PLAN DESIGN AND BENEFITS- IL Indemnity $500 80 (3/12)

PLAN FEATURES	MEMBER COST SHARE
Deductible (per calendar year)	$500 Individual $1,500 Family
Unless otherwise indicated, the Deductible must be met prior to benefits being payable. Member cost sharing for certain services including member cost sharing for prescription drugs, as indicated in the plan, are excluded from charges to meet the Deductible. Once the Family Deductible is met, all family members will be considered as having met their Deductible for the remainder of the calendar year.	
Plan Coinsurance	80%
Applies to all expenses unless otherwise stated.	
Maximum Out-of-Pocket Limit (Per calendar year, includes deductible. Excludes copayments, cost sharing for durable medical equipment and prescription drugs, amounts exceeding the recognized charge, and payment for failure to pre-certify.)	$2,500 Individual $7,500 Family
Once the Family Maximum Out-of-Pocket Limit is met, all family members will be considered as having met their Maximum Out-of-Pocket Limit for the remainder of the calendar year.	
Health Incentive Credit Program	Incentive Rewards will be credited towards the deductible and Maximum Out-of-Pocket Limit.
Wellness Programs through Simple Steps	Simple Steps Health Assessment and one Online Wellness Program
Reward	$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.
Lifetime Maximum	Unlimited
Provider Payment	Usual & Customary*
Primary Care Physician Selection	Not applicable
Certification Requirements- Certification for certain types of care must be obtained to avoid a reduction in benefits paid for that care. Certification for Hospital Admissions, Treatment Facility Admissions, Convalescent Facility Admissions, Home Health Care, and Hospice Care is required. Benefits will be reduced by 50% or $1000 whichever less if Certification is not obtained.	
Referral Requirement	None
PHYSICIAN SERVICES	**MEMBER COST SHARE**
Office Visits to Non-Specialist	80% after deductible
Includes services of an internist, general physician, family practitioner or pediatrician for routine care as well as diagnosis and treatment of an illness or injury.	
Specialist Office Visits	80% after deductible
Maternity OB Visits	80% after deductible
Surgery (in office)	80% after deductible
Allergy Testing (given by a physician)	80% after deductible
Allergy Injections (not given by a physician)	80% after deductible

PLAN DESIGN AND BENEFITS- IL Indemnity $500 80 (3/12)

PREVENTIVE CARE	MEMBER COST SHARE
Routine Adult Physical Exams/ Immunizations 1 exam every 24 months up to age 65, and 1 exam every 12 months for adults age 65 and older (includes immunizations)	$0 copay, deductible waived
Well Baby/Child Exams/Immunizations 7 exams in first 12 months of life, 3 exams in the 13th-24th months of life, 3 exams in the 25th-36th months of life, 1 exam every 12 months of life thereafter up to age 18 (includes immunizations)	$0 copay, deductible waived
Routine Gynecological Care Exams Includes Pap smear and related lab fees. One exam per calendar year	$0 copay, deductible waived
Routine Mammograms One baseline mammogram for covered females age 35-39 and one per calendar year for covered females age 40 and above	$0 copay, deductible waived
Routine Digital Rectal Exam / Prostate-Specific Antigen Test Age 40 and over for African American males and age 40 and over for males with a Family history of Prostate cancer.	$0 copay, deductible waived
Colorectal Cancer Screening Once every 3 years for all members age 50 and over and screening for persons who may be classified as high-risk for colorectal cancer	$0 copay, deductible waived
Routine Eye Exams at Specialist One routine exam per 24 months	$0 copay, deductible waived
Routine Hearing Exams Covered only as part of a routine physical exam.	$0 copay, deductible waived
DIAGNOSTIC PROCEDURES	**MEMBER COST SHARE**
Outpatient Diagnostic Laboratory and X-ray	80% after deductible
Outpatient Diagnostic X-ray for Complex Imaging Services (including, but not limited to, MRI, MRA, PET and CT Scans)	80% after deductible
EMERGENCY MEDICAL CARE	**MEMBER COST SHARE**
Urgent Care Provider	80% after deductible
Non-Urgent use of Urgent Care Provider	50% after deductible or $1000 whichever less
Emergency Room	80% after deductible
Non-Emergency care in an Emergency Room	50% after deductible or $1000 whichever less
Emergency Ambulance	80% after deductible
HOSPITAL CARE	**MEMBER COST SHARE**
Inpatient Coverage Including maternity (prenatal, delivery and postpartum) & transplants.	80% after deductible
Outpatient Surgery Provided in an outpatient hospital department or in a freestanding surgical facility.	80% after deductible

PLAN DESIGN AND BENEFITS- IL Indemnity $500 80 (3/12)

