### Important Questions and Answers

**What is the overall deductible?**
- **In Network:** Individual $2,000/Family $4,000.
- **Out of Network:** Individual $4,000 / Family $8,000.

**Why This Matters:**
Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.

**Are there services covered before you meet your deductible?**
- Yes. In-network preventive care is covered before you meet your deductible.

**Why This Matters:**
This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at [https://www.healthcare.gov/coverage/preventive-care-benefits/](https://www.healthcare.gov/coverage/preventive-care-benefits/).

**Are there other deductibles for specific services?**
- No.

**Why This Matters:**
You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.

**What is the out-of-pocket limit for this plan?**
- **In-Network:** Individual $5,000 / Family $8,000.
- **Out-of-Network:** Individual $7,000 / Family $14,000.

**Why This Matters:**
The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.

**What is not included in the out-of-pocket limit?**
- Premiums, balance-billing charges, penalties for failure to obtain pre-authorization for services & health care this plan doesn’t cover.

**Why This Matters:**
Even though you pay these expenses, they don’t count toward the out-of-pocket limit.

**Will you pay less if you use a network provider?**
- Yes. See [www.aetna.com/docfind](http://www.aetna.com/docfind) or call 1-800-370-4526 for a list of In-Network providers.

**Why This Matters:**
This plan uses a provider network. You will pay less if you use a provider in the plan’s network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider’s charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.

**Do you need a referral to see a specialist?**
- No.

**Why This Matters:**
You can see the specialist you choose without a referral.
All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If you visit a health care provider’s office or clinic</strong></td>
<td>Primary care visit to treat an injury or illness</td>
<td>In-Network Provider (You will pay the least) 20% coinsurance</td>
<td>Out-of-Network Provider (You will pay the most) 50% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Preventive care /screening /immunization</td>
<td>No charge</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td><strong>If you have a test</strong></td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td><strong>If you need drugs to treat your illness or condition</strong></td>
<td>Generic drugs</td>
<td>30% coinsurance</td>
<td>30% coinsurance* *(Plus difference between retail cost and in-network price)</td>
</tr>
<tr>
<td></td>
<td>Preferred brand drugs</td>
<td>50% coinsurance</td>
<td>50% coinsurance* *(Plus difference between retail cost and in-network price)</td>
</tr>
<tr>
<td></td>
<td>Non-preferred brand drugs</td>
<td>50% coinsurance</td>
<td>50% coinsurance* *(Plus difference between retail cost and in-network price)</td>
</tr>
<tr>
<td></td>
<td>Specialty drugs</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td><strong>If you have</strong></td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
</tr>
</tbody>
</table>

More information about **prescription drug coverage** is available at [www.caremark.com](http://www.caremark.com) or call 1-877-232-8128.
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>outpatient surgery</strong></td>
<td>Physician/surgeon fees</td>
<td>20% coinsurance</td>
<td></td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room care</td>
<td>20% coinsurance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>20% coinsurance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>20% coinsurance</td>
<td></td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>20% coinsurance</td>
<td>Pre-authorization required for out-of-network care. If pre-authorization is not obtained, benefits may be reduced or not covered.</td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Outpatient services</td>
<td>20% coinsurance</td>
<td>Mental Health &amp; Substance Abuse benefits not provided by Aetna. Coverage for these services is administered by Magellan Health. More information is available at <a href="http://www.magellanascend.com">www.magellanascend.com</a>, or contact Magellan at 1-800-513-2611. Pre-authorization may be required. If pre-authorization is not obtained, benefits may be reduced or not covered.</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>20% coinsurance</td>
<td></td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>20% coinsurance</td>
<td>Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) Pre-authorization may be required for out-of-network care. If pre-authorization is not obtained, benefits may be reduced or not covered.</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>20% coinsurance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>20% coinsurance</td>
<td></td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>20% coinsurance</td>
<td>Custodial care not covered. Pre-authorization required for out-of-network care. If pre-authorization is not obtained, benefits may be reduced or not covered.</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>20% coinsurance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>20% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>20% coinsurance</td>
<td>Custodial care not covered. Pre-authorization required for out-of-network care. If pre-authorization is not obtained, benefits may be reduced or not covered.</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>In-Network Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
</tr>
<tr>
<td>----------------------</td>
<td>-----------------------</td>
<td>---------------------------------------------</td>
<td>------------------------------------------------</td>
</tr>
<tr>
<td>Durable medical equipment</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td>Hospice services</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
<td>Pre-authorization required for out-of-network care. If pre-authorization is not obtained, benefits may be reduced or not covered.</td>
</tr>
</tbody>
</table>

