PLAN DESIGN AND BENEFITS - IL Savings Plus
HSA Comp $3500 90/50 (3/12)

PLAN FEATURES	NETWORK CARE Savings Plus Designated Network Providers	OUT-OF-NETWORK CARE Non-Designated/Out-of-Network Providers
Deductible (per calendar year)	$3,500 Individual $7,000 Family	$7,500 Individual $15,000 Family
Unless otherwise indicated, the Deductible must be met prior to benefits being payable. All covered expenses accumulate separately toward the network and out-of-network 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. No one family member can contribute more than the Individual Deductible amount to the Family Deductible.		
Plan Coinsurance (applies to all expenses unless otherwise stated)	90%	50%
Maximum Out-of-Pocket Limit (per calendar year, includes deductible)	$6,050 Individual $12,100 Family	$15,000 Individual $30,000 Family
All covered expenses accumulate separately toward the network and out-of-network Maximum Out-of-Pocket Limit. Certain member cost sharing elements may not apply toward the Maximum Out-of-Pocket Limit: amounts exceeding the recognized charge and payment for failure to pre-certify for certain out-of-network services. 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. No one family member can contribute more than the Individual Maximum Out-of-Pocket Limit amount to the Family Maximum Out-of-Pocket Limit.		
Lifetime Maximum	Unlimited	
Payment for Out-of-Network Care	Not applicable	Professional: 105% of Medicare* Facility: 140% of Medicare*
Primary Care Physician Selection	Not applicable	Not applicable
Certification Requirements - Certification for certain types of Out-of-Network 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 $1000 or 50%, whichever is less per occurrence if Certification is not obtained.		
Referral Requirement	None	None
PHYSICIAN SERVICES	**NETWORK CARE** **Savings Plus Designated Network Providers**	**OUT-OF-NETWORK CARE** **Non-Designated/Out-of-Network Providers**
Office Visits to Non-Specialist (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)	$30 copay, after deductible	50%, after deductible
E-visit to Non-Specialists and Specialists	$30 copay, after deductible	50%, after deductible
Walk-In-Clinics	$30 copay, after deductible	50%, after deductible
Specialist Office Visits	$30 copay, after deductible	50%, after deductible
Maternity OB Visits	90%, after deductible	50%, after deductible
Surgery (in office)	$30 copay, after deductible	50%, after deductible
Allergy Testing and Treatment (Including Allergy Injections with office visit billed)	Member cost sharing is based on the type of service performed and the place rendered.	50%, after deductible

PLAN DESIGN AND BENEFITS - IL Savings Plus
HSA Comp $3500 90/50 (3/12)

PHYSICIAN SERVICES (CONTINUED)	NETWORK CARE Savings Plus Designated Network Providers	OUT-OF-NETWORK CARE Non-Designated/Out-of-Network Providers
Allergy Injections (without office visit billed)	90%, after deductible	50%, after deductible
PREVENTIVE CARE	**NETWORK CARE Savings Plus Designated Network Providers**	**OUT-OF-NETWORK CARE Non-Designated/Out-of-Network Providers**
Routine Adult Physical Exams/ Immunizations 1 exam every 12 months. Network and out-of-network combined.	$0 copay, deductible waived	50%, after deductible
Well Child Exams/Immunizations 7 exams in first 12 months of life, 3 exams in the 13th-24th months of life, 3 exams in 25th to 36th months of life, 1 exam every 12 months of life thereafter up to age 22. Network and out-of-network combined.	$0 copay, deductible waived	50%, after deductible
Routine Gynecological Care Exams Includes Pap smear and related lab fees. One exam per calendar year. Network and out-of-network combined.	$0 copay, deductible waived	50%, after deductible
Routine Mammograms One baseline mammogram for covered females age 35-39 and one per calendar year for covered females age 40 and above. Network and out-of-network combined.	$0 copay, deductible waived	50%, after deductible
Routine Digital Rectal Exam / Prostate-Specific Antigen Test For covered males age 40 and over. Network and out-of-network combined.	$0 copay, deductible waived	50%, after deductible
Routine Colorectal Cancer Screening For all members age 50 and over. Frequency schedule applies. Network and out-of-network combined.	$0 copay, deductible waived	50%, after deductible
Routine Eye Exams at Specialist One routine exam per 24 months. Network and out-of-network combined.	$0 copay, deductible waived	50%, after deductible
Routine Hearing Exams	Not Covered	Not Covered
DIAGNOSTIC PROCEDURES	**NETWORK CARE Savings Plus Designated Network Providers**	**OUT-OF-NETWORK CARE Non-Designated/Out-of-Network Providers**
Outpatient Diagnostic Laboratory If performed as a part of a physician's office visit and billed by the physician, expenses are covered subject to the applicable physician's office visit member cost sharing.	90%, after deductible	50%, after deductible

PLAN DESIGN AND BENEFITS - IL Savings Plus
HSA Comp $3500 90/50 (3/12)

