

Carry This Card With You At All Times

Hospital Emergency Room	Hospitalization - 80%
Emergency Injury 100%	Office visits - 80%
Emergency Illness 100%	Diagnostic Lab, X-ray, Surgery, Anesthesia, Consultation, Inpatient Physician Care - 80%
Emergency Room Expenses for non-emergency illness are not covered	

\$50 Deductible Per Year waived if a coordinating policy also covers the insured.

This Program is underwritten by: Aetna Life Insurance Company (ALIC)



Student Insurance Plan 2009-2010

Underwritten by Aetna Life Insurance Company

Insurance ID card enclosed

For customer service contact:
Illinois State University
Student Insurance Office
(309) 438-2515



**ILLINOIS STATE
UNIVERSITY**
Illinois' first public university

Office of Student Health Insurance

Campus Box 2541

Normal, Illinois 61790

(309) 438-2515

Underwritten by:
Aetna Life Insurance Company (ALIC)

NAP

Insurance Identification Card

School Name: **Illinois State University**

Student Name: _____

Id Number/SS#: _____

Effective Date: _____

Policy #: _____

From: _____ To: _____

71123

The individual named on this card may be entitled to benefits under the ISU Student Insurance Plan. Coverage is provided on an academic basis. For confirmation of the insured status, contact Student Insurance representatives. TDD available for hearing impaired (309) 438-2498.

NOTE: Claims should be mailed to the name and address listed above.

To: Students and Parents

The Student Health Insurance Plan for Illinois State University students is underwritten by Aetna Life Insurance Company (ALIC).

We believe that the Student Health Insurance Plan will provide reasonable protection against the cost of medical bills resulting from an Accident or Sickness. The Plan is intended to supplement and complement services available to students through the Student Health Service, and coordinates payment of benefits with other group coverage that the insured may have. The Plan meets the student health insurance standards developed by the American College Health Association (ACHA).

ID Card: please refer to the back cover.

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GOT QUESTIONS? GET ANSWERS WITH AETNA NAVIGATOR®

As an Aetna Student Health insurance member, you have access to Aetna Navigator, your secure member website, packed with personalized benefits and health information.

You can take full advantage of our interactive website to complete a variety of self-service transactions online.

By logging into Aetna Navigator, you can:

- Review who is covered under your plan.
- 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.
- Send an email to Aetna Student Health Customer Service at your convenience.
- View the latest health information and news, and more!

How do I register?

- Go to www.aetnastudenthealth.com
- Click on the Aetna Navigator link.
- Follow the instructions for First Time User by clicking on the “Register Now” link.
- Select a user name, password and security phrase.

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

Need help with registering onto Aetna Navigator?

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

YOU CAN ALSO FIND HELP

For questions about:

- Insurance Benefits
- Coordination of Benefits
- How to File a Claim
- Claim Status

Please contact:

Student Insurance Office
Illinois State University
Campus Box 2541
Normal, IL 61790
(309) 438-2515

ILLINOIS STATE UNIVERSITY STUDENT HEALTH INSURANCE PLAN

This is a brief description of the Medical Expense Benefits available for Illinois State University students. The Plan is underwritten by Aetna Life Insurance Company (Aetna). The exact provisions governing this insurance are contained in the Master Policy. See the Student Insurance Office during business hours for additional information. The Plan is administered by Aetna Student Health
P.O. Box 15708
Boston, MA 02215-0014.

STUDENT ELIGIBILITY

As of the 15th calendar day of Fall and Spring semesters, students who are registered and participating in nine or more credit hours of course work are automatically enrolled in, and assessed a fee for, the Plan.

Registration of at least nine credit hours must occur prior to incurring a claim for insurance to be liable for that claim. Exceptions will be allowed for students who register after the claim is incurred, and complete academic credit for least nine hours for that term. Students with medical withdrawals causing them to receive a refund of tuition and fees due to conditions arising during the first 15 calendar days (8 days summer) of the Term which causes them to withdraw or to reduce hours below 9, will remain eligible and insured until the first day of the following Term. Students who were insured the previous term have the option of converting from this Plan to a Continuation Plan.

Continuous year-round coverage is available. If the student received academic credit for at least nine hours in Spring, and will not enroll for sufficient Summer hours to be assessed an insurance fee, the Summer fee can be paid the 8th calendar day of Summer term. If the student is participating in six or more credit hours of pre-registered Summer course work, the student is automatically enrolled in, and assessed a fee for, the Plan.

