

ILLINOIS AETNA ADVANTAGE PLAN OPTIONS

Managed Care Open Access and PPO Preventative & Hospital Care 1250		
MEMBER BENEFITS	In Network	Out-of-Network ⁺
Deductible		
Individual	\$1,250	\$2,500
Family	\$2,500	\$5,000
Coinsurance (Member's responsibility)	20% after deductible up to out-of-pocket max.	50% after deductible up to out-of-pocket max. <i>\$0 once out-of-pocket max. is satisfied</i>
Coinsurance Maximum		
Individual	\$3,000	\$7,500
Family	\$6,000	\$15,000
Out-of-Pocket Maximum		
Individual	\$4,250	\$10,000
Family	\$8,500	\$20,000 <i>Includes deductible</i>
Lifetime Maximum* per insured		\$1,000,000
Non-Specialist Office Visit <i>Unlimited visits</i> General Physician, Family Practitioner Pediatrician or Internist		Not Covered
Specialist Visit <i>Unlimited visits</i>		Not Covered
Hospital Admission	20% after deductible	50% after deductible
Outpatient Surgery	20% after deductible	50% after deductible
Emergency Room	\$100 copay** (waived if admitted); 20% coinsurance after deductible	
Annual Routine Gyn Exam <i>No waiting period, No calendar year max.</i> Annual Pap/Mammogram	\$0 copay deductible waived	50% after deductible
Maternity	Not Covered <i>Except for pregnancy complications</i>	
Preventive Health — Routine Physical <i>Aetna will pay up to \$200 per exam</i>	\$25 copay deductible waived <i>Includes lab and X-rays</i>	50% after deductible
Lab/X-Ray	Not Covered	
Skilled Nursing — in lieu of hospital <i>30 days per calendar year*</i>	20% after deductible	50% after deductible
Physical/Occupational Therapy and Chiropractic Care	Not Covered	
Home Health Care — in lieu of hospital <i>30 visits per calendar year*</i>	20% after deductible	50% after deductible
Durable Medical Equipment ***	Not Covered	
PHARMACY		
Pharmacy Deductible per individual	Not applicable	
Generic <i>Oral Contraceptives Included</i>	\$15 copay	\$15 copay plus 50%
Preferred Brand <i>Oral Contraceptives Included</i>	Not covered Aetna discount applies	Not covered
Non-Preferred Brand <i>Oral Contraceptives Included</i>	Not covered Aetna discount applies	Not covered Aetna discount applies
Calendar Year Maximum per individual*	Unlimited	

* Maximum applies to combined in and out of network benefits

** Copay is billed separately and not due at time of service. Copay does not count towards coinsurance or out-of-pocket maximum.

***Diabetic and Ostomy supplies are covered. A maximum of \$1,000 per calendar year for ostomy supplies.

+ Payment for out-of-network facility care is determined based upon Aetna's Allowable Fee Schedule. Payment for other out-of network care is determined based upon the negotiated charge that would apply if such services or supplies were received from a Preferred Provider.

A summary of exclusions is listed in the Aetna Advantage brochure. For a full list of benefit coverage and exclusions refer to the plan documents.

Plans may be subject to medical underwriting or other restrictions. Rates and benefits vary by location. 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. Health insurance plans contain exclusions and limitations. Material subject to change.

Aetna Advantage Plans for individual, families and the self employed are underwritten by Aetna Life Insurance Company (Aetna) directly and/or through an out of state blanket trust. In some states, individuals may qualify as a business group of one and may be eligible for guaranteed issue, small group health plans.

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