Coverage Period: 07/01/23-06/30/2024
Coverage for: Individual + Family | Plan Type: POS



The Summary of Benefits and Coverage (SBC) document will help you choose a health <u>plan</u>. The SBC shows you how you and the <u>plan</u> would share the cost for covered health care services. NOTE: Information about the cost of this <u>plan</u> (called the <u>premium</u>) 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 <u>allowed amount</u>, <u>balance billing</u>, <u>coinsurance</u>, <u>copayment</u>, <u>deductible</u>, <u>provider</u>, or other <u>underlined</u> 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 deductible?	\$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 deductible?	Yes. In- <u>network 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</u> <u>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 out-of-pocket limit?	<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-Network 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 provider</u> before 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.



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

		What You Will Pay			ay		
Common Medical Event	Services You May Need	In-Network Provider (You will pay the least)		Out-of-Network Provider (You will pay the most)		Limitations, Exceptions & Other Important Information	
	Primary care visit to treat an injury or illness	20% coinsura			coinsurance	None	
If you visit a health care <u>provider</u> 's office or clinic	Specialist visit Preventive care /screening /immunization	No charge	<u>ince</u>		coinsurance coinsurance	None You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.	
	Diagnostic test (x-ray, blood work)	20% coinsura	<u>ince</u>	40% <u>c</u>	coinsurance	None	
If you have a test	Imaging (CT/PET scans, MRIs)	20% coinsura	<u>ince</u>	40% <u>c</u>	coinsurance	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		Tier 1	Tie	er 2	Tier 3		
to treat your illness or condition More information about prescription drug coverage is available at www.caremark.com	Copayments (30 Day Supply)	Greater of 20% or \$7.00	Greate 20% o \$14.00	r	Greater of 20% or \$28.00	**Medications received at CVS Caremark Pharmacy or through CVS Caremark Mail	
	Copayments (90 Day Supply)	Greater of 20% or \$14.00	Greate 20% o \$28.00	r	Greater of 20% or \$56.00	Service Pharmacy. Deductible applies.	
or call 1-877-232-8128	Maintenance Choice** (90 Day Supply)	Greater of 10% or \$14.00	Greate 10% o \$28.00	r	Greater of 10% or \$56.00		

	What You Will Pay				
Common Medical Event	Services You May Need	In-Network Out-of-Netwo Provider Provider (You will pay the least) (You will pay the		Limitations, Exceptions & Other Important Information	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center) Physician/surgeon fees	20% <u>coinsurance</u> 20% <u>coinsurance</u>	40% coinsurance 40% coinsurance	None	
If you need	Emergency room care	20% coinsurance	20% coinsurance	Per visit deductible is waived if admitted.	
immediate medical	Emergency medical transportation	20% coinsurance	20% coinsurance	None	
attention	<u>Urgent care</u>	20% coinsurance	40% coinsurance	None	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	<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% coinsurance	40% coinsurance	None	
If you need mental health, behavioral health, or substance abuse services	Outpatient services Inpatient services	20% <u>coinsurance</u> 20% <u>coinsurance</u>	40% <u>coinsurance</u> 40% <u>coinsurance</u>	Pre-authorization required for out-of-network care.	
	Office visits	20% coinsurance	40% coinsurance	Cost sharing does not apply for preventive	
If you are pregnant	Childbirth/delivery professional services Childbirth/delivery facility services	20% <u>coinsurance</u> 20% <u>coinsurance</u>	40% <u>coinsurance</u> 40% <u>coinsurance</u>	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.	
If you need help recovering or have other special	Home health care	20% coinsurance	40% coinsurance	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.	
health needs	Rehabilitation services	20% coinsurance	40% coinsurance	None	
	Habilitation services	20% coinsurance	40% coinsurance	None	

Common Medic Event	cal Services You May Need	What Yo In-Network Provider (You will pay the least)	u Will Pay Out-of-Network Provider (You will pay the most)	Limitations, Exceptions & Other Important Information
	Skilled nursing care	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.
	Durable medical equipment	20% coinsurance	40% coinsurance	None
	Hospice services	20% <u>coinsurance</u>	40% coinsurance	<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 shild noo	Children's eye exam	Not covered	Not covered	None
If your child nee dental or eye car	I DIIDIDE DISCOS	Not covered	Not covered	None
defital of eye cal	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.)

- Cosmetic surgery
- Custodial care
- Routine 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 <u>plan</u> 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:

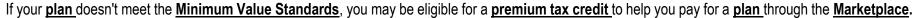
There are agencies that can help if you have a complaint against your <u>plan</u> for a denial of a <u>claim</u>. This complaint is called a <u>grievance</u> or <u>appeal</u>. For more information about your rights, look at the explanation of benefits you will receive for that medical <u>claim</u>. Your <u>plan</u> documents also provide complete information to submit a <u>claim</u>, <u>appeal</u>, or a <u>grievance</u> for any reason to your <u>plan</u>. 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 <u>Minimum Essential Coverage</u> 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.



