Equity League Health Trust
Effective date: 01-01-2010
QPOS® - Illinois

PLAN DESIGN AND BENEFITS
PROVIDED BY AETNA HEALTH OF ILLINOIS AND AETNA HEALTH INSURANCE COMPANY Inc. - FULL RISK

PLAN FEATURES	PARTICIPATING PROVIDERS / REFERRED	NON-PARTICIPATING PROVIDERS / PARTICIPATING PROVIDERS SELF REFERRED
Deductible (per calendar year)	None Individual None Family	$5,000 Individual $10,000 Family
Unless otherwise indicated, the Deductible must be met prior to benefits being payable.		
Member Coinsurance	Covered 100%	50%
Out-of-pocket maximum (per calendar year)	$1,500 Individual $3,000 Family	$10,000 Individual $20,000 Family
Member cost sharing for certain services may not apply toward the out-of-pocket maximum Only those participating providers/referred and non-participating providers/participating providers self referred out-of-pocket expenses resulting from the application of coinsurance percentage, deductibles and copays (except any penalty amounts and pharmacy cost sharing) may be used to satisfy the out-of-pocket maximum. Once Family out-of-pocket maximum is met, all family members will be considered as having met their out-of-pocket maximum for the remainder of the calendar year.		
Lifetime Maximum	Unlimited except where otherwise indicated.	$1,000,000 per lifetime
Primary Care Physician Selection	Required	Not applicable
Precertification Requirement Certain participating provider self-referred services require precertification or benefits will be reduced. Refer to your plan documents for a complete list of services that require precertification.		
Referral Requirements	Required for all non-emergency, non-urgent and non-Primary Care physicians services, except direct access services.	None
PREVENTIVE CARE	**PARTICIPATING PROVIDERS / REFERRED**	**NON-PARTICIPATING PROVIDERS / PARTICIPATING PROVIDERS SELF REFERRED**
Routine Adult Physical Exams/ Immunizations (Age and frequency schedules apply)	$10 copay	Not Covered
Well Child Exams / Immunizations (Age and frequency schedules apply)	$10 copay	Not Covered
Routine Gynecological Care Exams Includes Pap smear and related lab fees.	$20 copay One routine exam per 365 days.	Not Covered
Routine Mammograms	Covered 100%	50% after deductible
One baseline mammogram for females age 35 - 39; and one annual mammogram for females age 40 and over.		
Routine Digital Rectal Exams / Prostate Specific Antigen Test For males age 40 and over.	Member cost sharing is based on the type of service performed and the place of service where it is rendered.	Member cost sharing is based on the type of service performed and the place of service where it is rendered; after deductible
Colorectal Cancer Screening For all members 50 and over. Frequency schedule applies.	Member cost sharing is based on the type of service performed and the place of service where it is rendered.	Member cost sharing is based on the type of service performed and the place of service where it is rendered; after deductible
Routine Eye Exam Age/Frequency Schedule may apply.	$20 copay	Not Covered
Routine Hearing Screening	Subject to Routine Physical Exam cost sharing.	Not Covered
PHYSICIAN SERVICES	**PARTICIPATING PROVIDERS / REFERRED**	**NON-PARTICIPATING PROVIDERS / PARTICIPATING PROVIDERS SELF REFERRED**

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Office Visits to member's selected Primary Care Physician	Office Hours : $10 copay After Office Hours/Home : $15 copay	50% after deductible
Specialist Office Visits	$20 copay	50% after deductible
Includes services of an internist, general physician, family practitioner or pediatrician if the physician is not the member's selected PCP.		
Maternity OB Visits	$20 copay	50% after deductible
Allergy Treatment	Same as applicable participating provider office visit member cost sharing	50% after deductible
Allergy Testing	Same as applicable participating provider office visit member cost sharing	50% after deductible
DIAGNOSTIC PROCEDURES	**PARTICIPATING PROVIDERS / REFERRED**	**NON-PARTICIPATING PROVIDERS / PARTICIPATING PROVIDERS SELF REFERRED**
Diagnostic Laboratory	Covered 100%	50% after deductible
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 cost sharing.		
Diagnostic X-ray	$20 copay	50% after deductible
Outpatient hospital or other Outpatient facility		
EMERGENCY MEDICAL CARE	**PARTICIPATING PROVIDERS / REFERRED**	**NON-PARTICIPATING PROVIDERS / PARTICIPATING PROVIDERS SELF REFERRED**
Urgent Care	$35 copay	50% after deductible
Non-Urgent use of Urgent Care Provider	Not Covered	Not Covered
Emergency Room	$35 copay	Refer to participating provider benefit; after deductible
Non-Emergency Care in an Emergency Room	Not Covered	Not Covered
Ambulance	100% covered	Refer to participating provider benefit; after deductible
HOSPITAL CARE	**PARTICIPATING PROVIDERS / REFERRED**	**NON-PARTICIPATING PROVIDERS / PARTICIPATING PROVIDERS SELF REFERRED**
Inpatient Coverage	Covered 100%	50% per admission after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Inpatient Maternity Coverage	Covered 100%	50% per admission after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Outpatient Surgery	Covered 100%	50% per visit after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.		
MENTAL HEALTH SERVICES	**PARTICIPATING PROVIDERS / REFERRED**	**NON-PARTICIPATING PROVIDERS / PARTICIPATING PROVIDERS SELF REFERRED**
Inpatient Biologically Based Mental Illness	Covered 100%, 45 days per year	50% per admission after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Inpatient Non-Biologically Based Mental Illness	Covered 100%, 45 days per year	50% per admission after deductible

