Aetna Student Health

Plan Design and Benefits Summary
Illinois State University

Policy Year: 2021 - 2022
Policy Number: 711123

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Updates as of 1/11/22-please refer to the notice at the end of this Plan Summary

This is a brief description of the Student Health Plan. The Plan is available for Illinois State University students. The Plan is underwritten by Aetna Life Insurance Company (Aetna). The exact provisions, including definitions, governing this insurance are contained in the Policy issued to you and may be viewed online at **www.aetnastudenthealth.com.** If there is a difference between this Plan Summary and the Certificate, the Certificate will control.

Illinois State University 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.

Coverage Periods

Students: Coverage for all insured students enrolled for coverage in the Plan for the following Coverage Periods. Coverage will become effective at 12:01 AM on the Coverage Start Date indicated below and will terminate at 11:59 PM on the Coverage End Date indicated.

Coverage Period	Coverage Start Date	Coverage End Date	Waiver Deadline
Fall (Students not enrolled for Summer 20-21)	08/09/21	01/09/22	Prior to 15th calendar day of semester (08/30/2021)
Fall (Students enrolled for Summer 20-21)	08/16/21	01/09/22	Prior to 15th calendar day of semester (01/24/2022)
Spring (Students not enrolled in Fall 2021)	01/06/22	05/08/22	Prior to 15th calendar day of semester (01/24/2022)
Spring (Students enrolled in Fall 2021)	01/10/22	05/08/22	Prior to 15th calendar day of semester (05/16/2022)
Summer (All Students)	05/09/22	08/21/22	Prior to 8th calendar day of semester (05/16/2022)

Rates

The rates below include both premiums for the Plan underwritten by Aetna Life Insurance Company (Aetna), as well as an Illinois State University administrative fee.

Rates for Students			
	Fall	**Spring**	**Summer**
Student	**$281**	**$281**	**$211**

Student Coverage

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. Students with medical withdrawals causing them to receive a refund of tuition and fees due to conditions arising during the first **15 calendar days** (eight days summer) of the term which cause them to withdraw or to reduce hours **below nine**, will remain eligible and insured until the **first day** of the following term.

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 prior to 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.
- 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.

Home study, correspondence, outreach courses, and television (TV) courses, do not fulfill the eligibility requirement that the student actively attend classes. If it is discovered that this eligibility requirement has not been met, our only obligation is to refund premium, less any claims paid.

Enrollment

Eligible students will be automatically enrolled in this Plan, unless the completed waiver application has been received by Illinois State University by the specified waiver deadline dates listed in the Coverage Periods section of this Plan Design and Benefits Summary.

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 prior to the **15th calendar day** in any semester or prior to the **8th day** of the Summer Semester.

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.

Exception: Students with medical withdrawals causing them to receive a refund of tuition and fees due to conditions arising during the first **15 calendar days (eight days summer)** of the term which cause them to withdraw or to **reduce hours below nine**, will remain eligible and insured until the **first day** of the following term.

Please Note: A Covered Person entering the armed forces of any country will not be covered under the Policy, as of the date of such entry. A pro-rata refund of premium will be made for such person, upon written request, received by Aetna within **90 days** of withdrawal from school.

Excess Provision

This Plan is an excess only Plan. As an excess only Plan, this Plan pays the first $100 of **Covered Medical Expenses.** If there is no other medical coverage in effect, this Plan will continue to pay **Covered Medical Expenses** after the first $100 of **Covered Medical Expenses** has been paid. If there is other medical coverage in effect, claims for benefits in excess of the first $100 of **Covered Medical Expenses** will be payable by the other medical coverage until those benefits are exhausted. This excess only Plan is then responsible for the balance of **Covered Medical Expenses** up to the policy maximum benefit. This Plan's liability will be determined without consideration to any limitation clause or clauses regarding other coverage contained in any other medical coverage. Benefits Payable under this Plan shall be limited to the Plan's **Covered Medical Expenses** and reduced by the amount paid or payable by any other medical coverage. However, consideration will be given to the other medical coverage's liability due to a provider contract or other reasons when calculating this Plan's Benefits Payable.

For the purposes of calculating a benefit under this Plan, the liability of the other medical coverage shall be considered and shall not depend upon whether timely application for benefits from other medical coverage is made by the Covered Person or on the Covered Person's behalf. If any other medical coverage provides benefits on an excess only basis, the coverage for the Covered Person which has been in effect the longest shall pay benefits first.

"Other medical coverage" means any reimbursement for or recovery of any element of incurred covered charges available from any other source whatsoever whether through an insurance policy or other type of coverage, except gifts and donations, including but not limited to the following:

- Any group, accident-only, blanket, individual, or franchise policy of accident, disability, health, or accident and sickness insurance.
- Any arrangement of benefits for members of a group, whether insured or uninsured.
- Any prepaid service arrangement such as Blue Cross or Blue Shield, individual or group practice plans or health maintenance organizations.
- Any amount payable as a benefit for accidental bodily injury arising out of a motor vehicle accident to the extent such benefits are payable under the medical expense payment provision (or, by whatever terminology used to include such benefits mandated by law) of any motor vehicle insurance policy.
- Any amounts payable for injuries related to the Covered Person's job to the extent that he or she actually received benefits under a Workers' Compensation Law.
- Social Security Disability Benefits, except that Other Medical Insurance shall not include any increase in Social Security Disability Benefits payable to the Covered Person after the Covered Person becomes disabled while insured hereunder.
- Any benefits payable under any program provided or sponsored solely or primarily by any governmental agency or subdivision or through operation of law or regulation.

Medicare Eligibility Notice

You are not eligible to enroll in the student health plan if you have Medicare at the time of enrollment in this student plan. The plan does not provide coverage for people who have Medicare.

Termination and Refunds

Withdrawal from Classes – Leave of Absence:
If you withdraw from classes under a school-approved leave of absence, your coverage will remain in force through the end of the period for which payment has been received and no premiums will be refunded.

In-network Provider Network

Aetna Student Health offers Aetna's broad network of In-network Providers. You can save money by seeing In-network Providers because Aetna has negotiated special rates with them, and because the Plan's benefits are better.

If you need care that is covered under the Plan but not available from an In-network Provider, contact Member Services for assistance at the toll-free number on the back of your ID card. In this situation, Aetna may issue a pre-approval for you to receive the care from an Out-of-network Provider. When a pre-approval is issued by Aetna, the benefit level is the same as for In-network Providers.

Description of Benefits

The Plan excludes coverage for certain services (referred to as exceptions in the certificate of coverage) and has limitations on the amounts it will pay. While this Plan Design and Benefit Summary document will tell you about some of the important features of the Plan, other features may be important to you and some may further limit what the Plan will pay. To look at the full Plan description, which is contained in the Certificate of Coverage issued to you, go to **www.aetnastudenthealth.com.** If any discrepancy exists between this Benefit Summary and the Certificate of Coverage, the Certificate will control.

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

Policy year deductible	**In-network coverage**	**Out-of-network coverage**
You have to meet your policy year deductible before this plan pays for benefits.		
Student **Prescription Drug**	\$50 per policy year \$50 per policy year	
Policy year deductible waiver		
The policy year deductible is waived for all of the following eligible health services: • In-network and Out-of-Network care for *Preventive care and wellness* • When students have another insurance plan that is primary		
Maximum out-of-pocket limits **Maximum out-of-pocket limit** per **policy year**		
Student	\$1,250 per policy year	

The coinsurance listed in the schedule of benefits below reflects the plan coinsurance percentage. This is the coinsurance amount that the plan pays. You are responsible for paying any remaining coinsurance.

