Coverage Period: 07/01/2019 - 06/30/2020

Coverage for: Individual + Family | Plan Type: HMO

aetna® : STATE OF IL STATE HNO
Health Network OnlySM - State HNO



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.aetna.com/sbcsearch/getpolicydocs?u=081500-040020-001981 or by calling 1-800-370-4526. 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 1-800-370-4526 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For each <u>Plan</u> Year, \$0.	See the Common Medical Events chart below for your costs for services this <u>plan</u> covers.
Are there services covered before you meet your deductible?	No.	You will have to meet the <u>deductible</u> before the <u>plan</u> pays for any services.
Are there other deductibles for specific services?	Yes. \$100 for <u>prescription drugs</u> . There are no other specific <u>deductibles</u> .	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</u> <u>limit</u> for this <u>plan</u> ?	Participating: Individual \$3,000 / Family \$6,000.	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 & 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 http://www.aetna.com/docfind or call 1-800-370-4526 for a list of participating providers.	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 before</u> you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the specialist you choose without a referral.

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

		What You Will Pay		
Common Medical Event	Services You May Need	Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Primary care visit to treat an injury or illness	\$20 <u>copay</u> /visit	Not covered	None
If you visit a health care	Specialist visit	\$30 copay/visit	Not covered	None
If you visit a health care provider's office or clinic	Preventive care /screening /immunization	No charge	Not covered	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	Diagnostic test (x-ray, blood work)	No charge	Not covered	None
ii you nave a test	Imaging (CT/PET scans, MRIs)	No charge	Not covered	None
	Generic drugs	Copay/prescription, after specific deductible: \$8 for 30 day supply (retail), \$20 for 31-90 day supply (retail & mail order)	Not covered	Covers 30 day supply (retail), 31-90 day supply (retail & mail order). Includes contraceptive
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at	Preferred brand drugs	Copay/prescription, after specific deductible: \$26 for 30 day supply (retail), \$65 for 31-90 day supply (retail & mail order)	Not covered	drugs & devices obtainable from a pharmacy, oral & injectable fertility drugs. No charge for preferred Generic FDA-approved women's contraceptives in-network. Review your formulary for prescriptions requiring precertification or step therapy for coverage.
www.aetnapharmacy.com/p remier	Non-preferred brand drugs	Copay/prescription, after specific deductible: \$50 for 30 day supply (retail), \$125 for 31-90 day supply (retail & mail order)	Not covered	Your cost will be higher for choosing Brand over Generics.
	Specialty drugs	Applicable cost as noted above for generic or brand drugs	Not covered	All prescriptions must be filled through the Aetna Specialty Pharmacy Network.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$250 <u>copay</u> /visit	Not covered	None
go. j	Physician/surgeon fees	No charge	Not covered	None

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		What You Will Pay		
Common Medical Event	Services You May Need	Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Emergency room care	\$250 copay/visit	\$250 copay/visit	No coverage for non-emergency use.
If you need immediate medical attention	Emergency medical transportation	No charge	No charge	Non-emergency transport: not covered, except if pre-authorized.
	<u>Urgent care</u>	\$30 copay/visit	Not covered	No coverage for non-urgent use.
If you have a	Facility fee (e.g., hospital room)	\$350 copay/stay	Not covered	None
hospital stay	Physician/surgeon fees	No charge	Not covered	None
If you need mental health, behavioral health, or	Outpatient services	Office: \$30 copay/visit; other outpatient services: no charge	Not covered	None
substance abuse services	Inpatient services	\$350 <u>copay</u> /stay	Not covered	None
	Office visits	No charge	Not covered	Cost sharing does not apply for preventive
If you are pregnant	Childbirth/delivery professional services	No charge	Not covered	services. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery facility services	\$350 copay/stay	Not covered	
	Home health care	\$30 copay/visit	Not covered	None
	Rehabilitation services	\$30 copay/visit	Not covered	60 visits/calendar year for Physical, Occupational & Speech Therapy combined.
If you need help	Habilitation services	\$30 copay/visit	Not covered	None
recovering or have other	Skilled nursing care	No charge	Not covered	None
special health needs	Durable medical equipment	20% coinsurance	Not covered	Limited to 1 <u>durable medical equipment</u> for same/similar purpose. Excludes repairs for misuse/abuse.
	Hospice services	No charge	Not covered	None
If your child needs dental	Children's eye exam	Not covered	Not covered	Not covered.
or eye care	Children's glasses	Not covered	Not covered	Not covered.
or eye oure	Children's dental check-up	Not covered	Not covered	Not covered.

