

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)



**The
Chickering
Group**
An Aetna Company

ILLINOIS STATE UNIVERSITY



2007-2008 Health Insurance Plan

An Equal Opportunity/Affirmative Action University

Office of Student Health Insurance
Campus Box 2541
Normal, Illinois 61790
(309) 438-2515

Underwritten by:
Aetna Life Insurance Company (ALIC)



Insurance Identification Card

Illinois State University

School Name:

Illinois State University

Student Name:

Id Number/SS#:

Effective Date:

Policy #:

711123

To: _____

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 CHICKERING'S AETNA NAVIGATOR™

As a Chickering 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 Chickering Customer Service at your convenience.
- View the latest health information and news, and more!

How do I register?

- Go to www.aetna.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.

Informed Health® Line (800) 556-1555

Call toll free anytime, day or night. Talk to a registered nurse who can provide information and guidance to help you make informed choices about health care. Listen to the Audio Health Library, a recorded collection of more than 2,000 health topics. Aetna offers access to this telephone health service at no additional charge to its policyholders.

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 Chickering Claims Administrators, Inc., 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 at least nine hours for that term. Claims incurred prior to the 15th day which caused the student to be unable to participate in at least nine credit hours, will result in a refund of the insurance fee in accordance with the University Refund Policy and a Termination of Insurance back to the end of the last term of coverage. 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.

INSURANCE FEES/POLICY PERIOD

Semester	Cost	Coverage Period
Fall	\$161	8/13/07-1/13/08
Spring	\$161	1/10/08-5/18/08
Summer	\$116	5/19/08-8/17/08

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 Chickering Claims Administrators, Inc. within 90 days of withdrawal from school.

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, Chickering Claims Administrator, Inc., 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 following benefits are subject to the imposition of Policy limits and exclusions.

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.
Aggregate Maximum	\$1,000,000 per Lifetime

Inpatient Hospitalization Benefits

Hospital Room and Board Expenses	80% of the average semi-private room charge.
Ancillary Hospital Expenses	80% of Covered Medical Expenses. Covered Medical Expenses include, but are not limited to: X-rays (including X-ray and radium therapy), laboratory tests, anesthetics (and their administration by a hospital employee), use of an operating room, temporary surgical appliances, hospital-rendered drugs and medicines and their administration, blood transfusions and the administration thereof, blood plasma, oxygen and the rental of equipment for the administration thereof, and hospital-rendered physiotherapy.
Physician Hospital Visit Expenses	80% of Covered Medical Expenses.

SUMMARY OF BENEFITS CHART (CONTINUED)

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.
Non-Emergency Expenses	Not covered unless previously authorized in writing by the Student Health Service or unless the Student Health Service is closed for an academic break. If authorized, payment will be made as follows once the Policy Year Deductible has been met: 80% of Covered Medical Expenses.
Physician's Expenses <i>(if not employed by hospital)</i>	80% of Covered Medical Expenses.

SUMMARY OF BENEFITS CHART (CONTINUED)

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.

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.

SUMMARY OF BENEFITS CHART (CONTINUED)

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>
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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.
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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.
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SUMMARY OF BENEFITS CHART (CONTINUED)

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)
Routine Mammography Expenses	80% of Covered Medical Expenses. Coverage will be provided for one baseline mammogram for women between ages 35 and 40 and one annual mammogram for women aged 40 and older. At the age and intervals considered Medically Necessary by the woman's health care provider for women under 40 years of age and having a family history of breast cancer or other risk factors.
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.

Informed Health® Line

Aetna's Informed Health® Line gives you easy access credible health information. All Informed Health Line services are available 24 hours a day, 365 days a year on demand from any touch-tone phone or computer within the United States (including Alaska and Hawaii).

1. 24-Hour Nurse Line

Call our toll-free number to access registered nurses who are experienced in providing information on a variety of health topics.* The nurses can help you:

- Learn about medical procedures and possible treatment options.
- Improve the way you communicate with your health care providers.

Informed Health® Line (continued)

Find out how to describe health symptoms more effectively, ask the right questions and provide a clear history of your eating, exercise and lifestyle habits.

To reach an Informed Health® Line Nurse, please call (800) 556-1555.

For TDD (hearing and speech impaired only), please call (800) 270-2386.

2. Audio Health Library

The Informed Health® Line audio health library contains information on thousands of health topics such as common conditions and diseases, gender- and age-specific health issues, dental care, mental health and substance abuse, weight loss and much more.

To access the audio health library system, call the Informed Health Line toll-free number and simply enter the topic codes you're interested in. And if you have questions, you can transfer easily to an Informed Health Line nurse at any time.