Eligible health services	In-network coverage	Out-of-network coverage
Routine physical exams		
Performed at a physician's office	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	100% (of the recognized charge) per visit No copayment or policy year deductible applies
Maximum age and visit limits per policy year through age 21	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures//Health Resources and Services Administration guidelines for children and adolescents.	
Covered persons age 22 and over: Maximum visits per policy year	1 visit	
Preventive care immunizations		
Performed in a facility or at a physician's office	100% (of the negotiated charge) per visit. No copayment or policy year deductible applies	100% (of the recognized charge) per visit No copayment or policy year deductible applies
Maximums	Subject to any age limits provided for in the comprehensive guidelines supported by Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.	
Routine gynecological exams (including Pap smears and cytology tests)		
Performed at a physician's, obstetrician (OB), gynecologist (GYN) or OB/GYN office	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	100% (of the recognized charge) per visit No copayment or policy year deductible applies
Maximums	1 visit	
Preventive screening and counseling services		
Preventive screening and counseling services for Obesity and/or healthy diet counseling, Misuse of alcohol & drugs, Tobacco Products, Depression Screening, Sexually transmitted infection counseling & Genetic risk counseling for breast and ovarian cancer	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	100% (of the recognized charge) per visit No copayment or policy year deductible applies

Eligible health services	In-network coverage	Out-of-network coverage
Obesity and/or healthy diet counseling Maximum visits	Age 0-22: unlimited visits. Age 22 and older: 26 visits per 12 months, of which up to 10 visits may be used for healthy diet counseling.	
Substance use disorders maximum per policy year	5 visits	
Use of tobacco products counseling Maximum visits per policy year	8 visits	
Depression screening counseling Maximum visits per policy year	1 visit	
Sexually transmitted infection counseling Maximum visits per policy year	2 visits	
Skin cancer behavioral counseling office visits	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	100% (of the recognized charge) per visit No copayment or policy year deductible applies
Falls prevention counseling office visits	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	100% (of the recognized charge) per visit No copayment or policy year deductible applies
Routine cancer screenings	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	100% (of the recognized charge) per visit No copayment or policy year deductible applies
Maximums	Subject to any age; family history; and frequency guidelines as set forth in the most current: • Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force; and • The comprehensive guidelines supported by the Health Resources and Services Administration.	
Lung cancer screening maximums	1 screening every 12 months	
Prenatal care services (Preventive care services only)	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	80% (of the recognized charge) per visit No copayment or policy year deductible applies

Eligible health services	In-network coverage	Out-of-network coverage
Lactation support and counseling services	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	80% (of the recognized charge) per visit No copayment or policy year deductible applies
Lactation counseling services maximum visits per policy year either in a group or individual setting	6 visits	
Breast pump supplies and accessories	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	80% (of the recognized charge) per visit No copayment or policy year deductible applies
Family planning services – female contraceptives		
Female contraceptive counseling services office visit	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	100% (of the recognized charge) per visit No copayment or policy year deductible applies
Contraceptive counseling services maximum visits per policy year either in a group or individual setting	2 visits	
Female contraceptive prescription drugs and devices provided, administered, or removed, by a provider during an office visit	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	100% (of the recognized charge) per visit No copayment or policy year deductible applies
Female voluntary sterilization-Inpatient & Outpatient provider services	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	100% (of the recognized charge) per visit No copayment or policy year deductible applies
The following are not covered under this benefit: • Services provided as a result of complications resulting from a female voluntary sterilization procedure and related follow-up care • Any contraceptive methods that are only "reviewed" by the FDA and not "approved" by the FDA • Male contraceptive methods, sterilization procedures or devices		

Eligible health services	In-network coverage	Out-of-network coverage
Physicians and other health professionals		
Physician, specialist including Consultants Office visits (non-surgical/ non-preventive care by a physician and specialist) includ telemedicine consultations	80% (of the negotiated charge) per visit Policy year deductible applies	80% (of the recognized charge) per visit Policy year deductible applies
Allergy testing and treatment		
Allergy testing & Allergy injections treatment including Allergy sera and extracts administered via injection performed at a physician's or specialist's office	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Physician and specialist - surgical services		
Inpatient surgery performed during your stay in a hospital or birthing center by a surgeon (includes anesthetist and surgical assistant expenses)	80% (of the negotiated charge) Policy year deductible applies	$0 copayment then the plan pays 80% (of the balance of the recognized charge) per admission Policy year deductible applies
The following are not covered under this benefit: • The services of any other physician who helps the operating physician • A stay in a hospital (Hospital stays are covered in the *Eligible health services and exclusions – Hospital and other facility care* section) • Services of another physician for the administration of a local anesthetic		
Outpatient surgery performed at a physician's or specialist's office or outpatient department of a hospital or surgery center by a surgeon (includes anesthetist and surgical assistant expenses)	80% (of the negotiated charge) Policy year deductible applies	$0 copayment then the plan pays 80% (of the balance of the recognized charge) per admission Policy year deductible applies
The following are not covered under this benefit: • The services of any other physician who helps the operating physician • A stay in a hospital (Hospital stays are covered in the *Eligible health services and exclusions – Hospital and other facility care* section) • A separate facility charge for surgery performed in a physician's office • Services of another physician for the administration of a local anesthetic		

Eligible health services	In-network coverage	Out-of-network coverage
Alternatives to physician office visits		
Walk-in clinic visits (non-emergency visit)	80% (of the negotiated charge) per visit Policy year deductible applies	80% (of the recognized charge) per visit Policy year deductible applies
Hospital and other facility care		
Inpatient hospital (room and board) and other miscellaneous services and supplies) Includes birthing center facility charges	80% (of the negotiated charge) per admission Policy year deductible applies	80% (of the recognized charge) per admission Policy year deductible applies
In-hospital non-surgical physician services	80% (of the negotiated charge) per visit Policy year deductible applies	80% (of the recognized charge) per visit Policy year deductible applies
Alternatives to hospital stays		
Outpatient surgery (facility charges) performed in the outpatient department of a hospital or surgery center For **physician** charges, refer to the *Physician and specialist - outpatient surgical services* benefit	80% (of the negotiated charge) per visit Policy year deductible applies	80% (of the recognized charge) per visit Policy year deductible applies
The following are not covered under this benefit: • The services of any other physician who helps the operating physician • A stay in a hospital (See the *Hospital care – facility charges* benefit in this section) • A separate facility charge for surgery performed in a physician's office • Services of another physician for the administration of a local anesthetic		
Home health care	80% (of the negotiated charge) per visit Policy year deductible applies	80% (of the recognized charge) per visit Policy year deductible applies
The following are not covered under this benefit: • Services for infusion therapy • Nursing and home health aide services or therapeutic support services provided outside of the home (such as in conjunction with school, vacation, work or recreational activities) • Transportation • Services or supplies provided to a minor or dependent adult when a family member or caregiver is not present • Homemaker or housekeeper services		

