Aetna MedPremier Major Medical

Benefit Overview of plan features for Full-time employees. Please see Plan Summary for detailed information about the benefits and exclusions and shall prevail over the terms of this benefit overview.

	Full-Time Benefits	
Monthly Hours	120+	
Medical Benefits	In-Network	Out-of-Network
Plan Coinsurance	90%	70%
Individual / Family Deductible	$1,000 / $2,000	$2,000 / $4,000
Individual / Family Coinsurance Limit	$3,000 / $6,000	$6,000 / $12,000
Lifetime Maximum	Unlimited	Unlimited
Doctor's Office Visit*		
▪ Non-Specialist	$25 copay	Plan pays 70%; after deductible
▪ Specialist	$45 copay	Plan pays 70%; after deductible
Inpatient Hospital	Plan pays 90%; after deductible	Plan pays 70%; after deductible
Outpatient Hospital	Plan pays 90%; after deductible	Plan pays 70%; after deductible
Emergency Room Benefit	Plan pays 90%	Same as In-Network
Pharmacy Benefit	Copay:	
▪ Prescription Drug	Generic: $20	Plan pays 70% of submitted cost; after applicable copay
	Brand: $40	
	Non-Formulary: $70	
	Speciality: $70	Not covered
Mail Order Pharmacy	2x copay	Not covered
Durable Medical Equipment	Plan pays 90%; after deductible	Plan pays 70%; after deductible
Ancillary Benefits		
Dental Benefit		
Annual Maximum per covered person	$1,250	
Annual Deductible per covered person	$25	
Preventive, Diagnostic and Routine Restorative Care	80% up to the Annual Maximum	
Major Restorative Care	50% up to the Annual Maximum	
Vision Benefits		
Vision Exam (every 12 months)	$85	
Single Lenses (every 24 months)	$95	
Contact Lenses (every 24 months)	$95	
Bi-Focal Lenses (every 24 months)	$120	
Frames (every 24 months)	$120	
Short Term Disability Benefits (EE Only)**		
Maximum Weekly Benefit+	$270	
Maximum Benefit Period *(number of weeks)*	26	
Benefits begin on 8th day (pays immediately if hospitalized)		
+ *The actual weekly benefit will be the amount selected or 60% of the employee's salary, whichever is less*		
Transamerica Life and AD&D (EE only)		
Life	$10,000	
Accidental Death and Dismemberment	$10,000	
Employee Assistance Program (EAP)	Included	
HealthiestYou Telehealth Services	Included	
Employer Hourly Fringe Contribution:	**$3.27**	
Additional Monthly for Dependents:		
Spouse	$564.46	
Child(ren)	$460.52	
Spouse & Child(ren)	$982.09	

Washington residents have a non-specialist office visit copay of $15 and a specialist office visit copay of $20

** *Short Term Disability coverage is not available if you work in California, Hawaii, New Jersey, New York, Rhode Island, and Puerto Rico.*

Plan Summary
Aetna MedPremier

for full-time employees working 120 hours or more per month

The Aetna MedPremier Plan for full-time employees is designed for employees who are regularly scheduled to work a minimum of 30 hours per week, or 120 hours per month.

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Act-1 Group
Proposed Effective Date: 01-01-2019
Open Choice PPO

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

PLAN FEATURES	IN-NETWORK	OUT-OF-NETWORK
Deductible (per year)	$1,000 Individual $2,000 Family	$2,000 Individual $4,000 Family
All covered expenses, accumulate separately toward the preferred or non-preferred Deductible. Unless otherwise indicated, the deductible must be met prior to benefits being payable. Member cost sharing for certain services, as indicated in the plan, are excluded from charges to meet the Deductible. Pharmacy expenses do not apply towards the Deductible. The family Deductible is a cumulative Deductible for all family members. The family Deductible can be met by a combination of family members; however, no single individual within the family will be subject to more than the individual Deductible amount.		
Member Coinsurance Applies to all expenses unless otherwise stated.	10%	30%
Payment Limit (per year)	$3,000 Individual $6,000 Family	$6,000 Individual $12,000 Family
All covered expenses accumulate separately toward the preferred or non-preferred Payment Limit. Certain member cost sharing elements may not apply toward the Payment Limit. Pharmacy expenses apply towards the Payment Limit. Only those out-of-pocket expenses resulting from the application of coinsurance percentage, copays, and deductibles (except any penalty amounts) may be used to satisfy the Payment Limit. The family Payment Limit is a cumulative Payment Limit for all family members. The family Payment Limit can be met by a combination of family members; however, no single individual within the family will be subject to more than the individual Payment Limit amount.		
Lifetime Maximum Unlimited except where otherwise indicated.		
Payment for Non-Preferred Care**	Not Applicable	Professional: Prevailing Charges Facility: Prevailing Charges
Primary Care Physician Selection	Not Applicable	Not Applicable
Certification Requirements - Certification for certain types of Non-Preferred care must be obtained to avoid a reduction in benefits paid for that care. Certification for Hospital Admissions, Treatment Facility Admissions, Convalescent Facility Admissions, Home Health Care, Hospice Care and Private Duty Nursing is required - excluded amount applied separately to each type of expense is $200 per occurrence, whichever is less.		
Referral Requirement	None	None
PREVENTIVE CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Routine Adult Physical Exams/ Immunizations 1 exam every 12 months for members age 22 to age 65; 1 exam every 12 months for adults age 65 and older.	Covered 100%; deductible waived	30%; after deductible
Routine Well Child Exams/Immunizations 7 exams in the first 12 months of life, 3 exams in the second 12 months of life, 3 exams in the third 12 months of life, 1 exam per year thereafter to age 22.	Covered 100%; deductible waived	30%; after deductible
Routine Gynecological Care Exams 1 obgyn exam and pap smear per calendar year	Covered 100%; deductible waived	30%; after deductible

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

Routine Mammograms	Covered 100%; deductible waived	30%; after deductible
Women's Health	Covered 100%; deductible waived	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. Contraceptive methods, sterilization procedures, patient education and counseling. Limitations may apply.		
Routine Digital Rectal Exam	Covered 100%; deductible waived	30%; after deductible
Recommended: For covered males age 40 and over.		
Prostate-specific Antigen Test	Covered 100%; deductible waived	30%; after deductible
Recommended: For covered males age 40 and over.		
Colorectal Cancer Screening	Covered 100%; deductible waived	Covered under Routine Adult Exams
Recommended: For all members age 50 and over.		
Routine Eye Exams	$45 office visit copay; deductible waived	30%; after deductible
1 routine exam per 12 months.		
Routine Hearing Screening	Covered 100%; deductible waived	30%; after deductible
PHYSICIAN SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Office Visits to non-Specialist	$25 office visit copay; deductible waived	30%; after deductible
Includes services of an internist, general physician, family practitioner or pediatrician.		
Specialist Office Visits	$45 office visit copay; deductible waived	30%; after deductible
Hearing Exams	Not Covered	Not Covered
Pre-Natal Maternity	Covered 100%; deductible waived	30%; after deductible
Walk-in Clinics	$25 office visit copay; deductible waived	30%; after deductible
Walk-in Clinics are network, free-standing health care facilities. They are an alternative to a physician's office visit for treatment of unscheduled, non-emergency illnesses and injuries and the administration of certain immunizations. It is not an alternative for emergency room services or the ongoing care provided by a physician. Neither an emergency room, nor the outpatient department of a hospital, shall be considered a Walk-in Clinic.		
Allergy Testing	Your cost sharing is based on the type of service and where it is performed	Your cost sharing is based on the type of service and where it is performed
Allergy Injections	Your cost sharing is based on the type of service and where it is performed	Your cost sharing is based on the type of service and where it is performed
DIAGNOSTIC PROCEDURES	**IN-NETWORK**	**OUT-OF-NETWORK**
Diagnostic X-ray	10%; after deductible	30%; after deductible
If performed as a part of a physician office visit and billed by the physician, expenses are covered subject to the applicable physician's office visit member cost sharing.		
Diagnostic Laboratory	10%; after deductible	30%; after deductible
If performed as a part of a physician office visit and billed by the physician, expenses are covered subject to the applicable physician's office visit member cost sharing.		
Diagnostic Complex Imaging	10%; after deductible	30%; after deductible
If performed as a part of a physician office visit and billed by the physician, expenses are covered subject to the applicable physician's office visit member cost sharing.		

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

EMERGENCY MEDICAL CARE	IN-NETWORK	OUT-OF-NETWORK
Urgent Care Provider	Covered 100%; deductible waived	30%; after deductible
Non-Urgent Use of Urgent Care Provider	50%; after deductible	50%; after deductible
Emergency Room	10%; deductible waived	Same as in-network care
Non-Emergency Care in an Emergency Room	50%; after deductible	50%; after deductible
Emergency Use of Ambulance	10% after $25 copay; after 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
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Inpatient Maternity Coverage (includes delivery and postpartum care)	10%; after deductible	30%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Outpatient Hospital Expenses	10%; after deductible	30%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Outpatient Surgery - Hospital	10%; after deductible	30%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Outpatient Surgery - Freestanding Facility	10%; after deductible	30%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
MENTAL HEALTH SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Mental Health Inpatient	10%; after deductible	30%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Mental Health Office Visits	$45 copay; deductible waived	30%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Other Mental Health Services	10%; after deductible	30%; after deductible
SUBSTANCE ABUSE	**IN-NETWORK**	**OUT-OF-NETWORK**
Substance Abuse Inpatient	10%; after deductible	30%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Residential Treatment Facility	10%; after deductible	30%; after deductible
Substance Abuse Office Visits	$45 copay; deductible waived	30%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Other Substance Abuse Services	10%; after deductible	30%; after deductible
OTHER SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Skilled Nursing Facility	10%; after deductible	30%; after deductible
Limited to 60 days per calendar year.		
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Home Health Care	$45 copay; after deductible	30%; after deductible
Limited to 120 visits per year.		
Each visit by a nurse or therapist is one visit. Each visit up to 4 hours by a home health care aide is one visit.		
Hospice Care - Inpatient	10%; after deductible	30%; after deductible
Limited to 30 days per lifetime.		
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		

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

Hospice Care - Outpatient	10%; after deductible	30%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Private Duty Nursing - Outpatient	Not Covered	Not Covered
Spinal Manipulation Therapy	$45 copay; deductible waived	30%; after deductible
Limited to 20 visits per calendar year.		
Outpatient Short-Term Rehabilitation	$45 copay; deductible waived	30%; after deductible
Includes speech, physical, occupational therapy		
Autism Behavioral Therapy	$45 copay; deductible waived	30%; after deductible
Covered same as any other Outpatient Mental Health benefit		
Autism Applied Behavior Analysis	10%; after deductible	30%; after deductible
Covered same as any other Outpatient Mental Health benefit		
Autism Physical Therapy	$45 copay; deductible waived	30%; after deductible
Cost sharing covered same as any other Short Term Rehabilitation expense. Unlimited visits.		
Autism Occupational Therapy	$45 copay; deductible waived	30%; after deductible
Cost sharing covered same as any other Short Term Rehabilitation expense. Unlimited visits.		
Autism Speech Therapy	$45 copay; deductible waived	30%; after deductible
Cost sharing covered same as any other Short Term Rehabilitation expense. Unlimited visits.		
Durable Medical Equipment	10%; after deductible	30%; after deductible
Orthotics	10%; after deductible	30%; after deductible
Orthotics and special footwear covered for persons with foot disfigurement.		
Diabetic Supplies -- (if not covered under Pharmacy benefit)	Covered same as any other medical expense.	Covered same as any other medical expense.
Affordable Care Act mandated Women's Contraceptives	Covered 100%; deductible waived	Covered same as any other expense.
Women's Contraceptive drugs and devices not obtainable at a pharmacy	Covered 100%; deductible waived	Covered same as any other expense.
Infusion Therapy Administered in the home or physician's office	10%; after deductible	30%; after deductible
Infusion Therapy Administered in an outpatient hospital department or freestanding facility	10%; after deductible	30%; after deductible
Vision Eyewear	Not Covered	Not Covered
Transplants	10%; after deductible Preferred coverage is provided at an IOE contracted facility only.	30%; after deductible Non-Preferred coverage is provided at a Non-IOE facility.
Bariatric Surgery	Not Covered	Not Covered
"Other" Health Care -- 20% member coinsurance, after deductible, for services that are neither in-network nor out-of-network.		
FAMILY PLANNING	**IN-NETWORK**	**OUT-OF-NETWORK**
Infertility Treatment	Your cost sharing is based on the type of service and where it is performed	Your cost sharing is based on the type of service and where it is performed
Diagnosis and treatment of the underlying medical condition only.		

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

Comprehensive Infertility Services	Not Covered	Not Covered
Advanced Reproductive Technology (ART)	Not Covered	Not Covered
Vasectomy	Your cost sharing is based on the type of service and where it is performed	30%; after deductible
Tubal Ligation	Covered 100%; deductible waived	30%; after deductible
PHARMACY	**IN-NETWORK**	**OUT-OF-NETWORK**
Pharmacy Plan Type	Aetna Value Plus Open Formulary	
Preferred Generic Drugs		
Retail	$20 copay	30% of submitted cost
Mail Order	$40 copay	Not Applicable
Preferred Brand-Name Drugs		
Retail	$40 copay	30% of submitted cost
Mail Order	$80 copay	Not Applicable
Non-Preferred Generic and Brand-Name Drugs		
Retail	$70 copay	30% of submitted cost
Mail Order	$140 copay	Not Applicable
Value Plus Specialty Drugs		
Preferred Specialty	$70 copay	Not Covered
Non-Preferred Specialty	$70 copay	Not Covered
Pharmacy Day Supply and Requirements		
Retail	Up to a 30 day supply from Caremark National Network	
Mail Order	A 31-90 day supply from Caremark Rx Home Delivery®.	
Value Plus Specialty	Up to a 30 day supply First prescription fill at any retail or specialty pharmacy. Subsequent fills must be through our preferred specialty pharmacy network.	

Choose Generics with Dispense as Written (DAW) override - the member pays the applicable copay. If the physician requires brand, member would pay brand name copay. If the member requests brand-name when a generic is available, the member pays the applicable copay plus the difference between the generic price and the brand-name price.

Plan Includes: Diabetic supplies and Contraceptive drugs and devices obtainable from a pharmacy.
Contraceptives covered up to a 12 month supply.
Performance Enhancing Drugs limited to 4 tablets per month.
Oral fertility drugs included.
A limited list of over-the-counter medications are covered when filled with a prescription.
Oral chemotherapy drugs covered 100%
Value Plus Pre-certification included
Value Plus Step Therapy included
Seasonal Vaccinations covered 100% in-network
Preventive Vaccinations covered 100% in-network
One transition fill allowed within 90 days of member's effective date
Affordable Care Act mandated female contraceptives and preventive medications covered 100% in-network.

GENERAL PROVISIONS	
Dependents Eligibility	Spouse, children from birth to age 26 regardless of student status.

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

**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.

This amount is based on the out-of-network plan you or your employer picks.
• For doctors and other professionals the amount is based on the "prevailing" charges. We get this data from an external database.

• For hospitals and other facilities, the amount is based on "prevailing" charges. We get this data from an external database.

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, coinsurance 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, coinsurance and deductibles.

Plans are provided by: Aetna Life Insurance Company. 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.

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

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. You may be responsible for the health care provider's full charges for any non-covered services, including circumstances where you have exceeded a benefit limit contained in the plan. 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.

Rebates do not reduce the amount a member pays the pharmacy for covered prescriptions. For these purposes, the pharmacy's cost of purchasing drugs takes into account discounts, credits and other amounts that they may receive from wholesalers, manufacturers, suppliers and distributors.

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

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

Translation of the material into another language may be available. Please call Member Services at **1-866-337-8417.**

Puede estar disponible la traduccion de este material en otro idioma. Por favor llame a Servicios al Miembro al **1-866-337-8417.**

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

Aetna Ancillary Benefits

for full-time employees

The Aetna MedPremier Plan for full-time employees is designed for employees who are regularly scheduled to work a minimum of 30 hours per week, or 120 hours per month.

