Employer Name:	WSP USA Inc.
Name of Issuer:	Aetna (Medical) and ESI (Rx)
Group Health Plan Name:	Aetna Choice POS II Basic HDHP, Aetna Choice POS II Enhanced HDHP, Aetna Choice POS II, Open Access Aetna Select Plan
Plan Year:	2022

Illinois Consumer Coverage Disclosure Act

Written List of Covered Benefits:

A Comparison of Your Group Health Insurance Coverage to Coverage Under Individual Health Insurance in Illinois

Item	Essential Health Benefits	Benefit Covered under Individual Health Insurance Policy in Illinois?	Benefit Covered under Employer's Group Health Insurance Coverage Policy: Yes/No and Any Limits?*
1	Accidental Dental	Yes	*Yes*
2	Allergy Testing	Yes	*Yes*
3	At least one intranasal spray opioid reversal agent when initial prescriptions of opioids are dosages of 50MME or higher	Yes	No
4	Bariatric Surgery	Yes	*Yes*
5	Basic Dental Care - Child	Yes	No
6	Chemotherapy	Yes	*Yes*
7	Chiropractic Care	Yes [Limited to 25 visits per benefit period]	*Yes*
8	Cosmetic Surgery (for the correction of the congenital deformities or for conditions resulting from accidental injuries, scars, tumors or disease.)	Yes	*Yes*
9	Delivery and All Inpatient Services for Maternity Care	Yes	*Yes*
10	Dental Check-Up for Children	Yes	No
11	Diabetes Education (rendered by a physician, or duly certified, or licensed health care professional with expertise in diabetes management.)	Yes	*Yes*
12	Dialysis	Yes	*Yes*
13	Durable Medical Equipment	Yes	*Yes*
14	Emergency Room Services	Yes	Yes (for treatment of a covered emergency condition)
15	Emergency Transportation/Ambulance	Yes	*Yes*
16	Eye Glasses for Children	Yes [Limited to 1 item per benefit period]	No
17	Generic Drugs	Yes	*Yes*
18	Habilitation Services	Yes [Treatment must be medically necessary and therapeutic and not investigational]	Yes (for austism spectrum disorder treatment)
19	Hearing Aids	Yes [Bone anchored hearing aids; quantity limit for hearing aids for children is 2 per 3 years]	*Yes*
20	Hospice Services	Yes	*Yes*
21	Infertility Treatment	Yes [Limitations vary based upon procedure]	Yes (see exclusions and limitations)
22	Infusion Therapy	Yes	*Yes*
23	Inpatient Hospital Services (e.g., Hospital Stay)	Yes	*Yes*
24	Inpatient Physician and Surgical Services	Yes	*Yes*
25	Laboratory Outpatient and Professional Services (for outpatient services and when these services are related to surgery or medical care.)	Yes	*Yes*
26	Major Dental Care - Child	Yes [Limitations vary based upon procedure]	No
27	Mental/Behavioral Health Inpatient Services	Yes	*Yes*
28	Mental/Behavioral Health Outpatient Services	Yes	*Yes*
29	Non-Preferred Brand Drugs	Yes	*Yes*
30	Nutritional Counseling	Yes	*Yes*
31	Opioid prescriptions for acute pain are provided for no more than 7 days	Yes	No
32	Orthodontia - Child	Yes [Limitations vary based upon procedure]	No
33	Other Practitioner Office Visit (Nurse, Physician Assistant)	Yes	*Yes*
34	Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Yes	*Yes*
35	Outpatient Rehabilitation Services	Yes [Maintenance therapies not covered]	*Yes*
36	Outpatient Surgery Physician/Surgical Services	Yes	*Yes*
37	Preferred Brand Drugs	Yes	*Yes*
38	Prenatal and Postnatal Care	Yes	*Yes*
39	Preventive Care/Screening/Immunization	Yes	*Yes*
40	Primary Care Visit to Treat an Injury or Illness	Yes	*Yes*
41	Private-Duty Nursing	Yes [IP private duty nursing is not covered]	No
42	Prohibition on prior authorization, dispensing limits, and fail first policies for buprenorphine or brand equivalent products for medication assisted treatment of opioid use disorder	Yes	No
43	Prosthetic Devices	Yes	*Yes*
44	Radiation	Yes	*Yes*
45	Reconstructive Surgery for mastectomy-related services	Yes	*Yes*
46	Rehabilitative Occupational and Rehabilitative Physical Therapy	Yes [Maintenance occupational and physical therapy are not covered]	*Yes*
47	Rehabilitative Speech Therapy (When rendered for the treatment of psychosocial speech delay, behavioral problems (including impulsive behavior and impulsivity syndrome) attention disorder, conceptual handicap or mental retardation, except as may be provided under this Certificate for Autism Spectrum Disorder(s).)	Yes [Maintenance speech therapy not covered]	*Yes*
48	Routine Eye Exam for Children	Yes [Limited to 1 exam per benefit period]	Not Covered
49	Routine Foot Care (for persons diagnosed with diabetes)	Yes	*Yes*
50	Skilled Nursing Facility	Yes	*Yes*
51	Specialist Visit	Yes	*Yes*
52	Specialty Drugs	Yes	Yes (distributed through Participating Specialty Pharmacy)
53	Substance Abuse Disorder Inpatient Services	Yes	*Yes*
54	Substance Abuse Disorder Outpatient	Yes	*Yes*
55	Tele-psychiatry	Yes	*Yes*
56	Topical anti-inflammatory medication, including but not limited to Ketoprofen, Diclofenac, or another brand equivalent approved by the FDA for acute and chronic pain	Yes	No
57	Transplant	Yes	*Yes*
58	Treatment for Temporomandibular Joint Disorders	Yes	*Yes*
59	Urgent Care Centers or Facilities	Yes	Yes (unless you go for a non-urgent condition, then the plan may not cover the expense)
60	Well Baby Visits and Care	Yes	*Yes*
61	X-rays and Diagnostic Imaging (for outpatient services and when these services are related to surgery or medical care.)	Yes	*Yes*

* Please refer to plan documents for coverage and limitations.