New students who register for six or more class hours after the first day of Summer school classes have the option of paying a pro-rated fee for Summer school coverage if they plan to return to school in the Fall. Payment is due the first day of Summer classes.

Students with fewer than nine credit hours are eligible to purchase this Plan on an optional basis. Application and fee payment is due by the 15th day of the term (8th day of Summer term). Eligibility is limited to the following student categories and will be extended for no more than four consecutive terms by verification of participation in one or a combination of the following:

- Students participating in the Study Abroad program are assessed an insurance fee for the semester. Such students are eligible to apply to expand the coverage period by direct payment of the premium for the previous or subsequent term, dependent upon program dates and requirements.
- Students enrolling for fewer than nine hours due to the writing of a thesis or dissertation are eligible to purchase coverage if they were insured the previous term.
- Student teaching, professional practice, internship participants, and graduate students with assistantships are eligible to purchase coverage regardless of whether they were insured the previous term.
- Insured graduating students may continue coverage for the following term.

In these cases, the application must be submitted and the premium paid by the 15th calendar day of the semester.

Please note that internet classes and television courses do not fulfill the eligibility requirements that the covered student actively attends classes.

Students with a total of at least nine hours who have a combination of regular on-campus fee paying courses, plus some internet-only courses are eligible to purchase Student Insurance on an optional basis if they were insured with this Plan in the previous term.

INSURANCE FEES/POLICY PERIOD

Semester	Cost	Coverage Period
Fall 2009	\$161	8/10/09-1/10/10
Spring 2010	\$161	1/7/10-5/9/10
Summer 2010	\$116	5/10/10-8/22/10

**The rate above includes both premium for the student health plan, underwritten by Aetna Life Insurance Company, as well as Illinois State University's administrative fee to provide claims processing and customer service functions.*

PREMIUM REFUND POLICY

If you withdraw during the first 15 calendar days of the Fall/Spring Semester or the first eight days of the Summer Semester, you will receive a full refund of the insurance fee. If you withdraw after the first 15 calendar days of the Fall/Spring Semester or the first eight calendar days of the Summer Semester, your coverage will remain in effect until the end of the term.

Insured students entering the Armed Forces of any country will not be covered under the Policy as of the date of such entry. A pro-rata refund of the premium will be made for such person upon written request received by Aetna Student Health within 90 days of withdrawal from school.

Upon termination of coverage under this plan you may elect to enroll in the Continuation Plan. Please see the policy brochure on www.aetnastudenthealth.com for details.

WAIVER PROCESS/PROCEDURE

Waiver of this coverage will be authorized if the student presents evidence of other health insurance coverage under a plan which provides benefits equivalent to the Plan. Students must present the evidence of coverage and complete a petition at the Student Insurance Office within the first 15 calendar days in any semester or first eight days of the Summer Semester.

UTILIZING HEALTH SERVICES

A Student Health Service referral is not required. However, your needs may best be satisfied and costs contained when an organized system of health care providers at the Student Health Service manages the treatment. If you are under the Student Health Insurance Plan and are eligible to use the Health Services, this combination of care can minimize your out-of-pocket expenses.

DESIGNATED PROVIDERS

Students are encouraged to use these health care facilities which offer significant discounts resulting in lower out-of-pocket expenses. The facilities include those owned and operated by BroMenn Health Care: BroMenn Regional Medical Center, Healthpoint, BroMenn Life Care Center, Eureka Community Hospital, and Gailey Eye Surgery Center. These urgent care clinics are also Designated Providers: OSF Promptcare Ft. Jesse and OSF Promptcare Eastland Drive. Central Illinois Imaging Center and Sports Enhancement are also designated providers which offer significant discounts to insured ISU students.

Designated Providers are independent contractors and are neither employees nor agents of Illinois State University, Aetna Student Health, or Aetna.

DESCRIPTION OF BENEFITS

If any Covered Person incurs eligible expenses due to Accident or Sickness, the Plan will pay, subject to stated maximums and other Policy limitations, the amount of Covered Medical Expenses incurred.

The payment of the Deductible, the balance above any benefit amount, any charges in excess of the Reasonable Charge allowance, and any ineligible medical expenses are the responsibility of the Covered Person.