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BENEFITS SUMMARY

Aetna Voluntary Plans

Plan design and benefits insured and administered by Aetna Life Insurance Company (Aetna).

Unless otherwise indicated, all benefits and limitations are per covered person.

Inside this Benefits Summary:

- **Vision Care**
- **Dental**
- **Short Term Disability**

Vision Care	
Exam (Every 12 months)	$85
Single Lenses (Every 24 months)	$95
Contact Lenses (Every 24 months)	$95
Bifocal Lenses (Every 24 months)	$120
Frames (Every 24 months)	$120

Fees for other services must be paid by you. Benefit period is 12 consecutive months beginning on the later of your effective

Vision Care Exclusions:

This plan does not cover all health care expenses and has exclusions and limitations. Members should refer to their booklet certificate to determine which health care services are covered and to what extent. The following is a **partial list** of services and supplies that are generally *not covered*. **However, your plan may contain exceptions to this list based on state mandates or the plan design purchased.**

- Orthoptic vision training, subnormal vision aids, any associated supplemental testing.
- Medical and/or surgical treatment of the eyes or supporting structure.
- Any eye or vision examination, or any corrective eyewear, required by an employer as a condition of employment.

Dental

Annual Maximum (per covered person)	$1,250
Annual Deductible (per covered person)	$25
Preventive services (includes checkups and cleanings)	You are responsible for paying up to 20%† of the **Recognized Charges**. These services have no waiting period.
Basic services (includes fillings, oral surgery, and denture, crown and bridge repair)	You are responsible for paying up to 20%† of the **Recognized Charges**. You must be covered under the dental plan without interruption for 3 months before the plan begins to pay for these services.
Major services (includes Perio and Endodontics, crowns, bridges, and dentures)	You are responsible for paying up to 50%† of the **Recognized Charges**. You must be covered under the dental plan without interruption for 12 months before the plan begins to pay for these services.

† The percentage of the cost that you are responsible for paying a preferred provider is based on a ***Negotiated Charge***. A ***Negotiated Charge*** is the maximum amount that a preferred provider has agreed to charge for a covered visit, service, or supply. After your plan limits have been reached, the provider may require that you pay the full charge rather than the ***Negotiated Charge.***

The percentage of the cost that you are responsible for paying a non-preferred provider is based on a ***Recognized Charge.*** A ***Recognized Charge*** is the amount that Aetna recognizes as payable by the plan for a visit, service, or supply. For non-preferred providers (except inpatient and outpatient facilities and pharmacies), the ***Recognized Charge*** generally equals the 80th percentile of what providers in that geographic area charge for that service, based on the FAIR Health RV Benchmarks database from FAIR Health, Inc. This means that 80% of the charges in the database for geographic area are that amount or less – and 20% are more – for that service or supply. For preferred providers, the *Recognized Charge* equals the ***Negotiated Charge.*** A non-preferred provider may require that you pay more than the ***Recognized Charge,*** and this additional amount would be your responsibility.

The dental PPO network is not available in Alabama, Arkansas, Idaho, Hawaii, Louisiana, Montana, Mississippi, New Mexico or Puerto Rico. To locate a preferred provider, **call toll-free 1-866-292-3374 or visit www.aetna.com/dse/custom/bn.**

In Texas, the Preferred Provider Organization (PPO) network is known as the Participating Dental Network (PDN).

Dental Exclusions:

This plan does not cover all health care expenses and has exclusions and limitations. Members should refer to their booklet certificate to determine which health care services are covered and to what extent. The following is a **partial list** of services and supplies that are generally *not covered*. **However, your plan may contain exceptions to this list based on state mandates or the plan design purchased.**

The following charges are not covered under the dental plan, and they will not be recognized toward satisfaction of any deductible amount.

- Cosmetic procedures unless needed as a result of injury.
- Any procedure, service or supplies that are included as covered medical expenses under another group medical expense benefit plan.
- Prescribed drugs, pre-medication, analgesia or general anesthesia.
- Services provided for any type of temporomandibular (TMJ) or related structures, or myofascial pain.
- Charges in excess of the **Recognized Charge**, based on the 80th percentile of the FAIR Health RV Benchmarks.

Short Term Disability (STD)

Benefit Period	Weekly benefits for up to 26 weeks while you are disabled.
Benefit Amount	60% of base pay received from the employer that sponsors this program (includes reported tips, but not overtime) up to $270 maximum weekly benefit.
Waiting Period	Benefits begin after 7 days (plan pays immediately if hospitalized).

Coverage for employee only; coverage is not available if you work in California, Hawaii, New Jersey, New York, Rhode Island or Puerto Rico.

Short Term Disability Exclusions:

This plan does not cover all circumstances and has exclusions and limitations. Members should refer to their booklet certificate to determine which circumstances are covered and to what extent. The following is a **partial list** of circumstances that are generally *not covered* . **However, your plan may contain exceptions to this list based on state mandates or the plan design purchased.**

• Attempted suicide, while sane or insane, or intentional self-inflicted injury or sickness, unless as the result of a medical condition.
• Commission of or attempt to commit an act which is a felony in the jurisdiction in which the act occurred.
• Substance abuse.
• Occupational injury or sickness.

Questions and answers

What should I do in case of an emergency?

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

What if I don't understand something I've read here, or have more questions?

Please call us. We want you to understand these benefits before you decide to enroll. You may reach one of our Customer Service representatives Monday through Friday, 8 a.m. to 6 p.m., by calling toll free **1-866-292-3374**. We're here to answer questions before and after you enroll.

Important information about your benefits

Search our network for doctors, hospitals and other health care providers

Here's how you can find out if your health care provider is in our network. Log in to **www.aetna.com/dse/custom/bn** and follow the path to find a doctor, or call us at the toll-free number on your Aetna ID card. If you would like a printed list of doctors, contact Member Services at the toll-free number on your Aetna ID card. Our online directory is more than just a list of doctors' names and addresses. It also includes information about where the physician attended medical school, board certification status, language spoken and gender. You can even get driving directions to the office. If you don't have Internet access, call Member Services to ask about this information.

Complaints and appeals

Please tell us if you are not satisfied with a response you received from us or with how we do business. Call Member Services to file a verbal complaint or to ask for the address to mail a written complaint. You can also e-mail Member Services through the secure member website. If you're not satisfied after talking to a Member Services representative, you can ask us to send your issue to the appropriate department.

If you don't agree with a denied claim, you can file an appeal. To file an appeal, follow the directions in the letter or explanation of benefits statement that explains that your claim was denied. The letter also tells you what we need from you and how soon we will respond.

We protect your privacy

We consider personal information to be private. Our policies protect your personal information from unlawful use. By "personal information," we mean information that can identify you as a person, as well as your financial and health information. Personal information does not include what is available to the public. For example, anyone can access information about what the plan covers. It also does not include reports that do not identify you.

When necessary for your care or treatment, the operation of our health plans or other related activities, we use personal information within our company, share it with our affiliates and may disclose it to: your doctors, dentists, pharmacies, hospitals and other caregivers, other insurers, vendors, government departments and third-party administrators (TPAs).

We obtain information from many different sources —particularly you, your employer or benefits plan sponsor if applicable, other insurers, health maintenance organizations or TPAs, and health care providers.

These parties are required to keep your information private as required by law. Some of the ways in which we may use your information include: Paying claims, making decisions about what the plan covers, coordination of payments with other insurers, quality assessment, activities to improve our plans and audits.

We consider these activities key for the operation of our plans. When allowed by law, we use and disclose your personal information in the ways explained above without your permission. Our privacy notice includes a complete explanation of the ways we use and disclose your information. It also explains when we need your permission to use or disclose your information.

We are required to give you access to your information. If you think there is something wrong or missing in your personal information, you can ask that it be changed. We must complete your request within a reasonable amount of time. If we don't agree with the change, you can file an appeal.

If you'd like a copy of our privacy notice, call **1-866-292-3374** or visit us at **www.aetna.com**.

If you require language assistance, please call Member Services at 1-866-292-3374 and an Aetna representative will connect you with an interpreter. If you're deaf or hard of hearing, use your TTY and dial 711 for the Telecommunications Relay Service. Once connected, please enter or provide the Aetna telephone number you're calling.

Si usted necesita asistencia lingüística, por favor llame al Servicios al Miembro a 1-866-292-3374, y un representante de Aetna le conectará con un intérprete. Si usted es sordo o tiene problemas de audición, use su TTY y marcar 711 para el Servicio de Retransmisión de Telecomunicaciones (TRS). Una vez conectado, por favor entrar o proporcionar el número de teléfono de Aetna que está llamando.

This material is for information only and is not an offer or invitation to contract. Insurance plans contain exclusions and limitations. Providers are independent contractors and are not agents of Aetna. Provider participation may change without notice. Aetna does not provide care or guarantee access to health services. 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. Information is believed to be accurate as of the production date; however, it is subject to change.

Financial Sanctions Exclusions Clause

If coverage provided by this policy violates or will violate any US economic or trade sanctions, the coverage is immediately considered invalid. For example, Aetna companies cannot make payments or reimburse for health care or other claims or services if it violates a financial sanction regulation. This includes sanctions related to a blocked person or entity, or a country under sanction by the United States, unless permitted under a valid written Office of Foreign Assets Control (OFAC) license. For more information on OFAC, visit **http://www.treasury.gov/resource-center/sanctions/Pages/default.aspx.**

Policy forms issued include GR-9N, GR-29N.

Ancillary Benefits Exclusions & Limitations

The following expenses are not covered under the Aetna Dental Care Benefit:

(a) Class B expenses incurred during the first 12 months of coverage, unless the Insured provides proof of the coverage under a prior dental plan. However, credit is available only if the Insured notifies the Employer of such prior coverage, and fewer than 63 days elapse between coverage under the prior plan and coverage under this Plan, exclusive of any waiting period. Credit will be given for each day of coverage under all prior creditable coverage, provided fewer than 63 days elapsed between coverage under any two plans;
(b) replacement of existing dentures or bridgework less than five years old, or for replacement because of loss or theft;
(c) charges for orthodontics, unless shown in the Schedule of Benefits;
(d) charges for services with respect to congenital malformations (other than for a newborn child of the Insured);
(e) charges for dental care which are covered under any other part of this Plan;
(f) charges by anyone other than a Dentist, except for charges for dental prophylaxis performed by a Dental Hygienist, under the supervision and direction of a Dentist;
(g) charges for more than one fluoride treatment, one dental prophylaxis, or one bite-wing x-ray in a six-month period; and
(h) charges for more than one complete mouth x-ray in a two-year period.
(i) Charges for which the Covered Person is not legally required to pay or for charges which would not have been made if no charge had existed.

The following expenses are not covered under the Aetna Vision Care Benefit:

(a) charges for more than one routine eye exam in 12 consecutive months;
(b) charges for more than one pair of eye glasses including lenses and frames, or one pair of contact lenses within 24 consecutive months;
(c) charges for eye glasses or contact lenses not prescribed by an eye doctor;
(d) charges for sunglasses, plain or prescription, safety lenses, or goggles;
(e) charges for radial keratotomy or similar surgery done in treating myopia; and
(f) charges for eye surgery, or vision charges which are covered under any other part of this Plan.

Charges for which the Covered Person is not legally required to pay or for charges which would not have been made if no charge had existed.

Plan Summary

Transamerica Basic Term Life

for full-time employees working 120 hours or more per month

This Plan is for full-time employees participating in the CIT.

basic term life insurance

life | health

ACT-1 Group

This overview highlights the features of **basic term life insurance**, underwritten by Transamerica Life Insurance Company, which is an annually renewable, self-administered, basic term life insurance policy.

Employee Benefit	$10,000

benefit reduction schedule

Life insurance proceeds automatically reduce to the following percentages on the Anniversary Date that follows the Insured's birthday as follows:

birthday	life insurance proceeds payable
65th	65% of pre-age 65 death benefit
70th	50% of pre-age 65 death benefit
75th	25% of pre-age 65 death benefit

suicide exclusion

We will not pay any optional life insurance benefits, including increases, if the insured person dies by suicide, whether sane or insane, within two years (one year in CO, MO, and ND) from the date of the initial election of such benefits or increase. If this happens we will refund any premiums paid for such insurance or applicable increase.

accidental death and dismemberment rider (rider form series CRADBT00)

This rider provides the following benefits when an insured employee or an insured dependent suffers a loss as the result of an insured accident. These benefits are paid in addition to any life insurance proceeds payable under the policy.

accidental death benefit – Pays an amount equal to the life insurance proceeds if an insured person dies as the result of an accidental bodily injury.

dismemberment benefit – Pays the following percentage of an amount equal to the life insurance proceeds if an insured person suffers a dismemberment as the result of an accidental bodily injury. If more than one dismemberment occurs from the same accidental bodily injury, we will only pay for the loss which has the largest benefit.

Loss of two or more: hand, foot, or sight of one eye	100%
Loss of speech and loss of hearing in both ears	100%
Quadriplegia	100%
Paraplegia	75%
Loss of one: hand, foot, or sight of one eye	50%
Loss of speech or loss of hearing in both ears	50%
Hemiplegia	50%
Loss of hearing of one ear	25%
Loss of thumb and index finger on the same hand	25%

limitations and exclusions

No benefits will be paid for any loss caused in whole or in part by, or resulting from, any of the following:

1. Suicide or intentionally self-inflicted injury while sane or insane;
2. Sickness, disease, physical or mental infirmity, pregnancy, or any other kind of illness, or any medical or surgical care, diagnosis, or treatment for such condition;
3. Committing or attempting to commit a felony or engaging in an illegal occupation;
4. Voluntary use of any drug, whether legal or illegal, unless administered in accordance with a Physician's advice and written instruction;
5. Voluntary taking, absorbing, or inhaling a poison, gas, or fumes;
6. Involvement in an accident that occurs while driving a motor vehicle while intoxicated or under the influence according to the laws of the jurisdiction in which the accident occurs;
7. Travel in or descent from any vehicle or device for aerial navigation, except as a fare paying passenger in an aircraft operated by a commercial airline (other than a charter airline) on a regularly scheduled passenger trip;
8. Service in the military or any auxiliary unit attached thereto;
9. Participation in any of the following activities: motor vehicle or boat racing, hang gliding, sky diving, mountain or rock climbing, or any related hazardous activities; or
10. The release of nuclear energy.

NOTE: This rider is not available in Florida and Minnesota.

termination of rider - this rider will terminate on the earliest of the date the rider or policy lapses for failure to pay premiums, subject to the grace period; the date the policy terminates; or the date of the policyholder's written request to terminate this rider.

termination of coverage – An insured Person's coverage under this Rider will end on the earliest of the date the Rider terminates or the date the Insured Person's coverage ends under the Policy.

accelerated death benefit for terminal illness rider (rider form series CRTIBT00)

This rider allows insured employees to "tap into" their life insurance proceeds early. If an insured employee is diagnosed with a terminal illness for the first time while insurance is in force, the employee can receive 50% of the life insurance proceeds for the diagnosed person, not to exceed $100,000. The remaining proceeds will be paid to the beneficiary following the insured person's death. A terminal illness is an illness which is expected to result in death within 12 months.

We will deduct an administrative fee of $100 and 12 months' interest, in advance, on the accelerated amount. The interest rate will not be more than 7.4%.

The employee can only exercise this rider one time per insured person. Once an accelerated benefit is paid on an insured person, his or her coverage under this rider will end. If the acceleration is for the employee, benefit election changes will no longer be allowed.

