



The LBA and Aetna have teamed up to offer you three plan options to save you money.

The Aetna plans are the only plans endorsed by the LBA and supported by the local unions. You will receive information from other carriers about different plans but no other plan or carrier is endorsed by the LBA and your local union. We have partnered with **Doyle Rowe LTD**, a team familiar to your unions, to help you understand the plan options. Doyle Rowe LTD will help you understand your options, explain enrollment options, and answer questions. You may call them at **(866) 201-2524** from 8:30am to 4:30pm Central Time, Monday through Friday.

Aetna members will have access to:

- An Aetna customer service team available from **8:00AM to 6:00PM CST 1-866-307-6210**
- Tools that will help you navigate your health plan
- Teladoc: Talk to a doctor at anytime
- 24x7 Nurse advice line
- Online health & wellness programs

2024 Medical Plans

	Option 1	Savings Plus	Silver
Member	\$2602.72	\$2075.27	\$1851.96
Member + 1	\$4633.74	\$3693.80	\$3297.14
Family	\$6430.44	\$5125.12	\$4575.58

Pick your plan

View the chart below to compare the features for 2024.

		Option 1	Savings Plus	Silver
	Coverage/dependent coverage	In-network/ Out-of-network	In-network/ Out-of-network	In-network/ Out-of-network
Deductible	Employee	\$427/\$998	\$1,545/\$3,545	\$2,250/\$8,150
	Family	\$1,285/\$2,995	\$4,120/\$6,120	\$6,750/\$24,450
Out-of-pocket maximum	Employee	\$2,497/\$4,989	\$6,180/\$8,180	\$8,150/\$16,500
	Family	\$4,992/\$9,979	\$12,360/\$14,360	\$16,300/\$33,000
Covered services	Preventive care	0/30%	0/50%	0/40%
	Doctor visit	\$25/30%	\$20/50%	\$20/40%
	Specialist visit*	\$50/30%	\$45/50%	\$40/40%
	Walk-in clinic*	\$25/30%	\$20/50%	\$20/40%
	Urgent care*	100%/30%	100%/50%	\$50/40%
	Emergency room**	\$25/\$25	\$25/\$25	\$500/\$500
	Hospital inpatient*	10%/30%	\$258/\$350	20%/40%
	Hospital outpatient*	10%/30%	10%/50%	20%/40%



To enroll or to get more information:

- Call Doyle Rowe LTD at (866) 201-2524 from 8:30am to 4:30pm Central Time, Monday through Friday. **Please note that the LBA has a \$36 annual fee per household***

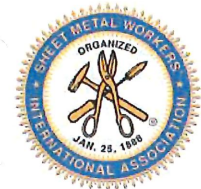
*Union membership not required

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 and its affiliates (Aetna).

Read more about the **Aetna PPO plans** options brought to you
by the Labor Benefits Association (LBA) with the support of all
these local unions



CHICAGO
Pipefitters
LOCAL 597



Bricklayers and Allied Craftworkers'
District Council 1

Boilermakers' Local 1

Cement Masons' Local 502

Chicago Regional Council of Carpenters

Elevator Constructors' Local 2

Glaziers Local 27

Heat & Frost Insulators' Local 17

IBEW Local 9

IBEW Local 21

IBEW Local 134

Ironworkers' Local 1

Ironworkers' Local 63

IUOE Local 150

IUOE Local 399

LiUNA Local 1001

LiUNA Local 1092

Machinists' Local 126

Painters District Council #14

Plumbers' Local 130

Pipefitters' Local 597

Roofers' Local 11

Sheet Metal Workers' Local 73

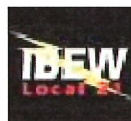
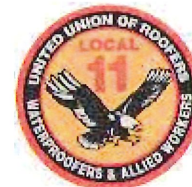
Sign Painters' Local 830

Sprinkler Fitters' Local 281

Teamsters' Local 700



IBEW
LOCAL 134



Healthier happens together™

Explore your robust benefits right here



Labor Benefits Association
2024 Health Care Benefits

[Aetna.com](https://www.aetna.com)

2212256-01-01. (5/23) 2024 Health care





What's inside

Plans

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Managing costs

Aetna® is the brand name used for products and services provided by one or more of the Aetna group of companies, including Aetna Life Insurance Company and its affiliates (Aetna). Aetna is part of the CVS Health® family of companies.



Health care made simple

At Aetna® and CVS Health®, we take care of the whole you. This means you'll get connected, convenient and affordable health care wherever — and whenever — you need it.

We offer customized health benefits plans, large provider networks, support programs, special discounts and much more. So you can relax knowing you'll have the tools and resources you need to live healthy. And no matter where you are on your path to better health, count on us for ongoing support. That's how healthier happens together™.

If you have questions, call us at **866-307-6210 (TTY: 711)** for medical plans.

To-dos before you choose

- ☐ **Use our provider search tool**
Our network represents about two-thirds of doctors and three-fourths of acute care hospitals nationwide. So you're sure to find the providers you need.
- ☐ **Estimate your health care costs**
Use our cost comparison tool to get an idea of total out-of-pocket costs, including your premium, copays and annual deductible.
- ☐ **Get to know each plan**
Review your benefits enrollment site to see which plan is right for you.
- ☐ **Review the extras**
See how the plan perks can add up to better care, more choices and lower costs, too.

Paying for care

An overview of terms

PROCESSING



Claims

Claims are requests for your plan to pay for services you receive. We use these to check what your plan will cover and the amount we'll pay. You can find updated status and amounts billed for your claim on your member website or the Aetna HealthSM app.



Provider bills

Bills show the amount you actually owe for services. You'll get this from your provider. You can make payments for what you owe directly to them or through the "Pay Your Provider" link on each of your claims.



Explanation of Benefits (EOB) statements

An Explanation of Benefits statement shows a breakdown of how we process claims. It's not a bill and may not show the current balance you owe. Anytime something changes with your claim, you'll get a new statement.



Coordination of benefits

Some members have health coverage under more than one plan. When this happens, we work with the other carriers to decide which plan pays first and which pays second, based on the rules in your plan documents. We call this process "coordination of benefits," or COB.

YOU PAY



Deductible

The deductible is the amount you pay for out-of-pocket costs for your covered health care before your plan begins to pay.

Each year, you pay 100% of your covered expenses until you meet your deductible amount. For most plans, eligible preventive care is covered at 100% with no deductible when you use network providers.

YOU + THE PLAN PAY



Cost sharing

Once you meet the deductible, you share the cost with the plan. This may be in the form of coinsurance and/or copayments (also called copays).

Coinsurance

A fixed percentage. For example, if your care is \$100 and your coinsurance is 20%, you pay \$20.

Copay

A fixed dollar amount. For example, you may pay \$25 per doctor office visit.

THE PLAN PAYS



Out-of-pocket maximum

The maximum you pay each year for covered expenses. Once you hit your maximum, the plan pays 100% of covered expenses for the rest of the year.

In network vs. out of network

In network



This network option may **cost you less.**

Highlights

Choosing in-network providers may help save you money.

These providers contract with us to offer rates that are often lower than their regular fees. They also work directly with us and send us claims for services you receive. Don't worry — this is all behind-the-scenes work when you stay in network.

Visit **Aetna.com** to find a network provider.

How it works

The provider files your claim and the plan pays them the amount it owes based on the negotiated rate. You pay the remaining costs.

Benefits

- ✓ Lower out-of-pocket costs
- ✓ No balance billing
- ✓ Less paperwork

Out of network



This network option may **cost you more.**

Highlights

Your plan may allow you to visit an out-of-network provider. To find out details, check your Summary of Benefits and Coverage document.

How it works

Out-of-network doctors and hospitals don't contract with us. So that means:

- They normally charge more for their services
- You might have to pay the difference between what your plan pays for services and the amount they charge

Plus, they generally don't send us claims or get approval for coverage when needed. So you may need to handle these details on your own.

Keep in mind



Covered

"Covered" doesn't mean free. A covered health care service is one that your plan recognizes. Your plan only pays for this service after you've met the deductible, coinsurance or copay.

Referral

A referral is like a permission slip from your primary care physician (PCP) to see a specialist or another provider. Many providers can easily send referrals electronically.

In-network providers

Network providers participate in our network and offer special, lower rates for our members. So staying in network can help you save money.



Plans

Choosing a plan that's right for you and your family is so important. That's why we offer affordable options to meet your unique needs. And we'll be right there to help you find the perfect fit.

Stay in network to help lower costs

When you go for care, keep in mind that staying in network has special perks. You may have lower out-of-pocket costs, because these providers have agreed to accept our contracted rate for services. Plus, they'll file claims for you, so you don't have to worry about any extra work.

Know what to expect if you go out of network

Some plans may have out-of-network benefits, too. Just know you may have higher out-of-pocket costs. Plus, you may have to file your own claims and/or get preapproval for some services.

Understand that we cover emergency care

In case of an emergency, we'll cover care both in and out of network. So whatever plan you choose, know you can count on us when the unexpected happens.

Medical

Aetna® Managed Choice® health insurance plan

Where your choice takes the lead

Our Managed Choice plan lets you visit any doctor you want.

You don't have to choose a primary care physician (PCP).^{*} But selecting a PCP is important because they do more than give you a checkup. They:

- Get to know you and your medical history
- Guide you on important health decisions and direct your care
- File claims for you

Plus, you may pay less out of pocket for their care.

You can also get referrals to see specialists and get the most out of your plan. If you don't choose one, you won't have access to network specialists at the higher benefits level. And your out-of-pocket costs may be higher.

^{*}In Texas, PCP is known as physician (primary care). In the State of Washington, PCP refers to primary care provider.



Our network

When you need to find the right care, it's always reassuring to know you have choices. Our vast network includes primary care doctors and specialists, hospitals and other health care providers.

And it's never been easier to connect with care. Just use our provider search tool on your member website or use the Aetna HealthSM app when you're on the go.

Our network

24-Hour Nurse Line*

A simple call can make all the difference

Have questions about upcoming medical visits and choices? You can talk to a registered nurse for information about tests, procedures and treatment options, 24 hours a day, 7 days a week. And the call is free. To find the phone number, just visit **Aetna.com** and log in to your member website.

* While only your doctor can diagnose, prescribe or give medical advice, our 24-Hour Nurse Line nurses can provide information on a variety of health topics. Contact your doctor first with any questions about your health care needs

MinuteClinic® and CVS® HealthHUB™

Access MinuteClinic and CVS HealthHUB services at a low cost to you

Get access to convenient, local care at a MinuteClinic location at no or a low cost to you, including care for:

- Allergies
- Ear infections
- Flu-like symptoms
- Bug bites, stings and more

MinuteClinic providers can also administer vaccines and write prescriptions, when medically appropriate.

In addition to standard MinuteClinic locations found inside select CVS Pharmacy® and Target stores, we are excited to let you know about a new, innovative health care resource available to you: CVS® HealthHUB™. CVS HealthHUB locations offer expanded MinuteClinic services, one-on-one guidance, and resources for people to manage their health — with a focus on chronic conditions.

What's more? You can access the expanded MinuteClinic services — including care for certain chronic conditions* — at CVS HealthHUB locations at no or low cost to you.**

For your best health, we encourage you to have a relationship with a primary care physician or other doctor. Tell them about your visit to MinuteClinic, or

MinuteClinic can send a summary of your visit directly to them.

* MinuteClinic currently provides treatment services for the following chronic conditions: diabetes, hypertension, hyperlipidemia, hypothyroidism, and sleep apnea.

** Applies only to covered services at MinuteClinic. This information does not apply to members enrolled in qualified high-deductible health plans: such members must meet their deductible. However, such services would be subject to negotiated contract rates. Once the deductible has been met, such members will be able to access MinuteClinic® services at no cost-share. Members in indemnity plans are not eligible for this benefit. Such members should refer to their benefit plan documents in order to determine coverage and applicable cost share for walk-in clinic benefits and services, as applicable. Visit **MinuteClinic.com** for age and service restrictions. Aetna® and MinuteClinic, LLC (which either operates or provides certain management support services to MinuteClinic-branded walk-in clinics) are part of the CVS Health® family of companies. Aetna is not responsible for services received at MinuteClinic locations.

Teladoc Health® general medicine services — by phone or video

24/7 access to quality care

After hours? Can't get to the doctor's office? Teladoc Health connects you with board-certified doctors anytime. They can treat many non-emergency medical issues by phone or video. This may help you avoid urgent care and emergency room visits, which can be costly and time-consuming.

And it's easy to use — you can speak to a doctor "on demand" in minutes.* Or just schedule a time that's more convenient for you. You can request visits by either:

- Going to **Teladoc.com/Aetna**
- Downloading the TeladocHealth app

Visit **Teladoc.com/Aetna** to find out more and set up your account.

*Ten minutes is the average wait time for an on-demand visit but wait times may be longer during peak hours or seasons.

Institutes of Quality® facilities

Meet our highest standards — and yours

As an Aetna® member, you'll have access to the Institutes of Quality. This network of hospitals and

Our network

facilities specializes in bariatric, cardiac and orthopedic procedures. You may even pay less out of pocket at an Institutes of Quality facility.*

These approved facilities must meet our strict standards for clinical quality and efficiency. We measure factors like:

- The level of patient care
- How often people return to the hospital after surgery
- The number of procedures a facility performs

To see our list of Institutes of Quality facilities, go to **Aetna.com** and choose "Find a doctor." Then use the filter tool to select "Institutes of Quality facilities."

*How much you pay depends on your health plan.

National Medical Excellence Program® transplant care

Our program puts your needs first

You may never need an organ transplant, bone marrow treatment or CAR-T therapy.

But you can rest a little easier if you do, because you have access to this special program. It helps you get the care and resources you need — when you need them most.

You and your family get one-on-one support from:

- Dedicated medical directors
- Nurse care managers* with special experience
- Dedicated claims and Member Services staff

*While only your doctor can diagnose, prescribe or give medical advice, the nurse care managers can provide information on a variety of related topics.

Online directory

Find network doctors, right at your fingertips

Need a doctor? Simply search by specialty and location in our online directory. You'll also find maps, directions and more. You can also look for doctors who speak different languages. Just visit **Aetna.com** and select "Find a doctor" to get started.

