



Coverage for: Individual + Family | Plan Type: HMO



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=202917-136927-562003> 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. \$175 for <u>prescription drugs</u> . There are no other specific deductibles.	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 \$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 www.aetna.com/docfind or call 1-800-370-4526 for a list of In- <u>Network</u> 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</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	\$40 <u>copay</u> /visit	Not covered	None
	<u>Specialist</u> visit	\$45 <u>copay</u> /visit	Not covered	None
	<u>Preventive care</u> / <u>screening</u> /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	<u>Diagnostic test</u> (x-ray, blood work)	No charge	Not covered	None
	Imaging (CT/PET scans, MRIs)	No charge	Not covered	None
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.aetnapharmacy.com/advancedcontrolaetnall	Preferred generic drugs (Includes Tier 1A - Value Drugs and Tier 1 Preferred Generic Prescription Drugs)	<u>Copay</u> /prescription, after specific <u>deductible</u> : Tier 1A \$4 for 30 day supply (retail), \$10 for 31-90 day supply (retail & mail order); Preferred Generic \$15 for 30 day supply (retail), \$37.50 for 31-90 day supply (retail & mail order)		Covers 30 day supply (retail), 31-90 day supply (retail & mail order). Includes contraceptive drugs & devices obtainable from a pharmacy, oral & injectable fertility drugs. No charge for preferred generic FDA-approved women's contraceptives <u>in-network</u> . Review your <u>formulary</u> for prescriptions requiring precertification for coverage. <u>Copay</u> /prescription for insulin, <u>deductible</u> doesn't apply: \$25 (preferred) and \$35 (non-preferred) for each 30 day supply. Your cost will be higher for choosing Brand over Generics. <u>Deductible</u> doesn't apply to insulin.
	Preferred brand drugs	<u>Copay</u> /prescription, after specific <u>deductible</u> : \$30 for 30 day supply (retail), \$75 for 31-90 day supply (retail & mail order)		

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)	
	Non-preferred generic/brand drugs	<u>Copay/prescription</u> , after specific deductible: \$60 for 30 day supply (retail), \$150 for 31-90 day supply (retail & mail order)		
	<u>Specialty drugs</u>	<u>Copay/prescription</u> , after specific deductible: \$120	Not covered	All prescriptions must be filled through the Aetna Specialty Pharmacy <u>Network</u> .
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$300 <u>copay/visit</u>	Not covered	None
	Physician/surgeon fees	No charge	Not covered	None
If you need immediate medical attention	<u>Emergency room care</u>	\$300 <u>copay/visit</u>	\$300 <u>copay/visit</u>	Out-of- <u>network</u> emergency use paid the same as in- <u>network</u> . No coverage for non-emergency use.
	<u>Emergency medical transportation</u>	No charge	No charge	Out-of- <u>network</u> emergency use paid the same as in- <u>network</u> . Non-emergency transport: not covered, except if pre-authorized.
	<u>Urgent care</u>	\$45 <u>copay/visit</u>	Not covered	No coverage for non-urgent use.
If you have a hospital stay	Facility fee (e.g., hospital room)	\$350 <u>copay/stay</u>	Not covered	None
	Physician/surgeon fees	No charge	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office: \$45 <u>copay/visit</u> ; other outpatient services: no charge	Not covered	None
	Inpatient services	\$350 <u>copay/stay</u>	Not covered	None
If you are pregnant	Office visits	No charge	Not covered	<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).
	Childbirth/delivery professional services	No charge	Not covered	
	Childbirth/delivery facility services	\$350 <u>copay/stay</u>	Not covered	
If you need help recovering or have other special health needs	<u>Home health care</u>	\$45 <u>copay/visit</u>	Not covered	None
	<u>Rehabilitation services</u>	\$45 <u>copay/visit</u>	Not covered	60 visits/ <u>plan</u> year for Physical, Occupational & Speech Therapy combined.
	<u>Habilitation services</u>	No charge	Not covered	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)	
	<u>Skilled nursing care</u>	No charge	Not covered	None
	<u>Durable medical equipment</u>	30% <u>coinsurance</u> , except no charge for DME supplies	Not covered	Limited to 1 <u>durable medical equipment</u> for same/similar purpose. Excludes repairs for misuse/abuse.
	<u>Hospice services</u>	No charge	Not covered	None
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Not covered.
	Children's glasses	Not covered	Not covered	Not covered.
	Children's dental check-up	Not covered	Not covered	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
- 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

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 - 1 hearing aid per ear/24 months.
- Infertility treatment - For more information & exceptions, see policy document using summary box link on page 1 or call the number on your ID card.

