

HMO Description of Coverage (CIP)

Basic Care (See Provider Directory to select an in-network provider)

Annual deductible	None
Out-of-pocket maximum	Individual \$3,000 Family \$6,000
Lifetime maximum	Unlimited
Pre-existing condition limitations	None

	Description of Coverage	Aetna Covers	You Pay
Hospital			
Number of days of inpatient care	Unlimited	100% after copay	\$250 copay per admission
Room and board	Semi-private room, intensive care		
Surgeon's fees	Inpatient or outpatient	100% coverage	\$0 copay
Provider's visit		100% coverage	\$0 copay
Medications		100% coverage	\$0 copay
Other miscellaneous charges	Except personal comfort items	100% coverage	\$0 copay
Emergency			
Emergency services (medical conditions of sufficient severity such that a prudent layperson could reasonably expect the absence of immediate medical attention to result in serious jeopardy of the person's health, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part)	Copay waived if admitted as an inpatient for same condition within 48 hours	100% after copay	\$200 copay
Emergency post-stabilization services	Copay dependent on nature of service		
Provider's Office			
Provider's office visits	Exam, diagnosis, treatment	100% after copay	\$30 copay per office visit
Preventive care	ACA guidelines apply	100% coverage	\$0 copay
Diagnostic tests and X-rays		100% coverage	\$0 copay
Immunizations		100% coverage	\$0 copay
Allergy treatment and testing		100% coverage	\$0 copay
Medical Services			
Outpatient surgery	Surgery and observation	100% after copay	\$200 copay
Maternity care	Hospital care Room and board, ancillary services, care of child during mother's stay Provider care Prenatal, delivery and post-natal care	100% after copay 100% coverage	\$250 copay per admission \$0 copay
Infertility services	See benefits certificate for details on coverage	100% after copay	
Mental health treatment		100% after copay	\$250 copay per admission \$30 copay per office visit
Substance abuse treatment	Inpatient Outpatient	100% after copay 100% after copay	\$250 copay per admission \$30 copay per office visit
Outpatient rehabilitation services	Up to 60-day treatment period per condition	100% after copay	\$30 copay per office visit
Speech therapy – Pervasive developmental disorders	20 visits per contract year	100% after copay	\$30 copay per office visit
Other Services			
Durable medical equipment	Prosthetic devices included	80%	20% DME, \$0 copay/prosthetic devices
Hospice	When authorized	100% coverage	\$0 copay
Home health care	When authorized	100% after copay	\$30 copay per visit
Prescription drugs	See prescription rider in certificate for details	100% after copay 100% after copay	\$12/\$24/\$48 copay \$96 copay
Dental services	Not covered	n/a	n/a
Vision care	Not covered	n/a	n/a
Skilled nursing facility	When authorized	100% coverage	\$0 copay
Ambulance	When medically necessary	100% coverage	\$0 copay
Chiropractic services		100% after copay	\$30 copay per office visit
Organ transplants	Out-of-pocket maximum applies	100% coverage	\$0 copay

For more information, visit our website at www.aetnastateofillinois.com or call 1-855-339-9731 (TTY users call 1-800-628-3323), Monday – Friday from 8 a.m. – 6 p.m. ET.

Effective July 1, 2017



Limitations and Exceptions

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 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
- Adult dental care and x-rays
- Donor egg retrieval
- Experimental and investigational procedures
- 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
- Non-medically necessary services or supplies
- Orthotics except as specified in the plan
- 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
- Weight reduction programs, or dietary supplements

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. Group Insurance Certificate and/or Group Policy) to determine governing contractual provisions, including procedures, exclusions and limitation relating to the plan. With the exception of Aetna Rx Home Delivery, all preferred providers and vendors are independent contractors in private practice and are neither employees nor agents of Aetna or its affiliates. Aetna Rx Home Delivery, LLC, is a subsidiary of Aetna Inc.

The availability of any particular provider cannot be guaranteed, and provider network composition is subject to change without notice.

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 includes 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 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 our website at www.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 uses 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.

TTY: 711

For language assistance in your language call 1-855-339-9731 at no cost. (English)

Para obtener asistencia lingüística en español, llame sin cargo al 1-855-339-9731. (Spanish)

欲取得繁體中文語言協助，請撥打 1-855-339-9731，無需付費。(Chinese)

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