In-network care

Who pays for what

Highlights

Choosing in-network providers may help save you money.

These providers contract with us to offer rates that are often lower than their regular fees. They also work directly with us and send us claims for services you receive. Don't worry — this is all behind-the-scenes work when you stay in network.

Visit **Aetna.com** to find a network provider.

Benefits

- ✓ **Lower out-of-pocket costs**
- ✓ **No balance billing**
- ✓ **Less paperwork**

How it works



Visit your doctor and show your Aetna® member ID card.



There's no need to pay at your visit unless you have a copay.

(Out of network, you may need to pay the full amount at your visit.)



Your doctor files your claim.
(Out of network, you file your own claims.)



The plan pays your doctor any amount it owes based on the negotiated rate.

(Out of network, the plan pays you back what it owes, up to the "reasonable and customary" limit.)



Your doctor bills you for any amount you owe.



Programs & resources

No health and benefits plan would be complete without extra support to help you feel your best. That's why you'll have a variety of ways to enhance your health and wellness.

So whether you're looking to improve your physical or mental health, or just need a little extra support, we've got the program that's right for you.

Programs & resources

Aetna Enhanced Maternity Program

Going through a maternity journey is different for everyone. That's why this program supports all women throughout their entire experience, whether they have risk factors or not.

Special program features include:

- **A fertility advocate*** to be your care manager and provide support if you're facing infertility
- **Predictive data** to help us identify pregnancies early on so we can provide timely, more responsive outreach to you
- **Preeclampsia prevention** by providing education and resources, if needed
- **Guided genetic counseling and screening services**, backed by medical expertise
- **Education and resources** to help close racial gaps in health care and support women of color

You can count on us for support — wherever you are in the maternity journey.

*While only your doctor can diagnose, prescribe or give medical advice, our fertility advocates/care managers can provide information on a variety of maternity-related topics.

Aetna Health ConnectionsSM Disease Management program

This program can help you take care of health conditions*

Maybe you've been working with your doctor to take care of a condition. Or perhaps you just received a diagnosis and are learning more about it. Either way, we're here to support you with this program. Our nurses, who act as health coaches, can help you follow your doctor's treatment plan — in the way that works best for you.

You can find support for more than 35 common conditions, including diabetes, heart disease, asthma, low back pain and many others. Just visit **Aetna.com** for the complete list.

*Our program and nurses do not diagnose or treat members. We assist you in getting the care you need and our program is not a substitute for the medical treatment and/or instructions provided by your health care providers.



Support & access

We make it easy to find what you need. Whether you want to look for the right care, manage your benefits, check on a claim, plan for an upcoming treatment or something else, it's easy to get simple, convenient information. All right at your fingertips.

Just connect with us however it's convenient for you. Call our team — we know the “ins and outs” of your benefits, and we’re just a phone call away. Or use your member website as your one-stop online resource. And don't forget to download the Aetna HealthSM app, where you can see your ID card, find care, make appointments and more — when you're on the go.

Support & access

Digital member ID card

Access your member ID card whenever you need it

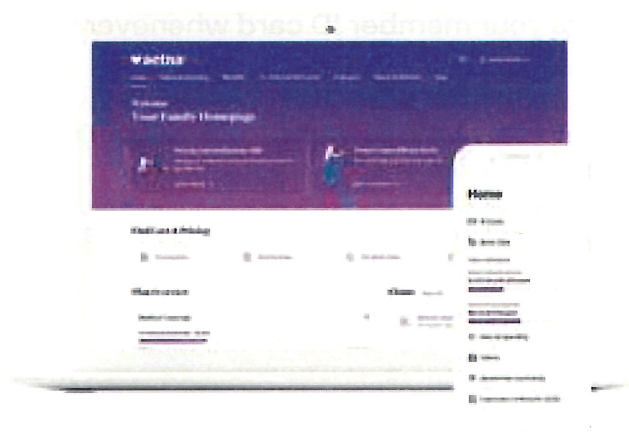
Have your digital ID card on hand, whenever you want, wherever you are with our Aetna HealthSM app. Or find it by going to **Aetna.com** and logging in to your member website. Want to print your ID card? No problem. Just look for that option at the top of the page.

Aetna® member website and Aetna HealthSM app

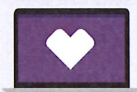
Manage your benefits, connect to care, handle claims — from anywhere..

As a member, you can:

- ✓ View your health plan summary and get information about coverage
- ✓ Track spending and progress toward your deductible or maximums for you and your family
- ✓ View and pay claims, and see the cost breakdown, including what your plan covers and your responsibility
- ✓ Use tools to help you choose quality in-network providers
- ✓ Get personalized reminders to help improve your health



Once you're a member, here's how you can connect:



Your Aetna member website

Go to **Aetna.com** to create an account and log in to your member website.



The Aetna Health app

Get the Aetna Health app by texting "GETAPP" to **90156** for a link to download and create an account. Message and data rates may apply.*



Provider search tool

You can find providers by **name, specialty and location**. You'll also find maps, directions and more. You can also look for providers who speak different languages. Visit **Aetna.com** to get started.

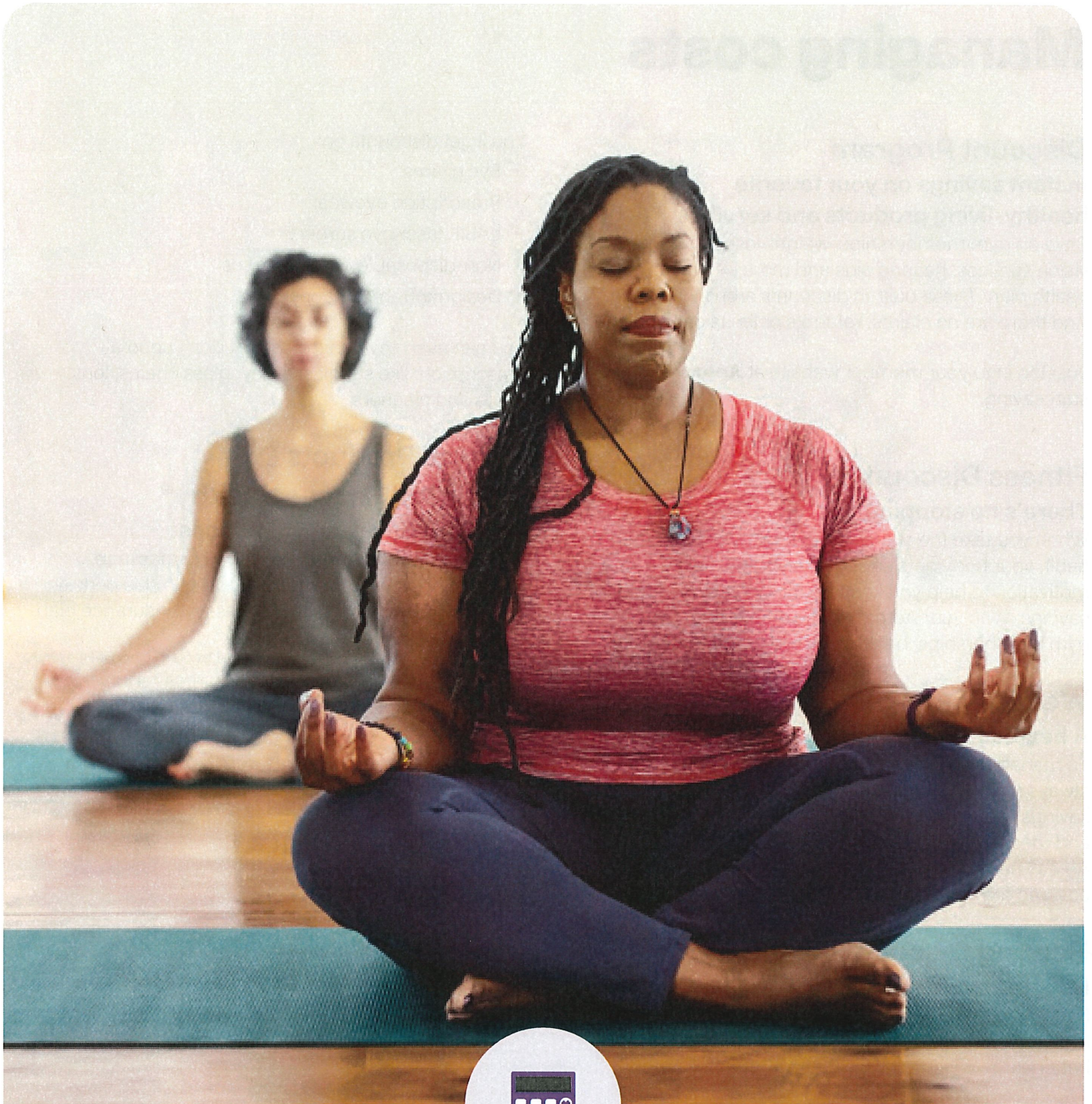


App Store



Google Play

*Terms and conditions: [Bit.ly/2n1JFYG](https://bit.ly/2n1JFYG). Privacy policy: [Aetna.com/legal-notice/privacy.html](https://aetna.com/legal-notice/privacy.html). By texting **90156**, you consent to receive a one-time marketing automated text message from Aetna with a link to download the Aetna Health app. Consent is not required to download the app. You can also download it from the App Store® or the Google Play™ store.



Managing costs

It's always important to plan ahead, stretch your health care dollars and avoid any surprise bills. And we're here to help you do just that. Read on to find out how members can save with special perks and discounts.

Managing costs

Discount Program

Instant savings on your favorite healthy-living products and services

Save on gym memberships, weight-loss programs, vision services, hearing aids and more — with any health plan. These built-in discounts aren't insurance. And there are no claims, referrals or limits on use.

Just log in to your member website at **Aetna.com** to start saving.

Fitness Discounts

There's no stopping you

When you take the stairs, snack healthy or kick a bad habit, your body gets stronger. And now, here's a little motivation to help you keep up the good work: good savings. With your Aetna® plan, you get discounts on gym memberships, health coaching and much more.

Weight Management Discounts

A healthier body, with a little help

To manage your weight with success, a little support is always nice. And you've got it right here — great savings on today's most popular weight-loss programs and meal plans. These discounts are included with your Aetna® health benefits and insurance plan. Your covered family members can use them, too.

Hearing Discounts

Hear better, for less

Need a little help with your hearing? Here's a great way to save on essentials like hearing aids, exams and even batteries.

It's a nice perk for Aetna® members. And the discounts are instant, so you save on the spot.

Aetna Vision Discounts

The clearer way to enjoy savings

Your vision may be just fine. Or it may need a little help. Either way, you can save with our vision discounts.

You'll get discounts on:

- Eye exams
- Prescription eyewear
- LASIK laser eye surgery
- Non-disposable contact lenses
- Designer frame options

You can even save on things that don't need a prescription, like sunglasses, eyeglass chains, lens cases and cleaners.

Natural Products & Services/ChooseHealthy®

Give your health a natural boost

Enjoy instant discounts on therapeutic massage, acupuncture ... even chiropractic visits.* This perk is included with your Aetna® benefits and insurance plan.

* Natural products and services are offered through ChooseHealthy®, a program provided by ChooseHealthy, Inc. which is a subsidiary of American Specialty Health Incorporated (ASH). ChooseHealthy is a registered trademark of ASH and is used with permission.

What to expect after enrollment



You'll get a **welcome message** that explains coverage and benefits.



You can access your member website and helpful **tools and resources**.



Use your **member website** to let us know the best way to communicate with you.



You'll get your **physical ID card**.



You can access your **digital ID card**.



WE'ER HERE TO HELP



If you have questions, just call us at the phone number on your **Aetna® member ID card**.



It's important to take care of the whole you.

This includes your physical and mental wellness. That's why your benefits include checkups, screenings, vaccines, prenatal care services, counseling and more. And there are no out-of-pocket costs when you stay in network. So it's good for your health — and your wallet.

Keep your health in check with preventive care

You can get:

- Annual routine physical exam for adults and children
- Immunizations
- Well-woman exam, including cervical cancer screening
- Preventive mammogram
- Diabetes screening for pregnant women
- Colorectal cancer screening, based on age
- Prostate cancer screening, based on age
- Counseling (alcohol, smoking, nutrition and more)

These are just a few examples of the services available. Be sure to check your plan for details. And talk with your doctor about the care that's right for you.

Not all services are covered. See plan documents for a complete description of benefits, exclusions and limitations of coverage. Plan features and availability may vary by location and are subject to change.

Providers are independent contractors and are not agents of Aetna®. Provider participation may change without notice.

Refer to **Aetna.com** for more information about Aetna® plans. You can view or print your plan disclosure from our **[Aetna.com/individuals-families/member-rights-resources/rights/disclosure-information.html](https://www.aetna.com/individuals-families/member-rights-resources/rights/disclosure-information.html)**

DISCOUNT OFFERS ARE NOT INSURANCE. They are not benefits under your insurance plan. You get access to discounts off the regular charge on products and services offered by third-party vendors and providers. Aetna makes no payment to the third parties — you are responsible for the full cost. Check any insurance plan benefits you have before using these discount offers, as those benefits may give you lower costs than these discounts. Non health related discounts are not available to New York Fully Insured policyholders.

Discount vendors and providers are not agents of Aetna and are solely responsible for the products and services they provide. Discount offers are not guaranteed and may be ended at any time. Aetna may get a fee when you buy these discounted products and services.

CVS® HealthHUB™ services are available only in select stores and the services offered may vary by location. See your CVS HealthHUB store for details. Pharmacy services provided by CVS Pharmacy®, Inc. Clinical services within a CVS HealthHUB location provided by a MinuteClinic® nurse practitioner or physician assistant except if otherwise indicated.