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, 1-866-445-5364, 1-866-323-5321 (TDD) or 1-866-445-5364 toll free, 1-217-782-4515, 1-217-558-2083 Fax number, <https://idoihelpcenter.illinois.gov/s/>, DOI.Complaints@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 <http://www.dol.gov/ebsa/healthreform>
- 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 on how 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:

- If your group health coverage is subject to ERISA, you may contact Aetna directly by calling the toll-free number on your Medical ID Card, or by calling our general number at 1-800-370-4526. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <http://www.dol.gov/ebsa/healthreform>
- Illinois Department of Insurance, Office of Consumer Health Insurance, 1-866-445-5364, 1-866-323-5321 (TDD) or 1-866-445-5364 toll free, 1-217-782-4515, 1-217-558-2083 Fax number, <https://idoihelpcenter.illinois.gov/s/>, DOI.Complaints@Illinois.gov.
- 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.
- Additionally, a consumer assistance program can help you file your appeal. Contact Illinois Department of Insurance, Office of Consumer Health Insurance, Consumer Services Section, 115 S. LaSalle Street, 13th floor, Chicago, IL 60603, 1-312-814-2420, 1-866-323-5321 (TDD) or 320 W. Washington Street, Springfield, IL 62767, 1-877-527-9341 toll free, 1-217-782-4515, 1-217-558-2083 Fax number, 1-866-323-5321 (TDD), <https://idoihelpcenter.illinois.gov/s/>

Does this plan provide Minimum Essential Coverage? Yes.

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

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 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 \$0
- Specialist copayment \$45
- Hospital (facility) copayment \$350
- Other copayment \$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	\$12,700
In this example, Peg would pay:	
<i>Cost Sharing</i>	
Deductibles*	\$10
Copayments	\$400
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$470

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

- The plan's overall deductible \$0
- Specialist copayment \$45
- Hospital (facility) copayment \$350
- Other copayment \$0

This EXAMPLE event includes services like:

- Primary care provider office visits (*including disease education*)
- Diagnostic tests (*blood work*)
- Prescription drugs
- Diabetic supplies (*glucose meter*)

Total Example Cost	\$5,600
In this example, Joe would pay:	
<i>Cost Sharing</i>	
Deductibles*	\$200
Copayments	\$900
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$1,120

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

- The plan's overall deductible \$0
- Specialist copayment \$45
- 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	\$5,600
In this example, Mia would pay:	
<i>Cost Sharing</i>	
Deductibles*	\$10
Copayments	\$500
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$510

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: 1-800-370-4526.

*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.