-----To see examples of how this <u>plan</u> 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 <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>	\$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:	
Cost Sharing	
Deductibles*	\$500
Copayments	\$0
Coinsurance	\$2,448
What isn't covered	
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:		
Cost Sharing		
Deductibles*	\$500	
Copayments	\$0	
Coinsurance	\$1,376	
What isn't covered		
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 <u>plan's</u> overall <u>deductible</u>	\$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:		
Cost Sharing		
Deductibles*	\$500	
Copayments	\$0	
Coinsurance	\$280	
What isn't covered		
Limits or exclusions	\$0	
The total Mia would pay is	\$780	

Note: These numbers assume the patient does not participate in the <u>plan's</u> wellness program. If you participate in the <u>plan's</u> 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 <u>plan</u> has other <u>deductibles</u> for specific services included in this coverage example. See "Are there other <u>deductibles</u> for specific services?" row above.

*Note: Your <u>deductible</u> may be different than the examples depending on your annual salary. For your applicable <u>deductible</u>, 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: <u>CRCoordinator@aetna.com</u>.

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 (Aetna).

TTY: 711

Language Assistance:

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

Albanian - Për asistencë në gjuhën shqipe telefononi falas në 1-855-856-0038.

Amharic - ለቋንቋ እንዛ በ አማርኛ በ 1-855-856-0038 በነጻ ይደውሉ

للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 1-855-856-0038

Armenian - Լեզվի ցուցաբերած աջակցության (հայերեն) զանգի 1-855-856-0038 առանց գնով։

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 nomero 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 - ငွေကုန်ကျစံစရာမလိုဘဲ (မြန်မာဘာသာစကား)ဖြင့် ဘာသာစကားအကူအညီရယူရန် 1-855-856-0038 ကို ခေါ် ဆိုပါ။

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 gåstu.

Cherokee - $\theta \circ \partial \mathcal{Y} \theta \circ \mathcal{Y$

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 I paya hinla 1-855-856-0038.

Cushite - Gargaarsa afaan Oromiffa hiikuu argachuuf lakkokkofsa bilbilaa 1-855-856-0038 irratti bilisaan 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 ભાષામાં સહ્યય માટે કોઈ પણ ખર્ચ વગર 1-855-856-0038 પર કૉલ કરો.

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 - हिन्दी 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.

lbo - Maka enyemaka asusu na Igbo kpoo 1-855-856-0038 na akwughi ugwo o bula

llocano - 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 - လာတါမာစားတါကတိုးကျိုဉ်အင်္ဂါ ကျိုဉ် ကိုး 1-855-856-0038 လာတအိုဉ်ဒီးတါလာ၁ိဘူဉ်လာ၁ိစ္စာဘဉ်

Korean - 한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-888-982-3862번으로 전화해 주십시오.

Kru-Bassa - Be´m`ké gbo-kpá-kpá dyé pidyi dé Bašsoó-wuduùn wee, dá 1-855-856-0038

برای راهنمایی به زبان فارسی با شماره 0038-855-1-4 به خورایی پهیومندی بکهن.

Laotian - ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ, ກະລຸນາໂທຫາ-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, សម្ចាប់ជំនួយភាសាជា ភាសាខ្មមរែ សូមទូរស័ព្ទទទៅកាន់លខេ 1-855-856-0038 ដោយឥតគិតថ្លប់។

Cambodian -

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 kuoony ë thok ë Thuonjän col 1-855-856-0038 kecin ayöc.

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

Panjabi - ਪੰਜਾਬੀ ਵਿੱਚ ਭਾਸ਼ਾਈ ਸਹਾਇਤਾ ਲਈ, 1-855-856-0038 'ਤੇ ਮੁਫ਼ਤ ਕਾਲ ਕਰੋ।

Pennsylvania Dutch - Fer Helfe in Deitsch, ruf: 1-855-856-0038 aa. Es Aaruf koschtet nix.

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

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 totogi.

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 heɓu balal e ko yowitii e haala Pular noddee e oo numero ɗoo 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 - K = 22K K & D21 and 21 22 K wain on Ly ispr 1812, 20 1-855-856-0038 apr 2.

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

Telugu - భాషతో సాయం కొరకు ఎలాంటి ఖర్పు 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 ōtōngi.

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

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

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

ا رورک ل کتف م رب 1-855-856-0038 <u>عال کتن و اعمان الل رق م و در</u>

Vietnamese - Đê 'được hố 'trợ ngôn ngư bằng (ngôn ngư), hấy gọi miến phi 'đên số 1-855-856-0038.

Yiddish - פאר שפראך הילף אין אידיש רופט 1-855-856-0038 פריי פון אפצאל.

Yoruba - Fún ìrànlowo nípa èdè (Yorùbá) pe 1-855-856-0038 lái san owó kankan rárá.