

Plan Options

Illinois

Effective 01/01/2013



PREMIER \$1500 DEDUCTIBLE PLAN	PREMIER \$2500 DEDUCTIBLE PLAN	PREMIER \$5000 DEDUCTIBLE PLAN
(You pay the amounts below)	(You pay the amounts below)	(You pay the amounts below)

MEMBER BENEFITS	In-Network	Out-of-Network†	In-Network	Out-of-Network†	In-Network	Out-of-Network†
Deductible Individual / Family	\$1,500/\$3,000	\$3,000/\$6,000	\$2,500/\$5,000	\$5,000/\$10,000	\$5,000/\$10,000	\$10,000/\$20,000
Coinsurance (Member's Responsibility)	20% after deductible	40% after deductible	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Coinsurance Maximum Individual / Family	\$1,500/\$3,000	\$1,500/\$3,000	\$2,500/\$5,000	\$2,500/\$5,000	\$2,500/\$5,000	\$2,500/\$5,000
Out-of-Pocket Maximum (Includes Deductible) Individual / Family	\$3,000/\$6,000	\$4,500/\$9,000	\$5,000/\$10,000	\$7,500/\$15,000	\$7,500/\$15,000	\$12,500/\$25,000
Lifetime Maximum per Insured	Unlimited		Unlimited		Unlimited	
Non-Specialist Office Visit General Physician, Family Practitioner, Pediatrician or Internist	\$25 copay ded. waived	40% after deductible	\$30 copay ded. waived	40% after deductible	\$40 copay ded. waived	40% after deductible
Specialist Visit	\$35 copay ded. waived	40% after deductible	\$40 copay ded. waived	40% after deductible	\$50 copay ded. waived	40% after deductible
Hospital Admission	20% after deductible	40% after deductible	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Outpatient Surgery	20% after deductible	40% after deductible	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Emergency Room	\$100 copay** (waived if admitted) 20% after deductible		\$100 copay** (waived if admitted) 20% after deductible		\$100 copay** (waived if admitted) 20% after deductible	
Annual Routine GYN Exam Annual Pap	\$0 copay ded. waived	40% after deductible	\$0 copay ded. waived	40% after deductible	\$0 copay ded. waived	40% after deductible
Maternity	Not covered <i>Except for pregnancy complications</i>		Not covered <i>Except for pregnancy complications</i>		Not covered <i>Except for pregnancy complications</i>	
Preventive Health Routine Physical	\$0 copay ded. waived	40% after deductible	\$0 copay ded. waived	40% after deductible	\$0 copay ded. waived	40% after deductible
Lab / X-Ray	20% after deductible	40% after deductible	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Skilled Nursing In lieu of hospital <i>30 days per calendar year*</i>	20% after deductible	40% after deductible	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Physical / Occupational Therapy <i>24 visits per calendar year*</i>	20% after deductible	40% after deductible	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Home Health Care In lieu of hospital <i>30 visits per calendar year*</i>	20% after deductible	40% after deductible	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Durable Medical Equipment <i>Aetna will pay up to \$2,000 per calendar year*</i>	20% after deductible	40% after deductible	20% after deductible	40% after deductible	20% after deductible	40% after deductible
PHARMACY						
Pharmacy Deductible Individual / Family	\$250/\$500 NA to generic	\$250/\$500 NA to generic	\$500/\$1,000 NA to generic	\$500/\$1,000 NA to generic	\$500/\$1,000 NA to generic	\$500/\$1,000 NA to generic
Generic	\$15 copay ded. waived	\$15 copay plus 40% ded. waived	\$15 copay ded. waived	\$15 copay plus 40% ded. waived	\$15 copay ded. waived	\$15 copay plus 40% ded. waived
Preferred Brand	\$25 copay after deductible	\$25 copay plus 40% after ded.	\$25 copay after deductible	\$25 copay plus 40% after ded.	\$25 copay after deductible	\$25 copay plus 40% after ded.
Non-Preferred Brand	\$40 copay after deductible	\$40 copay plus 40% after ded.	\$40 copay after deductible	\$40 copay plus 40% after ded.	\$40 copay after deductible	\$40 copay plus 40% after ded.
Calendar Year Max per Individual	Unlimited		Unlimited		Unlimited	

* Maximum applies to combined in- and out-of-network benefits. For a full list of benefit coverage and exclusions refer to plan documents.