	Swap of 45 I/P days for 90 partial days	
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Outpatient Biologically Based Mental Illness	$20 per visit copay, 60 visits per year	50% per visit after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.		
Outpatient Non-Biologically Based Mental Illness	$20 per visit copay, 30 visit per year Swap of 10 I/P For 40 O/P Visits	50% per visit after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.		

ALCOHOL/DRUG ABUSE SERVICES	**PARTICIPATING PROVIDERS / REFERRED**	**NON-PARTICIPATING PROVIDERS / PARTICIPATING PROVIDERS SELF REFERRED**
Inpatient Detoxification	Covered 100%	50% per admission after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Outpatient Detoxification	$20 per visit copay	50% per visit after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.		
Inpatient Rehabilitation	Covered 100%	50% per admission after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Outpatient Rehabilitation	$20 per visit copay	50% per visit after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.		

OTHER SERVICES	**PARTICIPATING PROVIDERS / REFERRED**	**NON-PARTICIPATING PROVIDERS / PARTICIPATING PROVIDERS SELF REFERRED**
Skilled Nursing Facility	Covered 100% Limited to 60 days per calendar year	50% per admission after deductible Limited to 30 days per calendar year; after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Home Health Care	Covered 100% Limited to 60 visits per calendar year.	50% per visit after deductible Limited to 30 visits per calendar year.
Hospice Care - Inpatient	Covered 100%	50% per admission ($10,000 lifetime maximum combined inpatient and outpatient care.) after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Hospice Care - Outpatient	Covered 100%	50% per visit ($10,000 lifetime maximum combined inpatient and outpatient care.) after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.		
Private Duty Nursing	Not Covered	Not Covered
Outpatient Rehabilitation Therapy (Includes speech, physical and occupational therapy)	$20 per visit copay	50% per visit after deductible

	Limited to 60 visits per calendar year, plus an additional 20 visits for pervasive developmental disorders.	Limited to 60 visits per calendar year, plus an additional 20 visits for pervasive developmental disorders; after deductible
Subluxation	$20 per visit copay Unlimited visits	50% per visit after deductible Unlimited visits after deductible
Durable Medical Equipment	Covered at 100%	
Diabetic Supplies	Pharmacy cost sharing applies if Pharmacy coverage is included; otherwise PCP office visit cost sharing applies	50% after deductible
Dental	Not Covered	Not Covered
Transplants	Covered 100% Coverage is provided at an IOE contracted facility only	50% per admission Coverage is provided at an Non-IOE contracted facility only; after deductible
Bariatric	Member cost sharing is based on the type of service performed and the place of service where it is rendered.	Not Covered after deductible

The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.

FAMILY PLANNING	**PARTICIPATING PROVIDERS / REFERRED**	**NON-PARTICIPATING PROVIDERS / PARTICIPATING PROVIDERS SELF REFERRED**
Infertility Treatment Diagnosis and treatment of the underlying medical condition	Member cost sharing is based on the type of service performed and the place of service where it is rendered.	Member cost sharing is based on the type of service performed and the place of service where it is rendered; after deductible
Comprehensive Infertility Services	Applicable copay applies (does not apply towards the out-of-pocket maximum)	50% after deductible Limited to 4 attempts per lifetime, if live birth only 2 additional attempts covered; after deductible

Coverage includes Artificial Insemination and Ovulation Induction.