• Food or home delivered services • Maintenance therapy		
Eligible health services	**In-network coverage**	**Out-of-network coverage**
Hospice-Inpatient (room and board and other miscellaneous services and supplies)	80% (of the negotiated charge) per admission Policy year deductible applies	80% (of the recognized charge) per admission Policy year deductible applies
Hospice-Outpatient	80% (of the negotiated charge) per visit Policy year deductible applies	80% (of the recognized charge) per visit Policy year deductible applies
The following are not covered under this benefit: • Funeral arrangements • Pastoral counseling • Bereavement counseling • Financial or legal counseling which includes estate planning and the drafting of a will • Homemaker or caretaker services that are services which are not solely related to your care and may include: - Sitter or companion services for either you or other family members - Transportation - Maintenance of the house		
Outpatient private duty nursing	80% (of the negotiated charge) per visit Policy year deductible applies	80% (of the recognized charge) per visit Policy year deductible applies
Skilled nursing facility-Inpatient (room and board and miscellaneous inpatient care services and supplies) Subject to semi-private room rate unless intensive care unit is required Room and board includes intensive care	80% (of the negotiated charge) per admission Policy year deductible applies	80% (of the recognized charge) per admission Policy year deductible applies
Hospital emergency room	100% (of the negotiated charge) per visit Policy year deductible applies	Paid the same as in-network coverage
Emergency services resulting from a criminal sexual assault or abuse	100% (of the negotiated charge) per visit	Paid the same as in-network coverage

Important note:

- As out-of-network providers do not have a contract with us the provider may not accept payment of your cost share, (copayment/coinsurance), as payment in full. You may receive a bill for the difference between the amount billed by the provider and the amount paid by this plan. If the provider bills you for an amount above your cost share, you are not responsible for paying that amount. You should send the bill to the address listed on the back of your ID card, and we will resolve any payment dispute with the provider over that amount. Make sure the ID card number is on the bill.
- A separate hospital emergency room copayment/coinsurance will apply for each visit to an emergency room. If you are admitted to a hospital as an inpatient right after a visit to an emergency room, your emergency room copayment/coinsurance will be waived and your inpatient copayment/coinsurance will apply.
- Covered benefits that are applied to the hospital emergency room copayment/coinsurance cannot be applied to any other copayment/coinsurance under the plan. Likewise, a copayment/coinsurance that applies to other covered benefits under the plan cannot be applied to the hospital emergency room copayment/coinsurance.
- Separate copayment/coinsurance amounts may apply for certain services given to you in the hospital emergency room that are not part of the hospital emergency room benefit. These copayment/coinsurance amounts may be different from the hospital emergency room copayment/coinsurance. They are based on the specific service given to you.
- Services given to you in the hospital emergency room that are not part of the hospital emergency room benefit may be subject to copayment/coinsurance amounts.

Eligible health services	**In-network coverage**	**Out-of-network coverage**
Urgent care	80% (of the negotiated charge) per visit Policy year deductible applies	80% (of the recognized charge) per visit Policy year deductible applies
Pediatric dental care (Limited to covered persons through the end of the month in which the person turns age 19)		
Type A services	100% (of the negotiated charge) per visit No copayment or deductible applies	70% (of the recognized charge) per visit Policy year deductible applies
Type B services	70% (of the negotiated charge) per visit No copayment or deductible applies	50% (of the recognized charge) per visit Policy year deductible applies
Type C services	50% (of the negotiated charge) per visit No copayment or deductible applies	50% (of the recognized charge) per visit Policy year deductible applies

Eligible health services	In-network coverage	Out-of-network coverage
Orthodontic services	50% (of the negotiated charge) per visit No copayment or deductible applies	50% (of the recognized charge) per visit Policy year deductible applies
Dental emergency treatment	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received.

Pediatric dental care exclusions

The following are not covered under this benefit:

- Any instruction for diet, plaque control and oral hygiene
- Cosmetic services and supplies including plastic surgery, reconstructive surgery, cosmetic surgery, personalization or characterization of dentures or other services and supplies which improve alter or enhance appearance, augmentation and vestibuloplasty, and other substances to protect, clean, whiten bleach or alter the appearance of teeth; whether or not for psychological or emotional reasons; except to the extent coverage is specifically provided in the *Eligible health services and exclusions* section. Facings on molar crowns and pontics will always be considered cosmetic.
- Crown, inlays, onlays, and veneers unless:
  - It is treatment for decay or traumatic injury and teeth cannot be restored with a filling material or
  - The tooth is an abutment to a covered partial denture or fixed bridge
- Dental implants and braces(that are determined not to be medically necessary mouth guards, and other devices to protect, replace or reposition teeth
- Dentures, crowns, inlays, onlays, bridges, or other appliances or services used:
  - For splinting
  - To alter vertical dimension
  - To restore occlusion
  - For correcting attrition, abrasion, abfraction or erosion
- Treatment of any jaw joint disorder and treatments to alter bite or the alignment or operation of the jaw, including temporomandibular joint dysfunction disorder (TMJ) and craniomandibular joint dysfunction disorder (CMJ) treatment, orthognathic surgery, and treatment of malocclusion or devices to alter bite or alignment, except as covered in the *Eligible health services and exclusions – Specific conditions* section
- General anesthesia and intravenous sedation, unless specifically covered and only when done in connection with another eligible health service
- Orthodontic treatment except as covered in the [*Pediatric*] *dental care* section of the schedule of benefits
- Pontics, crowns, cast or processed restorations made with high noble metals (gold)
- Prescribed drugs, pre-medication
- Replacement of a device or appliance that is lost, missing or stolen, and for the replacement of appliances that have been damaged due to abuse, misuse or neglect and for an extra set of dentures

- Routine dental exams and other preventive services and supplies, except as specifically provided in the [*Pediatric*] *dental care* section of the schedule of benefits
- Services and supplies:
  - Done where there is no evidence of pathology, dysfunction, or disease other than covered preventive services
  - Provided for your personal comfort or convenience or the convenience of another person, including a provider
  - Provided in connection with treatment or care that is not covered under your policy
- Surgical removal of impacted wisdom teeth only for orthodontic reasons
- Treatment by other than a dentist or dental provider that is legally qualified to furnish dental services or supplies

Eligible health services	**In-network coverage**	**Out-of-network coverage**
Specific conditions		
Diabetic services and supplies (including equipment and training)	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Podiatric (foot care) treatment Physician and specialist non-routine foot care treatment	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
The following are not covered under this benefit: • Services and supplies for: - The treatment of calluses, bunions, toenails, flat feet, hammertoes, fallen arches - The treatment of weak feet, chronic foot pain or conditions caused by routine activities, such as walking, running, working or wearing shoes - Supplies (including orthopedic shoes), foot orthotics, arch supports, shoe inserts, ankle braces, guards, protectors, creams, ointments and other equipment, devices and supplies - Routine pedicure services, such as cutting of nails, corns and calluses when there is no illness or injury of the feet		
Impacted wisdom teeth	80% (of the negotiated charge) Policy year deductible applies	80% (of the recognized charge) Policy year deductible applies
Accidental injury to sound natural teeth	80% (of the negotiated charge) Policy year deductible applies	80% (of the recognized charge) Policy year deductible applies
The following are not covered under this benefit: • The care, filling, removal or replacement of teeth and treatment of diseases of the teeth • Dental services related to the gums • Apicoectomy (dental root resection) • Orthodontics • Root canal treatment • Soft tissue impactions • Bony impacted teeth • Alveolectomy		