If your child needs dental or eye care:
- Children's eye exam: Not covered
- Children's glasses: Not covered
- Children's dental check-up: Not covered

**Excluded Services & Other Covered Services:**

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.):
- Acupuncture
- Cosmetic surgery
- Custodial care
- Dental care
- Hearing aids
- Long-term care
- Private-duty nursing
- Routine foot care
- Routine eye care
- Weight loss programs - Except for required preventive services.

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.):
- Bariatric surgery
- Chiropractic care - 30 visits/plan year.
- Non-emergency care when traveling outside the U.S.
- Infertility treatment.

**Your Rights to Continue Coverage:**
There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is:
- Center for Consumer Information and Insurance Oversight, 1-877-267-2323 x61565 or www.ccio.cms.gov.

Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.
Your Grievance and Appeals Rights:
There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact:
- Aetna by calling the toll free number on your Medical ID Card, or by calling our general toll free number at 1-855-856-0038; or
- Illinois Department of Central Management Services, Group Insurance Division, at 1-800-442-1300 or by email at CMS.Ben.BCS@illinois.gov.

Does this plan provide Minimum Essential Coverage? Yes.
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan Meet Minimum Value Standard? No.
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

---------------To see examples of how this plan might cover costs for a sample medical situation, see the next section.-----------------
About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

### Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- The plan's overall deductible: $2,000
- Specialist Coinsurance: 20%
- Hospital (facility) Coinsurance: 20%
- Other Coinsurance: 20%

This EXAMPLE event includes services like:
- Specialist office visits (prenatal care)
- Childbirth/Delivery Professional Services
- Childbirth/Delivery Facility Services
- Diagnostic tests (ultrasounds and blood work)
- Specialist visit (anesthesia)

**Total Example Cost**: $12,800

**In this example, Peg would pay:**

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles*</td>
<td>$2,000</td>
</tr>
<tr>
<td>Copayments</td>
<td>$0</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$2,148</td>
</tr>
</tbody>
</table>

**What isn't covered**

- Limits or exclusions: $60
- The total Peg would pay is: **$4,208**

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: 1-855-856-0038.

*Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.

*Note: Your deductible may be different than the examples depending on your annual salary. For your applicable deductible, see page 1 of this document.

### Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- The plan's overall deductible: $2,000
- Specialist Coinsurance: 20%
- Hospital (facility) Coinsurance: 20%
- Other Coinsurance: 20%

This EXAMPLE event includes services like:
- Primary care physician office visits (including disease education)
- Diagnostic tests (blood work)
- Prescription drugs
- Durable medical equipment (glucose meter)

**Total Example Cost**: $7,400

**In this example, Joe would pay:**

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles*</td>
<td>$2,000</td>
</tr>
<tr>
<td>Copayments</td>
<td>$0</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$1,076</td>
</tr>
</tbody>
</table>

**What isn't covered**

- Limits or exclusions: $20
- The total Joe would pay is: **$3,096**

### Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- The plan's overall deductible: $2,000
- Specialist Coinsurance: 20%
- Hospital (facility) Coinsurance: 20%
- Other Coinsurance: 20%

This EXAMPLE event includes services like:
- Emergency room care (including medical supplies)
- Diagnostic test (x-ray)
- Durable medical equipment (crutches)
- Rehabilitation services (physical therapy)

**Total Example Cost**: $1,900

**In this example, Mia would pay:**

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles*</td>
<td>$2,000</td>
</tr>
<tr>
<td>Copayments</td>
<td>$0</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
</tr>
</tbody>
</table>

**What isn't covered**

- Limits or exclusions: $0
- The total Mia would pay is: **$1,900**

The plan would be responsible for the other costs of these EXAMPLE covered services.
Assistive Technology

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 1-855-856-0038.

Smartphone or Tablet

To view documents from your smartphone or tablet, the free WinZip app is required. It may be available from your App Store.

Non-Discrimination

Aetna complies with applicable Federal civil rights laws and does not discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, or disability.

