case of medical withdrawal or during school authorized breaks.

Withdrawal From School

If you leave Portland State University for reason of a covered accident or sickness resulting in a University approved Medical Leave of Absence, you will be eligible for continued coverage under this Plan for only the first term immediately following your leave, provided you were enrolled in this Plan for the term previous to your leave. Enrollment must be initiated by the student and is not automatic. All applicable enrollment deadline dates apply. You must pay the applicable insurance premium. A maximum of one term of medical leave will be granted by Portland State University during your academic career.

*NOTE: Most self-support, continuing education and course credits received from TV, Internet, Video or Satellite are not eligible for the Health Fee, which gives access to the Center for Student Health & Counseling (SHAC), and are also not eligible for this insurance.
INSURANCE WAIVER INFORMATION

IF YOU HAVE INSURANCE that is comparable* to the PSU Student Health Insurance Plan offered through a different insurance company (i.e. through an employer, spouse, parent/guardian, scholarship, etc.), and DO NOT want to take part in this PSU Plan, you must complete the online waiver process by the Drop Deadline or your student account will be charged. Students only need one approved waiver per academic year.

IF YOU DO NOT HAVE INSURANCE no action is required. You will automatically be enrolled in the PSU Aetna Student Health Insurance Plan each term you are eligible, (Fall, Winter, Spring/Summer combination), and your student account will be charged.

*Comparable coverage requires no more than a $2,500 deductible, includes prescriptions, coverage for in and out patient medical benefits and mental health coverage. To WAIVE OUT of the insurance plan you must complete the online waiver at www.pdx.edu/shac. For more information visit www.pdx.edu/shac/insurance.

PREMIUM REFUND

REFUNDS - A refund of premium will be granted for the reasons below only. No other refunds will be granted.
1. All hard-waiver and mandatory (insurance is required as a condition of enrollment on campus) enrollments will NOT receive a refund of your insurance premium After the Drop Deadline of the term has passed.
2. For direct enrollments with Wells Fargo Insurance that are paid using a credit card: if you withdraw from school within the first 14 days of the coverage period, you will receive a full refund of the insurance premium provided that you did not file a medical claim during this period. Written proof of withdrawal from the school must be provided. If you withdraw after 14 days of the coverage period, your coverage will remain in effect until the end of the term for which you have paid the premium. Refund requests for these enrollments should be directed to Wells Fargo Insurance at (800) 853-5899. Approved refunds will be assessed a $25 processing fee.
3. If you enter the armed forces of any country you will not be covered under the Policy as of the date of such entry. A pro-rata refund of premium will be made for such person, upon written request received by WFIS within 45 days of entry into service.

PREFERRED PROVIDER NETWORK

Aetna Student Health has arranged for you to access the Aetna preferred provider network. It is to your advantage to utilize a Preferred Care Provider because savings can be achieved from the Negotiated Charges these providers have agreed to accept as payment for their services. Students are responsible for informing their Physicians of potential out-of-pocket expenses for a referral to both a Preferred Care Provider and a Non-Preferred Care Provider. Preferred Care Providers are independent contractors and are neither employees nor agents of Portland State University nor Aetna Student Health. To find a preferred provider, you can use Aetna's online DocFind® service located at www.aetnastudenthealth.com. Click on “Find Your School” and enter your school name. You can use DocFind® to find out whether a specific provider belongs to Aetna’s network or to find preferred providers practicing in your area.
### SCHEDULE OF MEDICAL EXPENSE BENEFITS

<table>
<thead>
<tr>
<th>Annual Maximum</th>
<th>$500,000 Per Insured Per Policy Year</th>
</tr>
</thead>
</table>
| Annual Deductible | Preferred Providers - $0  
| | Non-Preferred Providers - $250 Per Covered Person/$1,000 Per family |
| Annual Out of Pocket Maximum | Preferred Care - $3,500 Per Insured (does not include copays)  
| | Non-Preferred Care - $7,000 Per Insured (includes deductible and coinsurance) |

In addition to the Plan’s Aggregate Maximum the Policy may contain benefit level maximums. Please review this Summary of Benefits section for any additional benefit level maximums. If you or your Physician have any questions regarding benefits, please contact Aetna Student Health at (877) 850-6062. Please refer to the Exclusions and Limitations listed on p.9 of this Brochure for more detailed information on covered benefits.

The exact provisions governing this insurance are contained in the Master Policy issued to the University and may be reviewed at wfis.wellsfargo.com/psu. If care is received from a Preferred Provider, any Covered Medical Expenses will be paid at the Preferred Provider level of benefits. If Covered Medical Expenses are incurred due to an emergency treatment, benefits will be paid at the Preferred Provider level of benefits. In all other situations, reduced or lower benefits will be provided when a Non-Preferred Provider is used. Unless indicated otherwise, Non-Preferred will be reimbursed at 60% of Recognized Charge.

