

PLAN DESIGN AND BENEFITS - IL HMO 1 (3/12)

PLAN FEATURES	PARTICIPATING PROVIDERS
Deductible Amount The family Deductible is a cumulative Deductible for all family members.	\$0 per Member per calendar year \$0 per Family per calendar year
Plan Coinsurance	70%
Maximum Out-of-Pocket Limit The family Maximum Out-of-Pocket Limit is a cumulative Maximum Out-of-Pocket Limit for all family members.	\$1,500 per Member per calendar year \$3,000 per Family per calendar year
Member must demonstrate the Copayment amounts that have been paid during the year.	
Health Incentive Credit Program Wellness Programs through Simple Steps Reward	Incentive Rewards will be credited towards the deductible and Maximum Out-of-Pocket Limit. Simple Steps Health Assessment and one Online Wellness Program \$50.00 per employee and/or spouse with a family limit of \$100.00 per year for completion of the Health Assessment and one Online Wellness Program.
Primary Care Physician Selection	Required
Referral Requirement	Required for all non-emergency, non-urgent and non-Primary Care Physician services, except direct access services
PHYSICIAN SERVICES	PARTICIPATING PROVIDERS
Primary Care Physician Visits	\$30 per visit
Specialist Physician Services	\$50 per visit
E-visit (register at www.relayhealth.com)	\$30 per visit
Walk-In-Clinics	\$30 per visit
Maternity / OB Visits	70% (of the contracted rate) per visit
Surgery (in office)	70% (of the contracted rate) per visit
PREVENTIVE CARE	PARTICIPATING PROVIDERS
Routine Adult Physical Exams / Immunizations	\$0 per visit
Well Child Physical Examination including Immunizations	\$0 per visit
Routine Gynecological Exams Includes Pap smear and related lab fees 365 consecutive day period	\$0 per visit
Mammography	\$0 per visit
Routine Digital Rectal Exams/Prostate Specific Antigen Test Age/Frequency Schedule may apply.	\$0 per visit
Colorectal Cancer Screening For all members age 50 and over. Frequency schedule applies.	\$0 per visit
DIAGNOSTIC PROCEDURES	PARTICIPATING PROVIDERS
Diagnostic Laboratory Testing- Performed at a Hospital Outpatient Facility	70% (of the contracted rate) per visit
Performed at a facility other than a Hospital Outpatient Facility	70% (of the contracted rate) per visit
Diagnostic X-Ray Testing- Performed at a Hospital Outpatient Facility	70% (of the contracted rate) per visit
Performed at a Facility other than Hospital Outpatient Facility	70% (of the contracted rate) per visit
Complex Imaging Services, including but not limited to: MRI, CAT, and PET	70% (of the contracted rate) per visit
EMERGENCY/URGENT MEDICAL CARE	PARTICIPATING PROVIDERS
Urgent Care Facility	\$50 per visit
Non-Urgent use of Urgent Care Provider	Not Covered

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EMERGENCY/URGENT MEDICAL CARE (CONTINUED)	PARTICIPATING PROVIDERS
Outpatient Emergency Services Hospital Emergency or Outpatient Department	\$200 per visit
Non-Emergency care in an Outpatient Emergency Services	Not Covered
Ambulance	70% (of the contracted rate) per trip
HOSPITAL CARE	PARTICIPATING PROVIDERS
Acute	70% (of the contracted rate) per admission
Maternity	70% (of the contracted rate) per admission
Transplant Benefits When provided at an Institute of Excellence™ (IOE) facility: When provided at a non-Institute of Excellence facility: No benefit provided.	70% (of the contracted rate) per admission
Outpatient Surgery Performed at a Hospital Outpatient Facility	70% (of the contracted rate) per visit
MENTAL HEALTH SERVICES	PARTICIPATING PROVIDERS
Inpatient Mental Health	70% (of the contracted rate) per admission
Outpatient Mental Health Visits	\$50 per visit
ALCOHOL/DRUG ABUSE SERVICES	PARTICIPATING PROVIDERS
Inpatient Detoxification and Rehabilitation	70% (of the contracted rate) per admission
Outpatient Detoxification and Rehabilitation	\$50 per visit
OTHER SERVICES	PARTICIPATING PROVIDERS
Skilled Nursing Facility Maximum of 60 days per calendar year	70% (of the contracted rate) per admission
Outpatient Home Health Visits 60 visits per calendar year	70% (of the contracted rate) per visit
Hospice Care - Inpatient	70% (of the contracted rate) per admission
Hospice Care - Outpatient	\$50 per visit
Outpatient Physical, Occupational and Speech Therapy 60 combined physical, occupational and speech therapy visits per period per incident of illness or injury beginning with the first day of treatment per calendar year.	\$50 per visit
Outpatient Facility Visits	70% (of the contracted rate) per visit
Subluxation	\$50 per visit
Durable Medical Equipment DME Maximum benefit \$2,500 per Member per calendar year	70% (of the cost) per item
FAMILY PLANNING	PARTICIPATING PROVIDERS
Infertility Treatment Coverage only for the diagnosis and treatment of the underlying medical condition	Member cost sharing is based on the type of service performed and the place rendered.
Comprehensive Infertility Services Services and supplies are only covered for groups with 26 or more eligibles Coverage includes Artificial Insemination and Ovulation induction.	Member cost sharing is based on the type of service performed and the place rendered.

