



The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. **NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, <https://www.aetnastateofillinois.com/health-plans> or by calling 1-855-856-0038. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at <https://www.healthcare.gov/sbc-glossary/> or call 1-855-856-0038 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	\$500 per recipient.	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u> ?	Yes. In- <u>network</u> <u>preventive care</u> is covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/
Are there other <u>deductibles</u> for specific services?	Yes. \$200 per in-network hospital admission; \$400 per out-of-network hospital admission; \$400 per emergency room visit; \$200 for organ and tissue transplants.	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	In- <u>Network</u> : Individual \$1,200 / Family \$2,750. Out-of- <u>Network</u> : Individual \$4,400 / Family \$8,800.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u> ?	<u>Premiums</u> , <u>balance-billing</u> charges, penalties for failure to obtain <u>pre-authorization</u> for services & health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u> ?	Yes. See www.aetna.com/docfind or call 1-800-370-4526 for a list of In- <u>Network</u> <u>providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .



All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	<u>Specialist</u> visit	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	<u>Preventive care /screening /immunization</u>	No charge	40% <u>coinsurance</u>	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Requires <u>pre-authorization</u> . If necessary <u>pre-authorization</u> is not obtained, benefits may be reduced or not covered.
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.caremark.com or call 1-877-232-8128	Tier I	30 day supply: Greater of 20% or \$7 ; 90 day supply: Greater of 20% or \$14	Maintenance Choice (90 Day Supply)** Greater of 10%; Deductible applies	**Medications received at CVS Caremark Pharmacy or through CVS Caremark Mail Service Pharmacy
	Tier II	30 day supply: Greater of 20% or \$14 ; 90 day supply: Greater of 20% or \$28	Maintenance Choice (90 Day Supply)** Greater of 10%; Deductible applies	
	Tier III	30 day supply: Greater of 20% or \$28 ; 90 day supply: Greater of 20% or \$56	Maintenance Choice (90 Day Supply)** Greater of 10%; Deductible applies	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	<u>Emergency room care</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Per visit deductible is waived if admitted.
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	<u>Urgent care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Pre-authorization</u> required for out-of-network care. If <u>pre-authorization</u> is not obtained, benefits may be reduced or not covered.
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Pre-authorization</u> required for out-of-network care.
	Inpatient services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
If you are pregnant	Office visits	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Cost sharing</u> does not apply for <u>preventive services</u> . Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) <u>Pre-authorization</u> may be required for out-of-network care. If <u>pre-authorization</u> is not obtained, benefits may be reduced or not covered.
	Childbirth/delivery professional services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
	Childbirth/delivery facility services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Custodial care not covered. <u>Pre-authorization</u> required for out-of-network care. If <u>pre-authorization</u> is not obtained, benefits may be reduced or not covered.
	<u>Rehabilitation services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	<u>Habilitation services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Custodial care not covered. <u>Pre-authorization</u> required for out-of-network care. If <u>pre-authorization</u> is not obtained, benefits may be reduced or not covered.
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Hospice services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Pre-authorization</u> required for out-of-network care. If <u>pre-authorization</u> is not obtained, benefits may be reduced or not covered.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

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
- Long-term care
- Private-duty nursing
- Routine eye care
- Routine foot 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.
- Hearing aids
- 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.cciio.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? Yes.

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** \$500
- **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:	
<i>Cost Sharing</i>	
Deductibles*	\$500
Copayments	\$0
Coinsurance	\$2,448
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$3,008

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

- The **plan's** overall **deductible** \$500
- **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:	
<i>Cost Sharing</i>	
Deductibles*	\$500
Copayments	\$0
Coinsurance	\$1,376
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$1,896

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

- The **plan's** overall **deductible** \$500
- **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:	
<i>Cost Sharing</i>	
Deductibles*	\$500
Copayments	\$0
Coinsurance	\$280
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$780

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.