Expenses provided by the Portland State University Center for Student Health and Counseling (SHAC) that are otherwise not covered by the PSU Health Fee, including labs, LDD testing, X-Rays and Immunizations, are paid at 100% of the Negotiated Charge by the Student Health Insurance Plan with the exception to dental injury or impacted wisdom teeth removal benefits. Policy exclusions and limitations apply to those expenses unless otherwise listed in the Schedule of Benefits. Copays and deductibles do not apply to SHAC expenses.

#### INPATIENT HOSPITALIZATION EXPENSES

<table>
<thead>
<tr>
<th>Expense Type</th>
<th>Preferred Care</th>
<th>Non-Preferred Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Room and Board Expense, daily semi-private room rate.</td>
<td>80% of the Negotiated Charge after $150 Copay</td>
<td>60% of the Recognized Charge</td>
</tr>
<tr>
<td>Intensive Care Unit Expense</td>
<td>80% of the Negotiated Charge after $150 Copay</td>
<td>60% of the Recognized Charge</td>
</tr>
<tr>
<td>Miscellaneous Hospital Expense, include, but are not limited to: laboratory tests, x-rays, surgical dressings, anesthesia, supplies and equipment use, and medicines.</td>
<td>80% of the Negotiated Charge</td>
<td>60% of the Recognized Charge</td>
</tr>
<tr>
<td>Physician Hospital Visit/Consultation Expenses, non-surgical services of the Physician or a consulting Physician.</td>
<td>80% of the Negotiated Charge</td>
<td>60% of the Recognized Charge</td>
</tr>
</tbody>
</table>

#### SURGICAL EXPENSES (INPATIENT AND OUTPATIENT)

<table>
<thead>
<tr>
<th>Expense Type</th>
<th>Preferred Care</th>
<th>Non-Preferred Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgical Expense</td>
<td>80% of the Negotiated Charge after $100 Copay per surgery</td>
<td>60% of the Recognized Charge</td>
</tr>
<tr>
<td>Anesthetist &amp; Assistant Surgeon Expense</td>
<td>80% of the Negotiated Charge</td>
<td>60% of the Recognized Charge</td>
</tr>
<tr>
<td>Ambulatory Surgical Expense</td>
<td>80% of the Negotiated Charge after $100 Copay</td>
<td>60% of the Recognized Charge</td>
</tr>
</tbody>
</table>

#### OUTPATIENT EXPENSES

<table>
<thead>
<tr>
<th>Expense Type</th>
<th>Preferred Care</th>
<th>Non-Preferred Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician’s Office Visits Expense</td>
<td>100% of the Negotiated Charge after $20 Copay per visit</td>
<td>60% of the Recognized Charge after $40 Deductible per visit</td>
</tr>
<tr>
<td>Consultant or Specialist Expense</td>
<td>100% of the Negotiated Charge after $20 Copay per visit</td>
<td>60% of the Recognized Charge after $40 Deductible per visit</td>
</tr>
<tr>
<td>Emergency Room Visit Expense, Copay/Deductible waived if admitted.</td>
<td>80% of the Negotiated Charge after $150 Copay per visit</td>
<td>80% of the Recognized Charge after $150 Deductible per visit</td>
</tr>
<tr>
<td>Urgent Care Expense, benefits include charges for an urgent care provider to evaluate and treat an urgent condition.</td>
<td>80% of the Negotiated Charge after $20 Copay per visit</td>
<td>60% of the Recognized Charge after $40 Deductible per visit</td>
</tr>
<tr>
<td>Therapy Expense, Physical Therapy, Chiropractic Care, Speech Therapy, Inhalation Therapy, or Occupational Therapy. Benefits are limited to 12 visits per Policy Year combined for Physical Therapy and Chiropractic Care.</td>
<td>80% of the Negotiated Charge after $20 Copay per visit</td>
<td>60% of the Recognized Charge after $40 Deductible per visit</td>
</tr>
</tbody>
</table>
### SCHEDULE OF MEDICAL EXPENSE BENEFITS (CONT’D)