Teladoc Health is not available to all members. Teladoc Health and Teladoc Health physicians are independent contractors and are not agents of Aetna. For a complete description of the limitations of Teladoc Health services, visit **[Teladoc.com/Aetna](https://www.teladoc.com/Aetna)**. Teladoc Health and the Teladoc Health logo are registered trademarks or trademarks of Teladoc Health, Inc



Option 1

LABOR BENEFITS ASSOCIATION

Effective Date: 01-01-2024

Open Access® Managed Choice® POS - Illinois

PLAN DESIGN & BENEFITS
MEDICAL PLAN PROVIDED BY AETNA LIFE INSURANCE COMPANY

PLAN FEATURES	IN-NETWORK	OUT-OF-NETWORK
Benefit limitations - Some service or supplies have limits on them per year. There might be a maximum number of visits or days, or a dollar limit per year. In such cases, the benefit year begins on January 1 (unless otherwise noted). Refer to your plan documents to learn more.		
Deductible (per calendar year)	\$427 per Individual \$1,285 per Family	\$998 per Individual \$2,995 per Family
Covered expenses in-network add up towards your in-network deductible. Covered expenses out-of-network add up towards your out-of-network deductible. You must first meet the deductible before the plan begins paying benefits, unless otherwise noted. The amount you pay (cost sharing) for some medical services does not count toward your deductible. Prescription drug costs do not count toward the deductible. Refer to your plan documents for details. Your family will have one deductible. You will meet it when the expenses of several family members add up to the family deductible. No one person will have to pay more than the individual deductible.		
Member coinsurance	You pay 10%	You pay 30%
Applies to all expenses except as noted.		
Out-of-pocket limit (per calendar year)	\$2,497 per Individual \$4,992 per Family	\$4,989 per Individual \$9,979 per Family
Covered expenses in-network add up towards your in-network out-of-pocket limit. Covered expenses out-of-network add up towards your out-of-network out-of-pocket limit. Some of your cost sharing may not count toward the out-of-pocket limit. Your pharmacy expenses count toward your out-of-pocket limit. In-network expenses include coinsurance/copays and deductibles. Out-of-network expenses include coinsurance and deductibles. Penalty amounts do not apply. Your family will have one out-of-pocket limit. You will meet it when the expenses of several family members add up to the family out-of-pocket limit. No one person will have to pay more than the individual out-of-pocket limit amount.		
Lifetime maximum	Unlimited except where otherwise indicated.	
Payment for out-of-network care**	Does not apply	Professional: 105% of Medicare Facility: 140% of Medicare
Primary care physician selection	Encouraged	Does not apply
Precertification requirements - Some out-of-network services need approval by us in advance (precertification). Without this approval, we reduce benefits by \$400. Refer to your plan documents for a full list of services that need this approval.		
Referral requirement	Not required	None
PREVENTIVE CARE	IN-NETWORK	OUT-OF-NETWORK
Routine adult physical exams/immunizations 1 exam every 12 months until age 65, then 1 exam every 12 months age 65 and older	Covered 100%; no deductible	30%; after deductible
Routine well child exams/immunizations • 7 exams in the first 12 months • 3 exams from age 13 through 24 months • 3 exams from age 25 through 36 months • 1 exam every 12 months from age 3 until age 22 years	Covered 100%; no deductible	30%; after deductible
Childhood immunizations HPV Immunizations covered to age 27.	Covered 100%; no deductible	Covered 100%; no deductible
Routine gynecological care exams 1 exam and pap smear per year, includes related fees.	Covered 100%; no deductible	30%; after deductible
Routine mammogram Recommended: One per year for members age 40 and over	Covered 100%; no deductible	30%; after deductible



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Women's health	Covered 100%; no deductible	30%; after deductible
Includes: Screening for gestational diabetes, HPV (Human- Papillomavirus) DNA testing, counseling for sexually transmitted infections, counseling and screening for human immunodeficiency virus, screening and counseling for interpersonal and domestic violence, breastfeeding support, supplies and counseling. Also includes: contraceptive methods (ACA mandated contraceptives, including contraceptives and devices you can't get at a pharmacy), sterilization procedures (including tubal ligation), patient education and counseling. Limits may apply.		
Pre-natal maternity	Covered 100%; no deductible	30%; after deductible
Routine digital rectal exam	Covered 100%; no deductible	30%; after deductible
Recommended: For members age 40 and over		
Prostate-specific antigen test	Covered 100%; no deductible	30%; after deductible
Recommended: For members age 40 and over		
Colorectal cancer screening	Covered 100%; no deductible	30%; after deductible
Recommended: For members age 45 and over Includes screening exam, sigmoidoscopy, and/or fecal occult blood test for a person age 30 and over every 3 years.		
Routine eye exams	\$50 copay; no deductible	30%; after deductible
1 routine exam per 24 months.		
Routine hearing screening	Covered 100%; no deductible	30%; after deductible
PHYSICIAN SERVICES	IN-NETWORK	OUT-OF-NETWORK
Office visits to primary care physician (PCP)	\$25 office visit copay; no deductible	30%; after deductible
Includes services of an internist, general physician, family practitioner or pediatrician.		
Specialist office visits	\$50 office visit copay; no deductible	30%; after deductible
Hearing exams	Not Covered	Not Covered
Walk-in clinics	\$25 copay; no deductible	30%; after deductible
Designated Walk-in clinics Covered 100%; no deductible		
Walk-in clinics are free-standing health care facilities. Sometimes they may be within a pharmacy, drug store, supermarket, or other retail store. They offer some limited medical care and services. Not walk-in clinics: Urgent care centers, emergency rooms, the outpatient department of a hospital, ambulatory surgical centers, and physician offices.		
Allergy testing	Your cost sharing amount depends on the type of service and where you receive it.	Your cost sharing amount depends on the type of service and where you receive it.
Allergy injections	Your cost sharing amount depends on the type of service and where you receive it.	Your cost sharing amount depends on the type of service and where you receive it.
DIAGNOSTIC PROCEDURES	IN-NETWORK	OUT-OF-NETWORK
Diagnostic X-ray (Other than complex imaging services)	10%; after deductible	30%; after deductible
When your physician performs and bills for this service at their office, you pay your office visit cost share amount.		
Diagnostic laboratory	10%; after deductible	30%; after deductible
When your physician performs and bills for this service at their office, you pay your office visit cost share amount.		
Diagnostic complex imaging	10%; after deductible	30%; after deductible
When your physician performs and bills for this service at their office, you pay your office visit cost share amount.		
EMERGENCY MEDICAL CARE	IN-NETWORK	OUT-OF-NETWORK
Urgent care provider	Covered 100%; no deductible	30%; after deductible
Non-urgent use of urgent care provider	50%; after deductible	50%; after deductible
Emergency room	10% after \$25 copay; no deductible	Same as in-network care
Copay waived if admitted		



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Non-emergency care in an emergency room	Not Covered	Not Covered
Emergency use of ambulance	10% after \$25 copay; no deductible	Same as in-network care
Non-emergency use of ambulance	Not Covered	Not Covered
HOSPITAL CARE	IN-NETWORK	OUT-OF-NETWORK
Inpatient coverage	10%; after deductible	30%; after deductible
When you're admitted into a hospital for the care you need, your cost sharing amount counts toward all covered benefits you receive.		
Inpatient maternity coverage (includes delivery and postpartum care)	10%; after deductible	30%; after deductible
When you're admitted into a hospital for the care you need, your cost sharing amount counts toward all covered benefits you receive.		
Outpatient hospital	10%; after deductible	30%; after deductible
When you receive outpatient care at a hospital but don't stay overnight, your cost sharing amount counts toward all covered benefits during your visit.		
Outpatient surgery - hospital	10%; after deductible	30%; after deductible
When you receive outpatient care at a hospital but don't stay overnight, your cost sharing amount counts toward all covered benefits during your visit.		
Outpatient surgery - freestanding facility	10%; after deductible	30%; after deductible
When you receive outpatient care at a hospital but don't stay overnight, your cost sharing amount counts toward all covered benefits during your visit.		
MENTAL HEALTH SERVICES	IN-NETWORK	OUT-OF-NETWORK
Inpatient	10%; after deductible	30%; after deductible
When you're admitted into a hospital for the care you need, your cost sharing amount counts toward all covered benefits you receive.		
Mental health office visits	\$50 copay; no deductible	30%; after deductible
Other mental health services	Covered 100%; no deductible	30%; after deductible
When you receive outpatient care at a facility but don't stay overnight, your cost sharing amount counts toward all covered benefits during your visit.		
SUBSTANCE ABUSE	IN-NETWORK	OUT-OF-NETWORK
Inpatient	10%; after deductible	30%; after deductible
When you're admitted into a hospital for the care you need, your cost sharing amount counts toward all covered benefits you receive.		
Residential treatment facility	10%; after deductible	30%; after deductible
When you're admitted into a facility for the care you need, your cost sharing amount counts toward all covered benefits you receive.		
Substance abuse office visits	\$50 copay; no deductible	30%; after deductible
Other substance abuse services	Covered 100%; no deductible	30%; after deductible
When you receive outpatient care at a facility but don't stay overnight, your cost sharing amount counts toward all covered benefits during your visit.		
THERAPY SERVICES	IN-NETWORK	OUT-OF-NETWORK
Spinal manipulation therapy Limited to 25 visits per year	\$50 copay; no deductible	30%; after deductible



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Outpatient short-term rehabilitation Limited to 60 visits per year Includes physical, occupational, and speech therapies.	\$50 copay; no deductible	30%; after deductible
Habilitative physical therapy	Covered 100%; no deductible	30%; after deductible
Habilitative occupational therapy	Covered 100%; no deductible	30%; after deductible
Habilitative speech therapy	Covered 100%; no deductible	30%; after deductible
Autism related physical therapy	Covered 100%; no deductible	30%; after deductible
Autism related occupational therapy	Covered 100%; no deductible	30%; after deductible
Autism related speech therapy	Covered 100%; no deductible	30%; after deductible
Autism related behavioral therapy These benefits are combined with outpatient mental health visits	\$50 copay; no deductible	30%; after deductible
Autism related applied behavior analysis Your benefits for these services are the same as any other outpatient mental health other services benefit	Covered 100%; no deductible	30%; after deductible
OTHER SERVICES	IN-NETWORK	OUT-OF-NETWORK
Skilled nursing facility Limited to 60 days per year When you're admitted into a facility for the care you need, your cost sharing amount counts toward all covered benefits you receive.	10%; after deductible	30%; after deductible
Home health care Home health care services include private duty nursing Limited to three visits per day by staff from a home health care agency. One visit equals a period of four hours or less.	10%; after deductible	30%; after deductible
Hospice care - inpatient When you're admitted into a facility for the care you need, your cost sharing amount counts toward all covered benefits you receive.	10%; after deductible	30%; after deductible
Hospice care - outpatient When you receive outpatient care at a facility but don't stay overnight, your cost sharing amount counts toward all covered benefits during your visit.	10%; after deductible	30%; after deductible
Private duty nursing We count each period of up to 8 hours as one private duty nursing shift.	Covered as part of home health care	Covered as part of home health care
Durable medical equipment	10%; after deductible	30%; after deductible
Prosthetics	10%; after deductible	30%; after deductible
Orthotics	10%; after deductible	30%; after deductible
Diabetic supplies -- (if not covered under the prescription drug benefit)	Covered same as any other medical expense. You pay your prescription drug cost sharing amount if you have prescription drug coverage. If not, you pay your PCP visit cost sharing amount.	Covered same as any other medical expense. You pay your prescription drug cost sharing amount if you have prescription drug coverage. If not, you pay your PCP visit cost sharing amount.
Infusion therapy - home/office	\$50 copay; no deductible	30%; after deductible
Infusion therapy - outpatient hospital/freestanding facility	Your cost sharing amount depends on the type of service and where you receive it.	Your cost sharing amount depends on the type of service and where you receive it.
Hearing aids 1 hearing aid for each impaired ear per 36 month period to age 18	10%; after deductible	30%; after deductible



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Transplants	10%; after deductible In-network coverage is only available at Institutes of Excellence (IOE) contracted facility.	30%; after deductible Out-of-network coverage applies when you use a non-IOE facility. You will pay more out of pocket when using a non-IOE facility.
Bariatric surgery	Not Covered	Not Covered
Acupuncture Limited to 10 visits per year	\$25 copay; no deductible	30%; after deductible
FAMILY PLANNING	IN-NETWORK	OUT-OF-NETWORK
Infertility treatment	Your cost sharing amount depends on the type of service and where you receive it.	Your cost sharing amount depends on the type of service and where you receive it.
You have coverage for the diagnosis and treatment of the underlying cause of infertility.		
Comprehensive infertility services	10%; after deductible	30%; after deductible
Coverage includes artificial insemination and ovulation. Lifetime maximum applies to all procedures covered by any of our plans except where prohibited by law.		
Advanced Reproductive Technology (ART)	10%; after deductible	30%; after deductible
Limited to 4 courses of treatment per member's lifetime, if live birth 2 additional retrievals covered. Covers cryopreservation for only iatrogenic Infertility. Maximum applies to all procedures covered by any of our plans except where prohibited by law. ART coverage includes Invitro fertilization (IVF), zygote intrafallopian transfer (ZIFT), gamete intrafallopian transfer (GIFT), cryopreserved embryo transfers, intracytoplasmic sperm injection (ICSI) or ovum microsurgery, and cryopreservation, unlimited storage.		
Vasectomy	Covered 100%; no deductible	30%; after deductible
Tubal ligation	Covered 100%; no deductible	30%; after deductible
PHARMACY	IN-NETWORK	OUT-OF-NETWORK
Pharmacy plan type	Advanced Control Plan - Aetna	
Prescription Drug Deductible (per calendar year)	\$100 per Individual	\$100 per Individual
Covered prescription drug expenses add up toward both your in-network and out-of-network prescription drug deductible at the same time. You must first meet the prescription drug deductible before the plan begins paying prescription drug benefits, unless otherwise noted. Once you meet the family prescription drug deductible, then all family members have met it for the rest of the year. There is no individual prescription drug deductible for members of a family.		
Prescription drug out-of-pocket limit	Prescription drug expenses apply to your medical out-of-pocket limit.	
Covered prescription drug expenses add up toward both your in-network and out-of-network prescription drug out-of-pocket limit at the same time.		