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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
- Dental care (Adult & Child)
- Glasses (Child)

- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing

- Routine eye care (Adult & Child)
- 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
- Hearing aids Limited to \$600 maximum/3 years.
- Infertility treatment Limited to the diagnosis & treatment of underlying medical condition, artificial insemination & ovulation induction. Advanced reproductive technology: 4 oocyte retrievals/lifetime with 2 additional retrievals for live birth/lifetime.

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: Illinois Department of Insurance, Office of Consumer Health Insurance, 1-877-527-9431 toll free, http://insurance.illinois.gov/.

- For more information on your rights to continue coverage, contact the plan at 1-800-370-4526.
- If your group health coverage is subject to ERISA, you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or https://www.dol.gov/agencies/ebsa.
- For non-federal governmental group health plans, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.
- If your coverage is a church plan, church plans are not covered by the Federal COBRA continuation coverage rules. If the coverage is insured, individuals should contact their State insurance regulator regarding their possible rights to continuation coverage under State law.

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 directly by calling the toll free number on your Medical ID Card, or by calling our general toll free number at 1-800-370-4526.
- Illinois Department of Insurance, Office of Consumer Health Insurance, 1-877-527-9431 toll free, http://insurance.illinois.gov/.
- If your group health coverage is subject to ERISA, you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or https://www.dol.gov/agencies/ebsa.

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- For non-federal governmental group health <u>plans</u>, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.
- Additionally, a consumer assistance program can help you file your <u>appeal</u>. Contact Office of Consumer Health Insurance, Consumer Services Section, 122 South Michigan Avenue, 19th floor, Chicago, IL 60603, Or 320 W. Washington Street, Springfield, IL 62767-0001, 877-527-9431, http://insurance.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 Standards? 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 <u>plan</u> might cover costs for a sample medical situation, see the next section.-----

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About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this <u>plan</u> might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your <u>providers</u> charge, and many other factors. Focus on the <u>cost sharing</u> amounts (<u>deductibles</u>, <u>copayments</u> and <u>coinsurance</u>) and <u>excluded services</u> under the <u>plan</u>. Use this information to compare the portion of costs you might pay under different health <u>plans</u>. 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 <u>plan's</u> overall <u>deductible</u>	\$0
Specialist copayment	\$30
Hospital (facility) copayment	\$350
Other <u>copayment</u>	\$0

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:		
Cost Sharing		
Deductibles*	\$40	
Copayments	\$400	
Coinsurance	\$0	
What isn't covered		
Limits or exclusions	\$60	
The total Peg would pay is	\$500	

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

■ The <u>plan's</u> overall <u>deductible</u>	\$0
Specialist copayment	\$30
■ Hospital (facility) copayment	\$350
Other <u>copayment</u>	\$0

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:		
Cost Sharing		
Deductibles*	\$100	
Copayments	\$1,100	
Coinsurance	\$0	
What isn't covered		
Limits or exclusions	\$20	
The total Joe would pay is	\$1,220	

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The plan's overall deductible	\$0
Specialist copayment	\$30
■ Hospital (facility) copayment	\$350
Other copayment	\$0

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:		
Cost Sharing		
Deductibles	\$0	
Copayments	\$400	
Coinsurance	\$0	
What isn't covered		
Limits or exclusions	\$0	
The total Mia would pay is	\$400	

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

Assistive Technology

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 1-800-370-4526.

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).

Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company, Coventry Health Care plans and their affiliates.

TTY: 711

Language Assistance:

For language assistance in your language call 1-800-370-4526 at no cost.

Albanian - Për asistencë në gjuhën shqipe telefononi falas në 1-800-370-4526.