To maximize your savings and reduce out-of-pocket expenses, select a Designated Provider. It is to your advantage to utilize Designated Providers because significant savings can be achieved from the substantially lower rates these providers have agreed to accept as payment for their services.

In addition to the Plan's Aggregate Maximum the Policy may contain benefit level maximums. Please review the Summary of Benefits section of this brochure for any additional benefit level maximums.

SUMMARY OF BENEFITS CHART

The Illinois State University Student Health Insurance Plan may not cover all your health care expenses. The plan excludes coverage for certain services and contains limitations on the amounts it will pay. Please read the ISU Plan Brochure carefully before deciding whether this plan is right for you. While this document and the ISU Plan Brochure tell you about some of the important features of the plan, other features may be important to you and some further limit what the plan will pay. If you want to look at the full plan description, which is contained in the Master Policy issued to Illinois State University, you may view it at the Student Health Insurance Office or you may contact us at (309) 438-2515.

This plan will never pay more than \$1,000,000 per lifetime. Additional plan maximums may also apply. Some illnesses may cost more to treat and health care providers may bill you for what the plan does not cover.

This plan may not cover all of your health care expenses. The lifetime maximum is \$1,000,000.

Deductible	A \$50 per Policy Year Deductible shall be applied. Only Covered Medical Expenses are applied to satisfy the Deductible. The Deductible will be waived if the Covered Person has other insurance.
Out-of-Pocket Expense (<i>Stop Loss Provision</i>)	This feature is included in the Plan to prevent any individual's out-of-pocket expenses for Deductibles and Coinsurance from exceeding \$1,000 in Covered Medical Expenses in any one Policy Year. Once the Individual Out-of-Pocket Limit has been satisfied; Covered Medical Expenses will be payable at 100% for the remainder of the Policy Year, up to any benefit maximum, that may apply.

SUMMARY OF BENEFITS CHART (CONTINUED)

Aggregate Maximum	\$1,000,000 per Lifetime
Inpatient Hospitalization Benefits	
Hospital Room and Board Expenses	80% of the average semi-private room charge.
Miscellaneous Hospital Expenses	Covered Medical Expenses include, but are not limited to: laboratory tests, x-rays, surgical dressings, anesthesia, supplies and equipment use, and medicines.
Physician Hospital Visit Expenses	80% of Covered Medical Expenses.
Surgical Benefits (Inpatient and Outpatient)	
No benefits will be paid for inpatient surgery performed in a hospital which can be safely performed on an outpatient basis. Please contact your Student Insurance Representative for a list of procedures that must be performed on an outpatient basis. (In case of Medical Necessity, this requirement may be waived and inpatient benefits will apply.)	
Surgical Expenses	80% of Covered Medical Expenses.
Anesthesia Expenses	80% of Covered Medical Expenses.
Assistant Surgeon Expenses	80% of Covered Medical Expenses.
Outpatient Hospital Benefits	
Emergency Expenses	100% of Covered Medical Expenses. Covered Medical Expenses for diagnostic tests or procedures which are billed by a Physician, who is not an employee of the hospital, will be payable at 80%. Initial treatment for an accidental Injury must be received within 48 hours following the Accident. <i>Please Note: The use of emergency room services for a non emergency illness is not a covered benefit</i>

SUMMARY OF BENEFITS CHART (CONTINUED)

Physician's Expenses <i>(if not employed by hospital)</i>	80% of Covered Medical Expenses.
Physician Benefits	
Consultation Expenses	80% of Covered Medical Expenses. Benefits are payable when required to arrive at or confirm a diagnosis, or if a second opinion is required or desired.
Physician's Office Visit Expenses	80% of Covered Medical Expenses.
Mental Health Benefits and Drug Abuse Benefits	
Benefits will be payable as follows for treatment of mental health and drug abuse.	
Inpatient Expenses	80% of Covered Medical Expenses subject to a maximum of 30 days per Policy Year.
Outpatient Expenses	80% of Covered Medical Expenses subject to a maximum of 45 visits per Policy Year combined with outpatient alcoholism treatment.
Partial Hospitalization Expenses	Covered Medical Expenses also include the charges made for treatment received during partial hospitalization in a hospital or treatment facility. Benefits will be payable in place of an inpatient admission, whereby two days of partial hospitalization may be exchanged for one day of full hospitalization.