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Preferred generic drugs			
	Retail	20%	40% of submitted cost; after applicable in-network cost share
	Mail order	20%	40% of submitted cost; after applicable in-network cost share
Preferred brand-name drugs			
	Retail	20%	40% of submitted cost; after applicable in-network cost share
	Mail order	20%	40% of submitted cost; after applicable in-network cost share
Non-preferred generic and brand-name drugs			
	Retail	20%	40% of submitted cost; after applicable in-network cost share
	Mail order	20%	40% of submitted cost; after applicable in-network cost share
Pharmacy day supply and requirements			
	Retail	You can get up to a 30-day supply from Aetna National Network Percentage copays will not be doubled	
	Mail order	You can get a 31-90-day supply from CVS Caremark® Mail Service Pharmacy.	
	Specialty	You can get up to a 30-day supply of specialty drugs Advanced Control Formulary Aetna Insured List	
Your prescription drug plan also includes:			
<ul style="list-style-type: none">• Diabetic supplies• Insulin up to a \$100 member payment maximum per fill per 30-day supply• Sexual dysfunction drugs, including daily dose, additional 6 tablets a month for erectile dysfunction• A limited list of over-the-counter medications when filled with a prescription			
Family planning			
<ul style="list-style-type: none">• Oral and injectable fertility drugs included (physician charges for injections are not covered under RX, medical coverage is limited).• Contraceptives covered up to a 12-month supply. Contraceptive copay strategy applies.			
The following are covered 100% in-network:			
<ul style="list-style-type: none">• Oral chemotherapy drugs• Seasonal vaccinations• Preventive vaccinations• Affordable Care Act (ACA) eligible preventive medications and contraceptives			
Refer to Aetna.com for a complete list of eligible prescription drugs.			
Precertification requirements			
Some covered prescription drugs need approval from us before we will cover the drug.			
Some covered prescription drugs require step therapy before we cover them. With step therapy, you must first try one or more drugs before we will pay for drugs that require step therapy.			
To get the most up-to-date precertification requirements and a list of drugs that require step therapy, see your plan documents or go online to your member website.			
Choose generics - Sometimes you or your provider may ask for a brand-name prescription drug when a generic is available. If so, you will pay the brand-name copay plus the difference between the generic price and the brand-name price.			

GENERAL PROVISIONS

Dependents who are eligible to be on your plan	Spouse, children from birth to age 26. Student status of children does not matter.
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****We cover the cost of services based on whether doctors are "in network" or "out of network." We want to help you understand how much we pay for your out-of-network care. At the same time, we want to make it clear how much more you will need to pay for this "out-of-network" care.**

You may choose a provider (doctor or hospital) in our network. You may choose to visit an out-of-network provider. If you choose a doctor who is out of network, your health plan may pay some of that doctor's bill. Most of the time, you will pay a lot more money out of your own pocket if you choose to use an out-of-network doctor or hospital.

When you choose out-of-network care, we limit the amount it will pay. This limit is called the "recognized" or "allowed" amount.

- For doctors and other professionals the amount is based on what Medicare pays for these services. The government sets the Medicare rate. Exactly how much we "recognize" depends on the plan you or your employer picks.

- For hospitals and other facilities, the amount is based on what Medicare pays for these services. The government sets the Medicare rate. Exactly how much we "recognize" depends on the plan you or your employer picks.

Your doctor sets his or her own rate to charge you. It may be higher -- sometimes much higher -- than what your plan "recognizes." Your doctor may bill you for the dollar amount that we don't "recognize." You must also pay any copayments, coinsurance and deductibles under your plan. No dollar amount above the "recognized charge" counts toward your deductible or out-of-pocket maximums. To learn more about how we pay out-of-network benefits visit our website.

You can avoid these extra costs by getting your care from Aetna's broad network of health care providers. Go to www.aetna.com and click on "Find a Doctor" on the left side of the page. If you are already a member, sign on to your Navigator member site.

This applies when you choose to get care out of network. When you have no choice (for example: emergency room visit after a car accident, or for other emergency services), we will pay the bill as if you got care in network. You pay cost sharing and deductibles for your in-network level of benefits. Contact us if your provider asks you to pay more. You are not responsible for any outstanding balance billed by your providers for emergency services beyond your cost sharing and deductibles.

This way of paying out-of-network doctors and hospitals applies when you choose to get care out of network. When you have no choice (for example: emergency room visit after a car accident), we will pay the bill as if you got care in-network. You pay your plan's copayments and deductibles for your in-network level of benefits. Contact us if your provider asks you to pay more. You are not responsible for any outstanding balance billed by your providers for emergency services beyond your copayments and deductibles.

Plans are provided by: Aetna Health Inc. While this material is believed to be accurate as of the production date, it is subject to change.

Health benefits and health insurance plans contain exclusions and limitations. Not all health services are covered.

See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by location and are subject to change. Providers are independent contractors and are not our agents. Provider participation may change without notice. We do not provide care or guarantee access to health services.

If you are in a plan that requires the selection of a primary care physician and your primary care physician is part of an integrated delivery system or physician group, your primary care physician will generally refer you to specialists and hospitals that are affiliated with the delivery system or physician group.



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The following is a list of services and supplies that are *generally* not covered. However, your plan documents may contain exceptions to this list based on state mandates or the plan design or rider(s) purchased by your employer.

- All medical and hospital services not specifically covered in, or which are limited or excluded by your plan documents.
- Cosmetic surgery, including breast reduction.
- Custodial care.
- Dental care and dental X-rays.
- Donor egg retrieval
- Experimental and investigational procedures, except for coverage for medically necessary routine patient care costs for members participating in a cancer clinical trial.
- Hearing aids
- Home births
- Immunizations for travel or work, except where medically necessary or indicated.
- Implantable drugs and certain injectable drugs including injectable infertility drugs.
- Infertility services, including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI and other related services, unless specifically listed as covered in your plan documents.
- Long-term rehabilitation therapy.
- Non-medically necessary services or supplies.
- Outpatient prescription drugs (except for treatment of diabetes), unless covered by a prescription plan rider and over-the-counter medications (except as provided in a hospital) and supplies.
- Radial keratotomy or related procedures.
- Reversal of sterilization.
- Services for the treatment of sexual dysfunction/enhancement, including therapy, supplies or counseling or prescription drugs.
- Special duty nursing.
- Therapy or rehabilitation other than those listed as covered.
- Weight control services including surgical procedures, medical treatments, weight control/loss programs, dietary regimens and supplements, appetite suppressants and other medications; food or food supplements, exercise programs, exercise or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity, including Morbid Obesity, or for the purpose of weight reduction, regardless of the existence of comorbid conditions.

In case of emergency, call 911 or your local emergency hotline, or go directly to an emergency care facility.

Translation of this material into another language may be available. Please call Member Services at the number on the back of your ID card.

Puede estar disponible la traducción de este material en otro idioma. Por favor llame a Servicios al Miembro al **1-888-982-3862**.

Plan features and availability may vary by location and group size.

For more information about Aetna plans, refer to www.aetna.com.

Aetna and MinuteClinic, LLC (which either operates or provides certain management support services to MinuteClinic-branded walk-in clinics) are both within the CVS Health family.

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PLAN DESIGN & BENEFITS
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PLAN FEATURES	IN-NETWORK DESIGNATED PROVIDERS	OUT-OF-NETWORK
Benefit limitations - Some service or supplies have limits on them per year. There might be a maximum number of visits or days, or a dollar limit per year. In such cases, the benefit year begins on January 1 (unless otherwise noted). Refer to your plan documents to learn more.		
Deductible (per calendar year)	\$1,545 per Individual \$4,120 per Family	\$3,545 per Individual \$6,120 per Family
Covered expenses in-network add up towards your in-network deductible. Covered expenses out-of-network add up towards your out-of-network deductible. You must first meet the deductible before the plan begins paying benefits, unless otherwise noted. The amount you pay (cost sharing) for some medical services does not count toward your deductible. Prescription drug costs do not count toward the deductible. Refer to your plan documents for details. Your family will have one deductible. You will meet it when the expenses of several family members add up to the family deductible. No one person will have to pay more than the individual deductible.		
Member coinsurance	You pay 10%	You pay 50%
Applies to all expenses except as noted.		
Out-of-pocket limit (per calendar year)	\$6,180 per Individual \$12,360 per Family	\$8,180 per Individual \$14,360 per Family
Covered expenses in-network add up towards your in-network out-of-pocket limit. Covered expenses out-of-network add up towards your out-of-network out-of-pocket limit. Some of your cost sharing may not count toward the out-of-pocket limit. Your pharmacy expenses count toward your out-of-pocket limit. In-network expenses include coinsurance/copays and deductibles. Out-of-network expenses include coinsurance and deductibles. Penalty amounts do not apply. Your family will have one out-of-pocket limit. You will meet it when the expenses of several family members add up to the family out-of-pocket limit. No one person will have to pay more than the individual out-of-pocket limit amount.		
Lifetime maximum	Unlimited except where otherwise indicated.	
Payment for out-of-network care**	Does not apply	Professional: 105% of Medicare Facility: 140% of Medicare
Primary care physician selection	Encouraged	Does not apply
Precertification requirements - Some out-of-network services need approval by us in advance (precertification). Without this approval, we reduce benefits by \$400. Refer to your plan documents for a full list of services that need this approval.		
Referral requirement	Not required	None
Network Designations- In order to be covered at the preferred in-network benefit level you must use a designated provider for care. If you receive care from a non-designated provider your care may be paid at the out-of-network benefit level or may not be covered at all.		
PREVENTIVE CARE	IN-NETWORK DESIGNATED PROVIDERS	OUT-OF-NETWORK
Routine adult physical exams/immunizations	Covered 100%; no deductible	50%; after deductible
1 exam every 12 months until age 65, then 1 exam every 12 months age 65 and older		



Savings Plus

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Routine well child exams/immunizations • 7 exams in the first 12 months • 3 exams from age 13 through 24 months • 3 exams from age 25 through 36 months • 1 exam every 12 months from age 3 until age 22 years	Covered 100%; no deductible	50%; after deductible
Childhood immunizations HPV Immunizations covered to age 27.	Covered 100%; no deductible	Covered 100%; no deductible
Routine gynecological care exams 1 exam and pap smear per year, includes related fees.	Covered 100%; no deductible	50%; after deductible
Routine mammogram Recommended: One per year for members age 40 and over	Covered 100%; no deductible	50%; after deductible
Women's health Includes: Screening for gestational diabetes, HPV (Human- Papillomavirus) DNA testing, counseling for sexually transmitted infections, counseling and screening for human immunodeficiency virus, screening and counseling for interpersonal and domestic violence, breastfeeding support, supplies and counseling. Also includes: contraceptive methods (ACA mandated contraceptives, including contraceptives and devices you can't get at a pharmacy), sterilization procedures (including tubal ligation), patient education and counseling. Limits may apply.	Covered 100%; no deductible	50%; after deductible
Pre-natal maternity	Covered 100%; no deductible	50%; after deductible
Routine digital rectal exam Recommended: For members age 40 and over	Covered 100%; no deductible	50%; after deductible
Prostate-specific antigen test Recommended: For members age 40 and over	Covered 100%; no deductible	50%; after deductible
Colorectal cancer screening Recommended: For members age 45 and over Includes screening exam, sigmoidoscopy, and/or fecal occult blood test for a person age 30 and over every 3 years.	Covered 100%; no deductible	50%; after deductible
Routine eye exams 1 routine exam per 24 months.	\$45 copay; no deductible	50%; after deductible
Routine hearing screening	Covered 100%; no deductible	50%; after deductible
PHYSICIAN SERVICES	IN-NETWORK	OUT-OF-NETWORK
Office visits to primary care physician (PCP) Includes services of an internist, general physician, family practitioner or pediatrician.	\$20 office visit copay; no deductible	50%; after deductible
Specialist office visits	\$45 office visit copay; no deductible	50%; after deductible
Hearing exams	Not Covered	Not Covered
Walk-in clinics	\$20 copay; no deductible	50%; after deductible
	Designated Walk-in clinics Covered 100%; no deductible	
Walk-in clinics are free-standing health care facilities. Sometimes they may be within a pharmacy, drug store, supermarket, or other retail store. They offer some limited medical care and services. Not walk-in clinics: Urgent care centers, emergency rooms, the outpatient department of a hospital, ambulatory surgical centers, and physician offices.		
Allergy testing	Your cost sharing amount depends on the type of service and where you receive it.	Your cost sharing amount depends on the type of service and where you receive it.
Allergy injections	Your cost sharing amount depends on the type of service and where you receive it.	Your cost sharing amount depends on the type of service and where you receive it.