DIAGNOSTIC PROCEDURES (CONTINUED)	NETWORK CARE Savings Plus Designated Network Providers	OUT-OF-NETWORK CARE Non-Designated/Out-of-Network Providers
Outpatient Diagnostic X-ray (except for Complex Imaging Services) If performed as a part of a physician's office visit and billed by the physician, expenses are covered subject to the applicable physician's office visit member cost sharing.	90%, after deductible	50%, after deductible
Outpatient Diagnostic X-ray for Complex Imaging Services Including, but not limited to, MRI, MRA, PET and CT Scans	90%, after deductible	50%, after deductible
EMERGENCY MEDICAL CARE	**NETWORK CARE Savings Plus Designated Network Providers**	**OUT-OF-NETWORK CARE Non-Designated/Out-of-Network Providers**
Urgent Care Provider	$50 copay, after deductible	50%, after deductible
Non-Urgent Use of Urgent Care Provider	50% after deductible or $1000 after deductible, whichever less	50% after deductible or $1000 after deductible, whichever less
Emergency Room Copay waived if admitted.	90%, after deductible	Paid as Network Care.
Non-Emergency care in an Emergency Room	50% after deductible or $1000 after deductible, whichever less	50% after deductible or $1000 after deductible, whichever less
Emergency Ambulance	90%, after deductible	Paid as Network Care.
Non-Emergency Ambulance	90%, after deductible	50%, after deductible
HOSPITAL CARE	**NETWORK CARE Savings Plus Designated Network Providers**	**OUT-OF-NETWORK CARE Non-Designated/Out-of-Network Providers**
Inpatient Coverage Including maternity (prenatal, delivery and postpartum) & transplants. If transplant is performed through an Institute of Excellence™ facility, benefits would be paid at the network level. If procedure is not performed through Institutes of Excellence™ facility, benefits would be paid at the out-of-network level.	90%, after deductible	50%, after deductible
Outpatient Surgery Provided in an outpatient hospital department or a freestanding surgical facility	90%, after deductible	50%, after deductible
Outpatient Hospital Services other than Surgery Including, but not limited to, physical therapy, speech therapy, occupational therapy, spinal manipulation, dialysis, and radiation therapy.	90%, after deductible	50%, after deductible

PLAN DESIGN AND BENEFITS - IL Savings Plus
HSA Comp $3500 90/50 (3/12)

MENTAL HEALTH SERVICES	NETWORK CARE Savings Plus Designated Network Providers	OUT-OF-NETWORK CARE Non-Designated/Out-of-Network Providers
Inpatient Mental Illness	90%, after deductible	50%, after deductible
Outpatient Mental Illness	$30 copay, after deductible	50%, after deductible
ALCOHOL/DRUG ABUSE SERVICES	**NETWORK CARE Savings Plus Designated Network Providers**	**OUT-OF-NETWORK CARE Non-Designated/Out-of-Network Providers**
Inpatient Detoxification and Rehabilitation	90%, after deductible	50%, after deductible
Outpatient Detoxification and Rehabilitation	$30 copay, after deductible	50%, after deductible
OTHER SERVICES AND PLAN DETAILS	**NETWORK CARE Savings Plus Designated Network Providers**	**OUT-OF-NETWORK CARE Non-Designated/Out-of-Network Providers**
Skilled Nursing Facility Limited to 60 days per member per calendar year. Network and out-of-network combined.	90%, after deductible	50%, after deductible
Home Health Care Limited to 60 visits per member per calendar year. Network and out-of-network combined. 1 visit equals a period of 4 hours or less.	90%, after deductible	50%, after deductible
Infusion Therapy Provided in the home or physician's office	90%, after deductible	50%, after deductible
Infusion Therapy Provided in an outpatient hospital department of freestanding facility	90%, after deductible	50%, after deductible
Inpatient Hospice Care	90%, after deductible	50%, after deductible
Outpatient Hospice Care	90%, after deductible	50%, after deductible
Outpatient Speech Therapy Limited to 20 visits per member per calendar year. Network and out-of-network combined.	90%, after deductible	50%, after deductible
Outpatient Physical/Occupational Therapy Limited to 40 visits per member per calendar year. Network and out-of-network combined.	90%, after deductible	50%, after deductible
Spinal Manipulation Therapy (Chiropractic) Limited to 20 visits per member per calendar year. Network and out-of-network combined.	90%, after deductible	50%, after deductible
Durable Medical Equipment Maximum benefit of $2,500 per member per calendar year. Network and out-of-network combined.	90%, after deductible	50%, after deductible
Diabetic Supplies not obtainable at a pharmacy	Covered same as any other medical expense	Covered same as any other medical expense

PLAN DESIGN AND BENEFITS - IL Savings Plus
HSA Comp $3500 90/50 (3/12)

