Plan information

MedPremier

aetna™

ActOne Government Solutions
Effective Date: 01-01-2024
Open Choice® PPO - Nevada

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

PLAN FEATURES	IN-NETWORK	OUT-OF-NETWORK
Benefit limitations - Some service or supplies have limits on them per year. There might be a maximum number of visits or days, or a dollar limit per year. In such cases, the benefit year begins on January 1 (unless otherwise noted). Refer to your plan documents to learn more.		
Deductible (per calendar year)	$1,500 per Individual $3,000 per Family	$3,000 per Individual $6,000 per Family
Covered expenses in-network add up towards your in-network deductible. Covered expenses out-of-network add up towards your out-of-network deductible. You must first meet the deductible before the plan begins paying benefits, unless otherwise noted. The amount you pay (cost sharing) for some medical services does not count toward your deductible. Prescription drug costs do not count toward the deductible. Refer to your plan documents for details. Your family will have one deductible. You will meet it when the expenses of several family members add up to the family deductible. No one person will have to pay more than the individual deductible.		
Member coinsurance Applies to all expenses except as noted.	You pay 20%	You pay 50%
Out-of-pocket limit (per calendar year)	$3,000 per Individual $6,000 per Family	$6,000 per Individual $12,000 per Family
Covered expenses in-network add up towards your in-network out-of-pocket limit. Covered expenses out-of-network add up towards your out-of-network out-of-pocket limit. Some of your cost sharing may not count toward the out-of-pocket limit. Your pharmacy expenses count toward your out-of-pocket limit. In-network expenses include coinsurance/copays and deductibles. Out-of-network expenses include coinsurance and deductibles. Penalty amounts do not apply. Your family will have one out-of-pocket limit. You will meet it when the expenses of several family members add up to the family out-of-pocket limit. No one person will have to pay more than the individual out-of-pocket limit amount.		
Lifetime maximum Unlimited except where otherwise indicated.		
Payment for out-of-network care**	Does not apply	Professional: Prevailing Charges Facility: Prevailing Charges
Primary care physician selection	Encouraged	Does not apply
Precertification requirements - Some out-of-network services need approval by us in advance (precertification). Without this approval, we reduce benefits by $500. Refer to your plan documents for a full list of services that need this approval.		
Referral requirement	Not required	None
Telehealth consultations - You can access covered services for telehealth visits from different kinds of providers in your plan. Log on to **Aetna.com** to see a list of telehealth providers. You'll also find more about your options, including cost share amounts.		
PREVENTIVE CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Routine adult physical exams/ immunizations 1 exam every 12 months until age 65, then 1 exam every 12 months age 65 and older	Covered 100%; no deductible	50%; after deductible
Routine well child exams/immunizations • 7 exams in the first 12 months • 3 exams from age 13 through 24 months • 3 exams from age 25 through 36 months • 1 exam every 12 months from age 3 until age 22 years	Covered 100%; no deductible	50%; after deductible
Routine gynecological care exams 1 exam and pap smear per year, includes related fees.	Covered 100%; no deductible	50%; after deductible