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DIAGNOSTIC PROCEDURES	IN-NETWORK	OUT-OF-NETWORK
Diagnostic X-ray (Other than complex imaging services) When your physician performs and bills for this service at their office, you pay your office visit cost share amount.	10%; after deductible	50%; after deductible
Diagnostic laboratory When your physician performs and bills for this service at their office, you pay your office visit cost share amount.	10%; after deductible	50%; after deductible
Diagnostic complex imaging When your physician performs and bills for this service at their office, you pay your office visit cost share amount.	10%; after deductible	50%; after deductible
EMERGENCY MEDICAL CARE	IN-NETWORK DESIGNATED PROVIDERS	OUT-OF-NETWORK
Urgent care provider	Covered 100%; no deductible	50%; after deductible
Non-urgent use of urgent care provider	50%; after deductible	50%; after deductible
Emergency room Copay waived if admitted	10% after \$25 copay; no deductible	Same as in-network care
Non-emergency care in an emergency room	Not Covered	Not Covered
Emergency use of ambulance	10% after \$25 copay; no deductible	Same as in-network care
Non-emergency use of ambulance	Not Covered	Not Covered
HOSPITAL CARE	IN-NETWORK DESIGNATED PROVIDERS	OUT-OF-NETWORK
Inpatient coverage When you're admitted into a hospital for the care you need, your cost sharing amount counts toward all covered benefits you receive.	10% after \$258 copay; after deductible	50% after \$350 per visit deductible; after plan deductible
Inpatient maternity coverage (includes delivery and postpartum care) When you're admitted into a hospital for the care you need, your cost sharing amount counts toward all covered benefits you receive.	10% after \$258 copay; after deductible	50% after \$350 per visit deductible; after plan deductible
Outpatient hospital When you receive outpatient care at a hospital but don't stay overnight, your cost sharing amount counts toward all covered benefits during your visit.	10%; after deductible	50%; after deductible
Outpatient surgery - hospital When you receive outpatient care at a hospital but don't stay overnight, your cost sharing amount counts toward all covered benefits during your visit.	10% after \$200 copay; after deductible	50% after \$500 per visit deductible; after plan deductible
Outpatient surgery - freestanding facility When you receive outpatient care at a hospital but don't stay overnight, your cost sharing amount counts toward all covered benefits during your visit.	10% after \$200 copay; after deductible	50% after \$500 per visit deductible; after plan deductible
MENTAL HEALTH SERVICES	IN-NETWORK DESIGNATED PROVIDERS	OUT-OF-NETWORK
Inpatient When you're admitted into a hospital for the care you need, your cost sharing amount counts toward all covered benefits you receive.	10% after \$258 copay; after deductible	50% after \$350 per visit deductible; after plan deductible
Mental health office visits	\$45 copay; no deductible	50%; after deductible
Other mental health services When you receive outpatient care at a facility but don't stay overnight, your cost sharing amount counts toward all covered benefits during your visit.	Covered 100%; no deductible	50%; after deductible



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SUBSTANCE ABUSE	IN-NETWORK DESIGNATED PROVIDERS	OUT-OF-NETWORK
Inpatient When you're admitted into a hospital for the care you need, your cost sharing amount counts toward all covered benefits you receive.	10% after \$258 copay; after deductible	50% after \$350 per visit deductible; after plan deductible
Residential treatment facility When you're admitted into a facility for the care you need, your cost sharing amount counts toward all covered benefits you receive.	10% after \$258 copay; after deductible	50% after \$350 per visit deductible; after plan deductible
Substance abuse office visits	\$45 copay; no deductible	50%; after deductible
Other substance abuse services When you receive outpatient care at a facility but don't stay overnight, your cost sharing amount counts toward all covered benefits during your visit.	Covered 100%; no deductible	50%; after deductible
THERAPY SERVICES	IN-NETWORK	OUT-OF-NETWORK
Spinal manipulation therapy Limited to 25 visits per year	\$45 copay; no deductible	50%; after deductible
Outpatient short-term rehabilitation Limited to 60 visits per year Includes physical, occupational, and speech therapies.	\$45 copay; no deductible	50%; after deductible
Habilitative physical therapy	Covered 100%; no deductible	50%; after deductible
Habilitative occupational therapy	Covered 100%; no deductible	50%; after deductible
Habilitative speech therapy	Covered 100%; no deductible	50%; after deductible
Autism related physical therapy	Covered 100%; no deductible	50%; after deductible
Autism related occupational therapy	Covered 100%; no deductible	50%; after deductible
Autism related speech therapy	Covered 100%; no deductible	50%; after deductible
Autism related behavioral therapy These benefits are combined with outpatient mental health visits	\$45 copay; no deductible	50%; after deductible
Autism related applied behavior analysis Your benefits for these services are the same as any other outpatient mental health other services benefit	Covered 100%; no deductible	50%; after deductible
OTHER SERVICES	IN-NETWORK	OUT-OF-NETWORK
Skilled nursing facility Limited to 60 days per year When you're admitted into a facility for the care you need, your cost sharing amount counts toward all covered benefits you receive.	10% after \$258 copay; after deductible	50% after \$350 per visit deductible; after plan deductible
Home health care Home health care services include private duty nursing Limited to three visits per day by staff from a home health care agency. One visit equals a period of four hours or less.	10%; after deductible	50%; after deductible
Hospice care - inpatient When you're admitted into a facility for the care you need, your cost sharing amount counts toward all covered benefits you receive.	10% after \$258 copay; after deductible	50% after \$350 per visit deductible; after plan deductible
Hospice care - outpatient When you receive outpatient care at a facility but don't stay overnight, your cost sharing amount counts toward all covered benefits during your visit.	10%; after deductible	50%; after deductible
Private duty nursing We count each period of up to 8 hours as one private duty nursing shift.	Covered as part of home health care	Covered as part of home health care



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Durable medical equipment	10%; after deductible	50%; after deductible
Prosthetics	10%; after deductible	50%; after deductible
Orthotics	10%; after deductible	50%; after deductible
Diabetic supplies -- (if not covered under the prescription drug benefit)	Covered same as any other medical expense. You pay your prescription drug cost sharing amount if you have prescription drug coverage. If not, you pay your PCP visit cost sharing amount.	Covered same as any other medical expense. You pay your prescription drug cost sharing amount if you have prescription drug coverage. If not, you pay your PCP visit cost sharing amount.
Infusion therapy - home/office	\$45 copay; no deductible	50%; after deductible
Infusion therapy - outpatient hospital/freestanding facility	Your cost sharing amount depends on the type of service and where you receive it.	Your cost sharing amount depends on the type of service and where you receive it.
Hearing aids 1 hearing aid for each impaired ear per 36 month period to age 18	10%; after deductible	50%; after deductible
Transplants	10% after \$258 copay; after deductible In-network coverage is only available at Institutes of Excellence (IOE) contracted facility.	50% after \$350 per visit deductible; after plan deductible Out-of-network coverage applies when you use a non-IOE facility. You will pay more out of pocket when using a non-IOE facility.
Bariatric surgery	Not Covered	Not Covered
Acupuncture Limited to 10 visits per year	\$20 copay; no deductible	50%; after deductible
FAMILY PLANNING	IN-NETWORK DESIGNATED PROVIDERS	OUT-OF-NETWORK
Infertility treatment	Your cost sharing amount depends on the type of service and where you receive it. You have coverage for the diagnosis and treatment of the underlying cause of infertility.	Your cost sharing amount depends on the type of service and where you receive it.
Comprehensive infertility services	10%; after deductible Coverage includes artificial insemination and ovulation. Lifetime maximum applies to all procedures covered by any of our plans except where prohibited by law.	50%; after deductible
Advanced Reproductive Technology (ART)	10%; after deductible	50%; after deductible
Limited to 4 courses of treatment per member's lifetime, if live birth 2 additional retrievals covered. Covers cryopreservation for only iatrogenic Infertility. Maximum applies to all procedures covered by any of our plans except where prohibited by law. ART coverage includes Invitro fertilization (IVF), zygote intrafallopian transfer (ZIFT), gamete intrafallopian transfer (GIFT), cryopreserved embryo transfers, intracytoplasmic sperm injection (ICSI) or ovum microsurgery, and cryopreservation, unlimited storage.		
Vasectomy	Covered 100%; no deductible	50%; after deductible
Tubal ligation	Covered 100%; no deductible	50%; after deductible



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PHARMACY	IN-NETWORK	OUT-OF-NETWORK
Pharmacy plan type	Advanced Control Plan - Aetna	
Prescription Drug Deductible (per calendar year)	\$100 per Individual	\$100 per Individual
Covered prescription drug expenses add up toward both your in-network and out-of-network prescription drug deductible at the same time.		
You must first meet the prescription drug deductible before the plan begins paying prescription drug benefits, unless otherwise noted.		
Once you meet the family prescription drug deductible, then all family members have met it for the rest of the year. There is no individual prescription drug deductible for members of a family.		
Prescription drug out-of-pocket limit	Prescription drug expenses apply to your medical out-of-pocket limit.	
Covered prescription drug expenses add up toward both your in-network and out-of-network prescription drug out-of-pocket limit at the same time.		
Preferred generic drugs		
	Retail 20%	40% of submitted cost; after applicable in-network cost share
	Mail order 20%	40% of submitted cost; after applicable in-network cost share
Preferred brand-name drugs		
	Retail 20%	40% of submitted cost; after applicable in-network cost share
	Mail order 20%	40% of submitted cost; after applicable in-network cost share
Non-preferred generic and brand-name drugs		
	Retail 20%	40% of submitted cost; after applicable in-network cost share
	Mail order 20%	40% of submitted cost; after applicable in-network cost share
Pharmacy day supply and requirements		
	Retail	You can get up to a 30-day supply from Aetna National Network Percentage copays will not be doubled
	Mail order	You can get a 31-90-day supply from CVS Caremark® Mail Service Pharmacy.
	Specialty	You can get up to a 30-day supply of specialty drugs Advanced Control Formulary Aetna Insured List
Your prescription drug plan also includes:		
<ul style="list-style-type: none">• Diabetic supplies• Insulin up to a \$100 member payment maximum per fill per 30-day supply; no deductible for insulin drugs• Sexual dysfunction drugs, including daily dose, additional 6 tablets a month for erectile dysfunction• A limited list of over-the-counter medications when filled with a prescription		
Family planning		
<ul style="list-style-type: none">• Oral and injectable fertility drugs included (physician charges for injections are not covered under RX, medical coverage is limited).• Contraceptives covered up to a 12-month supply. Contraceptive copay strategy applies.		
The following are covered 100% in-network:		
<ul style="list-style-type: none">• Oral chemotherapy drugs• Seasonal vaccinations• Preventive vaccinations• Affordable Care Act (ACA) eligible preventive medications and contraceptives		
Refer to Aetna.com for a complete list of eligible prescription drugs.		



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Precertification requirements

Some covered prescription drugs need approval from us before we will cover the drug.

Some covered prescription drugs require step therapy before we cover them. With step therapy, you must first try one or more drugs before we will pay for drugs that require step therapy.

To get the most up-to-date precertification requirements and a list of drugs that require step therapy, see your plan documents or go online to your member website.

Choose generics - Sometimes you or your provider may ask for a brand-name prescription drug when a generic is available. If so, you will pay the brand-name copay plus the difference between the generic price and the brand-name price.

GENERAL PROVISIONS

Dependents who are eligible to be on your plan

Spouse, children from birth to age 26. Student status of children does not matter.

****We cover the cost of services based on whether doctors are "in network" or "out of network." We want to help you understand how much we pay for your out-of-network care. At the same time, we want to make it clear how much more you will need to pay for this "out-of-network" care.**

You may choose a provider (doctor or hospital) in our network. You may choose to visit an out-of-network provider. If you choose a doctor who is out of network, your health plan may pay some of that doctor's bill. Most of the time, you will pay a lot more money out of your own pocket if you choose to use an out-of-network doctor or hospital.

When you choose out-of-network care, we limit the amount it will pay. This limit is called the "recognized" or "allowed" amount.

- For doctors and other professionals the amount is based on what Medicare pays for these services. The government sets the Medicare rate. Exactly how much we "recognize" depends on the plan you or your employer picks.

- For hospitals and other facilities, the amount is based on what Medicare pays for these services. The government sets the Medicare rate. Exactly how much we "recognize" depends on the plan you or your employer picks.

Your doctor sets his or her own rate to charge you. It may be higher -- sometimes much higher -- than what your plan "recognizes." Your doctor may bill you for the dollar amount that we don't "recognize." You must also pay any copayments, coinsurance and deductibles under your plan. No dollar amount above the "recognized charge" counts toward your deductible or out-of-pocket maximums. To learn more about how we pay out-of-network benefits visit our website.

You can avoid these extra costs by getting your care from Aetna's broad network of health care providers. Go to www.aetna.com and click on "Find a Doctor" on the left side of the page. If you are already a member, sign on to your Navigator member site.

This applies when you choose to get care out of network. When you have no choice (for example: emergency room visit after a car accident, or for other emergency services), we will pay the bill as if you got care in network. You pay cost sharing and deductibles for your in-network level of benefits. Contact us if your provider asks you to pay more. You are not responsible for any outstanding balance billed by your providers for emergency services beyond your cost sharing and deductibles.

This way of paying out-of-network doctors and hospitals applies when you choose to get care out of network. When you have no choice (for example: emergency room visit after a car accident), we will pay the bill as if you got care in-network. You pay your plan's copayments and deductibles for your in-network level of benefits. Contact us if your provider asks you to pay more. You are not responsible for any outstanding balance billed by your providers for emergency services beyond your copayments and deductibles.

Plans are provided by: Aetna Health Inc. While this material is believed to be accurate as of the production date, it is subject to change.



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Health benefits and health insurance plans contain exclusions and limitations. Not all health services are covered.

See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by location and are subject to change. Providers are independent contractors and are not our agents. Provider participation may change without notice. We do not provide care or guarantee access to health services.

If you are in a plan that requires the selection of a primary care physician and your primary care physician is part of an integrated delivery system or physician group, your primary care physician will generally refer you to specialists and hospitals that are affiliated with the delivery system or physician group.

The following is a list of services and supplies that are *generally* not covered. However, your plan documents may contain exceptions to this list based on state mandates or the plan design or rider(s) purchased by your employer.

- All medical and hospital services not specifically covered in, or which are limited or excluded by your plan documents.
- Cosmetic surgery, including breast reduction.
- Custodial care.
- Dental care and dental X-rays.
- Donor egg retrieval
- Experimental and investigational procedures, except for coverage for medically necessary routine patient care costs for members participating in a cancer clinical trial.
- Hearing aids
- Home births
- Immunizations for travel or work, except where medically necessary or indicated.
- Implantable drugs and certain injectable drugs including injectable infertility drugs.
- Infertility services, including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI and other related services, unless specifically listed as covered in your plan documents.
- Long-term rehabilitation therapy.
- Non-medically necessary services or supplies.
- Outpatient prescription drugs (except for treatment of diabetes), unless covered by a prescription plan rider and over-the-counter medications (except as provided in a hospital) and supplies.
- Radial keratotomy or related procedures.
- Reversal of sterilization.
- Services for the treatment of sexual dysfunction/enhancement, including therapy, supplies or counseling or prescription drugs.
- Special duty nursing.
- Therapy or rehabilitation other than those listed as covered.
- Weight control services including surgical procedures, medical treatments, weight control/loss programs, dietary regimens and supplements, appetite suppressants and other medications; food or food supplements, exercise programs, exercise or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity, including Morbid Obesity, or for the purpose of weight reduction, regardless of the existence of comorbid conditions.

In case of emergency, call 911 or your local emergency hotline, or go directly to an emergency care facility.

Translation of this material into another language may be available. Please call Member Services at the number on the back of your ID card.

Puede estar disponible la traducción de este material en otro idioma. Por favor llame a Servicios al Miembro al **1-888-982-3862**.



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Plan features and availability may vary by location and group size.

For more information about Aetna plans, refer to www.aetna.com.

Aetna and MinuteClinic, LLC (which either operates or provides certain management support services to MinuteClinic-branded walk-in clinics) are both within the CVS Health family.