- Augmentation and vestibuloplasty treatment of periodontal disease
- False teeth
- Prosthetic restoration of dental implants
- Dental implants

Eligible health services	In-network coverage	Out-of-network coverage
Temporomandibular joint dysfunction (TMJ) [and craniomandibular joint dysfunction (CMJ)] treatment	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
The following are not covered under this benefit: Dental implants		
Clinical trial (routine patient costs)	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
The following are not covered under this benefit: • Services and supplies related to data collection and record-keeping that is solely needed due to the clinical trial (i.e. protocol-induced costs) • Services and supplies provided by the trial sponsor without charge to you • The experimental intervention itself (except medically necessary Category B investigational devices and promising experimental and investigational interventions for terminal illnesses in certain clinical trials in accordance with Aetna's claim policies)		
Dermatological treatment	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
The following are not covered under this benefit: Cosmetic treatment and procedures		
Obesity bariatric Surgery and services	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
The following are not covered under this benefit: - Drugs, stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food supplements, appetite suppressants and other medications - Hypnosis or other forms of therapy - Exercise programs, exercise equipment, membership to health or fitness clubs, recreational therapy or other forms of activity or activity enhancement		

Eligible health services	In-network coverage	Out-of-network coverage
Maternity care		
Maternity care (includes delivery and postpartum care services in a hospital or birthing center)	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
The following are not covered under this benefit:		

• Any services and supplies related to births that take place in the home or in any other place not licensed to perform deliveries		
Well newborn nursery care in a hospital or birthing center	80% (of the negotiated charge) Policy year deductible applies	80% (of the recognized charge) Policy year deductible applies
Family planning services – other		
Voluntary sterilization for males-surgical services	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Abortion	80% (of the negotiated charge) Policy year deductible applies	80% (of the recognized charge) Policy year deductible applies
The following are not covered under this benefit: • Reversal of voluntary sterilization procedures, including related follow-up care • Services provided as a result of complications resulting from a male voluntary sterilization procedure and related follow-up care		
Gender reassignment (sex change) treatment		
Surgical, hormone replacement therapy, and counseling treatment	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
All other cosmetic services and supplies not listed under eligible health services above are not covered under this benefit. This includes, but is not limited to the following: • Rhinoplasty • Face-lifting • Lip enhancement • Facial bone reduction • Blepharoplasty • Breast augmentation • Liposuction of the waist (body contouring) • Reduction thyroid chondroplasty (tracheal shave) • Nipple reconstruction • Hair removal (including electrolysis of face and neck) • Voice modification surgery (laryngoplasty or shortening of the vocal cords), and skin resurfacing, which are used in feminization • Voice and communication therapy • Chest binders • Chin implants, nose implants, and lip reduction, which are used to assist masculinization, are considered cosmetic		

Eligible health services	In-network coverage	Out-of-network coverage
Autism spectrum disorder		
Autism spectrum disorder treatment, diagnosis and testing and Applied behavior analysis (includes physician and specialist office visits)	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Mental Health & Substance use disorders related treatment		
Inpatient hospital mental health disorders treatment (room and board and other miscellaneous hospital services and supplies) Inpatient residential treatment facility mental health disorders treatment (room and board and other miscellaneous residential treatment facility services and supplies) Subject to semi-private room rate unless intensive care unit is required Mental health disorder room and board intensive care	80% (of the negotiated charge) per admission Policy year deductible applies	80% (of the recognized charge) per admission Policy year deductible applies
Outpatient mental health disorders treatment office visits to a physician or behavioral health provider (includes telemedicine consultations and cognitive behavioral therapy consultations)	80% (of the negotiated charge) per visit Policy year deductible applies	80% (of the recognized charge) per visit Policy year deductible applies
Other outpatient health disorders treatment (includes skilled behavioral health services in the home) (includes Partial hospitalization and Intensive	80% (of the negotiated charge) per visit Policy year deductible applies	80% (of the recognized charge) per visit Policy year deductible applies

Outpatient Program)			
Eligible health services	**In-network coverage (IOE facility)**	**In-network coverage (Non-IOE facility)**	**Out-of-network coverage**
Transplant services			
Inpatient and outpatient transplant facility services	Covered according to the type of benefit and the place where the service is received.		
Inpatient and outpatient transplant physician and specialist services	Covered according to the type of benefit and the place where the service is received.		
Transplant services-travel and lodging	Covered	Covered	Covered
Maximum payable for Travel and Lodging Expenses for any one transplant, including tandem transplants	$10,000	$10,000	$10,000
Maximum payable for Lodging Expenses per **IOE** patient	$50 per night	$50 per night	$50 per night
Maximum payable for Lodging Expenses per companion	$50 per night	$50 per night	$50 per night
The following are not covered under this benefit: • Services and supplies furnished to a donor when the recipient is not a covered person • Harvesting and storage of organs, without intending to use them for immediate transplantation for your existing illness • Harvesting and/or storage of bone marrow, hematopoietic stem cells, or other blood cells without intending to use them for transplantation within 12 months from harvesting, for an existing illness			
Eligible health services	**In-network coverage**	**Out-of-network coverage**	
Treatment of infertility			
Basic infertility services Inpatient and outpatient care - basic infertility	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.	
Comprehensive infertility services Inpatient and outpatient care	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.	
Advanced reproductive technology (ART) services	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.	

For treatment that includes an oocyte retrieval, maximum number of oocyte retrievals	4, however if a live birth follows a completed oocyte retrieval, 2 additional oocyte retrievals will be covered.

The following are not covered services under the infertility treatment benefit:

- All charges associated with:
  - Services provided to a surrogate. A surrogate is a female carrying her own genetically related child where the child is conceived with the intention of turning the child over to be raised by others, including the biological father. If you choose to use a surrogate, this exclusion does not apply to the cost for procedures to obtain the eggs, sperm or embryo from a covered person.
- Reversal of voluntary sterilizations, including follow-up care. However, if a voluntary sterilization is successfully reversed, infertility benefits are available if your diagnosis meets the definition of infertility
- Travel costs within 100 miles of your home or travel cost not required by Aetna
- Infertility treatment for covered dependents under age 18
- Non-medical costs of an egg or sperm donor
- Experimental or investigational infertility treatment as determined by the American Society for Reproductive Medicine
- [ART services are not provided for out-of-network care

Eligible health services	**In-network coverage**	**Out-of-network coverage**
Specific therapies and tests		
Diagnostic complex imaging services performed in the outpatient department of a hospital or other facility No additional expense, such as a copayment or deductible amount, will be imposed for mammograms	80% (of the negotiated charge) per visit Policy year deductible applies	80% (of the recognized charge) per visit Policy year deductible applies
Diagnostic lab work and radiological services performed in a physician's office, the outpatient department of a hospital or other facility No additional expense, such as a copayment or deductible amount, will be imposed for mammograms	80% (of the negotiated charge) per visit Policy year deductible applies	80% (of the recognized charge) per visit Policy year deductible applies