FAMILY PLANNING	NETWORK CARE Savings Plus Designated Network Providers	OUT-OF-NETWORK CARE Non-Designated/Out-of-Network Providers
Infertility Treatment Covered 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.	50%, after deductible
Comprehensive Infertility Services Services and supplies are only covered for groups with 26 or more eligible**.**	Member cost sharing is based on the type of service performed and the place rendered	50%, after deductible
Advanced Reproductive Technology (ART) 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. Services and supplies are only covered for groups with 26 or more eligible.	Member cost sharing is based on the type of service performed and the place rendered	50%, after deductible
Voluntary Sterilization Including tubal ligation and vasectomy.	90%, after deductible	50%, after deductible
PHARMACY-PRESCRIPTION DRUG BENEFITS	**PARTICIPATING PHARMACIES**	**NON-PARTICIPATING PHARMACIES**
Retail Up to a 30-day supply	$10 copay after integrated medical/pharmacy deductible for generic drugs, $40 copay after integrated medical/pharmacy deductible for brand name formulary drugs, and $65 copay after integrated medical/pharmacy deductible for brand name non-formulary drugs	70% of submitted cost after $10 copay after integrated medical/pharmacy deductible for generic drugs, 70% of submitted cost after $40 copay after integrated medical/pharmacy deductible for brand name formulary drugs, and 70% of submitted cost after $65 copay after integrated medical/pharmacy deductible for brand name non-formulary drugs
Mail Order Delivery 31-90 day supply	$20 copay after integrated medical/pharmacy deductible for generic drugs, $80 copay after integrated medical/pharmacy deductible for brand name formulary drugs, and $130 copay after integrated medical/pharmacy deductible for brand name non-formulary drugs	Not Covered
Specialty CareRx^{SM} Drugs	$100 copay after integrated medical/pharmacy deductible for formulary and non-formulary drugs	Not Covered
Specialty CareRx - First Prescription for a specialty drug must be filled at a participating retail pharmacy or Aetna Specialty Pharmacy®. Subsequent fills must be through Aetna Specialty Pharmacy®.		

PLAN DESIGN AND BENEFITS - IL Savings Plus
HSA Comp $3500 90/50 (3/12)

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 includes: contraceptive drugs and devices obtainable from a pharmacy and diabetic supplies obtainable from a pharmacy. Plan excludes: lifestyle/performance drugs
Precertification included and 90 day Transition of Care (TOC) for Precertification included.

*We cover the cost of services based on whether doctors are “in network” or “out-of-network.” We want to help you understand how much Aetna pays for your out-of-network care. At the same time, we want to make it clear how much more you will need to pay for this "out-of-network" care.

You may choose a provider (doctor or hospital) in our network. You may choose to visit an out-of-network provider. If you choose a doctor who is out-of-network, your Aetna health plan may pay some of that doctor's bill. Most of the time, you will pay a lot more money out of your own pocket if you choose to use an out-of-network doctor or hospital.

When you choose out-of-network care, Aetna limits the amount it will pay. This limit is called the “recognized” or “allowed” amount. When you choose out-of-network care, Aetna “recognizes” an amount based on what Medicare pays for these services. The government sets the Medicare rate.

Your doctor sets his or her own rate to charge you. It may be higher -- sometimes much higher -- than what your Aetna plan "recognizes." Your doctor may bill you for the dollar amount that Aetna doesn't "recognize." You must also pay any copayments, coinsurance and deductibles under your plan. No dollar amount above the "recognized charge" counts toward your deductible or out-of-pocket maximums. To learn more about how we pay out-of-network benefits visit Aetna.com. Type "how Aetna pays" in the search box.

You can avoid these extra costs by getting your care from Aetna's broad network of health care providers. Go to www.aetna.com and click on "Find a Doctor" on the left side of the page. If you are already a member, sign on to your Aetna Navigator member site.

This applies when you choose to get care out-of-network. When you have no choice (for example: emergency room visit after a car accident, or for other emergency services), we will pay the bill as if you got care in network. You pay cost sharing and deductibles for your in-network level of benefits. Contact Aetna if your provider asks you to pay more. You are not responsible for any outstanding balance billed by your providers for emergency services beyond your cost sharing and deductibles.

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.

PLAN DESIGN AND BENEFITS - IL Savings Plus
HSA Comp $3500 90/50 (3/12)

• 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*
• Medical expenses for a pre-existing condition are not covered (full postponement rule) for the first 365 days after the insured's enrollment date. Lookback period for determining a pre-existing condition (conditions for which diagnosis, care or treatment was recommended or received) is 180 days prior to the enrollment date. The pre-existing condition limitation period will be reduced by the number of days of prior creditable coverage the member has as of the enrollment date.

• 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.

PLAN DESIGN AND BENEFITS - IL Savings Plus
HSA Comp $3500 90/50 (3/12)

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 not an offer or invitation to contract. An application must be completed to obtain coverage. Plan features and availability may vary by location and group size. Not all heath services are covered. See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Plan features are subject to change. With the exception of Aetna Rx Home Delivery, Providers are independent contractors and are not agents of Aetna. Provider participation may change without notice. Aetna does not provide care or guarantee access to health services.

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.

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.

© 2012 Aetna Inc.