SUMMARY OF BENEFITS CHART (CONTINUED)

Alcoholism Benefits	
Inpatient Expenses	80% of Covered Medical Expenses.
Outpatient Expenses	80% of Covered Medical Expenses subject to a maximum of 45 visits per Policy Year combined with outpatient mental health and drug abuse expenses.
Maternity Benefits	
Maternity Expenses	<p>Covered Medical Expenses for pregnancy, childbirth, and complications of pregnancy are payable on the same basis as any other Sickness. In the event of an inpatient confinement, such benefits would be payable for inpatient care of the Covered Person and any newborn child for a minimum of 48 hours after a vaginal delivery and for a minimum of 96 hours after a cesarean delivery. Upon discharge, benefits will be payable for one post-delivery home visit by a health care provider, if the visit is prescribed by the attending Physician. If a Covered Person is discharged earlier, benefits will be payable for one post-delivery home visit by a health care provider within 24 hours of discharge and, if prescribed by the attending Physician, one additional home visit.</p> <p>Excluded expenses are: routine sonograms, prenatal vitamins, and any charge related to the baby's care.</p>
Voluntary Termination of Pregnancy Expenses	Covered Medical Expenses for abortions are limited to \$475 per abortion if gestation is 12 weeks or less and general anesthesia is not Medically Necessary.

SUMMARY OF BENEFITS CHART (CONTINUED)

Additional Benefits	
Ambulance Expenses	80% of the Covered Medical Expenses of a hospital or private ambulance will be paid when required to transport a Covered Person to or from a hospital. Services must be to the nearest hospital where care for the Covered Person's condition is available.
Chiropractic Expenses	Limited to \$25 per visit, up to a maximum of \$300 per Policy Year. The initial examination and X-rays are covered under the Policy at 80% of Covered Medical Expenses and are not counted toward meeting the chiropractic maximum benefit payable.
Physical Therapy Expenses	Limited to a maximum of \$500 per Policy Year (waived if PT is initiated within 30 days following a covered surgery)
Mammogram and Ultrasound Expenses Benefit	Benefits are payable for charges for mammograms and ultrasound. The charges must be incurred while a covered person is insured for these benefits. Benefits will be paid for Expenses incurred for the following: <ol style="list-style-type: none"> (1) A baseline mammogram for women between the ages of 35 to 40; (2) A mammogram at the age and intervals considered medically necessary by the woman's health care provider for women under age 40 with a family history of breast cancer, <u>prior personal history of breast cancer</u>, <u>positive genetic testing</u>, or other risk factors; (3) A mammogram on an annual basis for women 40 years of age and older; and

SUMMARY OF BENEFITS CHART (CONTINUED)

Mammogram and Ultrasound Expenses Benefit (continued)	(4) Comprehensive ultrasound screening of an entire breast or breasts if a mammogram demonstrates heterogeneous or dense breast tissue, when medically necessary as determined by a Physician . Benefits are payable as any Sickness.
Routine Pap Smear Expenses	80% of Covered Medical Expenses. Coverage will be provided for one annual Pap smear for women age 18 and older.
Durable Medical Equipment Expenses	80% of Covered Medical Equipment Expenses.
Non-Prescription Enteral Formula Expenses	Covered Medical Expenses include charges incurred by a covered person; for non-prescription enteral formulas for which a physician has issued a written order; and are for the treatment of malabsorption caused by: Eosinophilic disorders and short bowel disorders. Benefits are payable as any Sickness.

Aetna VisionSM Discount Program

Aetna VisionSM Discount Program: The Aetna Vision discount program helps you save on vision exams and many eye care products, including sunglasses, contact lenses, non-prescription sunglasses, contact lens solutions and other eye care accessories. Plus, you can receive up to a 15% discount on LASIK surgery (the laser vision correction procedure).

Optional Discount Services¹

Vital Savings by Aetna^{SM 1}

All students are eligible to purchase discount cards that provide savings on dental service, prescriptions, or both.

Vital Savings on DentalSM offers students access to wide array of dental services-even without insurance. It puts important dental care within affordable reach, along with access to one of the largest dental discount networks, Aetna Dental AccessSM.

The Vital Savings on PharmacySM card is a discount program helping students lower their prescription drug costs. Instead of paying full price for prescription medications, present this card to participating pharmacies and receive a discount at the time of purchase.