<table>
<thead>
<tr>
<th>OUTPATIENT EXPENSES (CONTINUED)</th>
<th>PREFERRED CARE</th>
<th>NON-PREFERRED CARE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Dental Injury Expense</strong>, injury to sound natural teeth, benefits limited to $2,500 per Policy Year.</td>
<td>80% of Actual Charge</td>
<td>80% of Actual Charge</td>
</tr>
<tr>
<td><strong>Impacted Wisdom Teeth Expense</strong></td>
<td>80% of Actual Charge</td>
<td>80% of Actual Charge</td>
</tr>
<tr>
<td><strong>MENTAL HEALTH AND SUBSTANCE ABUSE BENEFITS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Inpatient Mental Health Expense</strong>, charges incurred while confined as a full-time inpatient in a hospital or residential treatment facility for the treatment of mental and nervous disorders. Prior review and approval must be obtained from Aetna Student Health.</td>
<td>80% of the Negotiated Charge after $100 Copay per admission</td>
<td>60% of the Recognized Charge</td>
</tr>
<tr>
<td><strong>Outpatient Mental Health Expense</strong>, (charges for marriage and family therapies are not covered.)</td>
<td>100% of the Negotiated Charge after $15 Copay per visit</td>
<td>60% of the Recognized Charge</td>
</tr>
<tr>
<td><strong>Inpatient Alcoholism and Drug Addiction Treatment Expense</strong></td>
<td>80% of Negotiated Charge after $100 Copay per admission</td>
<td>60% of the Recognized Charge</td>
</tr>
<tr>
<td><strong>Outpatient Alcoholism and Drug Addiction Treatment Expense</strong></td>
<td>100% of Negotiated Charge after $15 Copay per visit</td>
<td>60% of the Recognized Charge</td>
</tr>
<tr>
<td><strong>Testing and Treatment for Learning Disability/Attention Deficit Disorder Expense</strong></td>
<td>80% of Negotiated Charge after $25 Copay per visit</td>
<td>60% of the Recognized Charge</td>
</tr>
<tr>
<td><strong>ADDITIONAL EXPENSES</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Women’s Health Care Expense</strong>, includes one baseline mammogram for women Mammogram 35-40. Women 40 and older have coverage for a Mammogram annually. Covered medical expenses include an annual Pap Smear screening for women 18 and older.</td>
<td>100% of Negotiated Charge No Copay</td>
<td>60% of the Recognized Charge</td>
</tr>
<tr>
<td><strong>Preventative Care Services</strong>, including but not limited to routine physical exams, immunizations and diagnostic X-ray &amp; lab for routine physical exams.</td>
<td>100% of Negotiated Charge No Copay</td>
<td>60% of the Recognized Charge</td>
</tr>
<tr>
<td><strong>Diagnostic Laboratory and X-Ray Expense</strong></td>
<td>80% of Negotiated Charge</td>
<td>60% of the Recognized Charge</td>
</tr>
<tr>
<td><strong>Acupuncture Expense</strong>, benefits limited to a Per Policy Year Annual Maximum of $1,000, Annual Maximum does not apply when in lieu of Anesthesia.</td>
<td>80% of the Negotiated Charge after $30 Copay per visit</td>
<td>60% of the Recognized Charge</td>
</tr>
<tr>
<td><strong>High Cost Procedure Expense</strong>, Covered Procedures in excess of $200, such as, but not limited to outpatient diagnostic C.A.T. scans, Magnetic Resonance Imaging and Laser Treatments.</td>
<td>80% of Negotiated Charge after $100 Copay</td>
<td>60% of the Recognized Charge</td>
</tr>
<tr>
<td><strong>Allergy Testing and Treatment Expense</strong>, includes charges incurred for diagnostic testing and treatment of allergies and immunology services.</td>
<td>Payable as any other sickness</td>
<td>Payable as any other sickness</td>
</tr>
<tr>
<td><strong>Durable Medical Equipment Expense</strong></td>
<td>80% of Negotiated Charge</td>
<td>60% of Actual Charge</td>
</tr>
<tr>
<td><strong>Maternity Expenses</strong>, covered Medical Expenses include inpatient care of the covered person and any newborn child for a minimum of 48 hours after a vaginal delivery and for a minimum of 96 hours after a cesarean delivery.</td>
<td>Payable as any other sickness</td>
<td>Payable as any other sickness</td>
</tr>
<tr>
<td><strong>Elective Abortion Expense</strong>, benefits limited to $2,500 per Policy Year.</td>
<td>80% of the Negotiated Charge</td>
<td>60% of the Recognized Charge</td>
</tr>
<tr>
<td><strong>Transgender Surgery Expense</strong>, benefits are limited to $75,000 per policy year.</td>
<td>Payable as any other sickness</td>
<td>Payable as any other sickness</td>
</tr>
<tr>
<td><strong>Diabetic Testing Supplies Expense;</strong> including test strips, diabetic test agents, glucose tablets, lancets/lancing devices, and alcohol swabs and blood glucose monitors.</td>
<td>80% of the Negotiated Charge</td>
<td>60% of the Recognized Charge</td>
</tr>
</tbody>
</table>
This plan will not pay more than the overall maximum benefit of $500,000 during the plan year.

Once any of these limits have been reached, the plan will not pay any more towards the cost of the applicable services, and your health provider can bill you for what the plan does not pay. Some illnesses cost more to treat than this plan will cover.