PLAN DESIGN & BENEFITS
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Routine mammogram Recommended: One per year for members age 40 and over	Covered 100%; no deductible	50%; after deductible
Women's health Includes: Screening for gestational diabetes, HPV (Human- Papillomavirus) DNA testing, counseling for sexually transmitted infections, counseling and screening for human immunodeficiency virus, screening and counseling for interpersonal and domestic violence, breastfeeding support, supplies and counseling. Also includes: contraceptive methods (ACA mandated contraceptives, including contraceptives and devices you can't get at a pharmacy), sterilization procedures (including tubal ligation), patient education and counseling. Limits may apply.	Covered 100%; no deductible	50%; after deductible
Pre-natal maternity	Covered 100%; no deductible	50%; after deductible
Routine digital rectal exam Recommended: For members age 40 and over	Covered 100%; no deductible	50%; after deductible
Prostate-specific antigen test Recommended: For members age 40 and over	Covered 100%; no deductible	50%; after deductible
Colorectal cancer screening Recommended: For members age 45 and over	Covered 100%; no deductible	50%; after deductible
Routine eye exams 1 routine exam per 12 months.	$45 copay; no deductible	50%; after deductible
Routine hearing screening	Covered 100%; no deductible	50%; after deductible
PHYSICIAN SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Office visits to non-specialist Includes services of an internist, general physician, family practitioner or pediatrician.	$25 office visit copay; no deductible	50%; after deductible
Telehealth consultation with non-specialist	$25 office visit copay; no deductible	50%; after deductible
Specialist office visits	$45 office visit copay; no deductible	50%; after deductible
Telehealth consultation with specialist	$45 office visit copay; no deductible	50%; after deductible
Hearing exams	Not Covered	Not Covered
Walk-in clinics Walk-in clinics are free-standing health care facilities. Sometimes they may be within a pharmacy, drug store, supermarket, or other retail store. They offer some limited medical care and services. Not walk-in clinics: Urgent care centers, emergency rooms, the outpatient department of a hospital, ambulatory surgical centers, and physician offices.	$25 copay; no deductible **Designated Walk-in clinics** Covered 100%; no deductible	50%; after deductible
Allergy testing	Your cost sharing amount depends on the type of service and where you receive it.	Your cost sharing amount depends on the type of service and where you receive it.
Allergy injections	Your cost sharing amount depends on the type of service and where you receive it.	Your cost sharing amount depends on the type of service and where you receive it.
DIAGNOSTIC PROCEDURES	**IN-NETWORK**	**OUT-OF-NETWORK**
Diagnostic X-ray (Other than complex imaging services) When your physician performs and bills for this service at their office, you pay your office visit cost share amount.	20%; after deductible	50%; after deductible
Diagnostic laboratory When your physician performs and bills for this service at their office, you pay your office visit cost share amount.	20%; after deductible	50%; after deductible
Diagnostic complex imaging When your physician performs and bills for this service at their office, you pay your office visit cost share amount.	20%; after deductible	50%; after deductible

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

EMERGENCY MEDICAL CARE	IN-NETWORK	OUT-OF-NETWORK
Urgent care provider	20% after $35 office visit copay; no deductible	50%; after deductible
Non-urgent use of urgent care provider	50%; after deductible	50%; after deductible
Emergency room Copay waived if admitted	20% after $300 copay; no deductible	Same as in-network care
Non-emergency care in an emergency room	50%; after deductible	50%; after deductible
Emergency use of ambulance	20%; no deductible	Same as in-network care
Non-emergency use of ambulance	Not Covered	Not Covered
HOSPITAL CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient coverage	20%; after deductible	50%; after deductible
When you're admitted into a hospital for the care you need, your cost sharing amount counts toward all covered benefits you receive.		
Inpatient maternity coverage (includes delivery and postpartum care)	20%; after deductible	50%; after deductible
When you're admitted into a hospital for the care you need, your cost sharing amount counts toward all covered benefits you receive.		
Outpatient hospital	20%; after deductible	50%; after deductible
When you receive outpatient care at a hospital but don't stay overnight, your cost sharing amount counts toward all covered benefits during your visit.		
Outpatient surgery - hospital	20%; after deductible	50%; after deductible
When you receive outpatient care at a hospital but don't stay overnight, your cost sharing amount counts toward all covered benefits during your visit.		
Outpatient surgery - freestanding facility	20%; after deductible	50%; after deductible
When you receive outpatient care at a hospital but don't stay overnight, your cost sharing amount counts toward all covered benefits during your visit.		
MENTAL HEALTH SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient	20%; after deductible	50%; after deductible
When you're admitted into a hospital for the care you need, your cost sharing amount counts toward all covered benefits you receive.		
Mental health office visits	$45 copay; no deductible	50%; after deductible
Mental health telehealth consultations	$45 office visit copay; no deductible	50%; after deductible
Other mental health services	20%; after deductible	50%; after deductible
When you receive outpatient care at a facility but don't stay overnight, your cost sharing amount counts toward all covered benefits during your visit.		