TTY: 711

- English -** To access language services at no cost to you, call 1-800-370-4526.
- Amharic - የቋንቋ አገልግሎቶችን ያለክፍያ ለማግኘት፣ በ 1-800-370-4526 ይደውሉ።.
- Arabic - للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء الاتصال على الرقم 1-800-370-4526.
- Armenian - Անվճար լեզվալիան ծառայություններից օգտվելու համար զանգահարեք 1-800-370-4526 հեռախոսահամարով:
- Carolinian (Kapasal Falawasch) - ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-800-370-4526.
- Chamorro - Para un hago' i setbision lengguåhi ni dibåtde para hågu, ågang 1-800-370-4526.
- Chinese Traditional - 如欲使用免費語言服務，請致電 1-800-370-4526.
- Cushitic-Oromo - Tajaajiloota afaanii garuu bilisaa ati argaachuuf, bilibili 1-800-370-4526.
- French - Afin d'accéder aux services langagiers sans frais, composez le 1-800-370-4526.
- French Creole (Haitian) - Pou jwenn sèvis lang gratis, rele 1-800-370-4526.
- German - Um auf für Sie kostenlose Sprachdienstleistungen zuzugreifen, rufen Sie 1-800-370-4526 an.
- Greek - Για να επικοινωνήσετε χωρίς χρέωση με το κέντρο υποστήριξης πελατών στη γλώσσα σας, τηλεφωνήστε στον αριθμό 1-800-370-4526.
- Gujarati - તમારેકોઇ જાતના બચાવવાની ભાષાની સે વાની ઓની પહોંર માટે, કોલ કરો 1-800-370-4526.
- Hindi - आपकेलिए बनिा ककसी कीमत केभाषा सेवाओंका उपयोग करनेकेलिए, 1-800-370-4526 पर कॉल करें।.
- Hmong - Xav tau kev pab txhais lus tsis muaj nqi them rau koj, hu 1-800-370-4526.
- Italian - Per accedere ai servizi linguistici, senza alcun costo per lei, chiami il numero 1-800-370-4526.
- Japanese - 言語サービスを無料でご利用いただくには、1-800-370-4526 までお電話ください。
- Karen - လာတာကမနုာ်ကိာ်အတာ်မစာအတာ်ဖဲးတာ်မတဖု်လာတအိာ်ဒီးအပူလာကဘာ်ဟ့ာ်အိအဂီာ်ဘာ်န့ာ် ကိး 1-800-370-4526 တက့ာ်.
- Korean - 무료 언어 서비스를 이용하려면 1-800-370-4526 번으로 전화해 주십시오.
- Laotian - ເພື່ອຂ້າໃຊ້ການບໍລິການພາສາໂດຍບໍ່ເສຍຄ່າຕໍ່ກັບທ່ານ, ໃຫ້ໃບທາດປີ 1-800-370-4526.
- Mon-Khmer, Cambodian - ដើម្បីទទួលបានសេវាភាសាដោយឥតគិតថ្លៃសម្រាប់លោកអ្នក សូមហៅទូរស័ព្ទទៅកាន់លេខ 1-800-370-4526 ។
- Navajo - T'áá ni nizaad k'éhjí bee níká a'doowoł doo b'ááq'á ílínígóó kojí' hólne' 1-800-370-4526.
- Pennsylvania Dutch - Um Schprooch Services zu griege mitaus Koscht, ruff 1-800-370-4526.

- Persian-Farsi - برای دسترسی به خدمات زبان به طور رایگان، با شماره 1-800-370-4526 تماس بگیرید .
- Polish - Aby uzyskać dostęp do bezpłatnych usług językowych proszę zadzwonić 1-800-370-4526.
- Portuguese - Para acessar os serviços de idiomas sem custo para você, ligue para 1-800-370-4526.
- Punjabi - ਤੁਹਾਡੇ ਲਈ ਬਨਿੰ ਕਸਿ ਕੀਮਤ ਵਾਲੀਆਂ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ ਦੀ ਵਰਤੋ ਕਰਨ ਲਈ, 1-800-370-4526 'ਤੇ ਫੋਨ ਕਰੋ।
- Russian - Для того чтобы бесплатно получить помощь переводчика, позвоните по телефону 1-800-370-4526.
- Samoan - Mo le mauaina o auaunaga tau gagana e aunoa ma se totogi, vala'au le 1-800-370-4526.
- Serbo-Croatian - Za besplatne prevodilačke usluge pozovite 1-800-370-4526.
- Spanish - Para acceder a los servicios de idiomas sin costo, llame al 1-800-370-4526.
- Syriac-Assyrian - ܠܗܘܢܐ ܕܘܫܬܪܝܢܐ ܕܘܫܬܪܝܢܐ ܕܘܫܬܪܝܢܐ ܕܘܫܬܪܝܢܐ ܕܘܫܬܪܝܢܐ ܕܘܫܬܪܝܢܐ ܕܘܫܬܪܝܢܐ ܕܘܫܬܪܝܢܐ ܕܘܫܬܪܝܢܐ ܕܘܫܬܪܝܢܐ ܕܘܫܬܪܝܢܐ 1-800-370-4526.
- Tagalog - Para ma-access ang mga serbisyo sa wika nang wala kayong babayaran, tumawag sa 1-800-370-4526.
- Thai - หากท่านต้องการเข้าถึงการบริการทางด้านภาษาโดยไม่มีค่าใช้จ่าย โปรดโทร 1-800-370-4526.
- Ukrainian - Щоб отримати безкоштовний доступ до мовних послуг, задзвоніть за номером 1-800-370-4526.
- Vietnamese - Nếu quý vị muốn sử dụng miễn phí các dịch vụ ngôn ngữ, hãy gọi tới số 1-800-370-4526.