Aetna provides free aids/services to people with disabilities and to people who need language assistance.

If you need a qualified interpreter, written information in other formats, translation or other services, call the number on your ID card.

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:

Civil Rights Coordinator,

P.O. Box 14462, Lexington, KY 40512 (CA HMO customers: PO Box 24030 Fresno, CA 93779),

1-800-648-7817, TTY: 711, Fax: 859-425-3379 (CA HMO customers: 1-860-262-7705),

Email: CRCoordinator@aetna.com.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, or at 1-800-368-1019, 800-537-7697 (TDD).

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TTY: 711

Language Assistance:

For language assistance in your language call 1-855-856-0038 at no cost.

Albanian - Për asistencën e gjuhës shqipe telefononi falas në 1-855-856-0038.
Amharic - እንደሚወexistent እንጎም የሚያገኝ ከ 1-855-856-0038 የተያወጡ መወ የዓለም እንጎም የሚያገግዘብ.
Arabic - للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 1-855-856-0038.
Armenian - Հենց գնաղափոխությունը պատահանջից (հայերեն) գալիս 1-855-856-0038 առանց qնմ.
Bahasa Indonesia - Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-855-856-0038 tanpa dikenakan biaya.
Bantu-Kirundi - Niba urondera uwugufasha mu Kirundi, twakure kuri iyi numero 1-855-856-0038 ku busa.
Bengali-Bangala - বাংলায় ভাষা সহায়তার জন্য বিনামূল্যে 1-855-856-0038-তে কল করুন।
Bisayan-Visayan - Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawag sa 1-855-856-0038 nga walay bayad.
Burmese - မြန်မာ ဘာသာ လိုအပ်ချက်တွေကို စက်တင်ဘာ 1-855-856-0038 အတွက် သို့မဟုတ် ကြည်မှု နှင့် ဆရာများကို လိုအပ်စေပါ။
Catalan - Per rebre assistència en (català), truqui al número gratuït 1-855-856-0038.
Chamorro - Para ayuda gi fino' (Chamoru), ågang 1-855-856-0038 sin gástu.
Cherokee - የስወipeline የወስክ ገወዳን የስወሚስር ጥንት (GWW) የስወሚስር 1-855-856-0038 የሚስር ገወዳን የስወሚስር እና የስወሚስር.
Chinese - 欲取得繁體中文語言協助，請撥打 1-855-856-0038，無需付費。
Choctaw - (Chahta) anumpa ya apela a chi l paya hinla 1-855-856-0038.
Cushite - Gargaarsa afaan Oromiffa hiikuur argachuuuf lakkokoofsa bilbilaa 1-855-856-0038 irratti bilisanaa bilbilaa.
Dutch - Bel voor tolk- en vertaaldiensten in het Nederlands gratis naar 1-855-856-0038.
French - Pour une assistance linguistique en français appeler le 1-855-856-0038 sans frais.
French Creole - Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo 1-855-856-0038 gratis.
German - Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 1-855-856-0038 an.
Greek - Για γλωσσική βοήθεια στα Ελληνικά καλέστε το 1-855-856-0038 χωρίς χρέωση.
Gujarati - ગુજરાતીમાં સહાય મળે કોઈ પણ વર્ષ વગર 1-855-856-0038 પર કોલ કરો.

Hindi - हिन्दी में भाषा सहायता के लिए, 1-855-856-0038 पर मुफ्त कॉल करें।

Hmong - Maka enyemaka asûsû na Igbo kqoq 1-855-856-0038 na akwûghi ugwô o bûla

Ilocano - Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-855-856-0038 nga awan ti bayadanyo.

Italian - Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 1-855-856-0038.

Japanese - 日本語で援助をご希望の方は、1-855-856-0038 まで無料でお電話ください。

Karen - Be’im kê gbo-kpá-kpá dyé pidyi qé Basoó-wuqüin wée, qá 1-855-856-0038

Kurdish - برای راهنمایی به زبان فارسی با شماره 1-855-856-0038 بحث کنید.