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PLAN FEATURES	IN-NETWORK	OUT-OF-NETWORK
Benefit limitations - Some service or supplies have limits on them per year. There might be a maximum number of visits or days, or a dollar limit per year. In such cases, the benefit year begins on January 1 (unless otherwise noted). Refer to your plan documents to learn more.		
Deductible (per calendar year)	\$2,250 per Individual \$6,750 per Family	\$8,150 per Individual \$24,450 per Family
Covered expenses in-network add up towards your in-network deductible. Covered expenses out-of-network add up towards your out-of-network deductible. You must first meet the deductible before the plan begins paying benefits, unless otherwise noted. The amount you pay (cost sharing) for some medical services does not count toward your deductible. Prescription drug costs do not count toward the deductible. Refer to your plan documents for details. Your family will have one deductible. You will meet it when the expenses of several family members add up to the family deductible. No one person will have to pay more than the individual deductible.		
Member coinsurance	You pay 20%	You pay 40%
Applies to all expenses except as noted.		
Out-of-pocket limit (per calendar year)	\$8,150 per Individual \$16,300 per Family	\$16,500 per Individual \$33,000 per Family
Covered expenses in-network add up towards your in-network out-of-pocket limit. Covered expenses out-of-network add up towards your out-of-network out-of-pocket limit. Some of your cost sharing may not count toward the out-of-pocket limit. Your pharmacy expenses count toward your out-of-pocket limit. In-network expenses include coinsurance/copays and deductibles. Out-of-network expenses include coinsurance and deductibles. Penalty amounts do not apply. Your family will have one out-of-pocket limit. You will meet it when the expenses of several family members add up to the family out-of-pocket limit. No one person will have to pay more than the individual out-of-pocket limit amount.		
Lifetime maximum	Unlimited except where otherwise indicated.	
Payment for out-of-network care**	Does not apply	Professional: 105% of Medicare Facility: 140% of Medicare
Primary care physician selection	Encouraged	Does not apply
Precertification requirements - Some out-of-network services need approval by us in advance (precertification). Without this approval, we reduce benefits by \$400. Refer to your plan documents for a full list of services that need this approval.		
Referral requirement	Not required	None
PREVENTIVE CARE	IN-NETWORK	OUT-OF-NETWORK
Routine adult physical exams/immunizations	Covered 100%; no deductible	40%; after deductible
1 exam every 12 months until age 65, then 1 exam every 12 months age 65 and older		
Routine well child exams/immunizations	Covered 100%; no deductible	40%; after deductible
• 7 exams in the first 12 months • 3 exams from age 13 through 24 months • 3 exams from age 25 through 36 months • 1 exam every 12 months from age 3 until age 22 years		
Childhood immunizations	Covered 100%; no deductible	Covered 100%; no deductible
HPV Immunizations covered to age 27.		
Routine gynecological care exams	Covered 100%; no deductible	40%; after deductible
1 exam and pap smear per year, includes related fees.		
Routine mammogram	Covered 100%; no deductible	40%; after deductible
Recommended: One per year for members age 40 and over		



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Women's health	Covered 100%; no deductible	40%; after deductible
Includes: Screening for gestational diabetes, HPV (Human- Papillomavirus) DNA testing, counseling for sexually transmitted infections, counseling and screening for human immunodeficiency virus, screening and counseling for interpersonal and domestic violence, breastfeeding support, supplies and counseling. Also includes: contraceptive methods (ACA mandated contraceptives, including contraceptives and devices you can't get at a pharmacy), sterilization procedures (including tubal ligation), patient education and counseling. Limits may apply.		
Pre-natal maternity	Covered 100%; no deductible	40%; after deductible
Routine digital rectal exam	Covered 100%; no deductible	40%; after deductible
Recommended: For members age 40 and over		
Prostate-specific antigen test	Covered 100%; no deductible	40%; after deductible
Recommended: For members age 40 and over		
Colorectal cancer screening	Covered 100%; no deductible	40%; after deductible
Recommended: For members age 45 and over Includes screening exam, sigmoidoscopy, and/or fecal occult blood test for a person age 30 and over every 3 years.		
Routine eye exams	Covered 100%; no deductible	40%; after deductible
1 routine exam per 24 months.		
Routine hearing screening	Covered 100%; no deductible	40%; after deductible
PHYSICIAN SERVICES	IN-NETWORK	OUT-OF-NETWORK
Office visits to primary care physician (PCP)	\$20 office visit copay; no deductible	40%; after deductible
Includes services of an internist, general physician, family practitioner or pediatrician.		
Specialist office visits	\$40 office visit copay; no deductible	40%; after deductible
Hearing exams	Not Covered	Not Covered
Walk-in clinics	\$20 copay; no deductible	40%; after deductible
Designated Walk-in clinics Covered 100%; no deductible		
Walk-in clinics are free-standing health care facilities. Sometimes they may be within a pharmacy, drug store, supermarket, or other retail store. They offer some limited medical care and services. Not walk-in clinics: Urgent care centers, emergency rooms, the outpatient department of a hospital, ambulatory surgical centers, and physician offices.		
Allergy testing	Your cost sharing amount depends on the type of service and where you receive it.	Your cost sharing amount depends on the type of service and where you receive it.
Allergy injections	Your cost sharing amount depends on the type of service and where you receive it.	Your cost sharing amount depends on the type of service and where you receive it.
DIAGNOSTIC PROCEDURES	IN-NETWORK	OUT-OF-NETWORK
Diagnostic X-ray (Other than complex imaging services)	20%; after deductible	40%; after deductible
When your physician performs and bills for this service at their office, you pay your office visit cost share amount.		
Diagnostic laboratory	20%; after deductible	40%; after deductible
When your physician performs and bills for this service at their office, you pay your office visit cost share amount.		
Diagnostic complex imaging	20%; after deductible	40%; after deductible
When your physician performs and bills for this service at their office, you pay your office visit cost share amount.		
EMERGENCY MEDICAL CARE	IN-NETWORK	OUT-OF-NETWORK
Urgent care provider	\$50 office visit copay; no deductible	40%; after deductible
Non-urgent use of urgent care provider	50%; after deductible	50%; after deductible
Emergency room	20% after \$500 copay; no deductible	Same as in-network care
Copay waived if admitted		



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Non-emergency care in an emergency room	Not Covered	Not Covered
Emergency use of ambulance	20% after \$500 copay; no deductible	Same as in-network care
Non-emergency use of ambulance	Not Covered	Not Covered
HOSPITAL CARE	IN-NETWORK	OUT-OF-NETWORK
Inpatient coverage	20%; after deductible	40%; after deductible
When you're admitted into a hospital for the care you need, your cost sharing amount counts toward all covered benefits you receive.		
Inpatient maternity coverage (includes delivery and postpartum care)	20%; after deductible	40%; after deductible
When you're admitted into a hospital for the care you need, your cost sharing amount counts toward all covered benefits you receive.		
Outpatient hospital	20%; after deductible	40%; after deductible
When you receive outpatient care at a hospital but don't stay overnight, your cost sharing amount counts toward all covered benefits during your visit.		
Outpatient surgery - hospital	20%; after deductible	40%; after deductible
When you receive outpatient care at a hospital but don't stay overnight, your cost sharing amount counts toward all covered benefits during your visit.		
Outpatient surgery - freestanding facility	20%; after deductible	40%; after deductible
When you receive outpatient care at a hospital but don't stay overnight, your cost sharing amount counts toward all covered benefits during your visit.		
MENTAL HEALTH SERVICES	IN-NETWORK	OUT-OF-NETWORK
Inpatient	20%; after deductible	40%; after deductible
When you're admitted into a hospital for the care you need, your cost sharing amount counts toward all covered benefits you receive.		
Mental health office visits	\$40 copay; no deductible	40%; after deductible
Other mental health services	Covered 100%; no deductible	40%; after deductible
When you receive outpatient care at a facility but don't stay overnight, your cost sharing amount counts toward all covered benefits during your visit.		
SUBSTANCE ABUSE	IN-NETWORK	OUT-OF-NETWORK
Inpatient	20%; after deductible	40%; after deductible
When you're admitted into a hospital for the care you need, your cost sharing amount counts toward all covered benefits you receive.		
Residential treatment facility	20%; after deductible	40%; after deductible
When you're admitted into a facility for the care you need, your cost sharing amount counts toward all covered benefits you receive.		
Substance abuse office visits	\$40 copay; no deductible	40%; after deductible
Other substance abuse services	Covered 100%; no deductible	40%; after deductible
When you receive outpatient care at a facility but don't stay overnight, your cost sharing amount counts toward all covered benefits during your visit.		
THERAPY SERVICES	IN-NETWORK	OUT-OF-NETWORK
Spinal manipulation therapy	\$40 copay; no deductible	40%; after deductible
Limited to 25 visits per year		



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Outpatient short-term rehabilitation Limited to 60 visits per year Includes physical, occupational, and speech therapies.	\$40 copay; no deductible	40%; after deductible
Habilitative physical therapy	Covered 100%; no deductible	40%; after deductible
Habilitative occupational therapy	Covered 100%; no deductible	40%; after deductible
Habilitative speech therapy	Covered 100%; no deductible	40%; after deductible
Autism related physical therapy	Covered 100%; no deductible	40%; after deductible
Autism related occupational therapy	Covered 100%; no deductible	40%; after deductible
Autism related speech therapy	Covered 100%; no deductible	40%; after deductible
Autism related behavioral therapy These benefits are combined with outpatient mental health visits	\$40 copay; no deductible	40%; after deductible
Autism related applied behavior analysis Your benefits for these services are the same as any other outpatient mental health other services benefit	Covered 100%; no deductible	40%; after deductible
OTHER SERVICES	IN-NETWORK	OUT-OF-NETWORK
Skilled nursing facility Limited to 60 days per year When you're admitted into a facility for the care you need, your cost sharing amount counts toward all covered benefits you receive.	20%; after deductible	40%; after deductible
Home health care Home health care services include private duty nursing Limited to three visits per day by staff from a home health care agency. One visit equals a period of four hours or less.	20%; after deductible	40%; after deductible
Hospice care - inpatient When you're admitted into a facility for the care you need, your cost sharing amount counts toward all covered benefits you receive.	20%; after deductible	40%; after deductible
Hospice care - outpatient When you receive outpatient care at a facility but don't stay overnight, your cost sharing amount counts toward all covered benefits during your visit.	20%; after deductible	40%; after deductible
Private duty nursing We count each period of up to 8 hours as one private duty nursing shift.	Covered as part of home health care	Covered as part of home health care
Durable medical equipment	20%; after deductible	40%; after deductible
Prosthetics	20%; after deductible	40%; after deductible
Orthotics	20%; after deductible	40%; after deductible
Diabetic supplies -- (if not covered under the prescription drug benefit)	Covered same as any other medical expense. You pay your prescription drug cost sharing amount if you have prescription drug coverage. If not, you pay your PCP visit cost sharing amount.	Covered same as any other medical expense. You pay your prescription drug cost sharing amount if you have prescription drug coverage. If not, you pay your PCP visit cost sharing amount.
Infusion therapy - home/office	\$40 copay; no deductible	40%; after deductible
Infusion therapy - outpatient hospital/freestanding facility	Your cost sharing amount depends on the type of service and where you receive it.	Your cost sharing amount depends on the type of service and where you receive it.
Hearing aids 1 hearing aid for each impaired ear per 36 month period to age 18	20%; after deductible	40%; after deductible



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Transplants	20%; after deductible In-network coverage is only available at Institutes of Excellence (IOE) contracted facility.	40%; after deductible Out-of-network coverage applies when you use a non-IOE facility. You will pay more out of pocket when using a non-IOE facility.
Bariatric surgery	Not Covered	Not Covered
Acupuncture Limited to 10 visits per year	\$20 copay; no deductible	40%; after deductible
FAMILY PLANNING	IN-NETWORK	OUT-OF-NETWORK
Infertility treatment	Your cost sharing amount depends on the type of service and where you receive it.	Your cost sharing amount depends on the type of service and where you receive it.
You have coverage for the diagnosis and treatment of the underlying cause of infertility.		
Comprehensive infertility services	20%; after deductible	40%; after deductible
Coverage includes artificial insemination and ovulation. Lifetime maximum applies to all procedures covered by any of our plans except where prohibited by law.		
Advanced Reproductive Technology (ART)	20%; after deductible	40%; after deductible
Limited to 4 courses of treatment per member's lifetime, if live birth 2 additional retrievals covered. Covers cryopreservation for only iatrogenic Infertility. Maximum applies to all procedures covered by any of our plans except where prohibited by law.		
ART coverage includes Invitro fertilization (IVF), zygote intrafallopian transfer (ZIFT), gamete intrafallopian transfer (GIFT), cryopreserved embryo transfers, intracytoplasmic sperm injection (ICSI) or ovum microsurgery, and cryopreservation, unlimited storage.		
Vasectomy	Covered 100%; no deductible	40%; after deductible
Tubal ligation	Covered 100%; no deductible	40%; after deductible



Silver Plan

LABOR BENEFITS ASSOCIATION

Effective Date: 01-01-2024

Open Access® Managed Choice® POS - Illinois

**PLAN DESIGN & BENEFITS
MEDICAL PLAN PROVIDED BY AETNA LIFE INSURANCE COMPANY**

PHARMACY		IN-NETWORK	OUT-OF-NETWORK
Pharmacy plan type		Advanced Control Plan - Aetna	
Prescription Drug Deductible (per calendar year)		\$100 per Individual	\$100 per Individual
Covered prescription drug expenses add up toward both your in-network and out-of-network prescription drug deductible at the same time.			
You must first meet the prescription drug deductible before the plan begins paying prescription drug benefits, unless otherwise noted.			
Once you meet the family prescription drug deductible, then all family members have met it for the rest of the year. There is no individual prescription drug deductible for members of a family.			
Prescription drug out-of-pocket limit		Prescription drug expenses apply to your medical out-of-pocket limit.	
Covered prescription drug expenses add up toward both your in-network and out-of-network prescription drug out-of-pocket limit at the same time.			
Preferred generic drugs			
	Retail	\$10 copay	40% of submitted cost; after applicable in-network cost share
	Mail order	\$20 copay	40% of submitted cost; after Nonapplicable in-network cost share
Preferred brand-name drugs			
	Retail	\$20 copay	40% of submitted cost; after applicable in-network cost share
	Mail order	\$40 copay	40% of submitted cost; after applicable in-network cost share
Non-preferred generic and brand-name drugs			
	Retail	50%	40% of submitted cost; after applicable in-network cost share
	Mail order	50%	40% of submitted cost; after applicable in-network cost share
Specialty drugs			
	Preferred specialty	35%	Not Covered
	Non-preferred specialty	35%	Not Covered
Pharmacy day supply and requirements			
	Retail	You can get up to a 30-day supply from Aetna National Network Percentage copays will not be doubled	
	Mail order	You can get a 31-90-day supply from CVS Caremark® Mail Service Pharmacy.	
	Specialty	You can get up to a 30-day supply of specialty drugs Advanced Control Formulary Aetna Insured List	



Silver Plan

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PLAN DESIGN & BENEFITS
MEDICAL PLAN PROVIDED BY AETNA LIFE INSURANCE COMPANY

Your prescription drug plan also includes:

- Diabetic supplies
- Insulin up to a \$100 member payment maximum per fill per 30-day supply; no deductible for insulin drugs
- Sexual dysfunction drugs, including daily dose, additional 6 tablets a month for erectile dysfunction
- A limited list of over-the-counter medications when filled with a prescription

Family planning

- Oral and injectable fertility drugs included (physician charges for injections are not covered under RX, medical coverage is limited).
- Contraceptives covered up to a 12-month supply. Contraceptive copay strategy applies.