These optional discount cards can be purchased for \$29 each, or \$46 if purchased together. For complete details and how to enroll, be sure to visit www.shs.ilstu.edu/insurance.

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

GENERAL PROVISIONS

State Mandated Benefits

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

Right of Recovery

Subrogation

Aetna is assigned the right to recover from the negligent third party, or his or her insurer, to the extent of the benefits we paid for that illness or injury. By accepting benefits under this plan, you specifically acknowledge Aetna's right of subrogation. When this plan pays health care benefits for expenses incurred due to **Third Party Injuries**, Aetna shall be subrogated to your right of recovery against any negligent **Third Party** to the extent of the full cost of all benefits provided by this plan. Aetna may proceed against any party with or without your consent.

You are required to furnish any information or assistance, or provide any documents that Aetna may reasonably require in order to exercise our rights under this provision.

This provision applies whether or not the **Third Party** admits liability.

Reimbursement

If a covered person recovers expenses for illness or injury that occurred due to the negligence of a third party, Aetna has the right to first reimbursement for all benefits we paid from any and all damages collected from the negligent third party for those same expenses whether by action at law, settlement, or compromise, by the covered person, the covered person's parents if the covered person is a minor, or the covered person's legal representative as a result of that illness or injury.

You are required to furnish any information or assistance, or provide any documents that Aetna may reasonably require in order to exercise our rights under this provision.

This provision applies whether or not the third party admits liability. By accepting benefits under this plan, you also specifically acknowledge Aetna's right of reimbursement. If you recover expenses for illness or injury that occurred due to the negligence of a **Third Party**: (A) Aetna has the right to [first] reimbursement for all benefits Aetna paid from any and all damages collected from the negligent **Third Party** for those same expenses whether by action at law, settlement, or compromise, by you, your parents, if you are a minor, or your legal representative as a result of that sickness or injury; and (B) Aetna is assigned the right to recover from the **Third Party**, or his or her insurer, to the extent of the benefits Aetna paid for that sickness or injury.

Aetna shall have the right to first reimbursement out of all funds you, your parents, if you are a minor, or your legal representative, is or was able to obtain for the same expenses Aetna has paid as a result of that illness or injury.

You are required to furnish any information or assistance, or provide any documents that Aetna may reasonably require in order to exercise our rights under this provision. This provision applies whether or not the **Third Party** admits liability.

Effect of Other Plan Coverage

This provision applies if a Covered Student:

- (a) Is covered by any other group or blanket health care plan; and
- (b) Would, as a result, receive medical expense or service benefits in excess of the actual expenses incurred.

In this case, the Plan will pay such excess up to, but not to exceed, a combined 100% of the allowable expenses.

DEFINITIONS

This section includes some of the definitions applicable to the Plan. Please refer to the Master Policy for a complete list of definitions.

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

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

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

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

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

Covered Person: A Covered Student whose coverage is in effect under the Policy. See the Eligibility section of this Brochure for additional information.

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

Designated Care: Care provided by a Designated Care Provider.

Designated Care Provider: A health provider that is affiliated and has an agreement with a third party to furnish services and supplies at a Negotiated Charge.

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

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

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

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

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

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

- Be care or treatment which is likely to produce as significant a positive outcome as any alternative service or supply, both as to the Sickness or Injury involved and the person's overall health condition. It must be no more likely to produce a negative outcome than any alternative service or supply, both as to the Sickness or Injury involved and the person's overall health condition;
- Be a diagnostic procedure which is indicated by the health status of the person. It must be as likely to result in information that could affect the course of treatment as any alternative service or supply, both as to the Sickness or Injury involved and the person's overall health condition. It must be no more likely to produce a negative outcome than any alternative service or supply, both as to the Sickness or Injury involved and the person's overall health condition; and
- As to diagnosis, care, and treatment be no more costly (taking into account all health expenses incurred in connection with the treatment, service, or supply) than any alternative service or supply to meet the above tests. In determining if a service or supply is appropriate under the circumstances, Aetna will take into consideration:
 - Information relating to the affected person's health status;
 - Reports in peer reviewed medical literature;

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

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

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

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

Out-of-Pocket Limit: The amount that must be paid; by the covered student; or the covered student and their covered dependents; before Covered Medical Expenses will be payable at 100%; for the remainder of the Policy Year.