NOTE: This rider is not available in Ohio and Massachusetts.

termination of rider - this rider will terminate on the earliest of the date the rider or policy lapses for failure to pay premiums, subject to the grace period; the date the policy terminates; or the date of the policyholder's written request to terminate this rider.

termination of coverage – an insured person's coverage under this rider will end on the earliest of the date the rider terminates or the date the insured person's coverage ends under the policy, or the date an accelerated death benefit is paid on an insured person (for that person only).

waiver of premium rider (rider form series CRWPBT00)

This rider waives the premium if the insured employee becomes totally disabled for at least six consecutive months. The total disability must be caused by an injury or disease that first manifests itself while coverage is in force and must begin on or after the employee's 16th birthday and prior to age 60.

During the six-month waiting period, the full premium must be paid for the employee. Once the waiting period has been satisfied, we will issue a premium credit in an amount equal to the premiums that were due, and which were paid, for the employee's coverage during the waiting period. We will continue to issue a monthly premium credit for each month that the insured continues to be totally disabled, subject to the provisions in this rider. The benefits provided by this rider stop on the earliest of the following dates:

- the employee's total disability ends;
- the employee refuses to provide proof of continuing disability; if asked;
- the employee refuses to be examined by a physician of our choice, if asked;
- the employee turns 65;
- this rider terminates; or
- the policy ends.

termination of rider - this rider will terminate on the earliest of the date the rider or policy lapses for failure to pay premiums, subject to the grace period; the date the policy terminates; or the date of the policyholder's written request to terminate this rider.

termination of coverage – an insured person's coverage under this rider will end on the earliest of the policy anniversary date following the employee's 60th birthday; the date the rider terminates; or the date the insured person's coverage ends under the policy.

beneficiary designation

Employees designate their own beneficiaries. In community property states (AZ, CA, ID, LA, NM, NV, TX, WA, and WI), when someone other than the spouse is designated as the beneficiary, the spouse's consent is required. The employee will automatically be the beneficiary for any dependent insurance.

conversion option

An insured person can convert his or her basic term life policy to permanent* life insurance on a policy form that we then issue, without any optional riders, in an amount not to exceed the amount of insurance that is terminating under the policy. The premium for the permanent life insurance will be based upon the insured person's attained age and class of risk at the time of conversion, together with the form and amount of insurance chosen. No evidence of insurability will be required.

We must receive the conversion application and any required premium within 31 days of termination under the policy. If the insured person dies within the 31-day conversion period, benefits under this policy will be paid as if insurance had continued regardless of whether the insured person applied for conversion.

Conversion is not available if termination is the result of submitting a fraudulent claim or the employee's decision to not elect dependent life insurance for the next year.

**In using the term "permanent", it is important to note that insurance could lapse prior to the maturity date based on the planned periodic premiums, guaranteed interest rate, and guaranteed cost of insurance charges.*

Up to date information regarding our compensation practices can be found in the Disclosures section of our website at: www.tebcs.com.

This is a brief summary of Basic Term Life Insurance underwritten by Transamerica Life Insurance Company, Cedar Rapids, Iowa 52499. Policy form series CPBTL100; Rider form series CRADBT00, CRTIBT00 and CRWPBT00. Forms and form numbers may vary. Coverage may not be available in all jurisdictions. Limitations and exclusions apply. Refer to the policy, certificate and riders for complete details.

disclosures

group benefits disclosure policy

Transamerica Employee Benefits (TEB) is a unit of Transamerica Life Insurance Company and Transamerica Financial Life Insurance Company. TEB markets and administers voluntary insurance benefits through licensed insurance agents. These agents are typically appointed to see our products, and products of other providers, and receive various forms of compensation from us for the services provided. We believe our compensation arrangements with our agents are conducted with honesty, fairness and integrity. In addition, we realize that having trusted relationships between our agents and our customers is essential to all involved. To ensure this trust continues and to address any concerns within the industry, we have outlined our policy on agent compensation disclosure.

TEB's policy supports transparency and full disclosure of agent compensation to our customers and prospective customers. In addition, we have put controls in place to facilitate this disclosure and obligate our agents to disclose compensation information to customers: 1) when asked by a customer; 2) when receiving both a fee from the customer and compensation from TEB; and 3) when otherwise required by law. Agents must comply with all applicable laws in the sale of TEB products, including any pertaining to the disclosure of compensation information.

TEB's Group Benefits Compensation Disclosure Notice (below) describes the various means by which agents may be compensated for the sale of our products. It is the responsibility of your agent to share specific information with you about his or her compensation arrangements with TEB. Accordingly, please direct any compensation disclosure questions directly to your agent.

compensation disclosure notice to all policyholders

Agents who sell and service our products are paid a commission. It varies by the type of insurance policy sold and the state where the policy was sold, and is based on a percentage of the premium received in the first year, and at policy renewal. Agents may receive advances or loans against anticipated commissions for cases sold or to be sold. These advances may or may not require the payment of interest, depending upon the agent's total business and historical experience with TEB.

Agents may receive other compensation from TEB in the form of cash or non-cash awards or prizes, based upon a variety of factors that may include the level of premium written or earned, persistency and growth of premium, or other performance measures. Agents, who manage, supervise or recruit other agents or wholesale our products and services to other agents, may receive commission overrides on business that results from their efforts.

Some of our agents may receive additional payments for providing services in connection with the administration of our products. Fees for such services may be calculated on a per policy or per certificate basis or upon the premium volume associated with a specific case. TEB may additionally reimburse these agents/administrators for certain expenses, such as the cost of mailings.

Agents may occasionally obtain exclusive rights to market TEB products or services to agents, employers, employees or members of associations or unions. Certain groups or associations may also agree to endorse TEB's products to their members. TEB may pay a fee for these exclusive marketing rights or endorsements. See your proposed plan documents or policy certificate package for more information on any such arrangements.

Up-to-date information regarding our compensation practices can be found in the Disclosures Section of our website at www.tebcs.com.

Quality health plans & benefits
Healthier living
Financial well-being
Intelligent solutions

aetna®

We're here for you

Aetna Resources For Living℠

Kids, job, bills, health, world events. Life — it happens to all of us.

Some days it can be tough to manage the competing priorities in our lives, and keep it all running smoothly. If you need help with everyday issues that are becoming a little hard to handle, or you find yourself in a crisis situation, we're here for you.

Aetna Resources For Living is a confidential round-the-clock service that helps employees and their families balance the demands of work, life and personal issues.

We can offer support and resources for your concerns around parenting issues, work-related situations, relationship problems, substance abuse or even self-improvement.

Services are available to you and anyone in your household. Your program offers short-term counseling with a licensed clinician for you and each household member.

Work, life and everything in-between

Sometimes life can become work and work can become your life. Either way, we're here to help you balance the two. Maybe you just need someone to talk to about a recent transition or conflict at work, or maybe you're looking for some guidance with your personal relationships.

Just a call or click away, we can confidentially discuss your situation and help you find resources and information on issues including:

- Mental health and well-being
- Personal and professional relationships
- Substance abuse
- Family life
- Daily stress

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Confidential conversations

When you call us, a trained professional will confidentially help you assess your needs and provide referrals to local counselors. We have community and professional services available, such as psychologists, marriage and family therapists and substance abuse counselors, to help you balance your work and home life.

Ready when you are

We're available whenever you are. We're here 24 hours a day, 7 days a week either by phone or online. If it's not convenient to call, you can find resources and self-help tools for your personal, family and work-related concerns on the member website.

There is no charge to you or your family for using the service. If you choose to use any referrals to additional resources, their charges, if any, would be your responsibility. Check your company benefits plan for coverage of those additional services.

Confidential services available 24 hours a day, 7 days a week

Aetna Resources For Living℠ is the brand name used for products and services offered through the Aetna group of subsidiary companies. The EAP is administered by Aetna Behavioral Health, LLC. and in California for Knox-Keene plans, Aetna Health of California, Inc. and Health and Human Resources Center, Inc.

All EAP calls are confidential, except as required by law. This material is for informational purposes only. It contains only a partial, general description of programs and services and does not constitute a contract. EAP instructors, educators and network participating providers are independent contractors and are neither agents nor employees of Aetna. Aetna does not direct, manage, oversee or control the individual services provided by these persons and does not assume any responsibility or liability for the services they provide and, therefore, cannot guarantee any results or outcomes. The availability of any particular provider cannot be guaranteed and is subject to change. Information is believed to be accurate as of the production date; however, it is subject to change. For more information about Aetna plans, refer to **www.aetna.com**.

These services are convenient and confidential, available 24 hours a day, 7 days a week by calling 1-888-AETNA-EAP (1-888-238-6232) or visiting www.AetnaEAP.com.

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aetna®

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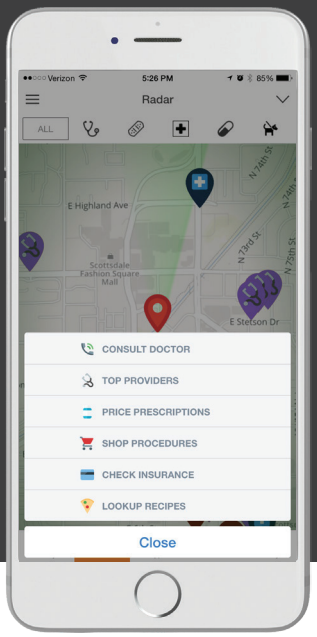
By Teladoc®

Your healthcare just got a whole lot easier!

With HealthiestYou you can connect to a doctor, get treatment, and get prescriptions, 24 hours a day, 7 days a week over the phone or via the mobile app. Using HealthiestYou can SAVE YOU TONS OF MONEY and no more sitting around in waiting rooms. And best of all, it's FREE



HY can handle over 70% of doctor office visits!

Top 9 Physician Consults

Allergies, Bronchitis, Earache, Sore Throat, Sinusitis, Pink Eye, Strep Throat, Respiratory Infection, and Urinary Tract Infection

24x7 UNLIMITED DOCTOR ACCESS

Are you sick? Call HealthiestYou first! Our physician network can diagnose, treat, and prescribe with no consult fees, anytime, anywhere. Really!

PRESCRIPTION SAVINGS

Need a prescription? Our geo-based prescription search engine can save you up to 85% on your prescription and will often beat your co-pay.

SHOP & PRICE PROCEDURES

Do you need an MRI or an Ultrasound? Our app puts you in the driver's seat by providing a vehicle to search and price procedures in your direct area. Happy shopping!

SYNC YOUR MEDICAL BENEFITS

Our app provides you a one stop shop to view your medical plan deductible in real time. Easily shop and book in-network and out-of-network providers for medical, dental, vision, and specialists.

LOCATE PROVIDERS

Need to search for a doctor, dentist, or other provider? Our app knows best and will easily lead you through the process. You can even research your doctor first!

HEALTH MANAGEMENT CONTENT

Are you stressed? Let HealthiestYou guide you to improved health and happiness with relevant health content delivered at the time of need.

Register and access your account

member.healthiestyou.com

And don't forget to

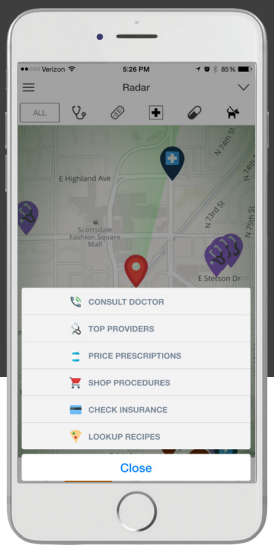
DOWNLOAD THE APP!

Download on the App Store

ANDROID APP ON Google play

healthiestyou

With HealthiestYou you can connect to a doctor, get treatment, and get prescriptions, 24 hours a day, 7 days a week over the phone or via the mobile app. Using HealthiestYou can SAVE YOU TONS OF MONEY and no more sitting around in waiting rooms. And best of all, it's FREE



How to get started with HealthiestYou:

Step 1: Setup your member portal

Head on over to **member.healthiestyou.com** and register for the member portal. Here you'll have access to the same amazing tools as our app but from your computer.

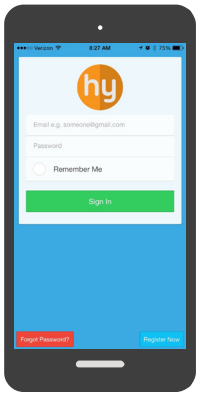
Step 2: Download the app

Search and download "HealthiestYou" or "HY" in the app store or Google Play! Available on your iPhone or Android device

Download on the App Store

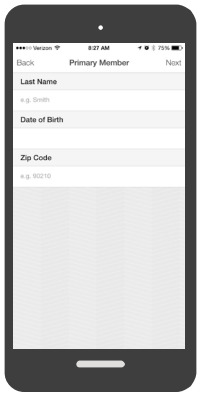
ANDROID APP ON Google play

Step 3: Setup the app



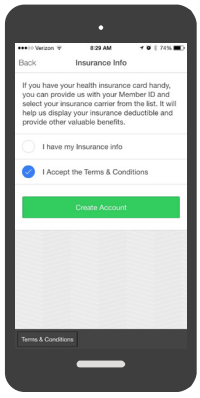
Click Register Now to get started

--Note, the app registration is separate from the online member portal registration



Select and enter the primary member's information:

- Last Name
- D.O.B.
- Zip Code
- Email address
- Password
- Phone #



If you have your insurance card handy, select "I have my Insurance info". You can enter your insurance information later too.

- Accept the Terms & Conditions"
- Click Create Account

Step 4: Use HealthiestYou next time you're sick

Open up the app and push the button to connect with a doctor. Shop and price drugs and procedures, sync and keep track of your deductible to make sure your minimizing your out of pocket cost, and much more.

No smartphone or internet? No problem, simply call to talk to a doctor

866.703.1259

Getting started is easy!

1. If you need your prescription filled right away, ask your doctor to write two prescriptions for your long-term medicines:
   - The first for a short-term supply (e.g., 30 days) to be filled right away at a participating retail pharmacy
   - The second for the maximum days supply allowed (up to a 90-day supply) with as many as three refills (if appropriate) to be mailed to CVS Caremark
2. Complete the mail service order form. You can fill out and print the form online at **Caremark.com** by clicking on New Prescriptions. An incomplete form can cause a delay in processing.
3. Mail your order form along with your prescription(s) and payment in the envelope provided, or use your own envelope to mail the form and payment to the CVS Caremark Mail Service Pharmacy address printed on the form. You can pay using an electronic check, Bill Me Later®, or credit card (VISA®, MasterCard®, Discover® or American Express®). Or you can pay by check or money order. Do not send cash.
4. Allow up to 10 days from the day you submit your order for delivery of your medicine.

If you're not in a hurry to get your medicine, then just get a 90-day prescription from your doctor to send to CVS Caremark.

Tips for saving time and money.

1. Ask your doctor about generic medicines. Research shows that you can **save an average of 30% to 80%**** when you fill your prescriptions with a generic instead of a brand-name drug.
2. If your prescription benefit program has a Preferred Drug List, print a copy of the list from Caremark.com and take it with you to your doctor's office. Using medicines on this list may save you and your prescription plan money.
3. Make sure the prescription you receive from your doctor is legible. It should include the patient's full name, the prescribing doctor's contact information and the prescription details - including the date it was written.

Caremark.com puts the power in your hands.

- Order the fastest refills
- Check drug cost
- View prescription history
- Find a participating local pharmacy
- Contact a pharmacist

Register today at **Caremark.com** to actively manage your own health and wellness. You will need information from your benefit ID card to register.

CVS CAREMARK

www.caremark.com

*Copayment, copay or coinsurance means the amount a plan participant is required to pay for a prescription in accordance with a Plan, which may be a deductible, a percentage of the prescription price, a fixed amount, or other charge, with the balance, if any, paid by the Plan.

**The amount of your savings will be based on your benefit plan. Source: Generic Pharmaceutical Association's Web site: www.gphaonline.org

CVS Caremark Mail Service Pharmacy

A User's Guide

CVS CAREMARK

The advantages of mail service.

Your prescription benefit plan administered by CVS Caremark includes the use of a mail service pharmacy. If you take one or more maintenance medicines, you may save money and time with mail service and have your medicine conveniently delivered to your home, office or location of choice.