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

SUBSTANCE ABUSE	IN-NETWORK	OUT-OF-NETWORK
Inpatient	20%; after deductible	50%; after deductible
When you're admitted into a hospital for the care you need, your cost sharing amount counts toward all covered benefits you receive.		
Residential treatment facility	20%; after deductible	50%; after deductible
When you're admitted into a facility for the care you need, your cost sharing amount counts toward all covered benefits you receive.		
Substance abuse office visits	$45 copay; no deductible	50%; after deductible
Substance abuse telehealth consultations	$45 office visit copay; no deductible	50%; after deductible
Other substance abuse services	20%; after deductible	50%; after deductible
When you receive outpatient care at a facility but don't stay overnight, your cost sharing amount counts toward all covered benefits during your visit.		
THERAPY SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Spinal manipulation therapy	$45 copay; no deductible	50%; after deductible
Limited to 12 visits per year		
Outpatient short-term rehabilitation	$45 copay; no deductible	50%; after deductible
Limited to 30 visits per year Includes physical, occupational, and speech therapies.		
Habilitative physical therapy	20%; after deductible	50%; after deductible
Habilitative occupational therapy	20%; after deductible	50%; after deductible
Habilitative speech therapy	20%; after deductible	50%; after deductible
Autism related physical therapy	20%; after deductible	50%; after deductible
Autism related occupational therapy	20%; after deductible	50%; after deductible
Autism related speech therapy	20%; after deductible	50%; after deductible
Autism related behavioral therapy	$45 copay; no deductible	50%; after deductible
These benefits are combined with outpatient mental health visits		
Autism related applied behavior analysis	20%; after deductible	50%; after deductible
Your benefits for these services are the same as any other outpatient mental health other services benefit		
OTHER SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Skilled nursing facility	20%; after deductible	50%; after deductible
Limited to 30 days per year When you're admitted into a facility for the care you need, your cost sharing amount counts toward all covered benefits you receive.		
Home health care	20%; after deductible	50%; after deductible
Limited to 60 visits per year Private duty nursing not included. Limited to three visits per day by staff from a home health care agency. One visit equals a period of four hours or less.		
Hospice care - inpatient	20%; after deductible	50%; after deductible
30 days/lifetime When you're admitted into a facility for the care you need, your cost sharing amount counts toward all covered benefits you receive.		
Hospice care - outpatient	20%; after deductible	50%; after deductible
When you receive outpatient care at a facility but don't stay overnight, your cost sharing amount counts toward all covered benefits during your visit.		

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

Private duty nursing	Not Covered	Not Covered
Durable medical equipment	20%; after deductible	50%; after deductible
Diabetic supplies -- (if not covered under the prescription drug benefit)	Covered same as any other medical expense. You pay your prescription drug cost sharing amount if you have prescription drug coverage. If not, you pay your PCP visit cost sharing amount.	Covered same as any other medical expense. You pay your prescription drug cost sharing amount if you have prescription drug coverage. If not, you pay your PCP visit cost sharing amount.
Infusion therapy - home/office	$45 copay; no deductible	50%; after deductible
Infusion therapy - outpatient hospital/freestanding facility	20%; after deductible	50%; after deductible
Gene-based, Cellular, and other Innovative Therapies (GCIT™)	Your cost sharing amount depends on the type of service and where you receive it. $50 copay: after deductible for gene therapy drugs, if applicable In-network coverage is provided at GCIT™ designated facilities only.	Not Covered
Transplants	20%; after deductible In-network coverage is only available at Institutes of Excellence (IOE) contracted facility.	50%; after deductible Out-of-network coverage applies when you use a non-IOE facility. You will pay more out of pocket when using a non-IOE facility.
Bariatric surgery	Not Covered	Not Covered
Acupuncture Limited to 10 visits per year	$25 copay; no deductible	50%; after deductible
"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 amount depends on the type of service and where you receive it.	Your cost sharing amount depends on the type of service and where you receive it.
You have coverage for the diagnosis and treatment of the underlying cause of infertility.		
Comprehensive infertility services Artificial insemination and ovulation induction	Not Covered	Not Covered
Advanced Reproductive Technology (ART)	Not Covered	Not Covered
In-vitro fertilization (IVF), zygote intrafallopian transfer (ZIFT), gamete intrafallopian transfer (GIFT), cryopreserved embryo transfers, intracytoplasmic sperm injection (ICSI), or ovum microsurgery		
Vasectomy	Your cost sharing amount depends on the type of service and where you receive it.	50%; after deductible
Tubal ligation	Covered 100%; no deductible	50%; after deductible