The following expenses do not apply toward meeting the Out-of-Pocket Limit:

- copays;
- expenses that are not Covered Medical Expenses;
- penalties,
- expenses for prescription drugs; and
- other expenses not covered by this Policy.

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

Pre-Existing Condition: An Accident, Sickness, or condition which was:

- (a) Diagnosed or treated within the 12-month period prior to the effective date;
- (b) Not diagnosed or treated by a legally qualified Physician before the Covered Person's effective date, but a legally qualified Physician demonstrates that there is a reasonable medical question that the Accident, Sickness, or condition involved did continue within 12 months prior to the Covered Person's effective date without necessity of consultation, advice, or treatment by a legally qualified Physician; or
- (c) Evident because of a clear, distinct symptom or symptoms within 12 months before the Covered Person's effective date and, in the opinion of a licensed Physician, would:
 1. Indicate that the Accident, Sickness, or condition probably began and manifested itself before the effective date of the Covered Person's coverage; and
 2. Cause an ordinarily prudent person to seek diagnosis, care, or treatment.

(This Pre-Existing Condition exclusion will apply if coverage lapses at any time other than during the Summer Semester. A lapse in coverage during the Summer Semester does not interrupt the fulfillment of this requirement providing the condition began or Injury occurred during a covered term. Conditions occurring during an uninsured Summer period will be considered Pre-Existing until a separate 12 month waiting period has been satisfied.)

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

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

In some circumstances, Aetna may have an agreement, either directly or indirectly through a third party, with a provider which sets the rate that Aetna will pay for a service or supply.

In these instances, in spite of the methodology described above, the Reasonable Charge is the rate established in such agreement. In determining the Reasonable Charge for a service or supply that is:

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

Aetna may take into account factors, such as:

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

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

EXCLUSIONS

This is only a partial list. Please refer to the School's Policy Brochure on line at www.aetnastudenthealth.com for a complete list of exclusions.

The Plan neither covers nor provides benefits for the following:

1. Expenses incurred by a Covered Person for a Pre-Existing Condition unless the Covered Person has been covered under the Policy for 12 consecutive months.
2. Expenses incurred for services normally provided without charge by the Health Service.
3. 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 any actions taken in self defense, so long as they are not taken against persons who are trying to restore law and order.
4. Expenses incurred for eye refraction, vision therapy, radial keratotomy, eyeglasses, contact lenses (except when required after cataract surgery), or other vision aids, and for the fitting or prescription of eyeglasses.

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5. Expenses incurred for dental treatment, except for treatment resulting from Injury to sound, natural teeth unless otherwise provided in the Policy.
 6. Expenses incurred for Injury resulting from the play or practice of intercollegiate sports (expenses incurred due to participation in sports clubs or intramural athletic activities is not excluded).
 7. Expenses 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 as significant a positive outcome as, and no more likely to produce a negative outcome than, any alternative service or supply, both as to the Sickness or Injury involved, and the person's overall health condition;
- Be a diagnostic procedure which is indicated by the health status of the person, and be as likely to result in information that could affect the course of treatment as, and no more likely to produce a negative outcome than, any alternative service or supply, both as to the Sickness or Injury involved, and the person's overall health condition; and
- As to diagnosis, care, and treatment be no more costly (taking into account all health expenses incurred in connection with the treatment, service, or supply) than any alternative service or supply to meet the above tests.

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

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

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

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

8. Expenses incurred for Outpatient Prescription Drugs except when administered during a hospital confinement.

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9. Expenses incurred for Injury or Sickness that arises out of or in the course of employment or for which benefits are payable under a Workers' Compensation or other similar law.
10. Expenses incurred for routine physical examinations, routine vision exams, routine dental exams, immunizations, or other preventive services and supplies, except to the extent coverage for such exams, immunizations, services, or supplies is specifically provided in the Policy.
11. Expenses incurred for any services rendered by a member of the Covered Person's immediate family or a person who lives in the Covered Person's home.
12. Expenses incurred for treatment provided in a governmental hospital unless there is a legal obligation to pay such charges.
13. Expenses incurred for plastic surgery, 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 will not apply to the extent needed to:
- (a) Improve the function of a part of the body that is not a tooth or structure that supports the teeth, and is malformed as a result of a severe birth defect (including harelip, webbed fingers or toes), or as direct result of disease or of surgery performed to treat a Sickness or Injury.
 - (b) Repair an Injury (including reconstructive surgery for a prosthetic device for a Covered Person who has undergone a mastectomy) which occurs while the Covered Person is covered under the Plan. Surgery must be performed in the Policy Year of the Accident which causes the Injury, or in the next Policy Year.