With the CVS Caremark Mail Service Pharmacy, you can:

- Receive an extended supply of medicine.
- Enjoy free regular delivery
- Speak to a registered pharmacist 24 hours a day, seven days a week
- Contact a pharmacist with your questions on Caremark.com
- Order prescription refills online or by phone anytime, day or night

Convenient refill options.

The information you receive with your medicine will show the date that you can request a refill and the number of refills you have remaining.

3 ways to refill:

- **Online** – Ordering refills at Caremark.com is convenient, fast and easy! Have your benefit ID card handy to register.
- **By Phone** – Call the toll-free Customer Care number on your prescription label for fully automated refill service. Have your benefit ID number ready.
- **By Mail** – You can also mail your refill request to CVS Caremark, but online and telephone orders tend to arrive sooner.

Allow up to 10 days from the day you submit your order for delivery of your medicine. Regular delivery is free. Overnight or second-day delivery is available for an additional charge.

Packaged for safety.

Your medicine will be mailed to you in plain, tamper-proof packaging. An order form and a return envelope are included with every delivery. All items in your order typically arrive in one package. If an item is not available, CVS Caremark will contact you to determine if you want the available items shipped or held until all items are ready.

Special handling.

Certain items require special handling and may be shipped by a faster method at no additional cost. In such cases, you may receive a call letting you know your order is being shipped.

- **Controlled substances and orders exceeding $1,200 in value** – shipped via two-day delivery service. An adult signature is required for delivery.
- **Temperature-sensitive items** – packaged and sent using special procedures, including ice packs, coolers, and/or express delivery when necessary.

What you will pay.

Your benefit materials explain your copayment* or coinsurance for mail service. You can receive up to a 90-day supply of your medicine for a copay that may be significantly less than you would pay at a participating retail pharmacy. If you are unsure of your cost, contact your benefit provider, call the toll-free number listed on your benefit ID card or in your Welcome Kit, or check drug costs on Caremark.com.

If you will be traveling.

If you need your medicine shipped to a temporary address, you can let us know by phone, on your order form or by updating your profile on Caremark.com. If you need more medicine while traveling than the quantity allowed by your prescriber or benefit plan (i.e., more than a 90-day supply), contact your benefit office for approval at least 30 days before you need a refill.

If your medicine looks different.

There may be times when a cost-saving generic drug is available to treat your condition. In this situation, you may receive the generic, unless your doctor tells us you must receive the brand-name medicine. A generic drug may look different, but all generic drugs are approved by the U.S. Food and Drug Administration to have the same active ingredients as the brand-name medicines

To learn more about your medicine.

Important information on common medicine uses, specific instructions and possible side effects is included with each order. If you need additional information, visit Caremark.com or call the toll-free number on your benefit ID card or in your Welcome Kit.

Aetna Vision Plan FAQs

How does it work?

Large providers will generally assume that because you have an Aetna policy, you have EyeMed® Vision Care and attempt to verify your benefits with them. However, because **your policy is not with EyeMed®**, they will not be able to verify your vision benefits. As an Aetna policy member, you are still entitled to general EyeMed® Vision discounts, but the provider must call The Boon Group® to verify coverage.

Who do I contact?

Vision providers must send their bills to The Boon Group® (file claims) the same as medical providers. Most vision providers use a unique electronic billing system which makes it impossible to bill the same way medical providers do. When that situation arises, they will tell you that they do not take the insurance and that you need to pay out-of-pocket. In this case, understand that you can file for reimbursement and your policy will cover the expenses as if the provider billed your insurance directly.

FAQs

Where can I find providers who accept the vision plan and bill the vision claim directly to the insurance company?

You can continue to use the Aetna Doc Find website located on your card to locate in network providers. Unfortunately, we do not have a way to determine which providers can bill us directly at this time. Please call the provider in advance to verify if they can send paper claims to us.
Link: http://www.aetna.com/dse/custom/bn

If I pay out-of-pocket how long does it take for me to receive reimbursement?

Claims are currently processed in 30 days.

Where can I submit my claim for reimbursement and what is needed?

In order to file for reimbursement, we need an itemized statement or receipt. Please include the receipt showing the bill was paid in full, otherwise the provider will receive payment if they are in-network.

Aetna Claims

PO BOX 14079
Lexington KY 40512-4079
Or Fax
ATTN Aetna Claims 859-455-8650

Vision insurance plans are underwritten by Aetna Life Insurance Company (Aetna) and administered by Boon Administrative Services, Inc.
57.03.907.1

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Important information about your health benefits

Open Choice® PPO
Aetna Open Access® HMO
Aetna Choice® POS
Aetna Open Access® Managed Choice®
Health Network Only
Health Network Option

www.aetna.com

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Understanding your plan of benefits

Aetna* health benefits plans cover most types of health care from a doctor or hospital. But they do not cover everything. The plan covers recommended preventive care and care that you need for medical reasons. It does not cover services you may just want to have, like plastic surgery. It also does not cover treatment that is not yet widely accepted. You should also be aware that some services may have limits. For example, a plan may allow only one eye exam per year.

Warning: If you or your family members are covered by more than one health care plan, you may not be able to collect benefits from both plans. Each plan may require you to follow its rules or use specific doctors and hospitals, and it may be impossible to comply with both plans at the same time. Before you enroll in this plan, read all of the rules very carefully and compare them with the rules of any other plan that covers you or your family.

Have a Student Plan?

If you have a Student Accident and Sickness plan, please visit **www.aetnastudenthealth.com** for questions or call Aetna Student Health at the toll-free number on your ID card for more information. For appeals, please forward your request to Chickering Claims Administrators, Inc., P.O. Box 15717, Boston, MA 02215-0014. Fully insured student health insurance plans are underwritten by Aetna Life Insurance Company (ALIC) and administered by Chickering Claims Administrators, Inc. (CCA). Self-insured plans are funded by the applicable school, with claims administration services provided by Chickering Claims Administrators, Inc. Aetna Student Health is the brand name for products and services provided by ALIC and CCA.

Not all of the information in this booklet applies to your specific plan

Most of the information in this booklet applies to all plans. But some does not. For example, not all plans have deductibles or prescription drug benefits. Information about those topics will only apply if the plan includes those rules.

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* Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies. Health benefits and health insurance plans are offered, underwritten and/or administered by Aetna Health Inc., Aetna Health Insurance Company and/or Aetna Life Insurance Company.

State-specific information throughout this booklet does not apply to all plans. To be sure, review your plan documents, ask your benefits administrator, or call Aetna Member Services. Some states may also have differences that are not reflected in this document.

Where to find information about your specific plan
Your "plan documents" list all the details for the plan you choose. This includes what's covered, what's not covered and what you will pay for services. Plan document names vary. They may include a Schedule of Benefits, Certificate of Coverage, Group Agreement, Group Insurance Certificate, Group Insurance Policy and/or any riders and updates that come with them.

If you can't find your plan documents, call Member Services to ask for a copy. Use the toll-free number on your Aetna ID card.

Getting help

Contact Member Services with questions

Call the toll-free number on your ID card. Or, call **1-800-US-Aetna (1-800-872-3862)** Monday through Friday, 7 a.m. to 7 p.m. ET. You can also send Member Services an e-mail. Just go to your secure Aetna Navigator® member website at **www.aetna.com**. Click on "Contact Us" after you log in.

Member Services can help you:

- Understand how your plan works or what you will pay
- Get information about how to file a claim
- Find care outside your area
- File a complaint or appeal
- Get copies of your plan documents
- Connect to behavioral health services (if included in your plan)
- Find specific health information
- Learn more about our Quality Management program

Search our network for doctors, hospitals and other health care providers

It's important to know which doctors are in our network. That's because some health plans only let you visit doctors, hospitals and other health care providers if they are in our network. Some plans allow you to go outside the network. But, you pay less when you visit doctors in the network.

Here's how you can find out if your health care provider is in our network.

- Log in to your secure Aetna Navigator® member website at **www.aetna.com**. Follow the path to find a doctor and enter your doctor's name in the search field.
- Call us at the toll-free number on your Aetna ID card, or call us at **1-888-87-AETNA (1-888-872-3862)**.

For up-to-date information about how to find health care services, please follow the instructions above. If you would like a printed list of doctors, contact Member Services at the toll-free number on your Aetna ID card.

Our online directory is more than just a list of doctors' names and addresses. It also includes information about:

- Where the physician attended medical school
- Board certification status
- Language spoken
- Gender

You can even get driving directions to the office. If you don't have Internet access, call Member Services to ask about this information.

If you live in **Georgia**, you can call toll-free at **1-800-223-6857** to confirm that the preferred provider in question is in the network and/or accepting new patients.

Hawaii Insurance Division – You may contact the Hawaii Insurance Division and the Office of Consumer Complaints at **1-808-586-2790**.

Michigan members may contact the Michigan Office of Financial and Insurance Services at **517-373-0220** to:

- Verify participating providers' license
- Access information on formal complaints and disciplinary actions filed or taken against a health care provider in the immediate preceding three years.

For more information on your health plan, call Member Services at **1-800-208-8755** or refer to your plan documents.

A provider's right to join the network – Kentucky

Any health care provider who meets our enrollment criteria and who is willing to meet the terms and conditions for participation has a right to become a participating provider in our network.

Customary waiting times – Kentucky

Routine	Within 7 days
Preventive Care	Within 8 weeks
Symptomatic, Non Urgent	Within 3 days
Urgent Complaint	Same day/within 24 hours
Emergency	Immediately or referred to ER

Help for those who speak another language and for the hearing impaired

Do you need help in another language? Member Services can connect you to a special line where you can talk to someone in your own language. You can also get help with a complaint or appeal.

Language hotline – **1-888-982-3862** *(140 languages are available, ask for an interpreter.)*

TDD **1-800-628-3323** *(hearing impaired only)*

Ayuda para las personas que hablan otro idioma y para personas con impedimentos auditivos

¿Necesita ayuda en otro idioma? Los representantes de Servicios al Miembro le pueden conectar a una línea especial donde puede hablar con alguien en su propio idioma. También puede obtener asistencia de un intérprete para presentar una queja o apelación.

Línea directa – **1-888-982-3862** *(Tenemos 140 idiomas disponibles. Debe pedir un intérprete.)*

TDD **1-800-628-3323** *(sólo para personas con impedimentos auditivos)*

What you pay

You will share in the cost of your health care. These are called "out-of-pocket" costs. Your plan documents show the amounts that apply to your specific plan. Those costs may include:

Copay	A set amount (for example, $15) you pay for covered health care service. You usually pay this when you get the service. The amount can vary by the type of service. For example, you may pay a different amount to see a specialist than you would pay to see your family doctor.	
Coinsurance	Your share of the costs for a covered service. This is usually a percent (for example, 20%) of the allowed amount for the service. For example, if the health plan's allowed amount for an office visit is $100 and you've met your deductible, your coinsurance payment of 20% would be $20. The health plan pays the rest of the allowed amount.	
Deductible	The amount you owe for health care services before your health plan begins to pay. For example, if your deductible is $1,000, you have to pay the first $1,000 for covered services before the plan begins to pay. You may not have to pay for some services.	
Other deductibles may apply at the same time:		
Inpatient Hospital Deductible	Applies when you are a patient in a hospital	**Note:** These are separate from your general deductible. For example, your plan may have a $1,000 general deductible and a $250 Emergency Room Deductible. This means you pay the first $1,000 before the plan pays anything. Once the plan starts to pay, if you go to the emergency room you will pay the first $250 of that bill.
Emergency Room Deductible	The amount you pay when you go to the emergency room, waived if you are admitted to the hospital within 24 hours	

Some doctors are not in the Aetna network even if they work in a network hospital

Louisiana notice: *"Health care services may be provided to you at a network health care facility by facility-based physicians who are not in your health plan. You may be responsible for payment of all or part of the fees for those* ***out-of-network services****, in addition to applicable amounts due for copayments, coinsurance, deductibles, and noncovered services.*

Specific information about in-network and out-of-network facility-based physicians can be found at the website address of your health plan or by calling the customer service telephone number of your health plan"

Provider networks improve care while lowering costs
Members who receive care from providers from value-based arrangements are participating in a network designed to improve care while lowering costs. These networks may be set up in different ways, but all include primary care doctors and specialists. They also typically include at least one hospital.

Like most plans, we usually pay doctors and hospitals on a fee-for-service basis. This means your doctor or hospital still gets paid for each visit. However, the value-based network's mission is to better coordinate patient care to improve efficiency, quality and patient satisfaction.

We agree with the network on certain goals,* such as:

- Clinical performance goals – completing enough screenings for cancer, diabetes and cholesterol
- Cost-efficiency goals – reducing avoidable ER visits, short-term hospital stays, repetitive tests and the overall cost of care

We pay these value-based networks more when they meet certain goals. The amount of these payments depends on how well the network meets their goals. The network may also have to make payments to us if they fail to meet their goals.

In most of our arrangements we will reward the network financially for both efficient care and higher quality of care. This helps encourage savings that are tied to value and better health outcomes for our members.

Doctors and hospitals that are members of a value-based (accountable care) network may have their own financial arrangements through the network itself. Ask your doctor for details.

Choose a doctor the fast and easy way with DocFind®. Simply log on to your secure Aetna Navigator® website at **www.aetna.com** and select "Find a Doctor, Pharmacy or Facility." After entering your search criteria, look for the ACO logo Ⓐ. If you need a printed directory instead, call the Member Services phone number on your member ID card.

*The specific goals will vary from network to network.

Costs and rules for using your plan

Your costs when you go outside the network

Network-only plans
Open Access HMO and Health Network Only plans are network-only plans. That means the plan covers health care services only when provided by a doctor who participates in the Aetna network. If you receive services from an out-of-network doctor or other health care provider, you will have to pay all of the costs for the services.

Plans that cover out-of-network services
With Open Choice, Health Network Option, Open Access Managed Choice and Aetna Choice POS plan, you may choose a doctor in our network. You may choose to visit an out-of-network doctor. We cover the cost of care based on if the provider, such as a doctor or hospital, is "in network" or "out of network." We want to help you understand how much we will 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 care. The following are examples for when you see a doctor:

"In network" means we have a contract with that doctor. Doctors agree to how much they will charge you for covered services. That amount is often less than what they would charge you if they were not in our network. Most of the time, it costs you less to use doctors in our network. Doctors also agree to not bill you for any amount over their contract rate. All you have to pay is your coinsurance or copayments, along with any deductible. Your network doctor will handle any precertification required by your plan.

"Out of network" means we do not have a contract with that doctor. We don't know exactly what an out-of-network doctor will charge you. If you choose a doctor who is out of network, your Aetna 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.

Your out-of-network doctor or hospital sets the rate to charge you. It may be much higher than what your Aetna plan "recognizes" or "allows." Your doctor may bill you for the dollar amount that your plan doesn't "recognize." You must also pay any copayments, coinsurance and deductibles that apply. No dollar amount above the "recognized charge" counts toward your deductible or out-of-pocket limits.

This means you are fully responsible for paying everything above the amount we allow for a service or procedure.

How we pay doctors who are not in our network
When you choose to see an out-of-network doctor, hospital or other health care provider, we pay for your care using a "prevailing" or "reasonable" charge obtained from an industry database; a rate based on what Medicare would pay for that service; or a local market fee set by Aetna. Your plan will state which method is used.

This way of paying out-of-network doctors and hospitals applies when you choose to get care out of network. See "Emergency and urgent care and care after office hours" for more.

Going in network just makes sense.
- We have negotiated discounted rates for you.
- In-network doctors and hospitals won't bill you for costs above our rates for covered services.
- You are in great hands with access to quality care from our national network.

To learn more about how we pay out-of-network benefits visit **www.aetna.com**. Type "how Aetna pays" in the search box.