The following are covered 100% in-network:

- Oral chemotherapy drugs
- Seasonal vaccinations
- Preventive vaccinations
- Affordable Care Act (ACA) eligible preventive medications and contraceptives

Refer to [Aetna.com](https://www.aetna.com) for a complete list of eligible prescription drugs.

Precertification requirements

Some covered prescription drugs need approval from us before we will cover the drug.

Some covered prescription drugs require step therapy before we cover them. With step therapy, you must first try one or more drugs before we will pay for drugs that require step therapy.

To get the most up-to-date precertification requirements and a list of drugs that require step therapy, see your plan documents or go online to your member website.

Choose generics - Sometimes you or your provider may ask for a brand-name prescription drug when a generic is available. If so, you will pay the brand-name copay plus the difference between the generic price and the brand-name price.

GENERAL PROVISIONS

Dependents who are eligible to be on your plan

Spouse, children from birth to age 26. Student status of children does not matter.

**We cover the cost of services based on whether doctors are "in network" or "out of network." We want to help you understand how much we pay for your out-of-network care. At the same time, we want to make it clear how much more you will need to pay for this "out-of-network" care.

You may choose a provider (doctor or hospital) in our network. You may choose to visit an out-of-network provider. If you choose a doctor who is out of network, your health plan may pay some of that doctor's bill. Most of the time, you will pay a lot more money out of your own pocket if you choose to use an out-of-network doctor or hospital.

When you choose out-of-network care, we limit the amount it will pay. This limit is called the "recognized" or "allowed" amount.

- For doctors and other professionals the amount is based on what Medicare pays for these services. The government sets the Medicare rate. Exactly how much we "recognize" depends on the plan you or your employer picks.

- For hospitals and other facilities, the amount is based on what Medicare pays for these services. The government sets the Medicare rate. Exactly how much we "recognize" depends on the plan you or your employer picks.



Silver Plan

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Effective Date: 01-01-2024

Open Access® Managed Choice® POS - Illinois

PLAN DESIGN & BENEFITS
MEDICAL PLAN PROVIDED BY AETNA LIFE INSURANCE COMPANY

Your doctor sets his or her own rate to charge you. It may be higher -- sometimes much higher -- than what your plan "recognizes." Your doctor may bill you for the dollar amount that we don't "recognize." You must also pay any copayments, coinsurance and deductibles under your plan. No dollar amount above the "recognized charge" counts toward your deductible or out-of-pocket maximums. To learn more about how we pay out-of-network benefits visit our website.

You can avoid these extra costs by getting your care from Aetna's broad network of health care providers. Go to www.aetna.com and click on "Find a Doctor" on the left side of the page. If you are already a member, sign on to your Navigator member site.

This applies when you choose to get care out of network. When you have no choice (for example: emergency room visit after a car accident, or for other emergency services), we will pay the bill as if you got care in network. You pay cost sharing and deductibles for your in-network level of benefits. Contact us if your provider asks you to pay more. You are not responsible for any outstanding balance billed by your providers for emergency services beyond your cost sharing and deductibles.

This way of paying out-of-network doctors and hospitals applies when you choose to get care out of network. When you have no choice (for example: emergency room visit after a car accident), we will pay the bill as if you got care in-network. You pay your plan's copayments and deductibles for your in-network level of benefits. Contact us if your provider asks you to pay more. You are not responsible for any outstanding balance billed by your providers for emergency services beyond your copayments and deductibles.

Plans are provided by: Aetna Health Inc. While this material is believed to be accurate as of the production date, it is subject to change.

Health benefits and health insurance plans contain exclusions and limitations. Not all health services are covered.

See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by location and are subject to change. Providers are independent contractors and are not our agents. Provider participation may change without notice. We do not provide care or guarantee access to health services.

If you are in a plan that requires the selection of a primary care physician and your primary care physician is part of an integrated delivery system or physician group, your primary care physician will generally refer you to specialists and hospitals that are affiliated with the delivery system or physician group.



Silver Plan

LABOR BENEFITS ASSOCIATION

Effective Date: 01-01-2024

Open Access® Managed Choice® POS - Illinois

PLAN DESIGN & BENEFITS
MEDICAL PLAN PROVIDED BY AETNA LIFE INSURANCE COMPANY

The following is a list of services and supplies that are *generally* not covered. However, your plan documents may contain exceptions to this list based on state mandates or the plan design or rider(s) purchased by your employer.

- All medical and hospital services not specifically covered in, or which are limited or excluded by your plan documents.
- Cosmetic surgery, including breast reduction.
- Custodial care.
- Dental care and dental X-rays.
- Donor egg retrieval
- Experimental and investigational procedures, except for coverage for medically necessary routine patient care costs for members participating in a cancer clinical trial.
- Hearing aids
- Home births
- Immunizations for travel or work, except where medically necessary or indicated.
- Implantable drugs and certain injectable drugs including injectable infertility drugs.
- Infertility services, including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI and other related services, unless specifically listed as covered in your plan documents.
- Long-term rehabilitation therapy.
- Non-medically necessary services or supplies.
- Outpatient prescription drugs (except for treatment of diabetes), unless covered by a prescription plan rider and over-the-counter medications (except as provided in a hospital) and supplies.
- Radial keratotomy or related procedures.
- Reversal of sterilization.
- Services for the treatment of sexual dysfunction/enhancement, including therapy, supplies or counseling or prescription drugs.
- Special duty nursing.
- Therapy or rehabilitation other than those listed as covered.
- Weight control services including surgical procedures, medical treatments, weight control/loss programs, dietary regimens and supplements, appetite suppressants and other medications; food or food supplements, exercise programs, exercise or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity, including Morbid Obesity, or for the purpose of weight reduction, regardless of the existence of comorbid conditions.

In case of emergency, call 911 or your local emergency hotline, or go directly to an emergency care facility.

Translation of this material into another language may be available. Please call Member Services at the number on the back of your ID card.

Puede estar disponible la traducción de este material en otro idioma. Por favor llame a Servicios al Miembro al **1-888-982-3862**.

Plan features and availability may vary by location and group size.

For more information about Aetna plans, refer to www.aetna.com.

Aetna and MinuteClinic, LLC (which either operates or provides certain management support services to MinuteClinic-branded walk-in clinics) are both within the CVS Health family.

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LABORERS' AND RETIREMENT BOARD EMPLOYEES' ANNUITY AND BENEFIT FUND OF CHICAGO

ANNUITY ASSIGNMENT AUTHORIZATION FORM

PURPOSE:

The purpose of this Annuity Assignment Authorization Form ("Form") is to authorize the Laborers' and Retirement Board Employees' Annuity and Benefit Fund of Chicago ("LABF") to assign all or a portion of a monthly annuity payment for the purpose of paying health insurance premiums on behalf of annuitant payees who elect to enroll in plans offered by third-party health insurance providers listed below in Section 2 of this Form. The LABF requires this Form to comply with Section 11-223.2 of the Illinois Pension Code (40 ILCS 5/11-223.2).

INSTRUCTIONS:

- Carefully read and complete the entire Annuity Assignment Authorization Form.

- Return signed Form to:

For all Blue Cross Blue Shield of IL plans:

Mail: LABF of Chicago
321 North Clark Street, Suite 1300
Chicago, IL 60654-4739
Fax: 312-236-0574
Email: insurance@labfchicago.org

For all Aetna plans:

Mail: Doyle Rowe Ltd.
1301 West 22nd Street, Suite 101
Oak Brook, IL 60523
Fax: 630-379-0857
Email: info@doyle Rowe.com

- If you have any questions regarding enrollment in any of the third-party plans listed in Section 2, contact the appropriate provider or administrator.

SECTION 1 – LABF ANNUITANT PAYEE INFORMATION (Please PRINT)

FIRST NAME	MIDDLE INITIAL	LAST NAME	SUFFIX (e.g. Jr, Sr)
DATE OF BIRTH	LAST 4 DIGITS OF SSN or LABF OFFICE NUMBER	PHONE NUMBER (w/area code) ()	

SECTION 2 – LIST OF THIRD-PARTY HEALTH INSURANCE PROVIDERS & ASSOCIATED PLANS

- City of Chicago** (plans administered by Blue Cross Blue Shield of IL and available to City of Chicago retirees who retired before August 23, 1989 and their dependents/beneficiaries)
- Blue Cross Blue Shield of IL** (plans sponsored by the City of Chicago and available to City of Chicago retirees who retired on or after August 23, 1989 and their dependents/beneficiaries)
- Aetna** (plans sponsored by the Labor Benefits Association and available to City of Chicago retirees and their dependents/beneficiaries)
- Blue Cross Blue Shield of IL** (plans sponsored by the Chicago Board of Education and available to Chicago Board of Education retirees and their dependents/beneficiaries)
- Blue Cross Blue Shield of IL** (plans sponsored by Chicago pension funds and available to pension fund retirees and their dependents/beneficiaries)

NOTE: PLEASE BE ADVISED THAT THE LABF, AS A MATTER OF LAW, CANNOT AND DOES NOT ENDORSE ANY HEALTHCARE PLANS, INCLUDING THOSE DESCRIBED IN THIS SECTION 2.

SECTION 3 – TERMS AND CONDITIONS

- As an annuitant payee of the LABF, you may use this Form to authorize the LABF to deduct one or more health insurance premiums and remit payment(s) to one or more health insurance providers listed in Section 2 above.
- The LABF is solely performing an administrative function in compliance with Section 11-223.2 of the Illinois Pension Code [40 ILCS 5/11-223.2].
- The LABF will only deduct a premium based on direction the LABF receives from one or more of the health insurance providers listed in Section 2 above, with the understanding that this action may require revisions and adjustments. Any dispute regarding deduction amounts is solely between you and the health insurance provider you select. If the premium exceeds your net annuity payment, the LABF will not deduct any premium; in this case, you are responsible for direct payment to your health insurance provider.
- You release the LABF, its staff, its officers, its Board of Trustees, and any of its advisors of any liability arising from the deduction of health insurance premiums from your annuity for the purpose of making payments on your behalf to one or more health insurance providers you select.

SECTION 4 – ANNUITANT PAYEE AUTHORIZATION

I, the Annuitant Payee named above, hereby: (1) certify that I have read and understand the Terms and Conditions stated above, (2) certify that the information I have provided on this Form is true and accurate to the best of my knowledge, (3) authorize and request the LABF to make health insurance premium payments on my behalf, through a deduction from my annuity benefit, to one or more of the health insurance providers listed in Section 2 of this Form, (4) acknowledge that this authorization will remain in full force and effect until I expressly change or revoke it in writing, and (5) that changing or revoking this authorization does not release me from any current or future financial obligation to any health insurance provider I may select from those listed in Section 2 of this Form.

SIGNATURE OF ANNUITANT PAYEE _____ DATE _____

Participant Authorization for the Deduction of Healthcare Premiums

IMPORTANT LEGAL NOTICE

The Municipal Employees' Annuity and Benefit Fund of Chicago (the "Fund") is proceeding with allowing for a monthly healthcare insurance premium deduction (the "Deduction") from an annuitant's net monthly annuity benefit (the "Annuity") to the healthcare insurance plan provider ("Provider") stated below. The Deduction is pursuant to the statutory authority under Section 8-244(b) (1) of the Illinois Pension Code, with the understanding that this action might require revisions and adjustments. The Fund takes no position with respect to annuitant health care options and does not endorse or sponsor any particular healthcare insurance carrier or healthcare insurance coverage. In processing the Deduction, the Fund is solely performing an administrative function and is only responsible for the Deduction of premiums requested by your Provider. Any dispute regarding the Deduction amount is solely between the annuitant and the Provider.

A completed and signed form does not guarantee that the Fund will process the Deduction from the Annuity. The Provider must comply with all Fund requirements to process any Deduction from an Annuity. The annuitant is responsible for making premium payments to their Provider until the Fund receives and processes the completed and signed form. The Fund will continue to make the Deduction until written notification of cancellation is received. If an annuitant's Deduction exceeds his/her Annuity, the Fund cannot make any Deduction on their behalf.

WAIVER OF CLAIMS AND AUTHORIZATION

Pursuant to Section 8-244(b) (1) of the Illinois Pension Code, I hereby authorize and direct the Fund to make a Deduction for my monthly healthcare premium. I understand that the Deduction will be taken from my net monthly annuity benefit.