PLEASE READ CAREFULLY BEFORE DECIDING WHETHER THIS PLAN IS RIGHT FOR YOU

- This plan will not pay more than the overall maximum benefit of $500,000 during the plan year.
- Once any of these limits have been reached, the plan will not pay any more towards the cost of the applicable services, and your health provider can bill you for what the plan does not pay. Some illnesses cost more to treat than this plan will cover.

PRESCRIPTION DRUG EXPENSES

Pre-existing Condition

If you have a pre-existing condition, this plan may not pay for the coverage of this condition for up to the first six months of coverage. For more information on pre-existing condition limitations and other plan exclusions, limitations and benefit maximums, please refer to the Portland State University Master Policy. This plan pays benefits only for expenses incurred while the coverage is in force and only for the medically necessary treatment of injury or disease. The coverage displayed in this document reflects certain mandate(s) of the state in which the policy was written. However, certain federal laws and regulations could also affect how this coverage pays. Unless otherwise indicated, all benefits and limitations are per covered person.

The pre-existing condition exclusion does not apply to pregnancy or an insured person who is under age 19.

Continuously Insured

Persons who have remained continuously insured under the Policy, and prior student health insurance policies issued to the school, will be covered for any Pre-existing Condition which manifests itself while continuously insured, except for expenses payable under prior policies in the absence of the Policy. Previously Covered persons must re-enroll for coverage by the specified enrollment deadline dates in order to avoid a break in coverage for conditions which existed in prior policy years. Once a break in continuous coverage of 63 days or greater occurs, the Pre-Existing Conditions Limitation will apply.

Coordination of Benefits

If the Covered Person is insured under more than one group health plan, the benefits of the plan that covers the insured student will be used before those of a plan that provides coverage as a dependent. When both parents have group health plans that provide coverage 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 this Plan may be coordinated with other benefits available to the Covered Person under any auto insurance, Workers’ Compensation, Medicare, or other coverage. The Plan pays in accordance with the rules set forth in the Policy.

Extension of Benefits

If a Covered Person is confined to a hospital on the date his or her insurance terminates, expenses incurred after the termination date and during the continuance of that hospital confinement, shall be payable in accordance with the policy, but only while they are incurred during the 90 day period, following such termination of insurance.
STATE MANDATED BENEFITS
The Plan will pay benefits in accordance with any applicable Oregon State Insurance Law(s).

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

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

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

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

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

The terms of this entire subrogation and reimbursement provision shall apply. This Plan is entitled to full recovery regardless of whether any liability for payment is admitted by any potentially responsible party, and regardless of whether the settlement or judgment received by the Covered Person identifies the medical benefits this Plan provided. This Plan is entitled to recover from any and all settlements or judgments, even those designated as “pain and suffering” or “non-economic damages” only.
This list is only a partial list. Please refer to the complete PSU brochure written by Aetna, available at available at wfis.wellsfargo.com/psu for a complete list of exclusions.

This Policy does not cover nor provide benefits for:

1. Expense incurred for eye refractions; vision therapy; radial keratotomy; eyeglasses; contact lenses (except when required after cataract surgery); or other vision or hearing aids; or prescriptions or examinations except as required for repair caused by a covered injury.

2. Expense incurred as a result of an injury or sickness due to working for wage or profit or for which benefits are payable under any Workers’ Compensation or Occupational Disease Law.

3. Expense incurred for elective treatment or elective surgery except as specifically provided elsewhere in this Policy and performed while this Policy is in effect.

4. Expense incurred for cosmetic surgery, reconstructive surgery, or other services and supplies which improve, alter, or enhance appearance, whether or not for psychological or emotional reasons, except to the extend needed to: a) Improve the function of a part of the body that is not a tooth or structure that supports the teeth, and is malformed as a result of a severe birth defect, including harelip, webbed fingers, or toes, or as direct result of disease, or surgery performed to treat a disease or injury. b) Repair an injury (including reconstructive surgery for prosthetic device for a covered person who has undergone a mastectomy) which occurs while the covered person is covered under this Policy. Surgery must be performed in the calendar year of the accident which causes the injury, or in the next calendar year.

5. Expense incurred as a result of commission of a felony.


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


9. Expenses incurred for any sinus surgery; except for acute purulent sinusitis.

10. 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.

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

12. Expense for treatment and supplies for programs involving cessation of tobacco use.

13. Expense incurred for injury resulting from the plan or practice of intercollegiate sports (participating in sports clubs; or intramural athletic activities; is not excluded).

14. Expenses for routine physical exams; including expenses in connection with well newborn care; routine vision exams; routine dental exams; routine hearing exams; immunizations; or other preventive services and supplies; except to the extent coverage of such exams; immunizations; services; or supplies is specifically provided in the Policy.

15. Expenses incurred for: care, treatment, services, or supplies; for or related to obstructive sleep apnea; and sleep disorders; including CPAP and UPP.