You never need referrals with open access plans

As an Aetna Open Access or PPO plan member, you never need a referral from your regular doctor to see a specialist. You also do not need to select a primary care provider (PCP), but we encourage you to do so to help you navigate the health care system. Regardless, some states require us to tell you about certain open access benefits. Be assured that all of your benefits are "open access," including the following:

Florida
- **Chiropractor and Podiatrist** – You have direct access to a participating primary care chiropractic and podiatric provider of your choice and do not need a referral from your PCP to access these benefits covered under your health benefits plan.
- **Dermatologist** – You have direct access to a participating primary care dermatologist provider of your choice and do not need a referral from your PCP to access these benefits covered under your health benefits plan.

Georgia
- **Ob/Gyn** – Female members have direct access to the participating primary Ob/Gyn provider of their choice and do not need a referral from their PCP for a routine well-woman exam, including a Pap smear when appropriate and an unlimited number of visits for gynecologic problems and follow-up care.
- **Dermatologist** – You have direct access to the participating dermatologist provider of your choice and do not need a referral from your primary care physician(s) to access dermatologic benefits covered under your health plan.

Kentucky
Participating primary chiropractic providers – If you live in Kentucky, you have direct access to the participating primary chiropractic provider of your choice. You do not need a referral from your PCP to access chiropractic benefits covered under your benefits plan.

North Carolina
Ob/Gyn – Any female member 13 years or older may visit any participating gynecologist for a routine well- woman exam, including a Pap smear when appropriate and an unlimited number of visits for gynecologic problems and follow-up care.

Tennessee
Routine Vision Care – You are covered for routine vision exams from participating providers without a referral from your PCP. Copayments may apply. For routine eye exams, you can visit a participating optometrist or ophthalmologist without a referral, once every 12 months. A contact lens fitting exam is not covered.

Precertification: Getting approvals for services

Sometimes we will pay for care only if we have given an approval before you get it. We call that "precertification." You usually only need precertification for more serious care like surgery or being admitted to a hospital. When you get care from a doctor in the Aetna network, your doctor gets precertification from us. But if you get your care outside our network, you must call us for precertification when that's required.

Your plan documents list all the services that require you to get precertification. If you don't, you will have to pay for all or a larger share of the cost for the service. Even with precertification, you will usually pay more when you use out-of-network doctors,

Call the number shown on your Aetna ID card to begin the process. You must get the precertification before you receive the care.

You do not have to get precertification for emergency services.

What we look for when reviewing a request
First, we check to see that you are still a member. And we make sure the service is considered medically necessary for your condition. We also make sure the service and place requested to perform the service are cost effective. We may suggest a different treatment or place of service that is just as effective but costs less.

We also look to see if you qualify for one of our case management programs. If so, one of our nurses may contact you.

Precertification does not verify if you have reached any plan dollar limits or visit maximums for the service requested. So, even if you get approval, the service may not be covered.

Filing claims in Oklahoma

Aetna participating doctors and other health care providers will file claims for you. However, you may need to file a claim for covered out-of-network services. You can download and print a claim form at **www.aetna.com/individuals-families-health-insurance/document-library/find-document-form.html**. You can also call Member Services at the number on your ID card to ask for a form. The claim form includes complete instructions including what documentation to send with it.

We determine how and whether a claim is paid based on the terms and conditions of the health coverage plan and our internal coverage policies. See "Knowing what is covered" on page 8 to learn more about coverage policies.

Information about specific benefits

Emergency and urgent care and care after office hours

An emergency medical condition means your symptoms are sudden and severe. If you don't get help right away, an average person with average medical knowledge will expect that you could die or risk your health. For a pregnant woman, that includes her unborn child.

Emergency care is covered anytime, anywhere in the world. If you need emergency care, follow these guidelines:

- Call 911 or go to the nearest emergency room. If you have time, call your doctor or PCP.
- Tell your doctor or PCP as soon as possible afterward. A friend or family member may call on your behalf.
- You do not have to get approval for emergency services.

In **Kentucky**, the definition for Emergency Medical Condition is, *"A medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, that a prudent layperson would reasonably have cause to believe constitutes a condition that the absence of immediate medical attention could reasonably be expected to result in: placing the health of the individual or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part; or with respect to a pregnant woman who is having contractions, a situation in which there is inadequate time to effect a safe transfer to another hospital before delivery; or a situation in which transfer may pose a threat to the health or safety of the woman or the unborn child."*

How we cover out-of-network emergency care

You are covered for emergency and urgently needed care. You have this coverage while you are traveling or if you are near your home. That includes students who are away at school. When you need care right away, go to any doctor, walk-in clinic, urgent care center or emergency room.

We'll review the information when the claim comes in. If we think the situation was not urgent, we might ask you for more information and may send you a form to fill out. Please complete the form, or call Member Services to give us the information over the phone.

Your plan pays out-of-network benefits 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, coinsurance, and deductibles for your in-network level of benefits. Under federal health care reform (Affordable Care Act), the government will allow some plans an exception to this rule. Contact Aetna if your provider asks you to pay more. We will help you determine if you need to pay that bill.

After-hours care – available 24/7

Call your doctor when you have medical questions or concerns. Your doctor should have an answering service if you call after the office closes. You can also go to an urgent care center, which may have limited hours. To find a center near you, log in to **www.aetna.com** and search our list of doctors and other health care providers. Check your plan documents to see how much you must pay for urgent care services.

Prescription drug benefit

Check your plan documents to see if your plan includes prescription drug benefits.

Some plans encourage generic drugs over brand-name drugs

A generic drug is the same as a brand-name drug in dose, use and form. They are FDA approved and safe to use. Generic drugs usually sell for less; so many plans give you incentives to use generics. That doesn't mean you can't use a brand-name drug, but you'll pay more for it. You'll pay your normal share of the cost, and you'll also pay the difference in the two prices.

We may also encourage you to use certain drugs

Some plans encourage you to buy certain prescription drugs over others. The plan may even pay a larger share for those drugs. We list those drugs in the Aetna Preferred Drug Guide (also known as a "drug formulary"). This list shows which prescription drugs are covered on a preferred basis. It also explains how we choose medications to be on the list.

When you get a drug that is not on the preferred drug list, your share of the cost will usually be more. Check your plan documents to see how much you will pay. You can use those drugs if your plan has an "open formulary," but you'll pay the highest copay under the plan. If your plan has a "closed formulary," those drugs are not covered.

Have questions? Get answers.

Ask your doctor about specific medications. Call the number on your Aetna ID card to ask about how your plan pays for them. Your plan documents also spell out what's covered and what is not.

Drug company rebates
Drug companies may give us rebates when our members buy certain drugs. We may share those rebates with your employer. Rebates usually apply to drugs on the preferred drug list. They may also apply to drugs not on the list. In plans where you pay a percent of the cost, your share of the cost is based on the price of the drug before Aetna receives any rebate. Sometimes, in plans where you pay a percent of the cost instead of a flat dollar amount, you may pay more for a drug on the preferred drug list than for a drug not on the list.

Mail-order and specialty-drug services from Aetna-owned pharmacies
Mail-order and specialty drug services are from pharmacies that Aetna owns. These pharmacies are called Aetna Rx Home Delivery and Aetna Specialty Pharmacy, which are for-profit pharmacies.

You might not have to stick to the list
Sometimes your doctor might recommend a drug that's not on the preferred drug list. If it is medically necessary for you to use that drug, you, someone helping you or your doctor can ask us to make an exception. Your pharmacist can also ask for an exception for antibiotics and pain medicines. Check your plan documents for details.

You may have to try one drug before you can try another
Step therapy means you have to try one or more drugs before a "step-therapy" drug will be covered. The preferred drug list includes step-therapy drugs. Your doctor might want you to skip one of these drugs for medical reasons. If so, you, someone helping you or your doctor can ask for a medical exception. Your pharmacist can also ask for an exception for antibiotics and pain medicines.

Some drugs are not covered at all
Prescription drug plans do not cover drugs that don't need a prescription. Your plan documents might also list specific drugs that are not covered. You cannot get a medical exception for these drugs.

New drugs may not be covered
Your plan may not cover drugs that we haven't reviewed yet. You, someone helping you or your doctor may have to get our approval to use one of these new drugs.

Get a copy of the preferred drug list
You can find the Aetna Preferred Drug Guide on our website at **www.aetna.com/formulary/**. You can also ask for a printed copy by calling the toll-free number on your Aetna ID card. We are constantly adding new drugs to the list. Look online or call Member Services for the latest updates.

Mental health and addiction benefits

You must use therapists and other mental health professionals who are in the Aetna network. Here's how to get mental health services:

- Call 911 if it's an emergency.
- Call the toll-free Behavioral Health number on your Aetna ID card.
- Call Member Services if no other number is listed.
- Employee Assistance Program (EAP) professionals can also help you find a mental health specialist.

Get information about using network therapists
We want you to feel good about using the Aetna network for mental health services. Visit **www.aetna.com/docfind** and click the "Get info on Patient Safety and Quality" link. No Internet? Call Member Services instead. Use the toll-free number on your Aetna ID card to ask for a printed copy.

Mental health programs to help prevent depression
Aetna Behavioral Health offers two prevention programs for our members:

- Beginning Right® Depression Program: Perinatal Depression Education, Screening and Treatment Referral and
- SASDA: Identification and Referral of Substance Abuse Screening for Adolescents with Depression and/or Anxiety Prevention

Call Member Services for more information on either of these prevention programs. Ask for the phone number of your local Care Management Center.

Transplants and other complex conditions

Our National Medical Excellence Program® (NME) is for members who need a transplant or have a condition that can only be treated at a certain hospital. You may need to visit an Aetna Institutes of Excellence™ hospital to get coverage for the treatment. Some plans won't cover the service if you don't. We choose hospitals for the NME program based on their expertise and experience with these services. We also follow any state rules when choosing these hospitals.

Breast reconstruction benefits

Notice regarding Women's Health and Cancer Rights Act of 1998

Coverage will be provided to a person who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with the mastectomy for:

- All stages of reconstruction of the breast on which a mastectomy has been performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses
- Treatment of physical complications of all stages of mastectomy, including lymph edemas

We will talk to you and your doctor about these rules when we provide the coverage. We will also follow your plan design. For example, the following may apply to your breast reconstruction benefits as outlined in your plan design:

- Limitations
- Copays
- Deductibles
- Referral requirements

If you have any questions about this coverage, please contact the Member Services number on your ID card.

Also, you can visit the following websites for more information:

U.S. Department of Health and Human Services – **http://cciio.cms.gov/programs/protections/WHCRA/whcra_factsheet.html**

U.S. Department of Labor – **www.dol.gov/ebsa/consumer_info_health.html**

Oklahoma Breast Cancer Patient Protection Act
The Oklahoma Breast Cancer Patient Protection Act requires plans to provide the following benefits:

- For members who receive benefits for a medically necessary mastectomy the plan must also cover at least 48 hours of inpatient care after the mastectomy, unless the member and attending doctor determine that a shorter hospital stay is appropriate.
- For members who receive a lymph node dissection, the plan must cover at least 24 hours of inpatient care after the lymph node dissection, unless the member and attending doctor determine that a shorter hospital stay is appropriate.
- For members who receive benefits for a medically necessary partial or total mastectomy, the plan must cover reconstructive breast surgery performed as a result of the mastectomy, except as prohibited by federal laws or regulations pertaining to Medicaid. When the reconstructive surgery is performed on a diseased breast, the plan will cover all stages of reconstructive surgery performed on a nondiseased breast to establish symmetry with the diseased breast. Adjustments made to the nondiseased breast must occur within 24 months of reconstruction of the diseased breast.

Other state-mandated benefits
West Virginia legislation mandates that group insurance policies and contracts that provide coverage for prescription drugs must include a rider providing coverage for contraceptive drugs and devices that are approved by the FDA or generics approved as substitutes by the FDA. However, "religious employers," as defined in the law, may elect not to include this coverage under their policy or contract. If a religious employer elects not to provide coverage for contraceptives, each member/enrollee covered under the contract is eligible to obtain a contraceptive rider directly from Aetna. Please refer to your plan administrator for specifics regarding your benefits.

Avoid unexpected bills. Check your plan documents to see what's covered before you get health care. Can't find your plan documents? Call Member Services to ask a specific question or have a copy mailed to you.

Knowing what is covered

Here are some of the ways we determine what is covered:

We check if it's "medically necessary"

Medical necessity is more than being ordered by a doctor. "Medically necessary" means your doctor ordered a product or service for an important medical reason. It might be to help prevent a disease or condition. Or to check if you have one. Or it might be to treat an injury or illness.

The product or service:

- Must meet a normal standard for doctors
- Must be the right type in the right amount for the right length of time and for the right body part
- Must be known to help the particular symptom
- Cannot be for the member's or the doctor's convenience
- Cannot cost more than another service or product that is just as effective

Only medical professionals can decide if a treatment or service is not medically necessary. We do not reward Aetna employees for denying coverage. Sometimes a physician's group will determine medical necessity. Those groups might use different resources than we do.

If we deny coverage, we'll send you and your doctor a letter. The letter will explain how to appeal the denial. You have the same right to appeal if a physician's group denied coverage. You can call Member Services to ask for a free copy of the materials we use to make coverage decisions. Or visit **www.aetna.com/about/cov_det_policies.html** to read our policies. Doctors can write or call our Patient Management department with questions. Contact Member Services either online or at the phone number on your Aetna ID card for the appropriate address and phone number.

Iowa
"Coverage decision" means a final adverse decision based on medical necessity. This definition does not include a denial of coverage for a service or treatment specifically listed in plan or evidence of coverage documents as excluded from coverage, or a denial of coverage for a service or treatment that has already been received and for which the enrollee has no financial liability.

We study the latest medical technology

We look at scientific evidence published in medical journals to help us decide what is medically necessary. This is the same information doctors use. We also make sure the product or service is in line with how doctors, who usually treat the illness or injury, use it. Our doctors may use nationally recognized resources like MCG (formerly Milliman Care Guidelines).

We also review the latest medical technology, including drugs, equipment and mental health treatments. Plus, we look at new ways to use old technologies. To make decisions, we may:

- Read medical journals to see the research. We want to know how safe and effective it is.
- See what other medical and government groups say about it. That includes the federal Agency for Health Care Research and Quality.
- Ask experts.
- Check how often and how successfully it has been used.

We publish our decisions in our Clinical Policy Bulletins.

We post our findings on www.aetna.com

We write a report about a product or service after we decide if it is medically necessary. We call the report a Clinical Policy Bulletin (CPB).

CPBs help us decide whether to approve a coverage request. Your plan may not cover everything our CPBs say is medically necessary. Each plan is different, so check your plan documents.

CPBs are not meant to advise you or your doctor on your care. Only your doctor can give you advice and treatment. Talk to your doctor about any CPB related to your coverage or condition.

You and your doctor can read our CPBs on our website at **www.aetna.com**. You can find them under "Individuals & Families." No Internet? Call Member Services at the toll-free number on your ID card. Ask for a copy of a CPB for any product or service.

We can help when more serious care is recommended

We may review a request for coverage to be sure the service is in line with recognized guidelines. Then we follow up. We call this "utilization management review."

It's a three step process:

First, we begin this process if your hospital stay lasts longer than what was approved. We make sure it is necessary for you to be in the hospital. We look at the level and quality of care you are getting. (In **South Dakota**, "concurrent review" is defined as a utilization review conducted during a patient's hospital stay or course of treatment in a facility or other inpatient or outpatient health care setting.)

Second, we begin planning your discharge. This process can begin at any time. We look to see if you may benefit from any of our programs. We might have a nurse case manager follow your progress. Or we might recommend that you try a wellness program after you're home.

Third, we may review your case after your discharge. We may look over your medical records and claims from your doctors and the hospital. We look to see that you got appropriate care. We also look for waste or unnecessary costs.

We follow specific rules to help us make your health a top concern:

- We do not reward Aetna employees for denying coverage.
- We do not encourage denials of coverage. In fact, we train staff to focus on the risks of members not getting proper care. Where such use is appropriate, our staff uses nationally recognized guidelines and resources, such as MCG (formerly Milliman Care Guidelines) to review claims. Physician's groups, such as independent practice associations, may use other resources they deem appropriate.