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

PHARMACY	IN-NETWORK	OUT-OF-NETWORK
Pharmacy plan type	Advanced Control Plan	
Prescription drug out-of-pocket limit	Prescription drug expenses apply to your medical out-of-pocket limit.	
Preferred generic drugs		
Retail	$20 copay	50% of submitted cost; after applicable in-network cost share
Mail order	$40 copay	50% of submitted cost; after applicable in-network cost share
Preferred brand-name drugs		
Retail	$60 copay	50% of submitted cost; after applicable in-network cost share
Mail order	$120 copay	50% of submitted cost; after applicable in-network cost share
Non-preferred generic and brand-name drugs		
Retail	$100 copay	50% of submitted cost; after applicable in-network cost share
Mail order	$200 copay	50% of submitted cost; after applicable in-network cost share
Specialty drugs		
Preferred specialty	40%	Not Covered
Non-preferred specialty	50%	Not Covered
Pharmacy day supply and requirements		
Retail	You can get up to a 30-day supply from CVS Caremark® National Network	
Mail order	You can get a 31-90-day supply from CVS Caremark® Mail Service Pharmacy.	
Specialty	You can get up to a 30-day supply of specialty drugs You may fill your first prescription at any retail or specialty pharmacy. After that, all other fills must be through our preferred specialty pharmacy network. Advanced Control Formulary Aetna Insured List	

Your prescription drug plan also includes:
• Diabetic supplies
• A limited list of over-the-counter medications when filled with a prescription

Family planning
• Oral fertility drugs included.
• Contraceptives covered up to a 12-month supply. Contraceptive copay strategy applies.

The following are covered 100% in-network:
• Oral chemotherapy drugs
• Seasonal vaccinations
• Preventive vaccinations
• Affordable Care Act (ACA) eligible preventive medications and contraceptives
Refer to **Aetna.com** for a complete list of eligible prescription drugs.

Precertification requirements
Some covered prescription drugs need approval from us before we will cover the drug.
Some covered prescription drugs require step therapy before we cover them. With step therapy, you must first try one or more drugs before we will pay for drugs that require step therapy.
To get the most up-to-date precertification requirements and a list of drugs that require step therapy, see your plan documents or go online to your member website.

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

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GENERAL PROVISIONS	
Dependents who are eligible to be on your plan	Spouse, children from birth to age 26. Student status of children does not matter.

**We cover the cost of services based on whether doctors are "in network" or "out of network." We want to help you understand how much we pay for your out-of-network care. At the same time, we want to make it clear how much more you will need to pay for this "out-of-network" care.
You may choose a provider (doctor or hospital) in our network. You may choose to visit an out-of-network provider. If you choose a doctor who is out of network, your health plan may pay some of that doctor's bill. Most of the time, you will pay a lot more money out of your own pocket if you choose to use an out-of-network doctor or hospital.

When you choose out-of-network care, we limit the amount it will pay. This limit is called the "recognized" or "allowed" amount.
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 what Medicare pays for these services. The government sets the Medicare rate. Exactly how much we "recognize" depends on the plan you or your employer picks.

Your doctor sets his or her own rate to charge you. It may be higher -- sometimes much higher -- than what your plan "recognizes." Your doctor may bill you for the dollar amount that we don't "recognize." You must also pay any copayments, coinsurance and deductibles under your plan. No dollar amount above the "recognized charge" counts toward your deductible or out-of-pocket maximums. To learn more about how we pay out-of-network benefits visit our website.
You can avoid these extra costs by getting your care from Aetna's broad network of health care providers. Go to www.aetna.com and click on "Find a Doctor" on the left side of the page. If you are already a member, sign on to your Navigator member site.
This applies when you choose to get care out of network. When you have no choice (for example: emergency room visit after a car accident, or for other emergency services), we will pay the bill as if you got care in network. You pay cost sharing and deductibles for your in-network level of benefits. Contact us if your provider asks you to pay more. You are not responsible for any outstanding balance billed by your providers for emergency services beyond your cost sharing and deductibles.
This way of paying out-of-network doctors and hospitals applies when you choose to get care out of network. When you have no choice (for example: emergency room visit after a car accident), we will pay the bill as if you got care in-network. You pay your plan's copayments and deductibles for your in-network level of benefits. Contact us if your provider asks you to pay more. You are not responsible for any outstanding balance billed by your providers for emergency services beyond your copayments and deductibles.