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14. Expenses incurred for the use of orthotics unless used exclusively to promote healing.
 15. Expenses incurred for the treatment of temporomandibular joint (TMJ) dysfunction and associated myofascial pain unless otherwise provided in the Policy.
 16. Expenses incurred for treatment rendered unless the Covered Person is under a legal obligation to pay for such treatment or expense.
 17. Expenses incurred for services and supplies for gamete intrafallopian transfer (GIFT), sterilization reversal, and fertilization by artificial means, such as artificial insemination, in vitro fertilization, and embryo transfer procedure.
 18. Expenses incurred for custodial care, private duty nursing, services, and supplies provided by a sanitarium, or rest cures. Custodial care means services and supplies furnished to a person mainly to help him or her in the activities of daily life.

This includes room and board and other institutional care. The person does not have to be disabled. Such services and supplies are custodial care without regard to: by whom they are prescribed; or by whom they are recommended; or by whom or by which they are performed.
 19. Expenses incurred after the date insurance terminates for a Covered Person except as may be specifically provided in the Extension of Benefits provision.
 20. Expenses incurred when the person or individual is acting beyond the scope of their/its legal authority.
 21. Expenses incurred for hearing aids, including hearing exams and the fitting or Prescription of hearing aids.

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22. Expenses incurred in excess of \$300 in any one Policy Year for non-surgical treatment of dislocations or subluxations of vertebrae (initial examinations and X-rays are covered under the Policy and are not subject to this limitation).
23. Expenses for transplants other than cornea and kidney.
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 insured is diabetic or suffers from circulatory problems.
25. Expenses incurred for services or supplies used to treat conditions, or for treatment, education testing, or training related to autism, hyperkinetic syndromes, learning disabilities, or developmental delays, behavioral problems, mental retardation, or senile deterioration beyond the period necessary to diagnose the condition.
26. Expenses for care or services to the extent the charge would have been covered under Medicare Part A or Part B, even though the individual is eligible but did not enroll in Part B.
27. Expenses for telephone consultations, charges for failure to keep a scheduled visit, or charges for completion of a claim form.
28. Expenses for the cost of material used in any occupational therapy.
29. Expenses for personal hygiene and convenience items, such as air conditioners, humidifiers, hot tubs, whirlpools, or physical exercise equipment, even if such items are prescribed by a Physician.

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30. Expenses for services or supplies provided for the treatment of obesity and/or weight control.
31. Expenses for incidental surgeries and standby charges of a Physician.
32. Expenses for treatment and supplies for programs involving cessation of tobacco use.
33. Expenses for services and supplies in connection with psychological testing or neuropsychological testing.
34. Expenses for Injuries sustained in a motor vehicle accident where the insured persons have a valid and collectible automobile medical payment insurance policy. The Policy will only pay for those losses which are not payable under the automobile medical payment insurance policy.
35. 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.
36. Expenses incurred as a result of an Injury sustained or Sickness contracted while in the service of the Armed Forces of any country. Upon a Covered Person's entering the Armed Forces of any country, the unearned pro-rata premium will be refunded to the Policyholder.
37. Expenses incurred for, or related to, sex change surgery or for any treatment of gender identity disorders.
38. Expenses incurred as a result of a felony.
39. Expenses for the repair or replacement of existing artificial limbs, orthopedic braces, or orthotic devices unless otherwise provided in the Policy.

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

41. 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

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- The care or treatment is effective for that disease, or shows promise of being effective for that disease, as demonstrated by scientific data. In making this determination, Aetna will take into account the results of a review by a panel of independent medical professionals. They will be selected by Aetna. This panel will include professionals who treat the type of disease involved. Also, this exclusion will not apply with respect to drugs that:
 - Have been granted treatment investigational new drug (IND), or Group c/treatment IND status; or
 - Are being studied at the Phase III level in a national clinical trial, sponsored by the National Cancer Institute. If Aetna determines that available, scientific evidence demonstrates that the drug is effective or shows promise of being effective for the disease.
42. Expenses incurred for gastric bypass, and any restrictive procedures, for weight loss.
43. Expenses incurred for breast reduction/mammoplasty.
44. Expenses incurred for gynecomastia (male breasts).
45. Expenses for charges that are not Reasonable Charges.
46. 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.
47. Expenses incurred for care, treatment, services, or supplies for or related to obstructive sleep apnea and sleep disorders, including CPAP and UPP.