HOSPITAL CARE (CONTINUED)	MEMBER COST SHARE
Outpatient Hospital Services other than Surgery Including, but not limited to, physical therapy, speech therapy, occupational therapy, spinal manipulation, dialysis and radiation therapy.	80% after deductible
MENTAL HEALTH SERVICES	**MEMBER COST SHARE**
Inpatient Mental Illness	80% after deductible
Outpatient Mental Illness	80% after deductible
ALCOHOL/DRUG ABUSE SERVICES	**MEMBER COST SHARE**
Inpatient Detoxification and Rehabiltation	80% after deductible
Outpatient Detoxification and Rehabilitation	80% after deductible
OTHER SERVICES	**MEMBER COST SHARE**
Convalescent Facility (skilled nursing facility) Limited to 60 days per member per calendar year	80% after deductible
Home Health Care Limited to 60 visits per member per calendar year 1 visit equals a period of 4 hours or less.	80% after deductible
Infusion Therapy	80% after deductible
Hospice Care	80% after deductible
Outpatient Speech Therapy Limited to 20 visits per member per calendar year	80% after deductible
Outpatient Physical/Occupational Therapy Limited to 40 visits per member per calendar year	80% after deductible
Chiropractic Services Limited to 20 visits per member per calendar year	80% after deductible
Durable Medical Equipment Maximum benefit of $2,500 per member per calendar year	80% after deductible
Diabetic Supplies not obtainable at a pharmacy	Covered same as any other medical expense.
FAMILY PLANNING	**MEMBER COST SHARE**
Infertility Treatment Coverage only for the diagnosis and treatment of the underlying medical condition.	80% after deductible
Comprehensive Infertility Services Services and supplies are only covered for groups with 26 or more eligible	80% after deductible
Advanced Reproductive Technology (ART) Services and supplies are only covered for groups with 26 or more eligible	80% after deductible
ART coverage includes: In vitro fertilization (IVF), zygote intra-fallopian transfer (ZIFT), gamete intrafallopian transfer (GIFT), cryopreserved embryo transfers, intracytoplasmic sperm injection (ICSI) or ovum microsurgery.	
Voluntary Sterilization Including tubal ligation and vasectomy.	80% after deductible

PLAN DESIGN AND BENEFITS- IL Indemnity $500 80 (3/12)

PHARMACY-PRESCRIPTION DRUG BENEFITS	MEMBER COST SHARE
Retail Up to a 30-day supply	**Participating Pharmacies:** $10 copay for generic drugs, $40 copay for brand name formulary drugs, and $65 copay for brand name non-formulary drugs **Non-Participating Pharmacies:** 70% of submitted cost after $10 copay for generic drugs, 70% of submitted cost after $40 copay for brand name formulary drugs, and 70% of submitted cost after $65 copay for brand name non-formulary drugs
Mail Order 31-90 day supply	**Participating Pharmacies:** $20 copay for generic drugs, $80 copay for brand name formulary drugs, and $130 copay for brand name non-formulary drugs **Non-Participating Pharmacies**: Not covered
Specialty CareRx[SM] Drugs	**Participating Pharmacies:** $100 copay for formulary and non-formulary drugs **Non-Participating Pharmacies:** Not covered
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	
Plan excludes: Lifestyle/performance drugs	
Precertification included and 90 day Transition of Care (TOC) for Precertification included	
*Payment for care is determined based upon the lowest of: the provider's usual charge for furnishing it; or the charge Aetna determines to be appropriate, based on factors such as the cost of providing the same or a similar service or supply and the manner in which charges for the service or supply are made. These charges are referred to in your plan as "reasonable" or "recognized" charges.	

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 or hospital services not specifically covered in, or which are limited or excluded in the plan documents;
• Charges related to any eye surgery mainly to correct refractive errors;
• Cosmetic surgery, including breast reduction;
• Custodial care;
• Dental care and X-rays;
• Donor egg retrieval*;
• Experimental and investigational procedures;
• Hearing aids;
• Immunizations for travel or work;
• Infertility services including, but not limited to, 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*

- Nonmedically necessary services or supplies;
- Orthotics;
- Over-the-counter medications and supplies;
- Reversal of sterilization;
- Services for the treatment of sexual dysfunction or inadequacies, including therapy, supplies, counseling and prescription drugs;
- Special duty nursing; and
- Weight control services including surgical procedures, medical treatments, weight control/loss programs, dietary regimens and supplements, appetite suppressants and other medications; food or food supplements, exercise programs, exercise or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity, including Morbid Obesity, or for the purpose of weight reduction, regardless of the existence of comorbid conditions.

*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.

If you had less than 12 months of creditable coverage immediately before the date you enrolled, your plan's pre-existing conditions exclusion period will be reduced by the amount (that is, number of days) of that prior coverage.

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 days 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-exisiting 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.

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. Precertification requirements may vary.

PLAN DESIGN AND BENEFITS- IL Indemnity $500 80 (3/12)

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. Aetna receives rebates from drug manufacturers that may be taken into account in determining Aetna's Preferred Drug List.

Rebates do not reduce the amount a member pays the pharmacy for covered prescriptions. 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.

In case of emergency, call 911 or your local emergency hotline, or go directly to an emergency care facility.

Plans are provided by Aetna Life Insurance Company.

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

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