What to do if you disagree with us

Complaints, appeals and external review

Please tell us if you are not satisfied with a response you received from us or with how we do business.

Call Member Services to file a verbal complaint or to ask for the address to mail a written complaint. The phone number is on your Aetna ID card. You can also e-mail Member Services through the secure member website.

If you're not satisfied after talking to a Member Services representative, you can ask us to send your issue to the appropriate department.

If you don't agree with a denied claim, you can file an appeal. To file an appeal, follow the directions in the letter or explanation of benefits statement that explains that your claim was denied. The letter also tells you what we need from you and how soon we will respond.

Get a review from someone outside Aetna

If the denial is based on a medical judgment, you may be able to get an outside review if you're not satisfied with your appeal. Follow the instructions on our response to your appeal. Call Member Services to ask for an External Review Form. You can also visit **www.aetna.com**. Enter "external review" into the search bar.

You can get an outside review for most claims. If the reason for your denial is that you are no longer eligible for the plan, you may not be able to get an outside review.

Some states have a separate external review process. These state processes can vary from state to state. You may even need to pay a filing fee as part of the state mandated program.

If your state does not have a separate external review process, then you would follow the federal external review process. Most claims are allowed to go to external review. An exception would be if you are denied because you're no longer eligible for the plan.

An Independent Review Organization (IRO) will assign your case to an outside expert. The expert will be a doctor or other professional who specializes in that area or type of appeal. You should have a decision within 45 calendar days of the request.

The outside reviewer's decision is final and binding; we will follow the outside reviewer's decision. We will also pay the cost of the review.

A "rush" review may be possible

If your doctor thinks you cannot wait 45 days, ask for an "expedited review." That means we will make our decision as soon as possible.

Member rights & responsibilities

Know your rights as a member

You have many legal rights as a member of a health plan. You also have many responsibilities. You have the right to suggest changes in our policies and procedures. This includes our Member Rights and Responsibilities.

Some of your rights are below. We also publish a list of rights and responsibilities on our website. Visit **www.aetna.com**. Click on "Rights & Resources" on the home page to view the list. You can also call Member Services at the number on your ID card to ask for a printed copy.

Making medical decisions before your procedure

An "advanced directive" tells your family and doctors what to do when you can't tell them yourself. You don't need an advanced directive to receive care. But you have the right to create one. Hospitals may ask if you have an advanced directive when you are admitted.

There are three types of advanced directives:

- Durable power of attorney – names the person you want to make medical decisions for you
- Living will – spells out the type and extent of care you want to receive
- Do-not-resuscitate order – states that you don't want CPR if your heart stops or a breathing tube if you stop breathing

You can create an advanced directive in several ways:

- Ask your doctor for an advanced directive form.
- Pick up a form at state or local offices on aging, bar associations, legal service programs or your local health department.
- Work with a lawyer to write an advanced directive.
- Create an advanced directive using computer software designed for this purpose.

Source: American Academy of Family Physicians. Advanced Directives and Do Not Resuscitate Orders. January 2012. Available at **http://familydoctor.org/familydoctor/en/healthcare-management/end-of-life-issues/advance-directives-and-do-not-resuscitate-orders.html**. Accessed April 2, 2013.

Learn about our quality management programs

We make sure your doctor provides quality care for you and your family. To learn more about these programs, go to our website at **www.aetna.com**. Enter "commitment to quality" in the search bar. You can also call Member Services to ask for a printed copy. See "Contact Us" on page 3.

We protect your privacy

We consider personal information to be private. Our policies protect your personal information from unlawful use. By "personal information," we mean:

- Information about your physical or mental health
- Information about the health care you receive
- Information about what your health care costs

Personal information does not include what is available to the public. For example, anyone can access information about what the plan covers. It also does not include reports that do not identify you.

Summary of the Aetna Privacy Policy

When necessary for your care or treatment, the operation of our health plans, or other related activities, we use personal information within our company, share it with our affiliates, and may disclose it to:

- Your doctors, dentists, pharmacies, hospitals and other caregivers
- Those who pay for your health care services. That can include health care provider organizations and employers who fund their own health plans or who share the costs
- Other insurers
- Vendors
- Government authorities
- Third party administrators

These parties are required to keep your information private as required by law.

Some of the ways in which we may use your information include:

- Paying claims
- Making decisions about what the plan covers
- Coordination of payments with other insurers
- Quality assessment
- Activities to improve our plans
- Audits

We consider these activities key for the operation of our health plans. If allowed by law, we usually will not ask if it's okay to use your information. However, we will ask for your permission to use your information for marketing purposes. We have policies in place if you are unable to give us permission to use your information. We are required to give you access to your information. You may also request corrections to your personal information. We must fulfill your requests within a reasonable amount of time.

If you'd like a copy of our privacy policy, call the toll-free number on your ID card or visit us at **www.aetna.com**.

Anyone can get health care

We do not consider your race, disability, religion, sex, sexual orientation, health, ethnicity, creed, age or national origin when giving you access to care. Network providers are legally required to the same.

We must comply with these laws:

- Title VI of the Civil Rights Act of 1964
- Age Discrimination Act of 1975
- Americans with Disabilities Act
- Laws that apply to those who receive federal funds
- All other laws that protect your rights to receive health care

How we use information about your race, ethnicity and the language you speak

You choose if you want to tell us your race/ethnicity and preferred language. We'll keep that information private. We use it to help us improve your access to health care. We also use it to help serve you better. See "We protect your privacy" to learn more about how we use and protect your private information. See also "Anyone can get health care."

Your rights to enroll later if you decide not to enroll now

When you lose your other coverage
You might choose not to enroll now because you already have health insurance. You may be able to enroll later if you lose that other coverage or if your employer stops contributing to the cost. This includes enrolling your spouse or children and other dependents. If that happens, you must apply within 31 days after your coverage ends (or after the employer stops contributing to the other coverage).

Getting proof that you had previous coverage

We may ask for proof that you had previous coverage when you apply. Other insurers may do the same. This helps determine if you are eligible for the plan. Your plan sponsor may have contracted with us to issue a certificate. Ask us for a Certificate of Prior Health Coverage anytime you want to check the status of your coverage. If you lost your coverage, you have 24 months to make this request. Just call Member Services at the toll-free number on your ID card.

When you have a new dependent
Getting married? Having a baby? A new dependent changes everything. And you can change your mind. You can enroll within 31 days after a life event if you chose not to enroll during the normal open enrollment period. Life events include:

- Marriage
- Birth
- Adoption
- Placement for adoption

Talk to your benefits administrator for more information or to request special enrollment.

Consumer Choice Option – Georgia

The Consumer Choice Option is available for Georgia residents enrolled in certain Aetna managed care plans. Under this option, with certain restrictions required by law and an additional monthly premium cost, members of certain Aetna managed care plans may nominate an out-of-network health care provider to provide covered services, for themselves and their covered family members. The out-of-network provider you nominate must agree to accept the Aetna compensation, to adhere to the plan's quality assurance requirements, and to meet all other reasonable criteria required by the plan of its in-network participating providers

It is possible the provider you nominate will not agree to participate. If the out-of-network provider you nominate agrees to participate, your benefits and any applicable copayments will be the same as for in-network providers. It will be available for an increased premium in addition to the premium you would otherwise pay. Your increased premium responsibility will vary depending on whether you have a single plan or family coverage, and on the type of insurance, riders, and coverage. Call **1-800-433-6917** for exact pricing and other information. Please have your Aetna member ID card available when you call.

Nondiscrimination for genetic testing

Aetna will not in any way use the results of genetic testing to discriminate against applicants or enrollees.

Hawaii Informed Consent

You have the right to be fully informed before making any decision about any treatment, benefit, or nontreatment. Your provider will:

- Discuss all treatment options, including the option of no treatment at all
- Ensure that persons with disabilities have an effective means of communication with the provider and other members of the managed care plan
- Discuss all risks, benefits, and consequences of treatment and nontreatment Your provider will also discuss with you and your immediate family both living wills and durable powers of attorney in relation to medical treatment.

More information is available

Georgia
A summary of any agreement or contract between Aetna and any health care provider will be made available upon request by calling the Member Services telephone number listed on your ID card. The summary will not include financial agreements as to actual rates, reimbursements, charges, or fees negotiated by Aetna and the provider. The summary will include a category or type of compensation paid by Aetna to each class of health care provider under contract with Aetna.

Illinois
Illinois law requires health plans to provide the following information each year to enrollees and to prospective enrollees upon request:

- A complete list of participating health care providers in the health care plan's service area
- A description of the following terms of coverage:
  1. The service area
  2. The covered benefits and services with all exclusions, exceptions and limitations
  3. The precertification and other utilization review procedures and requirements
  4. A description of the process for the selection of a PCP, any limitation on access to specialists, and the plan's standing referral policy
  5. The emergency coverage and benefits, including any restrictions on emergency care services
  6. The out-of-area coverage and benefits, if any
  7. The enrollee's financial responsibility for copayments, deductibles, premiums, and any other out-of-pocket expenses
  8. The provisions for continuity of treatment in the event a health care provider's participation terminates during the course of an enrollee's treatment by the provider
  9. The appeals process, forms, and time frames for health care services appeals, complaints, and external independent reviews, administrative complaints, and utilization review complaints, including a phone number to call to receive more information from the health care plan concerning the appeals process

10. A statement of all basic health care services and all specific benefits and services to be provided to enrollees by a state law or administrative rule

- A description of the financial relationship between the health plan and any health care provider, including, if requested, the percentage of copayments, deductibles, and total premiums spent on health care related expenses and the percentage of copayments, deductibles and total premiums spent on other expenses, including administrative expenses.

Kansas

Kansas law permits you to have the following information upon request: (1) a complete description of the health care services, items and other benefits to which you are entitled in the particular health plan which is covering or being offered to you; (2) a description of any limitations, exceptions or exclusions to coverage in the health benefit plan, including prior authorization policies, restricted drug formularies or other provisions that restrict your access to covered services or items; (3) a listing of the plan's participating providers, their business addresses and telephone numbers, their availability, and any limitation on your choice of provider; (4) notification in advance of any changes in the health benefit plan that either reduces the coverage or increases the cost to you; and (5) a description of the grievance and appeal procedures available under the health benefit plan and your rights regarding termination, disenrollment, nonrenewal or cancellation of coverage. If you are a member, contact Member Services by calling the toll-free number on your ID card to ask for more information. If you are not yet an Aetna member, contact your plan administrator.

Kentucky

Kentucky law requires Aetna to provide, upon enrollment and upon request, the following information: (1) a current participating provider directory with information on access to primary care providers and available providers; (2) general information on the type of financial incentives between contracted participating providers including any incentives and bonuses; and (3) our standard customary waiting times for appointments for urgent and routine care. Additionally, upon request, we will make available information about the provider network, including hospital affiliations and whether a particular network provider is board certified and whether a provider is currently accepting new patients. Members may contact Member Services at the toll-free number on their ID card for more information; all others contact your benefits administrator.

North Carolina

Procedures and medically based criteria for determining whether a specified procedure, test or treatment is experimental, are available upon request.

Rhode Island

Prospective and existing members can access the Consumer Disclosure Guide to Health Plans and the Consumer Right to Know about Health Plans documents at **www.aetna.com/products/member_disclosure.html**, or by calling **1-888-982-3862** to request a paper copy.

Aetna is committed to Accreditation by the National Committee for Quality Assurance (NCQA) as a means of demonstrating a commitment to continuous quality improvement and meeting customer expectations. A complete listing of health plans and their NCQA status can be found on the NCQA website located at **reportcard.ncqa.org**.

To refine your search, we suggest you search these areas: Managed Behavioral Healthcare Organizations – for behavioral health accreditation; Credentials Verification Organizations – for credentialing certification; Health Insurance Plans – for HMO and PPO health plans; Physician and Physician Practices – for physicians recognized by NCQA in the areas of heart/stroke care, diabetes care, back pain and medical home. Providers who have been duly recognized by the NCQA Recognition Programs are annotated in the provider listings section of the Aetna provider directory.

Providers, in all settings, achieve recognition by submitting data that demonstrates they are providing quality care. The program constantly assesses key measures that were carefully defined and tested for their relationship to improved care; therefore, NCQA provider recognition is subject to change.

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

Aetna does not provide care or guarantee access to health services. For up-to-date information, please visit our DocFind® directory at **www.aetna.com** or, if applicable, visit the NCQA's new top-level recognition listing at **recognition.ncqa.org**.

If you need this material translated into another language, please call Member Services at 1-800-323-9930.
Si usted necesita este material en otro lenguaje, por favor llame a Servicios al Miembro al 1-800-323-9930.

www.aetna.com

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Notice of Privacy Practices

Office Key 128

If you are enrolled in a medical, dental, hospital plan, or vision care plan, then this notice applies to you.

This Notice of Privacy Practices applies to Aetna's insured health benefits plans. It does not apply to any plans that are self-funded by an employer. Your employer will be able to tell you if your plan is insured or self-funded. If you plan is self-funded, you may want to ask for a copy of your employer's privacy notice.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Aetna[1] considers personal information confidential. We protect the privacy of that information in accordance with federal and state privacy laws, as well as our own company privacy policies.

This notice describes how we may use and disclose information about you in administering your benefits, and it explains your legal rights regarding the information. When we use the term "personal information," we mean information that identifies you as an individual, such as your name and Social Security Number, as well as financial, health and other information about you that is nonpublic, and that we obtain so we can provide you with insurance coverage. By "health information," we mean information that identifies you and relates to your medical history (i.e., the health care you receive or the amounts paid for that care).

This notice became effective on July 8, 2013.

How Aetna Uses and Discloses Personal Information

In order to provide you with insurance coverage, we need personal information about you, and we obtain that information from many different sources – particularly your employer or benefits plan sponsor, other insurers, HMOs, or third-party administrators (TPAs), and health care providers. In administering your health benefits, we may use and disclose personal information about you in various ways, including:

Health Care Operations: We may use and disclose personal information during the course of running our health business – that is, during operational activities such as quality assessment and improvement; licensing; accreditation by independent organizations; performance measurement and outcomes assessment; health services research; and preventive health, disease management, case management and care coordination. For example, we may use the information to provide disease management programs for members with specific conditions, such as diabetes, asthma, or heart failure. Other operational activities requiring use and disclosure include administration of reinsurance and stop loss; underwriting and rating; detection and investigation of fraud; administration of pharmaceutical programs and payments; transfer of policies or contracts from and to other health plans; facilitation of a sale, transfer, merger or consolidation of all or part of Aetna with another entity (including due diligence related to such activity); and other general administrative activities, including data and information systems management, and customer service.

Payment: To help pay for your covered services, we may use and disclose personal information in a number of ways – in conducting utilization and medical necessity reviews; coordinating care; determining eligibility; determining formulary compliance; collecting premiums; calculating cost-sharing amounts; and responding to complaints, appeals and requests for external review. For example, we may use your medical history and other health information about you to decide whether a particular treatment is medically necessary and what the payment should be – and during the process, we may disclose information to your provider. We also mail Explanation of Benefits forms and other information to the address we have on record for the subscriber (i.e., the primary insured). We also use personal information to obtain payment for any mail order pharmacy services provided to you.

Treatment: We may disclose information to doctors, dentists, pharmacies, hospitals, and other health care providers who take care of you. For example, doctors may request medical information from us to supplement their own records. We also may use personal information in providing mail order pharmacy services and by sending certain information to doctors for patient safety or other treatment-related reasons.

Disclosures to Other Covered Entities: We may disclose personal information to other covered entities, or business associates of those entities for treatment, payment and certain health care operations purposes. For example, we may disclose personal information to other health plans maintained by your employer if it has been arranged for us to do so in order to have certain expenses reimbursed.