Eligible health services	In-network coverage	Out-of-network coverage
Outpatient Chemotherapy, Radiation & Respiratory Therapy	80% (of the negotiated charge) per visit Policy year deductible applies	80% (of the recognized charge) per visit Policy year deductible applies
Outpatient physical, occupational, speech, and cognitive therapies (including Cardiac and Pulmonary Therapy) Combined for short-term rehabilitation services and habilitation therapy services	80% (of the negotiated charge) per visit Policy year deductible applies	80% (of the recognized charge) per visit Policy year deductible applies
Acupuncture therapy	80% (of the negotiated charge) per visit Policy year deductible applies	80% (of the recognized charge) per visit Policy year deductible applies
Chiropractic services	80% (of the negotiated charge) per visit Policy year deductible applies	80% (of the recognized charge) per visit Policy year deductible applies
Maximum visits per policy year	25	
Specialty prescription drugs purchased and injected or infused by your provider in an outpatient setting	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Other services and supplies		
Emergency ground, air, and water ambulance (includes non-emergency ambulance)	80% (of the negotiated charge) per trip Policy year deductible applies	Paid the same as in-network coverage
The following are not covered under this benefit: • Non-emergency fixed wing air ambulance from an out-of-network provider • Ambulance services for routine transportation to receive outpatient or inpatient care		
Durable medical and surgical equipment	80% (of the negotiated charge) per item Policy year deductible applies	80% (of the recognized charge) per item Policy year deductible applies
The following are not covered under this benefit: • Whirlpools • Portable whirlpool pumps • Sauna baths • Massage devices • Over bed tables		

• Elevators • Communication aids • Vision aids • Telephone alert systems • Personal hygiene and convenience items such as air conditioners, humidifiers, hot tubs, or physical exercise equipment even if they are prescribed by a physician		
Eligible health services	**In-network coverage**	**Out-of-network coverage**
Nutritional support	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
The following are not covered under this benefit: • Any food item, including infant formulas, nutritional supplements, vitamins, plus prescription vitamins, medical foods and other nutritional items, even if it is the sole source of nutrition. except as described above		
Prosthetic and customized orthotic devices (Includes Cranial prosthetics *(Medical wigs)*	80% (of the negotiated charge) per item Policy year deductible applies	80% (of the recognized charge) per item Policy year deductible applies
The following are not covered under this benefit: • Services covered under any other benefit • Orthopedic shoes, therapeutic shoes, foot orthotics, or other devices to support the feet, unless required for the treatment of or to prevent complications of diabetes, or if the orthopedic shoe is an integral part of a covered leg brace • Trusses, corsets, and other support items • Repair and replacement due to loss, misuse, abuse or theft • Communication aids		
Hearing aids and Exams		
Hearing aid exams	80% (of the negotiated charge) per visit Policy year deductible applies	80% (of the recognized charge) per visit Policy year deductible applies
Hearing aids	80% (of the negotiated charge) per visit Policy year deductible applies	80% (of the recognized charge) per visit Policy year deductible applies
Hearing aids maximum per ear	One hearing aid per ear every 12 month consecutive period	
The following are not covered under this benefit: • A replacement of: - A hearing aid that is lost, stolen or broken - A hearing aid installed within the prior [6-60 month] period • Replacement parts or repairs for a hearing aid • Batteries or cords • A hearing aid that does not meet the specifications prescribed for correction of hearing loss		

• Any ear or hearing exam performed by a **physician** who is not certified as an otolaryngologist or otologist		
Eligible health services	**In-network coverage**	**Out-of-network coverage**
Pediatric vision care (Limited to covered persons through the end of the month in which the person turns age 19)		
Performed by a legally qualified ophthalmologist or optometrist (includes comprehensive low vision evaluations)	100% (of the negotiated charge) per visit No policy year deductible applies	100% (of the recognized charge) per visit Policy year deductible applies
Maximum visits per policy year Low vision Maximum Fitting of contact Maximum	1 visit One comprehensive low vision evaluation every policy year 2 visits	
Pediatric vision care services & supplies-Eyeglass frames, prescription lenses or prescription contact lenses	100% (of the negotiated charge) per visit No policy year deductible applies	100% (of the recognized charge) per visit Policy year deductible applies
Maximum number Per year: Eyeglass frames Prescription lenses Contact lenses (includes non-conventional prescription contact lenses & aphakic lenses prescribed after cataract surgery)	One set of eyeglass frames One pair of prescription lenses Daily disposables: up to 3 month supply Extended wear disposable: up to 6 month supply Non-disposable lenses: one set	
Optical devices	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Maximum number of optical devices per policy year	One optical device	

PRESCRIBED MEDICINES EXPENSE	
*The prescription drug plan covered percentage is the percentage of prescription drug covered medical expenses that the plan pays.	
Generic and Brand Prescription Drugs	**Preferred Care**
For each 30 day supply filled at a retail pharmacy. **You must pay out of pocket and then submit your receipt to Aetna Student Health for reimbursement.**	80% of the Actual Charge after the $50 Prescription Deductible.
Copay and Deductible Waiver **Waiver for Risk-Reducing Breast Cancer Prescription Drugs**	

Risk-reducing breast cancer generic prescription drugs will be paid at 100%.

Waiver for Prescription Drug Contraceptives

The per prescription coinsurance will not apply to:

Female contraceptives that are:

- Oral prescription drugs that are generic prescription drugs.
- Injectable prescription drugs that are generic prescription drugs.
    - Female contraceptive devices.
    - FDA-approved female:
- generic emergency contraceptives; and
- generic over-the-counter (OTC) emergency contraceptives.

when obtained at a preferred care pharmacy. This means that such contraceptive methods will be paid at 100%. The per prescription coinsurance will continue to apply:

- When the contraceptive methods listed above are obtained at a non-preferred pharmacy.
- To female contraceptives that are:
    - Oral prescription drugs that are brand-name prescription drugs and biosimilar prescription drugs.
    - Injectable prescription drugs that are brand-name prescription drugs and biosimilar prescription drugs.
- To female contraceptive devices that are brand-name devices.
- To FDA-approved female:
    - brand-name and biosimilar emergency contraceptives; and
    - brand-name over-the-counter (OTC) emergency contraceptives.
- To FDA-approved female brand-name over-the-counter (OTC) contraceptives.
- To FDA-approved male brand-name over-the-counter (OTC) contraceptives.

However, the per prescription coinsurance will not apply to such contraceptive methods if:

- A generic equivalent, biosimilar or generic alternative, within the same therapeutic drug class is not available; or
- A covered person is granted a medical exception; or
- Physician specifies "Dispense as Written" (DAW).

