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| Employer Name: |
| Employer State of Situs: |
| Name of Issuer: |
| Plan Marketing Name: |
| Plan Year: |

Natus Sensory
Wisconsin
Aetna
Aetna PPO & Aetna HDHP PPO
2025

Ten (10) Essential Health Benefit (EHB) Categories:

- Ambulatory patient services (outpatient care you get without being admitted to a hospital)
- Emergency services
- Hospitalization (like surgery and overnight stays)
- Laboratory services
- Mental health and substance use disorder (MH/SUD) services, including behavioral health treatment (this includes counseling and psychotherapy)
- Pediatric services, including oral and vision care (but adult dental and vision coverage aren't essential health benefits)
- Pregnancy, maternity, and newborn care (both before and after birth)
- Prescription drugs
- Preventive and wellness services and chronic disease management
- Rehabilitative and habilitative services and devices (services and devices to help people with injuries, disabilities, or chronic conditions gain or recover mental and physical skills)

2020-2025 Illinois Essential Health Benefit (EHB) Listing (P.A. 102-0630)

| Item | EHB Benefit | EHB Category | Benchmark Page # Reference | Aetna PPO | Aetna HSA |
|------|---|--------------|----------------------------|--|--|
| 1 | Accidental Injury -- Dental | Ambulatory | Pgs. 10 & 17 | Yes* (please refer to plan documents for exclusions) | Yes* (please refer to plan documents for exclusions) |
| 2 | Allergy Injections and Testing | Ambulatory | Pg. 11 | Yes* (please refer to plan documents for exclusions) | Yes* (please refer to plan documents for exclusions) |
| 3 | Bone anchored hearing aids | Ambulatory | Pgs. 17 & 35 | Yes* (please refer to plan documents for exclusions) | Yes* (please refer to plan documents for exclusions) |
| 4 | Durable Medical Equipment | Ambulatory | Pg. 13 | Yes* (please refer to plan documents for exclusions) | Yes* (please refer to plan documents for exclusions) |
| 5 | Hospice | Ambulatory | Pg. 28 | Yes* (please refer to plan documents for exclusions) | Yes* (please refer to plan documents for exclusions) |
| 6 | Infertility (Fertility) Treatment | Ambulatory | Pgs. 23 - 24 | Yes* (please refer to plan documents for exclusions) | Yes* (please refer to plan documents for exclusions) |
| 7 | Outpatient Facility Fee (e.g., Ambulatory Surgery Center) | Ambulatory | Pg. 21 | Yes* (please refer to plan documents for exclusions) | Yes* (please refer to plan documents for exclusions) |

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|---|--|--------------------------------|---------------------------------------|--|--|
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| 8 | Outpatient Surgery Physician/Surgical Services (Ambulatory Patient Services) | Ambulatory | Pgs. 15 - 16 | Yes* (please refer to plan documents for exclusions) | Yes* (please refer to plan documents for exclusions) |
| 9 | Private-Duty Nursing | Ambulatory | Pgs. 17 & 34 | Not covered | Not covered |
| 10 | Prosthetics/Orthotics | Ambulatory | Pg. 13 | Yes* (please refer to plan documents for exclusions) | Yes* (please refer to plan documents for exclusions) |
| 11 | Sterilization (vasectomy men) | Ambulatory | Pg. 10 | Yes* (please refer to plan documents for exclusions) | Yes* (please refer to plan documents for exclusions) |
| 12 | Temporomandibular Joint Disorder (TMJ) | Ambulatory | Pgs. 13 & 24 | Yes* (please refer to plan documents for exclusions) | Yes* (please refer to plan documents for exclusions) |
| 13 | Emergency Room Services (Includes MH/SUD Emergency) | Emergency services | Pg. 7 | Yes* (please refer to plan documents for exclusions) | Yes* (please refer to plan documents for exclusions) |
| 14 | Emergency Transportation/ Ambulance | Emergency services | Pgs. 4 & 17 | Yes* (please refer to plan documents for exclusions) | Yes* (please refer to plan documents for exclusions) |
| 15 | Bariatric Surgery (Obesity) | Hospitalization | Pg. 21 | OAMC: Not Covered | OAMC: Not Covered |
| 16 | Breast Reconstruction After Mastectomy | Hospitalization | Pgs. 24 - 25 | Yes* (please refer to plan documents for exclusions) | Yes* (please refer to plan documents for exclusions) |
| 17 | Reconstructive Surgery | Hospitalization | Pgs. 25 - 26, & 35 | Yes* (please refer to plan documents for exclusions) | Yes* (please refer to plan documents for exclusions) |
| 18 | Inpatient Hospital Services (e.g., Hospital Stay) | Hospitalization | Pg. 15 | Yes* (please refer to plan documents for exclusions) | Yes* (please refer to plan documents for exclusions) |
| 19 | Skilled Nursing Facility | Hospitalization | Pg. 21 | Yes* (please refer to plan documents for exclusions) | Yes* (please refer to plan documents for exclusions) |
| 20 | Transplants - Human Organ Transplants (Including transportation & lodging) | Hospitalization | Pgs. 18 & 31 | Yes* (please refer to plan documents for exclusions) | Yes* (please refer to plan documents for exclusions) |
| 21 | Diagnostic Services | Laboratory services | Pgs. 6 & 12 | Yes* (please refer to plan documents for exclusions) | Yes* (please refer to plan documents for exclusions) |
| 22 | Intranasal opioid reversal agent associated with opioid prescriptions | MH/SUD | Pg. 32 | Yes* (please refer to plan documents for exclusions) | Yes* (please refer to plan documents for exclusions) |
| 23 | Mental (Behavioral) Health Treatment (Including Inpatient Treatment) | MH/SUD | Pgs. 8 -9, 21 | Yes* (please refer to plan documents for exclusions) | Yes* (please refer to plan documents for exclusions) |
| 24 | Opioid Medically Assisted Treatment (MAT) | MH/SUD | Pg. 21 | Yes* (please refer to plan documents for exclusions) | Yes* (please refer to plan documents for exclusions) |
| 25 | Substance Use Disorders (Including Inpatient Treatment) | MH/SUD | Pgs. 9 & 21 | Yes* (please refer to plan documents for exclusions) | Yes* (please refer to plan documents for exclusions) |
| 26 | Tele-Psychiatry | MH/SUD | Pg. 11 | Yes* (please refer to plan documents for exclusions) | Yes* (please refer to plan documents for exclusions) |
| 27 | Topical Anti-Inflammatory acute and chronic pain medication | MH/SUD | Pg. 32 | Yes* (please refer to plan documents for exclusions) | Yes* (please refer to plan documents for exclusions) |
| 28 | Pediatric Dental Care | Pediatric Oral and Vision Care | See AllKids Pediatric Dental Document | No - may be covered by a separate dental plan | No - may be covered by a separate dental plan |