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

*** Aetna discount available.

HIGH DEDUCTIBLE \$3000 PLAN (HSA COMPATIBLE)	HIGH DEDUCTIBLE \$5000 PLAN (HSA COMPATIBLE)	PREVENTIVE & HOSPITAL \$1250 DEDUCTIBLE PLAN	PREVENTIVE & HOSPITAL \$3000 DEDUCTIBLE PLAN (HSA COMPATIBLE)
(You pay the amounts below)	(You pay the amounts below)	(You pay the amounts below)	(You pay the amounts below)

In-Network	Out-of-Network [†]	In-Network	Out-of-Network [†]	In-Network	Out-of-Network [†]	In-Network	Out-of-Network [†]
\$3,000/\$6,000	\$6,000/\$12,000	\$5,000/\$10,000	\$10,000/\$20,000	\$1,250/\$2,500	\$2,500/\$5,000	\$3,000/\$6,000	\$6,000/\$12,000
0% after deductible	40% after deductible	0% after deductible	40% after deductible	20% after deductible	40% after deductible	20% after deductible	40% after deductible
\$0/\$0	\$6,500/\$13,000	\$0/\$0	\$2,500/\$5,000	\$2,500/\$5,000	\$5,000/\$10,000	\$2,000/\$4,000	\$4,000/\$8,000
\$3,000/\$6,000	\$12,500/\$25,000	\$5,000/\$10,000	\$12,500/\$25,000	\$3,750/\$7,500	\$7,500/\$15,000	\$5,000/\$10,000	\$10,000/\$20,000
Unlimited		Unlimited		Unlimited		Unlimited	
0% after deductible	40% after deductible	0% after deductible	40% after deductible	Not covered	Not covered	Not covered	Not covered
0% after deductible	40% after deductible	0% after deductible	40% after deductible	Not covered	Not covered	Not covered	Not covered
0% after deductible	40% after deductible	0% after deductible	40% after deductible	20% after deductible	40% after deductible	20% after deductible	40% after deductible
0% after deductible	40% after deductible	0% after deductible	40% after deductible	20% after deductible	40% after deductible	20% after deductible	40% after deductible
\$0 copay after deductible	\$0 copay after deductible	\$0 copay after deductible	\$0 copay after deductible	\$100 copay** (waived if admitted) 20% after deductible		\$100 copay** (waived if admitted) 20% after deductible	
\$0 copay ded. waived	40% after deductible	\$0 copay ded. waived	40% after deductible	\$0 copay ded. waived	40% after deductible	\$0 copay ded. waived	40% after deductible
Not covered <i>Except for pregnancy complications</i>		Not covered <i>Except for pregnancy complications</i>		Not covered <i>Except for pregnancy complications</i>		Not covered <i>Except for pregnancy complications</i>	
\$0 copay ded. waived	40% after deductible	\$0 copay ded. waived	40% after deductible	\$0 copay ded. waived	40% after deductible	\$0 copay ded. waived	40% after deductible
0% after deductible	40% after deductible	0% after deductible	40% after deductible	20% after ded. preoperative w/covered surgery only	40% after ded. preoperative w/covered surgery only	20% after ded. preoperative w/covered surgery only	40% after ded. preoperative w/covered surgery only
0% after deductible	40% after deductible	0% after deductible	40% after deductible	20% after deductible	40% after deductible	20% after deductible	40% after deductible
0% after deductible	40% after deductible	0% after deductible	40% after deductible	Not covered	Not covered	Not covered	Not covered
0% after deductible	40% after deductible	0% after deductible	40% after deductible	20% after deductible	40% after deductible	20% after deductible	40% after deductible
0% after deductible	40% after deductible	0% after deductible	40% after deductible	Not covered	Not covered	Not covered	Not covered
Integrated Medical/Rx Deductible		Integrated Medical/Rx Deductible		Not applicable	Not applicable	Not covered***	Not covered***
\$0 copay after medical ded.	40% after med. ded.	0% after med. ded.	40% after med. ded.	\$15 copay ded. waived	\$15 copay plus 40% ded. waived	Not covered***	Not covered***
\$0 copay after medical ded.	40% after med. ded.	0% after med. ded.	40% after med. ded.	Not covered***	Not covered***	Not covered***	Not covered***
\$0 copay after medical ded.	40% after med. ded.	0% after med. ded.	40% after med. ded.	Not covered***	Not covered***	Not covered***	Not covered***
Unlimited		Unlimited		Unlimited		Not applicable	Not applicable

[†] Payment for out-of-network facility covered expenses is determined based on the Aetna Market Fee Schedule. Payment for out-of-network non-facility covered expenses is determined based on the negotiated charge that would apply if such services were received from a Network Provider.

AARP® Essential Premier Health Insurance Plan is the name of the plan underwritten for AARP members by Aetna Life Insurance Company. In some states, individuals may qualify as a business group of one and may be eligible for guaranteed issue, small group health plans

AARP Essential Premier Health Insurance plans are medically underwritten by Aetna Life Insurance Company and to the extent permitted by law you may be declined coverage in accordance with your health condition. In some business group of one and may be eligible for guaranteed issue, small group health plans. If declined coverage, you may be federally eligible under the Health Insurance

Portability and Accountability Act (HIPAA) for a special guaranteed issue plan under your state's laws and regulations.

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Health insurance plans contain exclusions and limitations. 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.

Investment services are independently offered. Providers are independent contractors and are not agents of Aetna.

For a full and complete list of benefit coverage and exclusions refer to the plan documents.

Information is believed to be accurate as of the production date; however, it is subject to change.