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FAMILY PLANNING (CONTINUED)	PARTICIPATING PROVIDERS
<p>Advanced Reproductive Technology (ART) Services and supplies are only covered for groups with 26 or more eligibles ART coverage includes: In vitro fertilization (IVF), zygote intra-fallopian transfer (ZIFT), gamete intra-fallopian transfer (GIFT), cryo-preserved embryo transfers, intra-cytoplasmic sperm injection (ICSI) or ovum microsurgery.</p>	<p>Member cost sharing is based on the type of service performed and the place rendered.</p>
<p>Voluntary Sterilization Including tubal ligation and vasectomy.</p>	<p>Member cost sharing is based on the type of service performed and the place rendered.</p>
PHARMACY-PRESCRIPTION DRUG BENEFITS	PARTICIPATING PHARMACIES
<p>Participating Retail/Mail Order Delivery Less than a 31 day supply The Copayments do not apply to the Maximum Out-of- Pocket Limit</p>	<p>\$15 copay for generic drugs, \$35 copay for formulary brand-name drugs, and \$60 copay for generic and brand-name non-formulary drugs</p>
<p>Mail Order Delivery/Participating Retail More than a 30 day supply but less than a 90 day supply The Copayments do not apply to the Maximum Out-of-Pocket Limit</p>	<p>\$30 copay for generic drugs, \$70 copay for formulary brand-name drugs, and \$120 copay for generic and brand-name non-formulary drugs</p>
<p>Specialty CareRxSM Drugs</p>	<p>\$100 copay for formulary and non-formulary drugs</p>
<p>Mandatory Generic with DAW override (MG w/DAW Override) - The member pays the applicable copay only, if the physician requires brand. If the member requests brand when a generic is available, the member pays the applicable copay plus the difference between the generic price and the brand price</p>	
<p>Plan includes contraceptive drugs and devices obtainable from a pharmacy, injectable infertility drugs (for groups with 26 or more eligible employees) and diabetic supplies.</p>	
<p>Precertification and Step Therapy included and 90 day Transition of Care (TOC) for Precertification and Step Therapy included</p>	

What's Not Covered

This plan does not cover all health care expenses and includes exclusions and limitations. Members should refer to their plan documents to determine which health care services are covered and to what extent. The following is a partial list of services and supplies that are *generally not covered*. **However, your plan documents may contain exceptions to this list based on state mandates or the plan design or rider(s) purchased.**

All medical and hospital services not specifically covered in, or which are limited or excluded by your plan documents, including costs of services before coverage begins and after coverage terminates.

Cosmetic surgery.

Custodial care;

Dental care and dental x-rays;

Donor egg retrieval*.

Hearing aids.

Home births.

Immunizations for travel or work.

Implantable drugs and certain injectable drugs.

Infertility services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI and other related services unless specifically listed as covered in your plan documents*.

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Nonmedically necessary services or supplies.

Orthotics.

Over-the-counter medications and supplies.

Radial keratotomy or related procedures.

Reversal of sterilization.

Services for the treatment of sexual dysfunction or inadequacies, including therapy, supplies, or counseling.

Special duty nursing.

Therapy or rehabilitation other than those listed as covered in the plan documents.

***This exclusion only applies to groups with 25 or fewer eligibles and includes injectable infertility drugs. Services and supplies are covered for groups with 26 or more eligibles.**

Pre-existing Conditions Exclusion Provision

For members age 19 or over this plan imposes a pre-existing conditions exclusion, which may be waived in some circumstances (that is, creditable coverage) and may not be applicable to you. A pre-existing condition exclusion means that if you have a medical condition before coming to our plan, you might have to wait a certain period of time before the plan will provide coverage for that condition. This exclusion applies only to conditions for which medical advice, diagnosis or treatment was recommended or received or for which the individual took prescribed drugs within 6 months.