Any exclusion above will not apply to the extent that coverage is specifically provided by name in this Policy; or coverage of the charges is required under any law that applies to the coverage. If any discrepancy exists between this brochure and the Master Policy, the Master Policy will govern and control the payment of benefits.
HOW DO I FILE A CLAIM?

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

Aetna Student Health
P.O. Box 981106, El Paso, TX 79998
(877) 850-6062 (toll-free)

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

1. Bills must be submitted within 90 days from the date of treatment.
2. Payment for Covered Medical Expenses will be made directly to the hospital or Physician concerned unless bill receipts and proof of payment are submitted.
3. If itemized medical bills are available at the time the claim form is submitted, attach them to the claim form. Subsequent medical bills should be mailed promptly to the above address.
4. In the event of a disagreement over the payment of a claim, a written request to review the claim must be mailed to Aetna Student Health within 180 days from the date appearing on the Explanation of Benefits (EOB).
5. You will receive an “Explanation of Benefits” when your claims are processed. The Explanation of Benefits will explain how your claim was processed; according to the benefits of your Student Health Insurance Plan.

HOW TO APPEAL A CLAIM

In the event a Covered Person disagrees with how a claim was processed, he/she may request a review of the decision. The Covered Person’s requests must be made in writing within one hundred eighty (180) days of receipt of the Explanation of Benefits (EOB). The Covered Person’s request must include why he/she disagrees with the way the claim was processed. The request must also include any additional information that supports the claim (e.g., medical records, Physician’s office notes, operative reports, Physician’s letter of medical necessity, etc.). Please submit all requests to:

Aetna
P.O. Box 14464
Lexington, KY 40512

PRESCRIPTION DRUG CLAIM PROCEDURE

When obtaining a covered prescription, please present your ID card to a Preferred Pharmacy, along with your applicable copay. The pharmacy will bill Aetna for the cost of the drug, plus a dispensing fee, less the copay amount.

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. You will be reimbursed for covered medications, less your copay.

For an Aetna Prescription claim form go to www.aetnastudenthealth.com. Find your school, then click “Prescription” to obtain an RX claim form. Prescriptions from a Non-Preferred Pharmacy must be paid for in full at the time of service and submitted for reimbursement.
As a member of the Plan, you can also take advantage of the following services, discounts, and programs. These are not underwritten by Aetna and are NOT insurance. The member is responsible for the full cost of the discounted services. Please note that these programs are subject to change without notice. To learn more about these additional services and search for providers visit, www.aetnastudenthealth.com.

Aetna Fitness™ discount program: Access to preferred rates on gym memberships and discounts on at-home weight loss programs, home fitness options and one-on-one health coaching services through GlobalFit®.

Aetna Hearing™ discount program: Offers members and their families access to savings on hearing exams, hearing aids and other hearing services. Members can choose between two great offers at no additional premium cost, Hearing Care Solutions and HearPO®.

Aetna Natural Products and Services™ discount program: Access to savings on complementary health care products and services, including online consultations, not traditionally covered by their health benefits plan. All products and services are provided through the ChooseHealthy® program* and Vital Health Network (VHN).

*The ChooseHealthy program is made available through American Specialty Health Networks, Inc. (ASH Networks) and Healthyroads, Inc. subsidiaries of American Specialty Health Incorporated (ASH). ChooseHealthy is a federally registered trademark of ASH and used with permission herein.

Aetna Vision™ discount program: Access to discounts on vision exams, lenses and frames when a member utilizes a provider participating in the EyeMed Select Network.

Aetna Weight Management discount program: Access to discounts on the CalorieKing® Program and products, eDiets® diet plans and products, Jenny® weight loss programs and Nutrisystem® weight loss meal plans.

Oral Health Care discount program: Access to discounts on oral health care products. Save on xylitol mints, mouth rinses, gum, candies and toothpaste from Epic. Additionally, receive exclusive savings on Waterpik® dental water jets and sonic toothbrushes.

Aetna Specialty Pharmacy: provides specialty medications and support to members living with chronic conditions and illnesses. These medications are usually injected or infused, or some may be taken by mouth. For compounded medications, Aetna Specialty Pharmacy will coordinate getting your prescription to the compounding pharmacy that will be able to fill your prescription. For additional information please go to www.AetnaSpecialtyRx.com.

Quit Tobacco Cessation Program: Say good-bye to tobacco and hello to a healthier future! The one-year Quit Tobacco program is provided by Healthyroads, a leading provider of tobacco cessation programs. You’ll get personal attention from health professionals that can help find what works for you.

Beginning Right® Maternity Program: Make healthy choices for you and your baby. Learn what decisions are good ones for you and your baby. Our Beginning Right maternity program helps prepare you for the exciting changes pregnancy brings.

Discount programs provide access to discounted prices and are NOT insured benefits. The member is responsible for the full cost of the discounted services. Discount programs may be offered by vendors who are independent contractors and not employees or agents of Aetna or their affiliates. Aetna may receive a percentage of the fee you pay to the discount vendor.