Member Name (First, Middle Initial and Last): _____

Last 4 digits of Social Security Number: _____

Persons Insured (if other than Member): _____ Last 4 digits SS#: _____

Persons Insured (if other than Member): _____ Last 4 digits SS#: _____

Persons Insured (if other than Member): _____ Last 4 digits SS#: _____

Persons Insured (if other than Member): _____ Last 4 digits SS#: _____

Phone Number: _____

Provider Information:

Provider Name: AETNA Plan Name: _____

As a condition of authorizing this Deduction, I accept all responsibility for truth and accuracy of all information I have provided. I hereby release the Fund, its staff, its officers, its Board of Trustees, and any of its advisors from any liability arising from the administration of the Deduction out of my Annuity. By signing this form, I agree that I will not make any legal claim of any kind against the Fund, its staff, officers, its Board of Trustees, and any of its advisors. Should my authorization result in any liability to me, including interest, penalties or tax, I understand that my ability to participate in this program is a valuable benefit for which I am willing to sign this Waiver of All Claims.

I have read and understand the information contained on this form and its instructions and agree to all the conditions for this authorization, including the Waiver of All Claims against the Fund, its staff, its officers, its Board of Trustees, and any of its advisors.

Annuitant Signature _____ Date _____

Spouse Signature (If Applicable) _____

**** THIS LINE MUST BE FULLY EXECUTED AND SIGNED ****



Illinois Employee Enrollment/Change Form

Aetna Life Insurance Company

Aetna Health Inc.

Aetna Health Insurance Company

INSTRUCTIONS: You must complete this enrollment form in full. If you do not, we will return it to you, and that can delay its processing. You alone are responsible for its accuracy and completeness. **If you are declining coverage, you must complete section C.** Please use only black ink to complete this form.

Aetna member ID number (if available)

Employer group information – To be completed by employer

Employer/company name – full name of business or organization

Labor Benefits Association

Employer address (street, city, state, ZIP code) – primary location of business or organization

A. Type of activity – Employee completes sections A – F. Please print clearly.

Effective date 01/01/2024	<input type="checkbox"/> New hire <input type="checkbox"/> Rehire/reinstatement <input type="checkbox"/> New group enrollment <input type="checkbox"/> Late enrollment <input type="checkbox"/> Waiver <input type="checkbox"/> Open enrollment <input type="checkbox"/> Loss of coverage	<input type="checkbox"/> Add spouse <input type="checkbox"/> Add domestic partner <input type="checkbox"/> Add civil union partner <input type="checkbox"/> Add dependent child <input type="checkbox"/> Change of coverage <input type="checkbox"/> Name change	<input type="checkbox"/> Employee termination date <input type="checkbox"/> Remove spouse <input type="checkbox"/> Remove domestic partner <input type="checkbox"/> Remove civil union partner <input type="checkbox"/> Remove dependent child <input type="checkbox"/> Cancel coverage <input type="checkbox"/> Other _____
Date of hire			

☐ COBRA ☐ State continuation for: ☐ Employee ☐ Dependent Length of continuation: ☐ 18 months ☐ 36 months ☐ Other _____
Qualifying event _____ Original qualifying event date _____ Loss of coverage date _____

B. Employee information – You must complete this section.

Social Security number	Last name, first name, middle initial		Job title	
Home address	Apt. number	City, state	ZIP code	
Work address		City, state	ZIP code	
Home/cell telephone () -	Work telephone () -	Number of hours worked a week	Employee email	
Primary language spoken (optional)	Check one: <input type="checkbox"/> Full time <input type="checkbox"/> 1099 <input type="checkbox"/> Seasonal <input type="checkbox"/> COBRA <input type="checkbox"/> Part time <input type="checkbox"/> Retiree <input type="checkbox"/> Temporary <input type="checkbox"/> Union			

C. Declining coverage – Check all that apply.

I understand I am eligible to apply for this coverage through my employer. However, I am declining the coverage I checked below:

<input type="checkbox"/> Employee: <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision	Reason for declining coverage <input type="checkbox"/> Parental group coverage <input type="checkbox"/> Spouse/domestic partner/ civil union partner group coverage <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> Retiree coverage <input type="checkbox"/> COBRA coverage	<input type="checkbox"/> Insurance through another job <input type="checkbox"/> TRICARE/Military coverage <input type="checkbox"/> Individual coverage – On Exchange <input type="checkbox"/> Individual coverage – Off Exchange <input type="checkbox"/> Another group plan provided by my employer <input type="checkbox"/> Do not want <input type="checkbox"/> Other _____
<input type="checkbox"/> Spouse/domestic partner/ civil union partner: <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision		
<input type="checkbox"/> Children: <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision		

I certify I have the right to apply for this coverage. However, I am declining coverage as noted above. By declining this group coverage, I acknowledge that I and/or my dependents may have to wait until the plan's next anniversary date to be enrolled for group coverage.

Please sign here ONLY if you are declining coverage for yourself and/or dependents. **Employee signature: X** Date (Month/Day/Year)

Please PRINT employee name:

D. Plan options – Check one plan. Your selection must be offered by your employer.

Control number	Suffix	Account	Plan number	Customer code
1. Medical <input type="checkbox"/> Yes <input type="checkbox"/> No To enroll, check "yes" and enter the plan option elected below. Please print clearly. Plan option _____ You may only select a plan offered by your employer.				
Aetna Life Insurance Company, Aetna Health Inc. and/or Aetna Health Insurance Company underwrite/administer medical coverage.				
Control number	Suffix	Account	Plan number	
2. Dental <input type="checkbox"/> Yes <input type="checkbox"/> No To enroll, check "yes" and enter the plan option elected below. Please print clearly. Plan option/name _____ If FOC, choose: <input type="checkbox"/> DMO® or <input type="checkbox"/> PPO/Indemnity You may only select a dental plan if your employer offers dental coverage. Before today, were you covered under this employer's dental plan? <input type="checkbox"/> Yes <input type="checkbox"/> No Employees in AZ, CA, GA, MA, MD, MO, NC, NJ and TX must either live or work within the approved DMO® service area to be eligible to enroll in the DMO®. For groups 51-100 only: Creditable coverage is allowed for new members enrolling in voluntary takeover groups. New hires please see below if applicable: New Hire selecting a Voluntary plan and your Aetna plan is a takeover group: Were you covered for 12 months under a dental plan within the last 90 days that included both Preventive and Basic coverage? Discount dental and preventive only plans do not apply. <input type="checkbox"/> Yes <input type="checkbox"/> No Aetna Life Insurance Company underwrites the Aetna dental plans.				
Control number	Suffix	Account	Plan number	
3. Aetna VisionSM Preferred <input type="checkbox"/> Yes <input type="checkbox"/> No To enroll, check "yes" and enter the plan option elected below. Please print clearly. Plan option/name _____ You may only select a vision plan if your employer offers vision coverage.				
Aetna Life Insurance Company underwrites Vision insurance plans. First American Administrators, Inc. provides certain claims administration services. EyeMed Vision Care, LLC ("EyeMed") provides certain network administration services.				

E. Individuals covered – List individuals for whom you are enrolling or adding, changing or removing coverage. Please complete all information for all individuals. Add more sheets if needed.

NOTE FOR MEDICAL COVERAGE: While the Affordable Care Act mandates coverage of dependent children up to age 26, your plan may allow coverage beyond age 26. For instance, in Illinois, dependent coverage may be elected and can be extended up to age 30 if that dependent: 1) has served in the active or reserve component of the U.S. Armed Forces; 2) has received a release or discharge (other than a dishonorable discharge) from the military; 3) is unmarried; 4) is an Illinois resident; and 5) submits proof of military service using an Illinois Department of Veterans' Affairs Certificate of Release or Discharge from Active Duty form in order to enroll or remain enrolled past the age of 26. The Illinois Supplemental Enrollment Form for Military Veteran Dependents must be completed. Please refer to your plan documents or contact your benefits administrator.

1	<input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Remove	Employee name (Last, first, middle initial)			Sex (M/F)
Birthdate (MM/DD/YYYY) / /		Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Legally separated		Choosing coverage for: <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision	
Primary care physician (PCP) provider ID number		Current patient <input type="checkbox"/> Yes	Dental provider office ID number		Current patient <input type="checkbox"/> Yes
2	<input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Remove	Name (Last, first, middle initial) <input type="checkbox"/> Spouse <input type="checkbox"/> Domestic partner <input type="checkbox"/> Civil union partner			Sex (M/F)
		Social Security number			
Birthdate (MM/DD/YYYY) / /		Choosing coverage for: <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision			
PCP provider ID number		Current patient <input type="checkbox"/> Yes	Dental provider office ID number		Current patient <input type="checkbox"/> Yes

Continued on next page

E. Individuals covered (Continued)

3	<input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Remove	Name (Last, first, middle initial)	<input type="checkbox"/> Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Other _____	Sex (M/F)	Social Security number
	Birthdate (MM/DD/YYYY) / /		Incapacitated <input type="checkbox"/> Yes <input type="checkbox"/> No	Choosing coverage for: <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision	
	PCP provider ID number		Current patient <input type="checkbox"/> Yes	Dental provider office ID number	Current patient <input type="checkbox"/> Yes
4	<input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Remove	Name (Last, first, middle initial)	<input type="checkbox"/> Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Other _____	Sex (M/F)	Social Security number
	Birthdate (MM/DD/YYYY) / /		Incapacitated <input type="checkbox"/> Yes <input type="checkbox"/> No	Choosing coverage for: <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision	
	PCP provider ID number		Current patient <input type="checkbox"/> Yes	Dental provider office ID number	Current patient <input type="checkbox"/> Yes
5	<input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Remove	Name (Last, first, middle initial)	<input type="checkbox"/> Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Other _____	Sex (M/F)	Social Security number
	Birthdate (MM/DD/YYYY) / /		Incapacitated <input type="checkbox"/> Yes <input type="checkbox"/> No	Choosing coverage for: <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision	
	PCP provider ID number		Current patient <input type="checkbox"/> Yes	Dental provider office ID number	Current patient <input type="checkbox"/> Yes
6	<input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Remove	Name (Last, first, middle initial)	<input type="checkbox"/> Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Other _____	Sex (M/F)	Social Security number
	Birthdate (MM/DD/YYYY) / /		Incapacitated <input type="checkbox"/> Yes <input type="checkbox"/> No	Choosing coverage for: <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision	
	PCP provider ID number		Current patient <input type="checkbox"/> Yes	Dental provider office ID number	Current patient <input type="checkbox"/> Yes

F. Dependent information

List any dependent in section E with a different last name or living at another address.	
Name	Address

G. Coordination of benefits

Will you have other health insurance at the same time as this coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes , will the Aetna coverage you're applying for replace the coverage you have now? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Name of person	Carrier name	Name of person	Carrier name

Conditions of enrollment

I acknowledge that by enrolling in an Aetna plan, coverage is underwritten or administered by Aetna Life Insurance Company, Aetna Health Inc. and/or Aetna Health insurance Company (referred to as "Aetna"). For Vision coverage, First American Administrators, Inc. provides certain claims administration services. EyeMed Vision Care, LLC ("EyeMed") provides certain network administration services.

1. My employer's application determines coverage. I don't have coverage until Aetna approves my employee enrollment form and the employer application. Even if Aetna approves the employer application, material misstatements or omissions may result in denial of future claims. Aetna may rescind or reevaluate my coverage under the policy, as of the effective date, for eligibility and rating purposes. If Aetna voids or rescinds coverage, I may be entitled to a refund of any paid premiums from the effective date of coverage. Aetna will give at least 30 days advance written notice to any covered person affected by the proposed rescission. If I elect to receive electronic notifications, I will receive this notice in an electronic (email) format.

Continued on next page

Conditions of enrollment (Continued)

2. To support the coverages listed on this enrollment form, Aetna may need information about medical history, services or treatment provided to anyone listed on this form. This may include minimally necessary information about mental health and substance use disorder. In accordance with HIPAA regulations, I authorize that the following entities can provide this information to Aetna or its agents:
- Physicians
 - Other healthcare professionals
 - Hospitals
 - Other healthcare organizations ("providers"), including
 - Pharmacies
 - Pharmacy database benefit managers
3. In accordance with HIPAA regulations, I authorize Aetna to use and disclose such minimally necessary information to:
- Affiliates
 - Providers
 - Other insurers
 - Third party administration
 - Vendors
 - Consultants
 - Governmental authorities with jurisdiction when necessary for:
 - Care or treatment
 - Payment for services
 - Operation of my health plan
 - Conduct related activities
4. I discussed the terms of this authorization with my competent adult dependents. This authorization is valid for 30 months from the signature date. This authorization is valid for the term of the coverage for medical information collected in connection with a medical claim. This authorization is voluntary. But if I don't sign this form, my ability to enroll in the plan may be affected. I have the right to revoke this authorization in writing to Aetna at any time. I can't revoke authorization for information already used or disclosed before I revoked my authorization. I am entitled to receive a copy of this authorization upon request. A photocopy is as valid as the original.
- The Group Agreement/Group Policy determines the rights and responsibilities of members and will govern in the event they conflict with any:
 - Benefits comparison
 - Summary
 - Other description of the plan
 - Participating physicians, hospitals and other health care providers are independent contractors. They are not Aetna agents or employees. We cannot guarantee the availability of any particular provider. Any provider network is subject to change. We will provide a notice of the change in accordance with applicable state law.
5. I understand that, with certain exceptions described in the plan documents, HMO and DMO® plans only provide coverage for covered benefits. The plan documents also describe if I need a referral for certain procedures, and who can provide care. Covered services must be performed by:
- Participating primary care physicians
 - Participating primary care dentists
 - Participating specialists
 - Participating hospitals
 - Participating pharmacies
 - Participating dentists
 - Other participating providers as authorized by a referral from a participating primary care physician
6. I authorize the substitution of generic pharmaceuticals for the brand-name products, as provided by law, for prescriptions filled under any pharmacy benefit.

I represent that all information supplied in this form is true and complete. I agree to the conditions of enrollment and misrepresentation on this Employee Enrollment Form. I understand that, if I don't sign this form within 31 days, or Aetna does not receive the request within a reasonable time, my eligibility may be affected.

I authorize deductions from my earnings for any contributions required for coverage and I agree to make any necessary payments required for coverage.

To receive documents online, please visit your secure member account at aetna.com.

Intentional misrepresentation: Any person who knowingly and with intent to defraud any insurance company or other person files an enrollment form for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact materials thereto commits a fraudulent insurance act.

Please sign here ONLY if you are enrolling in coverage for yourself and/or dependents.

Employee signature (required)

X

Date (Month/Day/Year)