Additional Reasons for Disclosure

We may use or disclose health information about you in providing you with treatment alternatives, treatment reminders, or other health-related benefits and services. We also may disclose such information in support of:

- **Plan Administration** – to your employer, when we have been informed that appropriate language has been included in your plan documents, or when summary data is disclosed to assist in bidding or amending a group health plan.
- **Research** – to researchers, provided measures are taken to protect your privacy.
- **Business Partners** – to persons who provide services to us and assure us they will protect the information.
- **Industry Regulation** – to state insurance departments, boards of pharmacy, U.S. Food and Drug Administration, U.S. Department of Labor and other government agencies that regulate us.
- **Law Enforcement** – to federal, state, and local law enforcement officials.
- **Legal Proceedings** – in response to a court order or other lawful process.
- **Public Welfare** – to address matters of public interest as required or permitted by law (e.g., child abuse and neglect, threats to public health and safety, and national security).

Disclosure to Others Involved in Your Health Care

We may disclose personal information about you to a relative, a friend, the subscriber of your health benefits plan or any other person you identify, provided the information is directly relevant to that person's involvement with your health care or payment for that care. For example, if a family member or a caregiver calls us with prior knowledge of a claim, we may confirm whether or not the claim has been received and paid. You have the right to stop or limit this kind of disclosure by calling the toll-free Customer Service number at **1-866-292-3374**.

If you are a minor, you also may have the right to block parental access to your health information in certain circumstances, if permitted by state law. You can contact us using the toll-free Customer Service number at

1-866-292-3374 – or have your provider contact us.

Uses and Disclosures Requiring Your Written Authorization

In all situations other than those described above, we will ask for your written authorization before using or disclosing personal information about you. For example, we will get your authorization for marketing purposes that are unrelated to your benefit plans(s), before disclosing any psychotherapy notes, related to the sale of your health information and for other reasons as required by law. If you have given us an authorization, you may revoke it at any time, if we have not already acted on it. If you have questions regarding authorizations, please call the toll-free Customer Service number at **1-866-292-3374**.

Your Legal Rights

The federal privacy regulations give you several rights regarding your health information

- You have the right to ask us to communicate with you in a certain way or at a certain location. For example, if you are covered as an adult dependent, you might want us to send health information to a different address from that of your subscriber. We will accommodate reasonable requests.
- You have the right to ask us to restrict the way we use or disclose health information about you in connection with health care operations, payment, and treatment. We will consider, but may not agree to, such requests. You also have the right to ask us to restrict disclosures to persons involved in your health care.
- You have the right to ask us to obtain a copy of health information that is contained in a "designated record set" – medical records and other records maintained and used in making enrollment, payment, claims adjudication, medical management, and other decisions. We may ask you to make your request in writing, may charge a reasonable fee for producing and mailing the copies and, in certain cases, may deny the request.
- You have the right to ask us to amend health information that is in a "designated record set." Your request must be in writing and must include the reason for the request. If we deny the request, you may file a written statement of disagreement.
- You have the right to ask us to provide a list of certain disclosures we have made about you, such as disclosures of health information to government agencies that license us. Your request must be in writing. If you request such an accounting more than once in a 12-month period, we may charge a reasonable fee.
- You have the right to be notified following a breach involving your health information.
- You have the right to know the reasons for an unfavorable underwriting decisions. Previous unfavorable underwriting decisions may not be used as the basis for future underwriting decisions unless we make an independent evaluation of the basic facts. Your genetic information cannot be used for underwriting purposes.
- You have the right with very limited exceptions, not to be subjected to pretext interviews.[2]

You may make any of the requests described above, or may request a paper copy of this notice, by calling the toll-free Customer Service number at **1-866-292-3374**.

You also have the right to file a complaint if you think your privacy rights have been violated. To do so, please send your request to the following address **General Counsel 6300 Bridgepoint Parkway, Building 3, Suite 500, Austin TX 78730**. You also may write to the Secretary of the U.S. Department of Health and Human Services. You will not be penalized for filing a complaint.

Aetna's Legal Obligations

The federal privacy regulations require us to keep personal information about you private, to give you notice of our legal duties and privacy practices, and to follow the terms of the notice currently in effect.

Safeguarding Your Information

We guard your information with administrative, technical, and physical safeguards to protect it against unauthorized access and against threats and hazards to its security and integrity. We comply with all applicable state and federal law pertaining to the security and confidentiality of personal information.

This Notice is Subject to Change

We may change the terms of this notice and our privacy policies at any time. If we do, the new terms and policies will be effective for all of the information that we already have about you, as well as any information that we may receive or hold in the future.

Please note that we do not destroy personal information about you when you terminate your coverage with us.

It may be necessary to use and disclose this information for the purposes described above even after your coverage terminates, although policies and procedures will remain in place to protect against inappropriate use or disclosure.

If you have questions regarding this notice, please contact **our Privacy Officer** by mail **at General Counsel 6300 Bridgepoint Parkway, Building 3, Suite 500, Austin, TX 78730;** by phone by calling **512-652-7557; or by fax at 512-339-6662**. Include your name, phone and fax number.

Coverage may be underwritten or administered by one or more of the following companies: Aetna Health Inc.; Aetna Health of California Inc.; Aetna Dental of California Inc.; Aetna Dental Inc.; Aetna Life Insurance Company; Aetna Insurance Company of Connecticut; Aetna Health Insurance Company of New York; and Corporate Health Insurance Company. Mail order pharmacy services may be provided by Aetna Rx Home Delivery, LLC.

[1] For purposes of this notice, "Aetna" and the pronouns "we," "us" and "our" refer to all of the HMO and licensed insurer subsidiaries of Aetna Inc., including the entities listed on the last page of this notice. These entities have been designated as a single affiliated covered entity for federal privacy purposes.

[2] We do not participate in pretext interviews.

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Notice of Privacy Practices

Office Key 128

If you are enrolled in a term life, accidental death, or disability plan, then this notice applies to you.

THIS NOTICE* CONTAINS IMPORTANT INFORMATION ABOUT AETNA'S PRIVACY PRACTICES. PLEASE REVIEW IT CAREFULLY.

I. What is this notice?

To effectively administer our life and disability plans (collectively the "Benefits Plans"), Aetna† must collect and disclose nonpublic personal information. We consider this information private and confidential and have policies and procedures in place to protect the information against unlawful use and disclosure. This notice describes what types of information we collect, explains when and to whom we may disclose it, and provides you with additional important information. If you have questions about this notice, please call our toll-free customer service number:

Toll Free Number: 1-866-292-3374

II. What is "nonpublic personal information"?

Nonpublic personal information ("NPI") is information that identifies an individual enrolled in an Aetna Benefits Plan and relates to the person's participation in the Plan, the person's physical or mental health or condition, the provision of health care to that person, the person's employment, or payment of benefits to that person or the person's beneficiary. NPI does not include publicly available information, or information that is available or reported in a summarized or aggregate fashion but does not identify any individual person.

III. What types of personal information does Aetna collect?

Like all benefits companies, we collect the following types of information about you and your dependents and beneficiaries:

- Information we receive directly or indirectly from you, your employer or benefits plan sponsor, or previous benefits companies through applications, surveys, or other forms, in writing, in person, by telephone, or electronically (e.g., name, address, social security number, date of birth, marital status, dependent/beneficiary information, employment information, medical history).
- Information about your relationship and transactions with us, our affiliates, our agents, and others (e.g., underwriting and claims information, medical history, eligibility information, payment information, and service request, appeal and grievance information)
- Information we receive from consumer reporting agencies.

IV. How does Aetna protect this information?

At Aetna, we restrict access to NPI to those employees who need it to provide products or services to you and your dependents and beneficiaries. We maintain physical, electronic and procedural safeguards to protect NPI against unauthorized access and use. For example, access to our facilities is limited to authorized personnel and we protect information we maintain electronically through use of a variety of technical tools. We also have established a Privacy Office, which has overall responsibility for developing, implementing, educating company personnel about, and enforcing policies and procedures to safeguard NPI against inappropriate access, use and disclosure, consistent with applicable law.

What personal information does Aetna and other benefits plans use or disclose to third parties, and for what purposes?

We do not disclose NPI to anyone, except with member authorization (see Section VII) or otherwise as permitted by law. Disclosures permitted by law typically include those described in more detail below. When necessary for the operation of our Benefits Plans, or other related activities, we use NPI internally, share it with our affiliates, and disclose it to health care providers (doctors and other caregivers), other insurers, third party administrators, payors (employers who sponsor self-funded Benefits Plans and others who may be financially responsible for payment for the services or benefits you receive under your plan), vendors, consultants, government authorities, and their respective agents. These parties are required to keep NPI confidential as provided by applicable law. Here are some examples of what we do with the information we collect and the reasons it might be disclosed to third parties:

- Administration of life and disability benefits policies or contracts, which may involve claims payment and management; coordination of care, benefits, and other services; response to member inquiries or requests for services; building awareness about our products and programs; conduct of grievance and appeals programs; benefits and program analysis and reporting; fulfillment; risk management; detection and investigation of fraud and other unlawful conduct; auditing and quality assessment and improvement activities; underwriting and ratemaking; administration of reinsurance and excess or stop loss insurance policies and coordination with reinsurance and excess or stop loss insurers; and other activities described below.
- Operation of benefits programs in which we coordinate or blend the administration or case management of our disability plans with health or workers compensation benefit plans administered by Aetna or third parties.
- Performance measurement and outcomes assessment; claims analysis and reporting, and research.
- Data and information systems management.
- Performing mandatory regulatory compliance/reporting activities; responding to requests for information from regulatory authorities, responding to government agency or court subpoenas as required by law, reporting suspected or actual fraud or other criminal activity; conducting litigation, arbitration, or similar dispute resolution proceedings; and performing third-party liability (including administration of social security and workers compensation offsets), and related activities.
- Transfer of policies or contracts from and to other insurers or third party administrators; and facilitation of due diligence activities in connection with the purchase, sale or transfer of Benefits Plans.

In addition, we may disclose NPI to affiliated entities or nonaffiliated third parties as otherwise permitted by law. For other purposes, we seek special authorization before disclosing the information. In the event that a special authorization is required but the member in question is unable to give the authorization (for example, if the member is medically unable to do so), we will accept the authorization from any person legally permitted to give the authorization on behalf of the member.

IV. Why is it important that NPI be used and disclosed as described above?

We consider the activities described in Section V key for the administration of our group life and disability benefit plans. For example, target marketing helps us to better educate employees about the benefits available to them. Quality assessment and research programs help us to review and improve the services we provide. Coordinated or integrated disability and health benefit programs let us work more effectively with members to manage their disabilities and improve their health and productivity. Therefore, to the extent permitted by law, we use and disclose NPI as provided in Section V regardless of individual preferences. Of course, we recognize that many members do not want to receive unsolicited marketing materials unrelated to their Benefit Plans. Therefore, we seek special authorization before disclosing NPI for these marketing purposes.

VII. What does a person need to do to request other disclosures of personal information?

Many people ask us to disclose NPI to third parties or for reasons not described in Section V. For example, you may want us to make your records available to a neighbor who is helping you resolve a question about your claim. To authorize us to disclose any of your personal information to a person or organization or for reasons other than those described in Section V above, please call our toll-free customer service phone number listed in Section I to ask for a special authorization form. When you receive the form, fill it out and send it to us at the following address: **General Counsel 6300 Bridgepoint Parkway, Building 3, Suite 500, Austin TX 78730**. If you fill out a form and later change your mind about the special authorization, send a letter to us at the same address, letting us know that you would like to revoke the special authorization. Please provide your name, address, member identification number or Social Security number, and a telephone number where we can reach you to confirm your request.

If you want to access information about yourself, you should go to the provider (e.g., doctor or other caregiver) that generated the original records, which are more complete than any we maintain. We do not have custody or control of your medical records. You may also request documents reflecting information we receive from your employer or providers when we process claims submitted to us for payment. In these cases, we may charge an administrative fee to help cover our costs, except where prohibited by law. In all other cases, we will refer you to the applicable employer or providers. To request claims/encounter information we maintain for you and your dependents, please call our toll free customer service phone number listed in Section I or send a letter to **General Counsel 6300 Bridgepoint Parkway, Building 3, Suite 500, Austin TX 78730**. Include the name, address, member ID or Social Security number, and date of birth of each person whose information you request. If you are requesting claims/encounter information for your adult dependents, each such adult dependent must co-sign the letter. Where required by law, or if we are the source of a confirmed error in your records, we will correct or amend the records we maintain (but not the records maintained by your employer, provider or other third parties). If we do not agree that the records are incorrect, you can request we add a rebuttal statement to your file.

VIII. What does Aetna do with personal information about members who are no longer enrolled in an Aetna plan?

Aetna does not destroy NPI when individuals terminate their coverage with us. The information is necessary and used for many of the purposes described in Section V, even after an individual leaves a plan, and in many cases is subject to legal retention requirements. However, the policies and procedures that protect that information against inappropriate use and disclosure apply regardless of the status of any individual member.

IX. How is this notice distributed?

We plan to send this notice to our members upon enrollment in any of our full risk or insured Benefits Plans, when our confidentiality practices are materially changed, and at other times as required by law. We reserve the right to change the terms of this notice and to make the provisions of the new notice effective for all NPI we maintain. Updates of this notice can be requested by calling our toll-free customer service phone number listed in Section I, and also are available on our website, at www.aetna.com. A short version of this notice is included in many of our general marketing communications.

X. What should a person do if he or she believes this policy has been violated?

If you believe this policy has been violated with respect to information about you or your dependents or beneficiaries, please follow the grievance procedures described in your plan documents or call our toll-free customer service phone number listed in Section I.

XI. Other important information?

You have the right to know the reasons for an unfavorable underwriting decision. Previous unfavorable underwriting decisions may not be used as the basis for future underwriting decisions unless we make an independent evaluation of the basic facts.

You have the right with very limited exceptions, not to be subjected to pretext interviews.[1]

Coverage may be underwritten or administered by Aetna Life Insurance Company

* This Notice is not a part of your Plan Documents (Group Policy, Certificate/Evidence of Coverage, Booklet, Group Agreement, Schedule of Benefits, Group Insurance Certificate). It is provided to you for informational purposes only.

† For purposes of this notice, "Aetna" refers to the Aetna Inc. family of companies, including those doing business as Aetna Life Insurance Company.

[1] We do not participate in pretext interviews.

Non-Discrimination Notice

Aetna complies with applicable Federal civil rights laws and does not discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, or disability.

Aetna provides free aids/services to people with disabilities and to people who need language assistance. If you need a qualified interpreter, written information in other formats, translation or other services, call 1-866-337-8417.

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:

Civil Rights Coordinator, P.O. Box 14462, Lexington, KY 40512
1-800-648-7817, TTY: 711, Fax: 859-425-3379, CRCoordinator@aetna.com.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, or at 1-800-368-1019, 800-537-7697 (TDD).

Availability of Language Assistance Services

TTY: 711

For language assistance in your language call 1-866-337-8417 at no cost. (English)

Para obtener asistencia lingüística en su idioma, llame sin cargo al 1-866-337-8417. (Spanish)

欲取得以您的語言提供的語言協助，請撥打1-866-337-8417，無需付費。(Chinese)

Pour une assistance linguistique dans votre langue, appeler le 1-866-337-8417 sans frais. (French)

Para sa tulong sa inyong wika, tumawag sa 1-866-337-8417 nang walang bayad. (Tagalog)

Hilfe oder Informationen in deutscher Sprache erhalten Sie kostenlos unter der Nummer 1-866-337-8417. (German)

للمساعدة اللغوية بلغتك الرجاء الاتصال على الرقم المجاني 1-866-337-8417. (Arabic)

Pou jwenn asistans nan lang pa w, rele nimewo 1-866-337-8417 gratis. (French Creole)

Per ricevere assistenza nella sua lingua, può chiamare gratuitamente il numero 1-866-337-8417. (Italian)

日本語で援助をご希望の方は 1-866-337-8417（フリーダイアル）までお電話ください。(Japanese)

본인의 언어로 통역 서비스를 받고 싶으시면 비용 부담 없이 1-866-337-8417번으로 전화해 주십시오. (Korean)

برای راهنمایی به زبان شما با شماره 1-866-337-8417 بدون هیچ هزینه ای تماس بگیرید. (Persian)

Aby uzyskać pomoc w swoim języku, zadzwoń bezpłatnie pod numer 1-866-337-8417. (Polish)

Para obter assistência no seu idioma, ligue gratuitamente para o 1-866-337-8417. (Portuguese)

Чтобы получить помощь с переводом на ваш язык, позвоните по бесплатному номеру 1-866-337-8417. (Russian)

Để được hỗ trợ ngôn ngữ bằng ngôn ngữ của bạn, hãy gọi miễn phí đến số 1-866-337-8417. (Vietnamese)

Aviso de no discriminación

Aetna cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo.