Aetna’s Informed Health® Line*:

Call our toll-free number to talk to registered nurses. They can share information on a range of healthy topics**. The nurses can help you:

• Learn about medical procedures and treatment options.
• Improve how you talk with your doctor and other health care providers.
• Find out how to describe your symptoms better.
• Ask the right questions.
• Tell your doctor about your eating, exercise and lifestyle habits.

Call anytime. (United States only). Nurses are available 24-hours a day. To reach a nurse, call 1(800) 556-1555. TDD for hearing and speech-impaired people only: 1(800) 270-2386. Or reach them through E-mail. You can send an e-mail to IHL2@aetna.com for links to health information about your questions. Nurses reply within 24 hours. Note: Due to security reasons, the Informed Healthline will not open any attachments sent by e-mail. Or listen to the Audio Health Library*. It explains thousands of health conditions in English and Spanish. Transfer easily to a registered nurse at any time during the call.

*While only your doctor can diagnose, prescribe or give medical advice, the Informed Health Line nurses can provide information on more than 5,000 health topics. Contact your doctor first with any questions or concerns regarding your health care needs.

** Not all topics may be covered expenses under your plan.

Use the Healthwise® Knowledgebase to find out more about a health condition you have or medications you take. It explains things in terms that are easy to understand.

Get to it through your secure Aetna Navigator® member website, at www.aetnastudenthealth.com.
On Call International

Chickering Claims Administrators, Inc. (CCA) has contracted with On Call International (On Call) to provide Covered Persons with access to certain accidental death and dismemberment benefits, worldwide emergency medical, travel and security assistance services and other benefits. A brief description of these benefits is outlined below.

Accidental Death and Dismemberment (ADD) Benefits

These benefits are underwritten by United States Fire Insurance Company (USFIC) and include the following: Benefits are payable for the Accidental Death and Dismemberment of Covered Persons, up to a maximum of $10,000.

Medical Evacuation and Repatriation (MER) Benefits

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

- Unlimited Emergency Medical Evacuation
- Unlimited Medically Supervised Repatriation
- Unlimited Return of Deceased Remains
- Unlimited Family Reunion
- $2,500 Return of Traveling Companion
- $2,500 Bereavement Reunion - in the event of a Covered Person’s death, On Call will fly a family member to identify the remains and accompany the remains back to the deceased’s home country
- $2,500 Emergency Return Home in the event of death or life-threatening illness of a parent, sibling or spouse

Natural Disaster and Political Evacuation Services (NDPE)

The following benefits are underwritten by United States Fire Insurance Company (USFIC), with security assistance services provided by On Call. If a Covered Person requires emergency evacuation due to governmental or social upheaval, which places him/her in imminent bodily harm (as determined by On Call security personnel in accordance with local and U.S. authorities), On Call will arrange and pay for his/her transportation to the nearest safe location, and then to his/her home country. If a Covered Person requires emergency evacuation due to a natural disaster, which makes his/her location Uninhabitable, On Call will arrange and pay for his/her evacuation from a safe departure point to the nearest safe haven, and then home. Benefits are payable up to $100,000 per event per person.

Worldwide Emergency Travel Assistance (WETA) Services

On Call provides the following travel assistance services:

- 24/7 Emergency Travel Arrangements
- Translation Assistance
- Emergency Travel Funds Assistance
- Lost Luggage and Travel Documents Assistance
- Assistance with Replacement of Credit Card/Travelers Checks
- Medical/Dental/Pharmacy Referral Service
- Hospital Deposit Arrangements
- Dispatch of Physician
- Emergency Medical Record Assistance
- Legal Consultation and Referral
- Bail Bonds Assistance

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

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

NOTE: In order to obtain coverage, all MER, WETA and NDPE services must be provided and arranged through On Call. Reimbursement will not be provided for any services not provided and arranged through On Call. Although certain emergency medical services may be covered under the terms of the Covered Person’s student health insurance plan (the “Plan”), neither On Call nor its contracted insurance providers provide coverage for emergency medical treatment rendered by doctors, hospitals, pharmacies or other health care providers. Coverage for such services will be provided in accordance with the terms of the Plan and exclusions, limitations and benefit maximums may apply. Neither CCA, nor Aetna Life Insurance Company, nor their affiliates provide medical care or treatment and they are not responsible for outcomes.

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

CCA and On Call are independent contractors and not employees or agents of the other. CCA provides access to ADD, MER, WETA and NDPE benefits/services through a contractual arrangement with On Call. However, neither CCA nor any of its affiliates provides or administers ADD, MER, WETA or NDPE benefits/services and neither CCA nor any of its affiliates is responsible in any way for the benefits/services provided by or through On Call, USFIC, VSC or CV.
DEFINITIONS

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

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

**Aggregate Maximum:** The maximum benefit that will be paid under this Policy for all Covered Medical Expenses incurred by a covered person that accumulate per condition.