Amharic - ለቋንቋ እንዛ በ አማርኛ በ 1-800-370-4526 በነጻ ይደውሉ

للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 4526-370-4526 - 1-800

Armenian - Լեզվի ցուցաբերած աջակցության (հայերեն) զանգի 1-800-370-4526 առանց գնով։

Bahasa-Indonesia - Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-800-370-4526 tanpa dikenakan biaya.

Bantu-Kirundi - Niba urondera uwugufasha mu Kirundi, twakure kuri iyi nomero 1-800-370-4526 ku busa

Bengali-Bangala - বাংলাম ভাষা সহায়তার জন্য বিনামূল্য(1-800-370-4526-ত(কল করুন।

Bisayan-Visayan - Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawag sa 1-800-370-4526 nga walay bayad.

Burmese - ငွေကုန်ကျစံစရာမလိုဘဲ (မြန်မာဘာသာစကား)ဖြင့် ဘာသာစကားအကူအညီရယူရန် 1-800-370-4526 ကို ခေါ် ဆိုပါ။

Catalan - Per rebre assistència en (català), trugui al número gratuït 1-800-370-4526.

Chamorro - Para ayuda gi fino' (Chamoru), ågang 1-800-370-4526 sin gåstu.

Cherokee - Θ OYO SUHAOJ JHOSPOY OUT (CWY) OBWOIS 1-800-370-4526 OOT LAFOJ JEGPJ HERO.

Chinese - 欲取得繁體中文語言協助,請撥打 1-800-370-4526,無需付費。

Choctaw - (Chahta) anumpa ya apela a chi I paya hinla 1-800-370-4526.

Cushite - Gargaarsa afaan Oromiffa hiikuu argachuuf lakkokkofsa bilbilaa 1-800-370-4526 irratti bilisaan bilbilaa.

Dutch - Bel voor tolk- en vertaaldiensten in het Nederlands gratis naar 1-800-370-4526.

French - Pour une assistance linguistique en français appeler le 1-800-370-4526 sans frais.

French Creole - Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo 1-800-370-4526 gratis.

German - Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 1-800-370-4526 an.

Greek - Για γλωσσική βοήθεια στα Ελληνικά καλέστε το 1-800-370-4526 χωρίς χρέωση.

Gujarati - ગુજરાતીમાં ભાષામાં સહાય માટે કોઈ પણ ખરય વગર 1-800-370-4526 પર કૉલ કરો.

Hawaiian - No ke kōkua ma ka 'ōlelo Hawai'i, e kahea aku i ka helu kelepona 1-800-370-4526. Kāki 'ole 'ia kēia kōkua nei.

Hindi - हिन्दी में भाषा सहायता के लिए, 1-800-370-4526 पर मुफ्त कॉल करें।

Hmong - Yog xav tau kev pab txhais lus Hmoob hu dawb tau rau 1-800-370-4526.

lbo - Maka enyemaka asusu na Igbo kpoo 1-800-370-4526 na akwughi ugwo o bula

llocano - Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-800-370-4526 nga awan ti bayadanyo.

Italian - Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 1-800-370-4526.

Japanese - 日本語で援助をご希望の方は、1-800-370-4526 まで無料でお電話ください。

Karen - လာတာ်မာစားတာ်ကတိာကျိန်အင်္ဂ ကျိန် ကိုး 1-800-370-4526 လာတအိန်ဒီးတာ်လာ၁်ဘူန်လာ၁်စုးသာ

Korean - 한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-800-370-4526 번으로 전화해 주십시오.

Kru-Bassa - Be´m`ké gbo-kpá-kpá dyé pidyi dé Bašsoó-wuduun wee, dá 1-800-370-4526

برای راهنمایی به زبان فارسی با شماره 4526-370-800-1 به خورایی پهیومندی بکهن. - Kurdish

Laotian - ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ, ກະລຸນາໂທຫາ 1-800-370-4526 ໂດຍບໍ່ເສຍຄ່າໂທ.

Marathi - तीलभाषा(मराठी)सहाययासाठी 1-800-370-4526 क्रमांकावरकोणत्याहीखर्चाशविायकॉलकरा.

Marshallese - Ñan bōk jipañ ilo Kajin Majol, kallok 1-800-370-4526 ilo ejjelok wōnān.