Laotian - 1-855-856-0038 ແ�能 ທໜ໒໒໒໒໒໒໒໒໒໒໒໒໒໒໒໒໒໒໒໒໒໒໒໒໒໒໒໒໒໒໒໒໒໒໒໒໒໒໒໒໒໒໒໒໒໒໒໒໒໒໒໒໒໒໒໒໒໒໒໒໒໒໒໒໒໒໒໒໒໒໒໒໒໒໒໒໒໒໒໒໒໒໒໒໒໒໒໒໒໒໒໒໒໒໒໒໒໒໒໒໒໒໒໒໒໒໒໒໒໒໒໒໒໒໒໒໒໒໒"

Marathi - तीलभाषा (मराठी) सहाय्यासाठी 1-855-856-0038 क्रमांकावरकोणत्याहीखर्ााशिवायकॉलकरा.

Marshallese - Ñan bôk jipa îlo Kajin Majol, kallok 1-855-856-0038 îlo eijelok wônân.

Mon-Khmer - 1-855-856-0038 ការ ឱយដ្រ សម្រាប់ ភាសាខ្មែរ វាយប្រែ នូវ ត្រូវ មិន នោះ សាយ ស្តង់.

Navajo - T'áá shi shigaad k'ehjí bee shiká a'doowol nínízingo Diné k'ehjí koji' t'áá jík'e hólne' 1-855-856-0038

Nepali - (नेपाली) मा नि:शुल्क भाषा सहायता पाउनका लागि 1-855-856-0038 मा फोन गन्त्रहोस्।

Nilotic-Dinka - Tën kuoony ê thok ê Thuonjâñ ci 1-855-856-0038 kecin ayôc.

Norwegian - For språkassistanse på norsk, ring 1-855-856-0038 kostnadsfritt.

Panjabi - ਪੰਜਾਬੀ ਵਿੱਚ ਭਾਸ਼ਾਈ ਸਹਾਇਤਾ ਲਈ, 1-855-856-0038 'ਦੇ ਮੁਫ਼ਤ ਬਰਤ ਵਹੇ।


Persian - برای راهنمایی به زبان فارسی با شماره 1-855-856-0038 بدون هیچ هزینه ای تماس بگیرید. انگلیسی

Polish - Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-855-856-0038.
Para obter assistência linguística em português ligue para o 1-855-856-0038 gratuitamente.

Pentru asistență lingvistică în română lămurjiți la numărul gratuit 1-855-856-0038.

Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-855-856-0038.

Mo fesoasoani tau gagana I le Gagana Samoa vala'au le 1-855-856-0038 e aunoa ma se totogi.

Za jezičnu pomoć na hrvatskom jeziku pozovite besplatn broj 1-855-856-0038.

Para obtener asistencia lingüística en español, llame sin cargo al 1-855-856-0038.

Pentru asistenţă lingvistică în româneşte telefonaţi la numărul gratuit 1-855-856-0038.

Fii yo on hebu balal e ko yowittit e haala Pular noddee e oo numero doo 1-855-856-0038. Njodi woo fawaaki on.

Ukihitaji usaidizi katika lugha ya Kiswahili piga simu kwa 1-855-856-0038 bila malipo.

Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-855-856-0038 nang walang bayad.

สำหรับความช่วยเหลือทางภาษาเป็น ภาษาไทย โทร 1-855-856-0038 ฟรีไม่มีค่าใช้จ่าย.

Kapau ‘oku fiema’u hā tokoni ‘i he lea faka-Tonga telefoni 1-855-856-0038 ‘o ‘ikai hā ʻōtōngi.

Ren áninnisin chiakú ren (Kapasen Chuuk) kopwe kékkééri 1-855-856-0038 nge esapw kamé ngonuk.

(Dil) çağrısı dil yardım için. Hiçbir ücret ödededen 1-855-856-0038.

Щоб отримати допомогу перекладача української мови, зателефонуйте за безкоштовним номером 1-855-856-0038.

ا مېړښت لارې مېړښت مېړښت 1-855-856-0038, اړوند چې د نوي پښتو کېدونکي، د لومړي ولی ژنګلو لړې مېړښت

Để được hỗ trợ ngôn ngữ bằng (ngôn ngữ), hãy gọi miễn phí đến số 1-855-856-0038.

Fueri šapira ha ḏiḥ ala’i ḏa’i ḏa’i ḏa’i 1-855-856-0038, 1-855-856-0038.

Fún ọmọlọwọ nípa èdè (Yorùbá) pe 1-855-856-0038 ń ṣe ó wá ońìkọ̀kọ́ ìmò yọ̀ tó máa.