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

**Copay:** This is a fee charged to a person for Covered Medical Expenses. For Prescribed Medicines Expense, the copay is payable directly to the pharmacy for each: prescription, kit, or refill, at the time it is dispensed. In no event will the copay be greater than the pharmacy’s charge per: prescription, kit, or refill.

**Covered Medical Expense:** Those charges for any treatment, service or supplies covered by this Policy which are:

- not in excess of the recognized and customary charges, or
- not in excess of the charges that would have been made in the absence of this coverage, and
- incurred while this Policy is in force as to the covered person except with respect to any expenses payable under the Extension of Benefit Provisions.

**Covered person:** A covered student and any covered dependent while coverage under this Policy is in effect.

**Deductible:** The amount of Covered Medical Expenses that are paid by each covered person during the policy year before benefits are paid.

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

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

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

**Home Health Care:** “Agency to provide nursing in the home” means any person or governmental organization which provides in the home, through its employees or by contractual arrangement with other persons, skilled nursing and assistance and training in health and housekeeping skills. The term does not include a provider of supported living arrangement services during any period in which the provider of supported living arrangement services is engaged in providing supported living arrangement services.

1. “Agency to provide personal care services in the home” means any person, other than a natural person, which provides in the home, through its employees or by contractual arrangement with other persons, nonmedical services related to personal care to elderly persons or persons with disabilities to assist those persons with activities of daily living, including, without limitation:

   (a) The elimination of wastes from the body;
   (b) Dressing and undressing;
   (c) Bathing;
   (d) Grooming;
   (e) The preparation and eating of meals;
   (f) Laundry;
   (g) Shopping;
   (h) Cleaning;
   (i) Transportation; and
   (j) Any other minor needs related to the maintenance of personal hygiene.

2. The term does not include:

   (a) An independent contractor who provides nonmedical services specified by subsection 1 without the assistance of employees;
   (b) An organized group of persons composed of the family or friends of a person needing personal care services that employs or contracts with persons to provide services specified by subsection 1 for the person if:
     • The organization of the group of persons is set forth in a written document that is made available for review by the Health Division upon request; and
     • The personal care services are provided to only one person or one family who resides in the same residence; or
   (c) An intermediary service organization.

**Hospice:** 1. “Hospice care” means a centrally administered program of palliative services and supportive services provided by an interdisciplinary team directed by a physician. The program includes the provision of physical, psychological, custodial and spiritual care for persons who are terminally ill and their families. The care may be provided in the home, at a residential facility or at a medical facility at any time of the day or night. The term includes the supportive care and services provided to the family after the patient dies.

2. As used in this section:

   (a) “Family” includes the immediate family, the person who primarily cared for the patient and other persons with significant personal ties to the patient, whether or not related by blood.
   (b) “Interdisciplinary team” means a group of persons who work collectively to meet the special needs of terminally ill patients and their families and includes such persons as a physician, registered nurse, social worker, clergyman and trained volunteer.

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

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

In order for a treatment, service, or supply to be considered medically necessary, the service or supply must:

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

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

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

In no event will the following services or supplies be considered to be medically necessary:
- Those that do not require the technical skills of a medical, a mental health, or a dental professional, or
- Those furnished mainly for: the personal comfort, or convenience, of the person, any person who cares for him or her, or any person who is part of his or her family, any healthcare provider, or healthcare facility, or
- Those furnished solely because the person is an inpatient on any day on which the person's sickness or injury could safely and adequately be diagnosed or treated while not confined, or
- Those furnished solely because of the setting if the service or supply could safely and adequately be furnished, in a physician's or a dentist's office, or other less costly setting.

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

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

Non-Preferred Care Provider:
- a health care provider that has not contracted to furnish services or supplies at a negotiated charge, or

Pharmacy: An establishment where prescription drugs are legally dispensed.

Physician: (a) legally qualified physician licensed by the state in which he or she practices, and (b) any other practitioner that must by law be recognized as a doctor legally qualified to render treatment.

Pre-Existing Condition: Any injury, sickness, or condition that was diagnosed or treated, or would have caused a prudent person to seek diagnosis or treatment, within six months prior to the covered person's effective date of insurance.

Preferred Care: Care provided by
- a covered person's primary care physician, or a preferred care provider of the primary care physician, or
- a health care provider that is not a Preferred Care Provider for an emergency medical condition when travel to a Preferred Care Provider, is not feasible, or
- a Non-Preferred Urgent Care Provider when travel to a Preferred Urgent Care Provider for treatment is not feasible, and if authorized by Aetna.

Preferred Care 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 covered persons of which you are member.