Outpatient prescription drugs exclusions
The following are not covered under the outpatient prescription drugs benefit:

- Contraceptives
    - Contraceptive methods, procedures, services, and supplies for contraceptive purposes as elected by the policyholder due to an exemption or accommodation in accordance with applicable federal or state law and regulation

- Services provided as a result of complications resulting from voluntary sterilization procedure and related follow-up care

- Drugs or medications
  - Administered or entirely consumed at the time and place it is prescribed or provided
  - Which do not, by federal or state law, require a prescription order [i.e. over-the-counter (OTC) drugs)], even if a prescription is written except as specifically provided above
  - That include the same active ingredient or a modified version of an active ingredient as a covered prescription drug (unless a medical exception is approved)
  - That are therapeutically equivalent or therapeutically alternative to a covered prescription drug (unless a medical exception is approved)
  - That are therapeutically equivalent or therapeutically alternative to an over-the-counter (OTC) product (unless a medical exception is approved
  - Not approved by the FDA or not proven safe or effective
  - Provided under your medical plan while an inpatient of a healthcare facility
  - Recently approved by the U.S. Food and Drug Administration (FDA), but which have not yet been reviewed by our Pharmacy and Therapeutics Committee
  - That include vitamins and minerals unless recommended by the United States Preventive Services Task Force (USPSTF)
  - For which the cost is covered by a federal, state, or government agency (for example: Medicaid or Veterans Administration)
  - That are used to treat sexual dysfunction, enhance sexual performance or increase sexual desire, including drugs, implants, devices or preparations to correct or enhance erectile function, enhance sensitivity, or alter the shape or appearance of a sex organ
  - That are used for the purpose of weight gain or reduction, including but not limited to stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food or food supplements, appetite suppressants or other medications
  - That are drugs or growth hormones used to stimulate growth and treat idiopathic short stature unless there is evidence that the covered person meets one or more clinical criteria detailed in our precertification and clinical policies
- Genetic care
  - Any treatment, device, drug, service or supply to alter the body's genes, genetic make-up, or the expression of the body's genes except for the correction of congenital birth defects

A covered person, a covered person's designee or a covered person's prescriber may seek an expedited medical exception process to obtain coverage for non-covered drugs in exigent circumstances. An "exigent circumstance" exists when a covered person is suffering from a health condition that may seriously jeopardize a covered person's life, health, or ability to regain maximum function or when a covered person is undergoing a current course of treatment using a non-formulary drug.

The request for an expedited review of an exigent circumstance may be submitted by contacting Aetna's *Pre-certification Department* at **1-855-240-0535**, faxing the request to **1-877-269-9916**, or submitting the request in writing to:

CVS Health
ATTN: Aetna PA
1300 E. Campbell Road
Richardson, TX 75081

General Exclusions

Acupuncture therapy

- Maintenance treatment
- Acupuncture when provided for the following conditions:
  - Acute low back pain
  - Addiction
  - AIDS
  - Amblyopia
  - Allergic rehinitis
  - Asthma
  - Autism spectrum disorders
  - Bell's Palsy
  - Burning mouth syndrome
  - Cancer-related dyspnea
  - Carpal tunnel syndrome
  - Chemotherapy-induced leukopenia
  - Chemotherapy-induced neuopathic pain
  - Chronic pain syndrome (e.g., RSD, facial pain)
  - Chronic obstructive pulmonary disease
  - Diabetic peripheral neuropathy
  - Dry eyes
  - Erectile dysfunction
  - Facial spasm
  - Fetal breech presentation
  - Fibromyalgia
  - Fibrotic contractures
  - Glaucoma
  - Hypertension
  - Induction of labor
  - Infertility(e.g., to assist oocyte retrieval and embryo transfer during IVF tre atment cycle)
  - Insomnia
  - Irritable bowel syndrome
  - Menstrual cramps/dysmenorrhea
  - Mumps
  - Myofascial pain
  - Myopia
  - Neck pain/cervical spondylosis
  - Obesity
  - Painful neuropathies
  - Parkinson's disease
  - Peripheral arterial disease (e.g., intermittent claudication)
  - Phantom leg pain
  - Polycystic ovary syndrome
  - Post-herpetic neuralgia

- Psoriasis
- Psychiatric disorders (e.g., depression)
- Raynaud's disease pain
- Respiratory disorders
- Rheumatoid arthritis
- Rhinitis
- Sensorineural deafness
- Shoulder pain (e.g., bursitis)
- Stroke rehabilitation (e.g., dysphagia)
- Tennis elbow/ epicondylitis
- Tension headache
- Tinnitus
- Tobacco Cessation
- Urinary incontinence
- Uterine fibroids
- Xerostomia
- Whiplash

Alternative health care

- Services and supplies given by a provider for alternative health care. This includes but is not limited to aromatherapy, naturopathic medicine, herbal remedies, homeopathy, energy medicine, Christian faith-healing medicine, Ayurvedic medicine, yoga, hypnotherapy, and traditional Chinese medicine.

Armed forces

- Services and supplies received from a provider as a result of an injury sustained, or illness contracted, while in the service of the armed forces of any country. When you enter the armed forces of any country, we will refund any unearned pro-rata premium to the policyholder.

Beyond legal authority

- Services and supplies provided by a health professional or other provider that is acting beyond the scope of its legal authority

Blood, blood plasma, synthetic blood, blood derivatives or substitutes

Examples of these are:

- The provision of blood to the hospital, other than blood derived clotting factors
- Any related services including processing, storage or replacement expenses
- The services of blood donors, apheresis or plasmapheresis
- For autologous blood donations, only administration and processing expenses are covered

Breasts

- Services and supplies given by a provider for breast reduction or gynecomastia

Clinical trial therapies (experimental or investigational)

- Your plan does not cover clinical trial therapies (experimental or investigational), except as described in the *Eligible health services under your plan - Clinical trial therapies (experimental or investigational)* section

Cosmetic services and plastic surgery

- Any treatment, surgery (cosmetic or plastic), service or supply to alter, improve or enhance the shape or appearance of the body, whether or not for psychological or emotional reasons, except where described in the *Eligible health services under your plan - Reconstructive surgery and supplies* section. Injuries that occur during medical treatments are not considered accidental injuries even if unplanned or unexpected.

This exclusion does not apply to:

- Surgery after an accidental injury when performed as soon as medically feasible
- Coverage that may be provided under the *Eligible health services under your plan - Gender reassignment (sex change) treatment* section.
- The removal of breast implants due to an **illness** or **injury**

Court-ordered services and supplies

- This includes court-ordered services and supplies, or those required as a condition of parole, probation, release or as a result of any legal proceeding, unless they are a covered benefit under your plan. This exclusion does not apply to court-ordered FDA-approved prescription drugs for the treatment of substance use disorders and any associated counseling or wraparound services.

Custodial care

Examples are:

- Routine patient care such as changing dressings, periodic turning and positioning in bed
- Administering oral medications
- Care of a stable tracheostomy (including intermittent suctioning)
- Care of a stable colostomy/ileostomy
- Care of stable gastrostomy/jejunostomy/nasogastric tube (intermittent or continuous) feedings
- Care of a bladder catheter (including emptying/changing containers and clamping tubing)
- Watching or protecting you
- Respite care except in connection with hospice care, adult (or child) day care, or convalescent care
- Institutional care. This includes room and board for rest cures, adult day care and convalescent care
- Help with walking, grooming, bathing, dressing, getting in or out of bed, toileting, eating or preparing foods
- Any other services that a person without medical or paramedical training could be trained to perform
- Any service that can be performed by a person without any medical or paramedical training

Dental care for adults

- Dental services for adults including services related to:
  - The care, filling, removal or replacement of teeth and treatment of injuries to or diseases of the teeth
  - Dental services related to the gums
  - Apicoectomy (dental root resection)
  - Orthodontics
  - Root canal treatment
  - Soft tissue impactions
  - Alveolectomy
  - Augmentation and vestibuloplasty treatment of periodontal disease
  - False teeth
  - Prosthetic restoration of dental implants
  - Dental implants

  This exception does not include treatment of accidental **injuries** to sound natural teeth and treatment for diseases of the teeth, removal of bony impacted teeth, bone fractures, removal of tumors, and odontogenic cysts. . This exclusion also does not include tooth extraction **surgery** in preparation for radiation treatment of neoplastic jaw or throat diseases.