Generally, this period ends the day before your coverage becomes effective. However, if you were in a waiting period for coverage, 6 months period ends on the day before the waiting period begins. The exclusion period, if applicable, may last up to 12 months from your first day of coverage, or, if you were in a waiting period, from the first day of your waiting period. Coverage will be provided subject to a 50% copayment for the treatment of a preexisting condition.

If you had no prior creditable coverage within the 90 days prior to your enrollment date (either because you had no prior coverage or because there was more than a 90 day gap from the date your prior coverage terminated to your enrollment date), we will apply your plan's pre-existing conditions exclusion.

In order to reduce or possibly eliminate your exclusion period based on your creditable coverage, you should provide us a copy of any Certificates of Creditable Coverage you have. Please contact your Aetna Member Services representative at 1-888-802-3862 if you need assistance in obtaining a Certificate of Creditable Coverage from your prior carrier or if you have any questions on the information noted above.

The pre-existing condition exclusion does not apply to pregnancy nor to a child under the age of 19. Note: For late enrollees, coverage will be delayed until the plan's next open enrollment; the pre-existing exclusion will be applied from the individual's effective date of coverage.

This material is for informational purposes only and is neither an offer of coverage nor medical advice. It contains only a partial, general description of plan benefits or programs and does not constitute a contract. Aetna does not provide health care services and, therefore, cannot guarantee results or outcomes. Consult the plan documents (i.e. Schedule of Benefits, Certificate of Coverage, Evidence of Coverage, Group Agreement, Group Insurance Certificate and/or Group Policy) to determine governing contractual provisions, including procedures, exclusions and limitation relating to the plan. The availability of a plan or program may vary by geographic service area. Some benefits are subject to limitations or visit maximums. Participating physicians, hospitals and other health care providers are independent contractors and are neither agents nor employees of Aetna. The availability of any particular provider cannot be guaranteed, and provider network composition is subject to change. Notice of the change shall be provided in accordance with applicable state law.

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Some benefits are subject to limitations or visit maximums. Certain services require precertification, or prior approval of coverage. Failure to precertify for these services may lead to substantially reduced benefits or denial of coverage. Some of the benefits requiring precertification may include, but are not limited to, inpatient hospital, inpatient mental health, inpatient skilled nursing, outpatient surgery, substance abuse (detoxification, inpatient and outpatient rehabilitation). When the Member's preferred provider is coordinating care, the preferred provider will obtain the precertification. When the member utilizes a nonpreferred provider, Member must obtain the precertification. Precertification requirements may vary.

If your plan covers outpatient prescription drugs, your plan may include a drug formulary (preferred drug list). A formulary is a list of prescription drugs generally covered under your prescription drug benefits plan on a preferred basis subject to applicable limitations and conditions. Your pharmacy benefit is generally not limited to the drugs listed on the formulary. The medications listed on the formulary are subject to change in accordance with applicable state law. For information regarding how medications are reviewed and selected for the formulary, formulary information, and information about other pharmacy programs such as precertification and step-therapy, please refer to Aetna's website at Aetna.com, or the Aetna Medication Formulary Guide. Many drugs, including many of those listed on the formulary, are subject to rebate

arrangements between Aetna and the manufacturer of the drugs. Rebates received by Aetna from drug manufacturers are not reflected in the cost paid by a member for a prescription drug. In addition, in circumstances where your prescription plan utilizes copayments or coinsurance calculated on a percentage basis or a deductible, use of formulary drugs may not necessarily result in lower costs for the member. Members should consult with their treating physicians regarding questions about specific medications. Refer to your plan documents or contact Member Services for information regarding the terms and limitations of coverage.

Aetna Rx Home Delivery refers to Aetna Rx Home Delivery, LLC, a subsidiary of Aetna Inc., that is a licensed pharmacy providing mail-order pharmacy services. Aetna's negotiated charge with Aetna Rx Home Delivery may be higher than Aetna Rx Home Delivery's cost of purchasing drugs and providing mail-order pharmacy services.

"Aetna" is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies. HMO plans are provided or administered by: Aetna Health of Illinois Inc.

For more information about Aetna plans, refer to www.aetna.com.

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