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| 29 | Pediatric Vision Coverage | Pediatric Oral and Vision Care | Pgs. 26 - 27 | No - may be covered by a separate vision plan | No - may be covered by a separate vision plan |
| 30 | Maternity Service | Pregnancy, Maternity, and Newborn Care | Pgs. 8 & 22 | Yes* (please refer to plan documents for exclusions) | Yes* (please refer to plan documents for exclusions) |
| 31 | Outpatient Prescription Drugs | Prescription drugs | Pgs. 29 - 34 | Yes* (please refer to plan documents for exclusions) | Yes* (please refer to plan documents for exclusions) |
| 32 | Colorectal Cancer Examination and Screening | Preventive and Wellness Services | Pgs. 12 & 16 | Yes* (please refer to plan documents for exclusions) | Yes* (please refer to plan documents for exclusions) |
| 33 | Contraceptive/Birth Control Services | Preventive and Wellness Services | Pgs. 13 & 16 | Yes* (please refer to plan documents for exclusions) | Yes* (please refer to plan documents for exclusions) |
| 34 | Diabetes Self-Management Training and Education | Preventive and Wellness Services | Pgs. 11 & 35 | Yes* (please refer to plan documents for exclusions) | Yes* (please refer to plan documents for exclusions) |
| 35 | Diabetic Supplies for Treatment of Diabetes | Preventive and Wellness Services | Pgs. 31 - 32 | Yes* (please refer to plan documents for exclusions) | Yes* (please refer to plan documents for exclusions) |
| 36 | Mammography - Screening | Preventive and Wellness Services | Pgs. 12, 15, & 24 | Yes* (please refer to plan documents for exclusions) | Yes* (please refer to plan documents for exclusions) |
| 37 | Osteoporosis - Bone Mass Measurement | Preventive and Wellness Services | Pgs. 12 & 16 | Yes* (please refer to plan documents for exclusions) | Yes* (please refer to plan documents for exclusions) |
| 38 | Pap Tests/ Prostate- Specific Antigen Tests/ Ovarian Cancer Surveillance Test | Preventive and Wellness Services | Pg. 16 | Yes* (please refer to plan documents for exclusions) | Yes* (please refer to plan documents for exclusions) |
| 39 | Preventive Care Services | Preventive and Wellness Services | Pg. 18 | Yes* (please refer to plan documents for exclusions) | Yes* (please refer to plan documents for exclusions) |
| 40 | Sterilization (women) | Preventive and Wellness Services | Pgs. 10 & 19 | Yes* (please refer to plan documents for exclusions) | Yes* (please refer to plan documents for exclusions) |
| 41 | Chiropractic & Osteopathic Manipulation | Rehabilitative and Habilitative Services and Devices | Pgs. 12 - 13 | Yes* (please refer to plan documents for limitations) | Yes* (please refer to plan documents for limitations) |
| 42 | Habilitative and Rehabilitative Services | Rehabilitative and Habilitative Services and Devices | Pgs. 8, 9, 11, 12, 22, & 35 | Yes* (please refer to plan documents for exclusions) | Yes* (please refer to plan documents for exclusions) |

Special Note: Under Pub. Act 102-0104, eff. July 22, 2021, any EHBs listed above that are clinically appropriate and medically necessary to deliver via telehealth services must be covered in