Aetna ofrece recursos o servicios gratuitos a las personas con discapacidades y para las personas que necesitan ayuda en el idioma. Si usted necesita un intérprete calificado, información por escrito en otros formatos, traducción u otros servicios, llame al 1-866-337-8417.

Si considera que Aetna ha fracasado en proporcionar estos servicios o, de otra manera, discriminado en base a una clase protegida como se ha indicado anteriormente, también puede presentar una queja formal ante el Coordinador de Derechos Civiles poniéndose en contacto con:

Civil Rights Coordinator, P.O. Box 14462, Lexington, KY 40512

1-800-648-7817, TTY: 711, Fax: 859-425-3379, CRCoordinator@aetna.com.

También puede presentar una queja de derechos civiles con el U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, disponible en https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, o bien, al: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, o llamar al 1-800-368-1019, 800-537-7697 (TDD).

Disponibilidad de servicios de asistencia lingüística

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For language assistance in your language call 1-866-337-8417 at no cost. (English)

Para obtener asistencia lingüística en su idioma, llame sin cargo al 1-866-337-8417. (Spanish)

欲取得以您的語言提供的語言協助，請撥打1-866-337-8417，無需付費。(Chinese)

Pour une assistance linguistique dans votre langue, appeler le 1-866-337-8417 sans frais. (French)

Para sa tulong sa inyong wika, tumawag sa 1-866-337-8417 nang walang bayad. (Tagalog)

Hilfe oder Informationen in deutscher Sprache erhalten Sie kostenlos unter der Nummer 1-866-337-8417. (German)

للمساعدة اللغوية بلغتك الرجاء الاتصال على الرقم المجاني 1-866-337-8417. (Arabic)

Pou jwenn asistans nan lang pa w, rele nimewo 1-866-337-8417 gratis. (French Creole)

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日本語で援助をご希望の方は 1-866-337-8417（フリーダイアル）までお電話ください。(Japanese)

본인의 언어로 통역 서비스를 받고 싶으시면 비용 부담 없이 1-866-337-8417번으로 전화해 주십시오. (Korean)

برای راهنمایی به زبان شما با شماره 1-866-337-8417 بدون هیچ هزینه ای تماس بگیرید. (Persian)

Aby uzyskać pomoc w swoim języku, zadzwoń bezpłatnie pod numer 1-866-337-8417. (Polish)

Para obter assistência no seu idioma, ligue gratuitamente para o 1-866-337-8417. (Portuguese)

Чтобы получить помощь с переводом на ваш язык позвоните по бесплатному номеру 1-866-337-8417. (Russian)

Để được hỗ trợ ngôn ngữ bằng ngôn ngữ của bạn, hãy gọi miễn phí đến số 1-866-337-8417. (Vietnamese)

GENERAL NOTICE CONTINUATION COVERAGE RIGHTS UNDER COBRA

Introduction

You are receiving this notice because you have recently become covered under a group health plan (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.** When you become eligible for COBRA, you may also be eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985(COBRA). COBRA Continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower-out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan) even if that plan generally doesn't accept late enrollees.

What is COBRA Continuation Coverage?

COBRA Continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the plan as a "dependent child."

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to YOUR PLAN, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. The retired employee's spouse and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, commencement of a proceeding in bankruptcy with respect to the employer, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs.

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must send written notice of a qualifying event to the Plan Administrator at the following address:
"YOUR EMPLOYER" – ATTN: COBRA Administration, Comerica Lock Box, P.O. Box 671227, Dallas, TX 75267-1227. The notice must identify the qualifying event and the date such event occurred and include any supporting documentation available (such as a divorce decree) and the name and address of all qualified beneficiaries whose coverage is affected by the qualifying event.

How is COBRA Continuation Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. In the event that you become disabled prior to the 60th day of COBRA continuation coverage, you must provide a notice of such disability within 60 days of receiving a disability determination from the Social Security Administration, and in no event later than the expiration of the 18-month period of continuation coverage to the following:

"YOUR EMPLOYER", ATTN: COBRA Administration, Comerica Lock Box, P.O. Box 671227, Dallas, TX 75267-1227. Please include any available supporting documentation pertaining to the disability, including the Social Security Administration determination of disability.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred. In the event that you experience a second qualifying event while you are receiving COBRA Continuation Coverage, within 30 days of such qualifying event, please provide notice to:

"YOUR EMPLOYER", ATTN: COBRA Administration, Comerica Lock Box, P.O. Box 671227, Dallas, TX 75267-1227. The notice must identify the qualifying event and the date such event occurred and include any supporting documentation available (such as a divorce decree) and the name and address of all qualified beneficiaries whose coverage is affected by the qualifying event.

Are there other coverage options besides COBRA Continuation Coverage?

Yes, instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.). For more information about the Marketplace, visit www.HealthCare.gov.

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan Contact Information

For more information concerning your rights under COBRA, please contact:

"YOUR EMPLOYER"
ATTN: COBRA Administration Comerica
Lock Box
P.O. Box 671227
Dallas, TX 75267-
1227 888-835-3310

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of August 10, 2017. Contact your State for more information on eligibility –

ALABAMA – Medicaid	FLORIDA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
ALASKA – Medicaid	**GEORGIA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: http://dch.georgia.gov/medicaid - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
ARKANSAS – Medicaid	**INDIANA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**IOWA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: Colorado.gov/HCPF/Child-Health-Plan-Plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711	Website: http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp Phone: 1-888-346-9562
KANSAS – Medicaid	**NEW HAMPSHIRE – Medicaid**
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218
KENTUCKY – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
LOUISIANA – Medicaid	**NEW YORK – Medicaid**
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MAINE – Medicaid	**NORTH CAROLINA – Medicaid**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: https://dma.ncdhhs.gov/ Phone: 919-855-4100

MASSACHUSETTS – Medicaid and CHIP	NORTH DAKOTA – Medicaid
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MINNESOTA – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp Phone: 1-800-657-3739	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MISSOURI – Medicaid	**OREGON – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
MONTANA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462
NEBRASKA – Medicaid	**RHODE ISLAND – Medicaid**
Website: http://www.ACCESSNebraska.ne.gov Phone: (855) 632-7633 Lincoln: (402) 473-7000 Omaha: (402) 595-1178	Website: http://www.eohhs.ri.gov/ Phone: 855-697-4347
NEVADA – Medicaid	**SOUTH CAROLINA – Medicaid**
Medicaid Website: https://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900	Website: https://www.scdhhs.gov Phone: 1-888-549-0820
SOUTH DAKOTA - Medicaid	**WASHINGTON – Medicaid**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
VERMONT– Medicaid	**WYOMING – Medicaid**
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531
VIRGINIA – Medicaid and CHIP	
Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282	

To see if any other states have added a premium assistance program since August 10, 2017, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

aetna℠

MedPremier

Enrollment/Change Request

Insurance plans are underwritten by Aetna Life Insurance Company (Aetna).

ACT-1 Group
$3.27 MedPremier Plan

TO COMPLY WITH CALIFORNIA LAW, THE TERM "SPOUSE" SHALL BE CONSTRUED TO INCLUDE A DOMESTIC PARTNER.

Instructions: Read and fill out the Enrollment/Change Request (all pages). Make a copy for yourself. Please follow the instructions on your welcome letter regarding form submission.

INFORMATION ABOUT YOU Complete all information.

Print your name (first, middle initial, last)			Social Security Number	Date of birth (MM/DD/YYYY)
Home address	Apartment Number	City	State	Zip code
Home phone ( )	Work phone ( )	Email address	Sex ☐ Male ☐ Female	Primary language spoken (Idioma principal)

ACTION YOU WANT TO TAKE Check the box next to the action you want to take.

I am not currently enrolled and I want to…	☐ **Enroll** in the coverage choices selected below.
I am currently enrolled and I want to…	☐ **Update** my personal and/or my dependent and/or beneficiary information.

YOUR COVERAGE CHOICES Check(☑) the box for the level of coverage you want.

Coverage Type	Coverage Level	Monthly Cost
Medical	☐ Employee Only	$0.00
	☐ Employee + Spouse	$564.46
	☐ Employee + Child(ren)	$460.52
	☐ Employee + Family	$982.09

EMPLOYER GROUP INFORMATION This section is to be completed by your employer.

Employee ID	Hire date (MM/DD/YYYY)	Pay type	Total deduction ($)	**Effective date** (MM/DD/YYYY)
Location or site code	Authorized signature		Title	Today's date (MM/DD/YYYY)

INFORMATION ABOUT YOU Repeat your name and Social Security number here.

Print your name (first, middle initial, last) | Social Security Number

[INFORMATION ABOUT YOUR DEPENDENTS List the dependents for whom you are adding/changing/removing coverage.

If you have more dependents, write down their information on a separate sheet and attach it to this Enrollment/Change Request.

☐ Add ☐ Change ☐ Remove

Print dependent's name (first, middle initial, last) | Social Security Number

Sex ☐ Male / ☐ Female | Date of birth

Relationship: ☐ Spouse ☐ Domestic partner ☐ Child ☐ Other (Specify): _____

Address (if different than yours) | City | State | Zip code

☐ Add ☐ Change ☐ Remove

Print dependent's name (first, middle initial, last) | Social Security Number

Sex ☐ Male / ☐ Female | Date of birth

Relationship: ☐ Spouse ☐ Domestic partner ☐ Child ☐ Other (Specify):

Address (if different than yours) | City | State | Zip code

☐ Add ☐ Change ☐ Remove

Print dependent's name (first, middle initial, last) | Social Security Number

Sex ☐ Male / ☐ Female | Date of birth

Relationship: ☐ Spouse ☐ Domestic partner ☐ Child ☐ Other (Specify): _____

Address (if different than yours) | City | State | Zip code

MAKING CHANGES OUTSIDE OF AN OPEN ENROLLMENT Please read below to see if you are able to make changes to your coverage.

You can add to or increase your coverage during the plan year only if you have a **Qualifying Life Event (QLE)**. QLEs fall under one of these two categories:

Loss of Other Coverage (LOC): If you previously declined health coverage because you or your dependents were already covered under another health plan and you or your dependents have lost that other coverage, you may be able to enroll yourself and your dependents. If you had a recent LOC, go to the list on the right and check the box next to your LOC and supply the date of the LOC.

Family Status Change (FSC): Whether you are currently enrolled or previously declined coverage, you may be able to add or increase coverage when you experience certain FSC events. If you had a recent FSC, go to the list on the right and check the box next to your FSC and supply the date of the FSC.

[Next, complete the rest of this Enrollment/Change Request. When finished, make a copy and submit it to your employer with your documentation attached. You must submit this Enrollment/Change Request, together with documentation, to your employer within [31] days of the LOC/FSC.

Loss of Other Coverage (LOC):

- ☐ Divorce, legal separation or death
- ☐ Termination of employment of a dependent
- ☐ Reduction of a dependent's hours
- ☐ Termination of your or your dependents' COBRA rights
- ☐ Loss of employer's contribution to spouse's or domestic partner's coverage
- ☐ Dependent child losing eligibility as a dependent
- ☐ Other loss of coverage

Family Status Change (FSC):

- ☐ Divorce, legal separation or death
- ☐ Marriage
- ☐ Birth or adoption of a dependent
- ☐ Other

Date of LOC or FSC (mm/dd/yyyy)

YOUR AUTHORIZATION You must sign and date this Enrollment/Change Request for all new enrollments or coverage changes.

I represent that all information supplied in this Enrollment/Change Request is true and complete to the best of my knowledge and/or belief. I have read and agree to the Conditions of Enrollment on the last page of this Enrollment/Change Request.

Your signature | Today's date (MM/DD/YYYY)

CONDITIONS OF ENROLLMENT Applicant acknowledgments and agreements

NOTICE: California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.

On behalf of myself and the dependents listed on this Enrollment/Change Request, I agree to or with the following:

1. I acknowledge that by enrolling in an Aetna plan coverage is underwritten and administered by Aetna Life Insurance Company (Aetna) 151 Farmington Avenue, Hartford, CT 06156.
2. I authorize deductions from my earnings for any contributions required for coverage and I agree to make any necessary payments as required for coverage.
3. I understand and agree that this Enrollment/Change Request may be transmitted to Aetna or its agent by my employer or its agent. I authorize any physician, other healthcare professional, hospital or any other healthcare organization ("Providers") to give Aetna or its agent information concerning the medical history, services or treatment provided to anyone listed on this Enrollment/Change Request, including those involving mental health, substance abuse and AIDS. I further authorize Aetna to use such information and to disclose such information to affiliates, providers, payors, other insurers, third party administrators, vendors, consultants and governmental authorities with jurisdiction when necessary for my care or treatment, payment for services, the operation of my health plan, or to conduct related activities. I have discussed the terms of this authorization with my spouse or domestic partner and competent adult dependents and I have obtained their consent to those terms. I understand that this authorization is provided under state law and that it is not an "authorization" within the meaning of the federal Health Insurance Portability and Accountability Act. This authorization will remain valid for the term of the coverage and so long thereafter as allowed by law. I understand that I am entitled to receive a copy of this authorization upon request and that a photocopy is as valid as the original.
4. The plan documents will determine the rights and responsibilities of covered person(s) and will govern in the event they conflict with any benefits comparison, summary or other description of the plan.
5. **Attention California Residents: For your protection California law requires notice of the following to appear on this form**: The falsity of any statement in this Enrollment/Change Request shall not bar the right to recovery under the policy unless such false statement was made with actual intent to deceive or unless it materially affected either the acceptance of the risk or the hazard assumed by Aetna.
   Attention Pennsylvania Residents: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.
   Attention Rhode Island Residents: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

TRANSAMERICA®
Employee Benefits

Transamerica Life Insurance Company
Administered By
Boon Administrative Services, Inc.
6300 Bridgepoint Parkway, Building 3, Suite 500
Austin, TX 78730

Beneficiary Designation Form

Applicant (Last, First, M.I.)	Social Security No.	Product

Beneficiary (Last, First, M.I.)	Beneficiary Type*	%	Relationship	Social Security No.	Date of Birth
	☐ Primary ☐ Contingent				
	☐ Primary ☐ Contingent				
	☐ Primary ☐ Contingent				
	☐ Primary ☐ Contingent				
	☐ Primary ☐ Contingent				
	☐ Primary ☐ Contingent				
	☐ Primary ☐ Contingent				
	☐ Primary ☐ Contingent				
	☐ Primary ☐ Contingent				
	☐ Primary ☐ Contingent				

*Primary Beneficiary is the first to receive the benefit. Contingent Beneficiaries receive the benefits in the event the Primary Beneficiary is no longer living at the time the insured dies.

Insured Signature: _____ Date: _____

Please return all benefits related forms to Boon Administrative Services, Inc., your Benefits Administrator:

Boon Group
P.O. Box 9788
Austin, TX 78766
Email: enrollment@theboongroup.com
Fax: (512) 339-6662

Please allow 72 hours for processing.
Questions? Call Customer Service toll-free at (866)337-8417