Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services
STATE OF IL
LOCAL CARE HEALTH PLAN (LCHP): Aetna

Coverage Period: 07/01/2019-06/30/2020
Coverage for: Individual + Family | **Plan Type:** POS

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 deductible?	$1,000 per enrollee.	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.	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/
Are there other deductibles for specific services?	Yes. $350 per in-network hospital admission; $600 per out-of-network hospital admission; $400 per emergency room visit; $250 for organ and tissue transplants; $175 for prescription drugs.	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 $2,000 / Family $4,000. Out-of-Network: Individual $6,000 / Family $12,000.	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.	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 or call 1-800-370-4526 for a list of In-Network providers.	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.	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.

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% coinsurance	50% coinsurance	None
	Specialist visit	20% coinsurance	50% coinsurance	None
	Preventive care /screening /immunization	No charge	50% coinsurance	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.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	50% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	50% coinsurance	Requires pre-authorization. If necessary pre-authorization is not obtained, benefits may be reduced or not covered.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.caremark.com or call 1-877-232-8128	Generic drugs	30 day supply: $15.00; 90 day supply: $30.00	30 day supply: $15.00*; 90 day supply: $30.00* *Plus difference between retail cost and in-network price	Covers 30 day supply (retail); 61-90 day supply (mail order/maintenance). Your plan uses a preferred drug list which identifies the status of covered drugs. Some drugs may require pre-authorization. If necessary pre-authorization is not obtained, the drug may not be covered. Certain items identified by your plan as preventive care are covered in full not subject to the copayment amount indicated. You pay the difference in cost if you request a brand name drug instead of its generic equivalent plus the copayment. If drugs are purchased at out-of-network pharmacy, you must pay the full retail cost at time of purchase and request reimbursement of eligible charges by submitting a paper claim to CVS/caremark.
	Preferred brand drugs	30 day supply: $30.00; 90 day supply: $60.00	30 day supply: $30.00*; 90 day supply: $60.00* *Plus difference between retail cost and in-network price	
	Non-preferred brand drugs	30 day supply: $60.00; 90 day supply: $120.00	30 day supply: $60.00*; 90 day supply: $120.00* *Plus difference between retail cost and in-network price	

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)	
	Specialty drugs	30 day supply: $120.00; 90 day supply: $240.00	30 day supply: $120.00*; 90 day supply: $240.00* *Plus difference between retail cost and in-network price	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	50% coinsurance	None
	Physician/surgeon fees	20% coinsurance	50% coinsurance	None
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance,	Per visit deductible is waived if admitted.
	Emergency medical transportation	20% coinsurance	20% coinsurance	None
	Urgent care	20% coinsurance	50% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	50% coinsurance,	Pre-authorization required for out-of-network care. If pre-authorization is not obtained, benefits may be reduced or not covered.
	Physician/surgeon fees	20% coinsurance	50% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	50% coinsurance	Mental Health & Substance Abuse benefits not provided by Aetna. Coverage for these services is administered by Magellan Health. More information is available at www.magellanascend.com, 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.
	Inpatient services	20% coinsurance	50% coinsurance	
If you are pregnant	Office visits	20% coinsurance	50% coinsurance	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.
	Childbirth/delivery professional services	20% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	50% coinsurance	

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 help recovering or have other special health needs	Home health care	20% coinsurance	50% coinsurance	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.
	Rehabilitation services	20% coinsurance	50% coinsurance	None
	Habilitation services	20% coinsurance	50% coinsurance	None
	Skilled nursing care	20% coinsurance	50% coinsurance	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.
	Durable medical equipment	20% coinsurance	50% coinsurance	None
	Hospice services	20% coinsurance	50% coinsurance	Pre-authorization required for out-of-network care. If pre-authorization 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
- Hearing aids
- 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.
- 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? **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	$1,000
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:	
Cost Sharing	
Deductibles*	$1,000
Copayments	$0
Coinsurance	$2,348
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,408**

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

The plan's overall deductible	$1,000
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:	
Cost Sharing	
Deductibles*	$1,000
Copayments	$0
Coinsurance	$1,276
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,296**

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

The plan's overall deductible	$1,000
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:	
Cost Sharing	
Deductibles*	$1,000
Copayments	$0
Coinsurance	$180
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,180**

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.

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).

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 እገዛ በ አማርኛ በ 1-855-856-0038 በነጻ ይደውሉ
Arabic -	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 বিনামুল্যে 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 -	ငွေကုန်ကျခံစရာမလိုဘဲ (မြန်မာဘာသာစကား)ဖြင့် ဘာသာစကားအကူအညီရယူရန် 1-855-856-0038 ကို ခေါ်ဆိုပါ။
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 -	ᎾᏍᎩᎾ ᏕᏲᏂᎯᏍᏗ ᏗᏂᏍᎦᏢᏍᎩ ᎾᏠᎢ (ᏣᎳᎩ) ᏫᏏᎳᏫᎡᏍ 1-855-856-0038 ᎤᎾᎢ Ꮭ ᎠᎱᏍᏗ ᏧᎬᏩᏗ ᏂᎶᏒᎾ.
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 સહાય માટે કોઈ પણ ખર્ચ વગર 1-855-856-0038 પર કૉલ કરો.

Hawaiian -	No ke kōkua ma ka ʻōlelo Hawaiʻi, e kahea aku i ka helu kelepona 1-855-856-0038. Kāki ʻole ʻia 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.
Ibo -	Maka enyemaka asụsụ na Igbo kpọọ 1-855-856-0038 na akwụghị ụgwọ 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 -	လာတ်မၤစၢၤတ်ကတိၤကျိာ်အဂီၢ် ကျိာ် ကိး 1-855-856-0038 လာတအိာ်ဒီးတ်လၢာ်ဘျာ်လၢာ်စုၤဘာ်
Korean -	한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-888-982-3862번으로 전화해 주십시오.
Kru-Bassa -	Ɓɛ´m`ké gbo-kpá-kpá dyé pídyi ɖé Ɓaɓɔɔ̀-wuɖuǔn wɛ̃ɛ, ɖá 1-855-856-0038
Kurdish -	برای راهنمایی به زبان فارسی با شماره 1-855-856-0038 به خۆرایی پەیوەندی بکەن.
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 kuɔɔny ë thok ë Thuɔŋjäŋ cɔl 1-855-856-0038 kecïn aɣöc.
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.
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 asistenţă lingvistică în româneşte telefonaţi 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 hebu 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 -	1-855-856-0038
Tagalog -	Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-855-856-0038 nang walang bayad.
Telugu -	భాషతో సాయం కొరకు 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 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.
Urdu -	1-855-856-0038
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 פריי פון אפצאל.
Yoruba -	Fún ìrànlọwọ nípa èdè (Yorùbá) pe 1-855-856-0038 lái san owó kankan rárá.