Preferred Pharmacy: A pharmacy, including a mail order pharmacy, which is party to a contract with Aetna to dispense drugs to persons covered under this Policy, but only:
- while the contract remains in effect, and
- while such a pharmacy dispenses a prescription drug, under the terms of its contract with Aetna.

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

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

In determining the recognized charge for a service or supply that is:
- Unusual, or
- Not often provided in the area, or
- Provided by only a small number of providers in the area.

Aetna may take into account factors, such as:
- The complexity,
- The degree of skill needed,
- The type of specialty of the provider,
- The range of services or supplies provided by a facility, and

The prevailing charge in other areas.

The Company: is Wells Fargo Insurance, which administers the Plan.
SHAC provides high quality, accessible, medical, counseling, dental, testing and health promotion services to students. SHAC has an incredible staff of health care professionals who are all dedicated to keeping students healthy so they can stay in the classroom and focus on learning.

Located at 1880 SW 6th Avenue
University Center Building
(503) 725-2800
pdx.edu/shac/

**SHAC Eligibility and Cost**
All PSU students taking 5 or more in-load, non-self-support credits are eligible to use SHAC Services.

A health fee of $119 per term is included in student tuition (for those taking 5 or more in-load, non-self support credits), and covers the cost of most SHAC services, regardless of which health insurance plan the student carries.

- Medical Services have minimal to no extra charge.
- Learning Disability and ADHD Assessments require a fee.
- Counseling Services are covered in tuition.
- Dental fees are generally much lower than private clinics. For current dental fees visit [pdx.edu/shac/dental-fees](http://pdx.edu/shac/dental-fees).
- Testing Services is open to all students and the community. There are fees for most services.

**CLOSEST HOSPITALS AND URGENT CARE CENTERS**

**IN CASE OF MEDICAL EMERGENCY:**
To verify participation of these providers in the Aetna network, you may use Aetna’s online DocFind service located at [www.aetnastudenthealth.com](http://www.aetnastudenthealth.com).

**OHSU**: (503) 494-8311
3181 SW Sam Jackson Park Rd., Portland, OR 97239

**Legacy Good Samaritan Hospital**: (503) 413-7074
1015 NW 22nd Ave., Portland, OR 97210

**Providence Medical Group**: (503) 215-1111
4805 NE Glisan, Portland, OR 97213

**The Portland Clinic East**: (503) 233-6940
541 NE 20th Ave, Suite 210, Portland, Oregon 97232

**ZoomCare Urgent Care**: (503) 684-8252
Locations in SW, NW and SE Portland

**Doctors Express**: (503) 305-6262
Locations in SW, and NW Portland
CLAIMS ADMINISTERED BY: Aetna Student Health
Claims and Coverage Questions
P.O. Box 981106
El Paso, TX 79998
(877) 850-6062 (Toll-Free)
www.aetnastudenthealth.com

EMERGENCY TRAVEL ASSISTANCE: On Call International 24/7 Emergency Travel Assistance Services
(Provide this information to your Emergency Contact)
(866) 525-1956 (within U.S.)
If outside the U.S., call collect by dialing the U.S. access code plus (603) 328-1956
www.aetnastudenthealth.com

PREFERRED PROVIDER: Aetna Preferred Provider Network
To Find a Doctor or Provider
(877) 850-6062 (Toll-Free)
www.aetnastudenthealth.com

NURSE ADVICE LINE: PSU SHAC After Hours
(503) 725-2800
www.pdx.edu/shac/

PRESCRIPTIONS: Aetna Pharmacy Management
(888) 792-3862
www.aetna.com/docfind/custom/studenthealth

THE PLAN ADMINISTERED BY: Wells Fargo Insurance
Student Insurance Division
Eligibility, Enrollment and General Questions
OR License No. 802263
10940 White Rock Road, 2nd Floor
Rancho Cordova, CA 95670
(800) 853-5899
Fax: (877) 612-7966
wfis.wellsfargo.com/psu

WELLS FARGO INSURANCE PRIVACY POLICY
We know that your privacy is important to you and we strive to protect the confidentiality of your non-public personal information. We do not disclose any non-public personal information about our customers or former customers to anyone, except as permitted or required by law. We believe we maintain appropriate physical, electronic and procedural safeguards to ensure the security of your non-public personal information. You may obtain a detailed copy of our privacy policy through your school, or by calling us toll-free at (800) 853-5899 or by visiting us at wfis.wellsfargo.com/psu.

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

This material is for information only and is not an offer or invitation to contract. Health insurance plans contain exclusions, limitations and benefit maximums. Providers are independent contractors and are not agents of Aetna. Provider participation may change without notice. Aetna does not provide care or guarantee access to health services. Information is believed to be accurate as of the production date; however, it is subject to change. Policy forms issued in OK include: GR-96134.

NOTICE: Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or who conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

15.02.310.1 C