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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- Hawaiian - No ke kōkua ma ka ‘ōlelo Hawai‘i, e kahea aku i ka helu kelepona 1-855-856-0038. Kāki ‘ole ‘ia kēia kōkua nei.
- Hindi - हनिदी में भाषा सहायता के लिए, 1-855-856-0038 पर मुफ्त कॉल करें।
- Hmong - Yog xav tau kev pab txhais lus Hmoob hu dawb tau rau 1-855-856-0038.
- Ibo - Maka enyemaka asụsụ na Igbo kpọọ 1-855-856-0038 na akwughị ugwo ọ bụla
- 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 - လာဝတ်မစာတတ်ကတိကုန်အင်္ဂါ ကျိန် ကိး 1-855-856-0038 လာတအိန်ဒီးတတ်လာဝ်ဘူဝ်လာဝ်စုဘူဝ်
- Korean - 한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-888-982-3862번으로 전화해 주십시오.
- Kru-Bassa - Ɓe m'ké gbo-kpá-kpá dyé pídyi dé Ɓáwó-wuḍuŋ wɛɛ, dǎ 1-855-856-0038
- Kurdish - برای راهنمایی به زبان فارسی با شماره 1-855-856-0038 به خورایی یه یومندی بکن.
- Laotian - ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ, ກະລຸນາໂທຫາ 1-855-856-0038 ໂດຍບໍ່ເສຍຄ່າໂທ.
- Marathi - तीलभाषा (मराठी) सहाय्यासाठी 1-855-856-0038 क्रमांकावरकोणत्याहीखर्चाशिवायकॉलकरा.
- Marshallese - Ñan bōk jipañ ilo Kajin Majol, kallok 1-855-856-0038 ilo ejjelok wōnān.
- Micronesian-Pohnpeyan - Ohng palien sawas en soun kawewe ni omw lokaia Ponape koahl 1-855-856-0038 ni sohte isais.
- Mon-Khmer, Cambodian - សម្រាប់ជំនួយភាសាជា ភាសាខ្មែរ សូមទូរស័ព្ទទៅកាន់លេខ 1-855-856-0038 ដោយឥតគិតថ្លៃ។
- Navajo - T'áá shi shizaad k'ehjí bee shíká a'doowol nínízingo Diné k'ehjí koji' t'áá jíík'e hólne' 1-855-856-0038
- Nepali - (नेपाली) मा निःशुल्क भाषा सहायता पाउनका लागि 1- 855-856-0038 मा फोन गर्नुहोस् ।
- Nilotic-Dinka - Tën kuwoɲy ë thok ë Thuɔŋjäŋ ɔɔl 1-855-856-0038 kec'in ayöc.
- Norwegian - For språkassistanse på norsk, ring 1-855-856-0038 kostnadsfritt.
- Panjabi - ਪੰਜਾਬੀ ਵਿੱਚ ਭਾਸ਼ਾਈ ਸਹਾਇਤਾ ਲਈ, 1-855-856-0038 'ਤੇ ਮੁਫਤ ਕਾਲ ਕਰੋ।
- Pennsylvania Dutch - Fer Hefte in Deitsch, ruf: 1-855-856-0038 aa. Es Aaruf koschtet nix.
- 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.

- Portuguese - Para obter assistência linguística em português ligue para o 1-855-856-0038 gratuitamente.
- Romanian - Pentru asistență lingvistică în românește telefonați la numărul gratuit 1-855-856-0038
- Russian - Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-855-856-0038.
- Samoan - Mo fesoasoani tau gagana I le Gagana Samoa vala'au le 1-855-856-0038 e aunoa ma se totagi.
- Serbo-Croatian - Za jezičnu pomoć na hrvatskom jeziku pozovite besplatan broj 1-855-856-0038.
- Spanish - Para obtener asistencia lingüística en español, llame sin cargo al 1-855-856-0038.
- Sudanic-Fulfude - Fii yo on hebu balal e ko yowitii e haala Pular noddee e oo numero doo 1-855-856-0038. Njodi woo fawaaki on.
- Swahili - Ukihitaji usaidizi katika lugha ya Kiswahili piga simu kwa 1-855-856-0038 bila malipo.
- Syriac - ܠܚܘܒܐ ܠܗܘܠܐܝܬܐ ܠܗܘܠܐܝܬܐ ܠܗܘܠܐܝܬܐ ܠܗܘܠܐܝܬܐ ܠܗܘܠܐܝܬܐ ܠܗܘܠܐܝܬܐ 1-855-856-0038 ܠܗܘܠܐܝܬܐ.
- Tagalog - Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-855-856-0038 nang walang bayad.
- Telugu - భాషలో సాయం కోరకు ఎలాంటి ఖర్చు లేకుండా 1-855-856-0038 కు కాల్ చేయండి. (తెలుగు)
- Thai - สำหรับความช่วยเหลือทางด้านภาษาเป็น ภาษาไทย โทร 1-855-856-0038 ฟรีไม่มีค่าใช้จ่าย
- Tongan - Kapau 'oku fiema'u hā tokoni 'i he lea faka-Tonga telefoni 1-855-856-0038 'o 'ikai hā ʻōtōngi.
- Trukese - Ren ánninnisin chiakú ren (Kapasen Chuuk) kopwe kékkéeri 1-855-856-0038 nge esapw kamé ngonuk.
- Turkish - (Dil) çağrısı dil yardım için. Hiçbir ücret ödemedi 1-855-856-0038.
- Ukrainian - Щоб отримати допомогу перекладача української мови, зателефонуйте за безкоштовним номером 1-855-856-0038.
- Urdu - اگر کسی کو اردو کی زبان کی مدد کی ضرورت ہے تو براہ کرم 1-855-856-0038 پر کال کریں۔
- Vietnamese - Để được hỗ trợ ngôn ngữ bằng (ngôn ngữ), hãy gọi miễn phí đến số 1-855-856-0038.
- Yiddish - פאר שפראך הילף אין אידיש רופט 1-855-856-0038 פון אפצאל.
- Yoruba - Fún ìrànṣọwọ nípa èdè (Yorùbá) pe 1-855-856-0038 láí san owó kankan rárá.