Advanced Reproductive Technology (ART)	Applicable copay applies Limited to 4 oocyte retrievals plus 2 more if live birth achieved.	50% after deductible Limited to 4 attempts per lifetime, if live birth only 2 additional attempts covered; after deductible

ART coverage includes In-Vitro Fertilization (IVF), Zygote Intra-Fallopian Transfer (ZIFT), Gamete Intra-Fallopian Transfer (GIFT), cryopreserved embryo transfers, Intra-Cytoplasmic Sperm Injection (ICSI) or ovum microsurgery.

Voluntary Sterilization Including tubal ligation and vasectomy.	Subject to applicable service type member cost sharing	Subject to applicable service type member cost sharing after deductible

PHARMACY - PRESCRIPTION DRUG BENEFITS	**PARTICIPATING PROVIDERS / REFERRED**	**NON-PARTICIPATING PROVIDERS / PARTICIPATING PROVIDERS SELF REFERRED**
Retail (2 times retail copay for 31-90 day supply at participating pharmacies. Percentage copays will not be doubled)	$15 copay for formulary generic drugs, $25 copay for formulary brand-name drugs, and $40 copay for non-formulary brand-name and generic drugs up to a 30 day supply at participating pharmacies.	Not Covered

Mail order	$30 copay for formulary generic drugs, $50 copay for formulary brand-name drugs, and $80 copay for non-formulary brand-name and generic drugs up to a 31-90 day supply at participating pharmacies.	Not Covered

Pharmacy Managed Self Injectables (PMSI)
First prescription fill at any retail or mail order drug facility. Subsequent fills must be through Aetna Specialty Pharmacy®

No Mandatory Generic (NO MG) - Member is responsible to pay the applicable copay only.

Plan Includes: Contraceptive drugs and devices obtainable from a pharmacy.
Precert included and Step-therapy included

Dependents Eligibility	Spouse, children from birth to age 26 regardless of student status

Exclusions and Limitations

Plans are provided by: Aetna Health of Illinois Inc and Aetna Health Insurance Company. While this material is believed to be accurate as of the production date, it is subject to change.

Health benefits and health insurance plans contain exclusions and limitations. Not all health services are covered.

See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by location and are subject to change. You may be responsible for the health care provider's full charges for any non-covered services, including circumstances where you have exceeded a benefit limit contained in the plan. 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.

If you are in a plan that requires the selection of a primary care physician and your primary care physician is part of an integrated delivery system or physician group, your primary care physician will generally refer you to specialists and hospitals that are affiliated with the delivery system or physician group.

The following is a 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 by your employer.

- All medical and hospital services not specifically covered in, or which are limited or excluded by your plan documents.
- Cosmetic surgery, including breast reduction.
- Custodial care.
- Dental care and dental X-rays.
- Donor egg retrieval.
- Durable medical Equipment
- Experimental and investigational procedures, except for coverage for medically necessary routine patient care costs for members participating in a cancer clinical trial.
- Hearing aids
- Home births
- Immunizations for travel or work except where medically necessary or indicated.
- Implantable drugs and certain injectible drugs including injectible infertility 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.
- Long-term rehabilitation therapy.
- Non-medically necessary services or supplies.
- Orthotics except diabetic orthotics.
- Outpatient prescription drugs (except for treatment of diabetes), unless covered by a prescription plan rider and over-the-counter medications (except as provided in a hospital) and supplies.
- Radial keratotomy or related procedures.
- Reversal of sterilization.
- Services for the treatment of sexual dysfunction or inadequacies, including therapy, supplies or counseling or prescription drug
- Special duty nursing.
- Therapy or rehabilitation other than those listed as covered.
- Treatment of behavioral disorders.
- 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.

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. Aetna Rx Home Delivery refers to Aetna Rx Home Delivery, LLC, a licensed pharmacy subsidiary of Aetna Inc., that operates through mail order. The charges that Aetna negotiates with Aetna Rx Home Delivery may be higher than the cost they pay for the drugs and the cost of the mail order pharmacy services they provide. For these purposes, the pharmacy's cost of purchasing drugs takes into account discounts, credits and other amounts that they may receive from wholesalers, manufacturers, suppliers and distributors.

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

Translation of the material into another language may be available. Please call Member Services at
1-888-98-AETNA (1-888-982-3862).

Puede estar disponible la traduccion de este material en otro idioma. Por favor llame a Servicios al Miembro al
1-888-98-AETNA (1-888-982-3862).

Plan features and availability may vary by location and group size.

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

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