To access the Informed Health Line audio health library, please call (800) 556-1555.

For TDD (hearing and speech impaired only), please call (800) 270-2386.

3. Healthwise® Knowledgebase

If you prefer to view health information online, simply log on to your Aetna Navigator account and click on "Take Action On Your Health" which will link you to the Healthwise® Knowledgebase, one of the most advanced health databases available. The Healthwise Knowledgebase contains detailed information about health conditions, medical tests and procedures, medications and treatment options. It also features illustrations and decision-focused tools to help you make more informed health care decisions.

**Informed Health Line nurses cannot diagnose, prescribe or give medical advice. Contact your physician with any questions or concerns regarding your health care needs. Also, the topics discussed by the nurses, on the audio tapes or online may not necessarily be covered by your health plan.*

Vision One® Discount Program

The Vision One Discount Program helps you save on many eye care products, including sunglasses, contact lenses, non-prescription sunglasses, contact lens solutions and other eye care accessories. Plus, you can receive up to a 25% discount on LASIK surgery (the laser vision correction procedure). This program is not underwritten by Aetna.

You can obtain more detailed information regarding services, supplies, and discounts, as well as a list of providers by calling (800) 793-8616, from the Student Insurance office at (309) 438-2515, or by accessing Aetna's DocFind® at: www.aetna.com/docfind.

Local providers include Pearle Vision Express, Sears Optical and All About Eyes, among others.

Optional Discount Services

Vital Savings by AetnaSM

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.

GENERAL PROVISIONS

State Mandated Benefits

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

Reimbursement

When a Covered Person's Injury appears to be someone else's fault, benefits otherwise payable under this Policy for Covered Medical Expenses incurred as a result of that Injury will not be paid unless the Covered Person or his legal representative agrees:

- (a) To repay Aetna for such benefits to the extent they are for losses for which compensation is paid to the Covered Person by or on behalf of the person at fault;
- (b) To allow Aetna a lien on such compensation and to hold such compensation in trust for Aetna; and
- (c) To execute and give to Aetna any instruments needed to secure the rights under (a) and (b).

Subrogation

Further, when Aetna has paid benefits to or on behalf of the injured Covered Person, Aetna will be subrogated to all rights or recovery that the Covered Person has against the person at fault.

These subrogation rights will extend only to recovery of the amount Aetna has paid. The Covered Person must execute and deliver any instruments needed and do whatever else is necessary to secure those rights to Aetna.

Subrogation/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.

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 for 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 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 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 provision shall apply. This Plan is entitled to full recovery regardless of whether any liability for payment is admitted by any potentially responsible party, and regardless of whether the settlement or judgment received by the Covered Person identifies the medical benefits this Plan provided. This Plan is entitled to recover from any and all settlements or judgments, even those designated as "pain and suffering" or "non-economic damages" only.

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

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:

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- 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;
 - 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

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- 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

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.

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 (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

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- 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.

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:

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- (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.

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.

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.

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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.
 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.

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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

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- The written protocol or protocols used by the treating facility, or the protocol or protocols of any other facility studying substantially the same drug, device, procedure, or treatment, or the written informed consent used by the treating facility or by another facility studying the same drug, device, procedure, or treatment, states that it is experimental, investigational, or for research purposes.

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

- The disease can be expected to cause death within one year, in the absence of effective treatment; and
- The care or treatment is effective for that disease, or shows promise of being effective for that disease, as demonstrated by scientific data. In making this determination, Aetna will take into account the results of a review by a panel of independent medical professionals. They will be selected by Aetna. This panel will include professionals who treat the type of disease involved. Also, this exclusion will not apply with respect to drugs that:
 - Have been granted treatment investigational new drug (IND), or Group c/treatment IND status; or
 - Are being studied at the Phase III level in a national clinical trial, sponsored by the National Cancer Institute. If Aetna determines that available, scientific evidence demonstrates that the drug is effective or shows promise of being effective for the disease.

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

43. Expenses incurred for breast reduction/mammoplasty.

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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.

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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:

Chickering Claims Administrators, Inc.

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. Covered students who no longer meet the eligibility requirements and have terminated from the Student Health Insurance Plan, and wish to receive a certification of coverage, can contact the Customer Service number shown on the ID card.

Offered by:



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

Administered by:

Chickering Claims Administrators, Inc.
P.O. Box 15708
Boston, MA 02215-0014
(800) 859-8481
www.chickering.com

Underwritten by:

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

The Chickering Group is an internal business unit of Aetna Life Insurance Company

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 Chickering's Student Connection Link on the Internet at: www.chickering.com.