Educational services

Examples of these services are:

- Any service or supply for education, training or retraining services or testing, except where described in the *Eligible health services and exclusions– Diabetic services and supplies (including equipment and training)* section in the certificate. This includes:
  - Special education
  - Remedial education
  - Wilderness treatment programs (whether or not the program is part of a residential treatment facility or otherwise licensed institution)
  - Job training
  - Job hardening programs
- Educational services, schooling or any such related or similar program, including therapeutic programs within a school setting.

Elective treatment or elective surgery

- Elective treatment or elective surgery except as specifically covered under the student policy and provided while the student policy is in effect

Examinations

Any health or dental examinations needed:

- Because a third party requires the exam. Examples are, examinations to get or keep a job, or examinations required under a labor agreement or other contract
- Because a law requires it
- To buy insurance or to get or keep a license
- To travel

- To go to a school, camp, or sporting event, or to join in a sport or other recreational activity

Experimental or investigational

- Experimental or investigational drugs, devices, treatments or procedures unless otherwise covered under clinical trial therapies (experimental or investigational) or covered under clinical trials (routine patient costs). See the *Eligible health services and exclusions – Other services* section . Note that this exclusion will not impact your ability to obtain an external review of denial of coverage for a service or supply denied by us as **experimental or investigational.**

Facility charges

For care, services or supplies provided in:

- Rest homes
- Assisted living facilities
- Similar institutions serving as a persons' main residence or providing mainly custodial or rest care
- Health resorts
- Spas or sanitariums
- Infirmaries at schools, colleges, or camps

Genetic care

- Any treatment, device, drug, service or supply to alter the body's genes, genetic make-up, or the expression of the body's genes except for the correction of congenital birth defects

Growth/Height care

- A treatment, device, drug, service or supply to increase or decrease height or alter the rate of growth
- Surgical procedures, devices and growth hormones to stimulate growth

Illegal Occupation

- Services and supplies that you receive as a result of an **injury** due to your commission of a felony to which the contributing cause was the engagement of an illegal occupation

Incidental surgeries

- Charges made by a physician for incidental surgeries. These are non-medically necessary surgeries performed during the same procedure as a medically necessary surgery.

Jaw joint disorder

- Surgical treatment of jaw joint disorders
- Non-surgical treatment of jaw joint disorders
- Jaw joint disorders treatment performed by prosthesis placed directly on the teeth, surgical and non-surgical medical and dental services, and diagnostic or therapeutics services related to jaw joint disorders including associated myofascial pain

This exclusion does not apply to covered benefits for treatment of TMJ and CMJ as described in the *Eligible health services under your plan –Temporomandibular joint dysfunction (TMJ) and craniomandibular joint dysfunction (CMJ) treatment* section.

Judgment or settlement

- Services and supplies for the treatment of an injury or illness to the extent that payment is made as a judgment or settlement by any person deemed responsible for the injury or illness (or their insurers)

Mandatory no-fault laws

- Treatment for an injury to the extent benefits are payable under any state no-fault automobile coverage or first party medical benefits payable under any other mandatory no-fault law

Maintenance care

- Care made up of services and supplies that maintain, rather than improve, a level of physical or mental function, except for habilitation therapy services. See the *Eligible health services under your plan – Habilitation therapy service*s section

Medical supplies – outpatient disposable

- Any outpatient disposable supply or device. Examples of these are:
  - Sheaths
  - Bags
  - Elastic garments
  - Support hose
  - Bandages
  - Bedpans
  - Syringes
  - Blood or urine testing supplies
  - Other home test kits
  - Splints
  - Neck braces
  - Compresses
  - Other devices not intended for reuse by another patient

Medicare

- Services and supplies available under Medicare, if you are entitled to premium-free Medicare Part A or enrolled in Medicare Part B, or if you are not entitled to premium-free Medicare Part A or enrolled in Medicare Part B because you refused it, dropped it, or did not make a proper request for it

Non-medically necessary services and supplies

- Services and supplies which are not medically necessary for the diagnosis, care, or treatment of an illness or injury or the restoration of physiological functions This includes behavioral health services that are not primarily aimed at the treatment of illness, injury, restoration of physiological functions or that do not have a physiological or organic basis. This applies even if they are prescribed, recommended, or approved by your physician, dental provider, or vision care provider. This exception does not apply to *Preventive care and wellness* benefits.

Non-U.S. citizen

- Services and supplies received by a covered person (who is not a United States citizen) within the covered person's home country but only if the home country has a socialized medicine program.

Obesity (bariatric) surgery and services

- Weight management treatment or drugs intended to decrease or increase body weight, control weight or treat obesity, including morbid obesity except as described in the *Eligible health services and exclusions – Preventive care and wellness* section, including preventive services for obesity screening and weight management interventions. This is regardless of the existence of other medical conditions. Examples of these are:
  - Drugs, stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food supplements, appetite suppressants and other medications
  - Hypnosis or other forms of therapy
  - Exercise programs, exercise equipment, membership to health or fitness clubs, recreational therapy or other forms of activity or activity enhancement

Other primary payer

- Payment for a portion of the charge that Medicare or another party is responsible for as the primary payer

Personal care, comfort or convenience items

- Any service or supply primarily for your convenience and personal comfort or that of a third party

Riot

- Services and supplies that you receive from providers as a result of an injury from your "participation in a riot". This means when you take part in a riot in any way such as inciting, or conspiring to incite, the riot. It does not include actions that you take in self-defense as long as they are not against people who are trying to restore law and order.

Routine exams

- Routine physical exams, routine eye exams, routine dental exams, routine hearing exams and other preventive services and supplies, except as specifically provided in the *Eligible health services under your plan* section

School health services

- Services and supplies normally provided by the policyholder's:
  - School health services
  - Infirmary
  - Hospital
  - Pharmacy or

  by health professionals who
  - Are employed by
  - Are Affiliated with
  - Have an agreement or arrangement with, or

- Are otherwise designated by the policyholder.

Services provided by a family member

- Services provided by a spouse, domestic partner, civil union partner parent, child, step-child, brother, sister, in-law or any household member

Sexual dysfunction and enhancement

- Any treatment, prescription drug, service, or supply to treat sexual dysfunction, enhance sexual performance or increase sexual desire, including:
  - Surgery, prescription drugs, implants, devices or preparations to correct or enhance erectile function, enhance sensitivity, or alter the shape or appearance of a sex organ
  - Sex therapy, sex counseling, marriage counseling, or other counseling or advisory services
- Not eligible for coverage are prescription drugs in 90 day supplies

Strength and performance

- Services, devices and supplies such as drugs or preparations designed primarily for enhancing your:
  - Strength
  - Physical condition
  - Endurance
  - Physical performance

Therapies and tests

- Full body CT scans
- Hair analysis
- Hypnosis and hypnotherapy
- Massage therapy, except when used as a physical therapy modality
- Sensory or auditory integration therapy