Micronesian - Pohnpeyan Ohng palien sawas en soun kawewe ni omw lokaia Ponape koahl 1-800-370-4526 ni sohte isais.

Mon-Khmer, Cambodian - សម្ភាប់ជំនួយភាសាជា ភាសាខ្**មរ៉ែ សូមទូរស័ព្**ទទ**ៅកាន់លខេ 1-800-370-4526 ដ**ោយឥតគិតថ្លាំ។

Navajo - T'áá shi shizaad k'ehjí bee shíká a'doowol nínízingo Diné k'ehjí koji' t'áá jíík'e hólne' 1-800-370-4526

Nepali - (नेपाली) मा निःशुल्क भाषा सहायता पाउनका लागि 1-800-370-4526 मा फोन गर्नुहोस् ।

Nilotic-Dinka - Tën kupony ë thok ë Thuonjän col 1-800-370-4526 kecin ayöc.

Norwegian - For språkassistanse på norsk, ring 1-800-370-4526 kostnadsfritt.

Panjabi - ਪੰਜਾਬੀ ਵੱਚਿ ਭਾਸ਼ਾਈ ਸਹਾਇਤਾ ਲਈ, 1-800-370-4526 'ਤੇ ਮੁਫ਼ਤ ਕਾਲ ਕਰੋ।

Pennsylvania Dutch - Fer Helfe in Deitsch, ruf: 1-800-370-4526 aa. Es Aaruf koschtet nix.

برای راهنمایی به زبان فارسی با شماره 4526-370-100-1 بدون هیچ هزینه ای تماس بگیرید. انگلیسی Persian -

Polish - Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-800-370-4526.

Portuguese - Para obter assistência linguística em português ligue para o 1-800-370-4526 gratuitamente.

Romanian - Pentru asistență lingvistică în românește telefonați la numărul gratuit 1-800-370-4526

Russian - Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-800-370-4526.

Samoan - Mo fesoasoani tau gagana I le Gagana Samoa vala'au le 1-800-370-4526 e aunoa ma se totogi.

Serbo-Croatian - Za jezičnu pomoć na hrvatskom jeziku pozovite besplatan broj 1-800-370-4526.

Spanish - Para obtener asistencia lingüística en español, llame sin cargo al 1-800-370-4526.

Sudanic-Fulfude - Fii yo on heɓu balal e ko yowitii e haala Pular noddee e oo numero ɗoo 1-800-370-4526 Njodi woo fawaaki on.

Swahili - Ukihitaji usaidizi katika lugha ya Kiswahili piga simu kwa 1-800-370-4526 bila malipo.

Syriac - K share of 1-800-370-4526 apr. . .

Tagalog - Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-800-370-4526 nang walang bayad.

Telugu - భషతో సయంకోరకు ఎలెంటి ఖర్చు లేకుండా 1-800-370-4526 కు కల్ చేయండి. (తెలుగు)

Thai - สำหรับความช่วยเหลือทางด้านภาษาเป็น ภาษาไทย โทร 1-800-370-4526 ฟรีไม่มีค่าใช้จ่าย

Tongan - Kapau 'oku fiema'u hā tokoni 'i he lea faka-Tonga telefoni 1-800-370-4526 'o 'ikai hā tōtōngi.

Trukese - Ren áninnisin chiakú ren (Kapasen Chuuk) kopwe kékkééri 1-800-370-4526 nge esapw kamé ngonuk.

Turkish - (Dil) çağrısı dil yardım için. Hiçbir ücret ödemeden 1-800-370-4526.

Ukrainian - Щоб отримати допомогу перекладача української мови, зателефонуйте за безкоштовним номером 1-800-370-4526.

ا رورک ل گنتف م رپ 4526-370-300 <u>می لیک</u>تن و اعمین الی رور م و در - Urdu

Vietnamese - Đê 'được hố 'trợ ngôn ngư bằng (ngôn ngư), hấy gọi miến phi 'đên số '1-800-370-4526.

Yiddish - פאר שפראך הילף אין אידיש רופט 1-800-370-4526 פריי פון אפצאל

Yoruba - Fún ìrànlowo nípa èdè (Yorùbá) pe 1-800-370-4526 lái san owó kankan rárá.