48. Expenses incurred for elective treatment or elective surgery except as specifically provided elsewhere in the Policy and performed while the Policy is in effect.

Any of the exclusions described will not apply to the extent that coverage is specifically provided by name in the Policy, or coverage of the charges is required under any law that applies to the coverage.

EXTENSION OF BENEFITS

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

TERMINATION OF INSURANCE

Coverage will terminate at 12:01 a.m. on the earliest to occur of the following:

1. On the date the Policy is terminated.
2. For the Fall Semester, on the first day of the regularly scheduled classes for the Spring Semester.
3. For the Spring Semester, on the first day of classes for the Summer Session.
4. For the Summer Session, on the first day of regularly scheduled classes for the Fall Semester.

5. On the date of entry of the Covered Person into military service, except for temporary duty of 30 days. In the event the Covered Person ceases to be a student of the University and no refund of premium has been made, the insurance will terminate on the same date as indicated above for the semester for which the premium was paid.

CONTINUATION PRIVILEGE

Upon termination of the Plan, the Covered Person is entitled to continue coverage. This continuation privilege is available within 31 days from the termination date of the Plan. Such coverage shall be effective on the date following Termination of Insurance. The continuation plan is available for no more than a 12-month period. An Application is available upon request from the Student Insurance Office.

This continuation option is not available if the Covered Person:

1. Failed to pay any required fees under the Plan;
2. Is or could be covered by Medicare;
3. Has coverage canceled under the Plan due to fraud or misrepresentation.

CLAIM PROCEDURE

All claims, claims appeals, and requests for information on a claim should be directed to:

Illinois State University
Student Insurance Office
Campus Box 2541
Normal, IL 61790
(309) 438-2515

or

Stop by Room 230 Student Services Building.

Claim forms may be obtained from the Student Insurance Office. A TDD line is available for the hearing impaired: (309) 438-2498.

Notification of a claim for Accident or Sickness must be made within 12 months of the date of initial treatment or onset of the condition. It is the Covered Person's responsibility to furnish the University's Student Insurance Office with the completed claim form and itemized statements for all expenses incurred. Reimbursement for medical bills incurred in foreign countries will be made under the terms of the Policy on receipt of itemized bills with amounts converted to U.S. currency equivalents.

Automatic Assignment

Notwithstanding written direction by the Covered Person to the contrary, or as it may be evidenced by a bill paid in full, all or a portion of any benefits provided by the Plan may, at the Company's option, be paid directly to the institution or to the person who rendered the service for which a charge is being made. Any payment made by the Company in accordance with this provision shall discharge the Company from all further liability to the extent of the payment made.

Right of Recovery

If the Company makes any payment that according to the terms of the contract should not have been made, including payment made in error, we may recover that incorrect payment, whether or not it was due to our error, from the provider of services, or from any other appropriate party.

How to Appeal a Claim

In the event of a disagreement about how a claim was processed, the student may request a review of the decision. The request must be made in writing within 60 days of receipt of the Explanation of Benefits (EOB). The student's request must include why they disagree with the way the claim was processed. The request should also include any additional information that supports the claim (e.g., medical records, Physician's office notes, operative reports, a Physician's letter of Medical Necessity).

Please submit all requests to:

Aetna Student Health
P.O. Box 15717
Boston, MA 02215-0014

IMPORTANT NOTE

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

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

Administered by:

Aetna Student Health
P.O. Box 15708
Boston, MA 02215-0014
(800) 859-8481
www.aetnastudenthealth.com

Underwritten by:

Aetna Life Insurance Company (ALIC)
151 Farmington Avenue
Hartford, CT 06156
Policy No. 711123

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

Health information programs provide general health information and are not a substitute for diagnosis or treatment by a physician or other health care professionals. Preferred providers are independent contractors and are neither agents nor employees of the college or university, Aetna Student Health, or Aetna.

This material is for information only and is not an offer or invitation to contract. Health insurance plans contain exclusions and limitations. Your Plan may contain additional benefit level maximums. Please review the Summary of Benefits section of the Illinois State University brochure for information on additional maximums.

NOTICE

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