Tobacco cessation

- Any treatment, drug, service or supply to stop or reduce smoking or the use of other tobacco products or to treat or reduce nicotine addiction, dependence or cravings, including, medications, nicotine patches and gum unless recommended by the United States Preventive Services Task Force (USPSTF). This also includes:
  - Counseling, except as specifically provided in the *Eligible health services under your plan – Preventive care and wellness* section
  - Hypnosis and other therapies
  - Medications, except as specifically provided in the *Eligible health services under your plan – Outpatient prescription drugs* section
  - Nicotine patches
  - Gum

Treatment in a federal, state, or governmental entity

- Any care in a hospital or other facility owned or operated by any federal, state or other governmental entity, except to the extent coverage is required by applicable laws

Vision care for adults

- Routine vision exam provided by an ophthalmologist or optometrist, including refraction and glaucoma testing
- Vision care services and supplies

Wilderness treatment programs

See *Educational services* within this section

Work related illness or injuries

- Coverage available to you under worker's compensation or under a similar program under local, state or federal law for any illness or injury related to employment or self-employment.
- A source of coverage or reimbursement will be considered available to you even if you waived your right to payment from that source. You may also be covered under a workers' compensation law or similar law. If you submit proof that you are not covered for a particular illness or injury under such law, then that illness or injury will be considered "non-occupational" regardless of cause.

Sanctioned Countries

If coverage provided by this policy violates or will violate any economic or trade sanctions, the coverage is immediately considered invalid. For example, Aetna companies cannot make payments for health care or other claims or services if it violates a financial sanction regulation. This includes sanctions related to a blocked person or a country under sanction by the United States, unless permitted under a written Office of Foreign Asset Control (OFAC) license. For more information, visit http://www.treasury.gov/resource-center/sanctions/Pages/default.aspx.

Assistive Technology

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 1-877-480-4161.

Smartphone or Tablet

To view documents from your smartphone or tablet, the free WinZip app is required. It may be available from your App Store.

Non-Discrimination

Aetna is committed to being an inclusive health care company. Aetna does not discriminate on the basis of ancestry, race, ethnicity, color, religion, sex/gender (including pregnancy), national origin, sexual orientation, gender identity or expression, physical or mental disability, medical condition, age, veteran status, military status, marital status, genetic information, citizenship status, unemployment status, political affiliation, or on any other basis or characteristic prohibited by applicable federal, state or local law.

Aetna provides free aids and services to people with disabilities and free language services to people whose primary language is not English.

These aids and services include:

- Qualified language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Qualified interpreters
- Information written in other languages

If you need these services, contact the number on your ID card. Not an Aetna member? Call us at 1-877-480-4161.

If you have questions about our nondiscrimination policy or have a discrimination-related concern that you would like to discuss, please call us at 1-877-480-4161.

Please note, Aetna covers health services in compliance with applicable federal and state laws. Not all health services are covered. See plan documents for a complete description of benefits, exclusions, limitations, and conditions of coverage.

Language accessibility statement

Interpreter services are available for free.

Attention: If you speak English, language assistance service, free of charge, are available to you. Call **1-877-480-4161** (TTY: **711**).

Español/Spanish

Atención: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-877-480-4161** (TTY: **711**).

አማርኛ**/Amharic**

ልብ ይበሉ: አማርኛ ቋንቋ የሚናገሩ ከሆነ፥ የትርጉም ድጋፍ ሰጪ ድርጅቶች፣ ያለምንም ክፍያ እርስዎን ለማገልገል ተዘጋጅተዋል። የሚከተለው ቁጥር ላይ ይደውሉ **1-877-480-4161** (መስማት ለተሳናቸው: **711**).

العربية**/Arabic**

ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم **1-877-480-4161** (رقم الهاتف النصي: **711**).

Bàsɔ̀ɔ̀ Wùɖù/Bassa

Dè dɛ nìà kɛ dyeɖeˈ gbo: ɔ juˇkeˈ m̀ dyi Bàsɔ̀ɔ̀-wùɖù-po-nyɔ̀ juˇnɨˇ, nìɨˇ à wuɖu kà kò ɖò po-poɔ̀ ɓɛ́ m̀ gbo kpaˈa. Ðaˈ **1-877-480-4161** (TTY: **711**).

中文/Chinese

注意：如果您说中文，我们可为您提供免费的语言协助服务。请致电 **1-877-480-4161** (TTY: **711**)。

فارسی**/Farsi**

توجه: اگر به زبان فارسی صحبت می کنید، خدمات زبانی رایگان به شما ارایه میگردد، با شماره **1-877-480-4161** (TTY: **711**) تماس بگیرید.

Français/French

Attention : Si vous parlez français, vous pouvez disposer d'une assistance gratuite dans votre langue en composant le **1-877-480-4161** (TTY: **711**).

ગુજરાતી**/Gujarati**

ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હો તો ભાષાકીય સહાયતા સેવા તમને નિ:શુલ્ક ઉપલબ્ધ છે.
કૉલ કરો **1-877-480-4161** (TTY: **711**).

Kreyòl Ayisyen/Haitian Creole

Atansyon: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele **1-877-480-4161** (TTY: **711**).

Igbo

Nrụbama: Ọ bụrụ na ị na asụ Igbo, ọrụ enyemaka asụsụ, n'efu, dịịrị gị. Kpọọ **1-877-480-4161** (TTY: **711**).

한국어/Korean

주의: 한국어를 사용하시는 경우, 언어 지원 서비스가 무료로 제공됩니다. **1-877-480-4161**(TTY: **711**)번으로 전화해 주십시오.

Português/Portuguese

Atenção: a ajuda está disponível em português por meio do número **1-877-480-4161** (TTY: **711**).
Estes serviços são oferecidos gratuitamente.

Русский/Russian

Внимание: если вы говорите на русском языке, вам могут предоставить бесплатные услуги перевода. Звоните по телефону **1-877-480-4161** (TTY: **711**).

Tagalog

Paunawa: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **1-877-480-4161** (TTY: **711**).

/Urduاردو

توجہ دیں: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت دستیاب ہیں ۔ (TTY: **711**) **1-877-480-4161** پر کال کریں.

Tiếng Việt/Vietnamese

Lưu ý: Nếu quý vị nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho quý vị.
Gọi số **1-877-480-4161** (TTY: **711**).

Yorùbá/Yoruba

Àkíyèsí: Bí o bá nsọ èdè Yorùbá, ìrànlọ́wọ́ lórí èdè, lófẹ̀ẹ́, wà fún ọ. Pe **1-877-480-4161** (TTY: **711**).

Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company, Coventry Health Care plans and their affiliates (Aetna).

Office of Student Health Insurance
Campus Box 2541
Normal, Illinois 61790
(309) 438-2515
Insurance Identification Card
School Name: **Illinois State University**
Payer Number: 60054 0315
Student Name:
Id Number:
Group #: 711123

Carry This Card With You At All Times

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

$50 Deductible Per Policy Year waived if a coordinating policy also covers the insured.
This Program is underwritten by: Aetna Life Insurance Company (ALIC)
$50 Annual Prescribed Medicines deductible. aetna

The following changes have been made to the original plan design and benefits summary describing your plan.

Unless otherwise indicated, all changes listed below are retroactive to your plan's effective date.

Issue Date of this Update:
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Voluntary sterilization for males-surgical services	100% (of the negotiated charge) No copayment or Policy year deductible applies	100% (of the recognized charge) No copayment or Policy year deductible applies