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

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

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

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

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

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

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

Puede estar disponible la 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.

BENEFITS SUMMARY

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

Vision Exams (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

Fees for other services must be paid by you. Benefit period is 12 consecutive months beginning on the later of your effective date or your most recent eye exam covered under this plan.

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	
Maximum benefit per coverage year	$2,000
Deductible per coverage year	$25
Preventive services (includes checkups and cleanings)	You are responsible for paying up to 0%† 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. These services have no waiting period.
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.

To locate a preferred provider, call toll-free **1-866-292-3374** or visit **www.aetna.com/docfind/custom/aahc/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.

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/voluntary** 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, llame a Servicios al Miembro al 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 marque 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. Policies may not be available in all states, and rates and benefits may vary by location. 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**.

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 in Oklahoma and Idaho include GR-9/9N, GR-29/29N, GR-23.

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.

short term disability insurance

life | **health**

This proposal highlights the features of **basic short term disability income insurance**, underwritten by Transamerica Life Insurance Company, which is an annually renewable, self-administered, basic short term disability income insurance policy designed to insure all of your eligible employees. Quoted rates are valid for 90 days, after which they are subject to change without notice.

Maximum Weekly Benefit Amount	$400
Accident & Sickness Elimination Period	14 days
Maximum Disability Benefit Period	3 months
Maximum Percent of Compensation Payable	80%

This proposal describes insurance highlights only. This is not an offer. Limitations and exclusions apply. No contract will result until an application is submitted and approved by the insurance company and a policy is issued. For complete information, refer to the master policy and riders approved in your state. If there is any variance between the language found in this proposal and the policy language, the policy language will control. **This is not a policy of workers' compensation insurance.**

This is a brief summary of Basic Short Term Disability Income Insurance underwritten by Transamerica Life Insurance Company, Cedar Rapids, Iowa. Policy form series CPBDI100. Forms and form numbers may vary. This coverage may not be available in all jurisdictions. Limitations and exclusions apply. Refer to the policy and riders for complete details.

summary of benefits

total disability benefit

Disability Benefits will be paid if the Insured becomes Totally Disabled. Total Disability must be due to a covered Accident or Sickness, and begin while the Insured's coverage is in force. Total Disability will be deemed to have commenced on the date the Insured first receives treatment from a Physician following continuous cessation of work. We will pay benefits for each period of Total Disability that continues beyond the Elimination Period. We will not pay benefits beyond the Maximum Disability Period stated on the Insurance Schedule.

Disability Benefits will be paid for only one disability when more than one disability exists at the same time or a disability results from two or more causes. If any monthly benefit is to be paid for less than a full month, the amount of benefit will be reduced pro-rata on the basis that one day's benefit equals one-thirtieth (1/30th) the Disability Benefit. We will pay the Disability Benefit only for a period in which the Insured is under the Regular Care and Attendance of a Physician.

geographical limitations - If an Insured becomes disabled outside the United States or its territories, Disability Benefit payments will be limited to two months. To continue to receive any additional benefit payments, the Insured must reside in the United States or its territories.

family or medical leave of absence - If the Insured is not in Active Service due to an approved FMLA leave, then this insurance may be continued, until the earliest of the end of the leave period required by federal or state law, the date the insured notifies the employer that he or she will not return to work, or the date the Insured begins employment with another employer, provided we receive the required premium for the Insured's coverage.
An approved leave of absence does not include layoff or termination of employment. If the Insured goes on a leave of absence which is not subject to FMLA or any similar state law, the Insured's insurance may be continued until the end of the calendar month in which the leave began, provided we receive the required premium for the Insured's coverage for that month.

subsequent disabilities - Separate periods of disability resulting from unrelated conditions are considered a continuation of the previous disability, not a new disability, unless they are separated by at least seven calendar days, during which time the Insured returned to work.

successive disabilities - Those disabilities which result from the same or related causes for which benefits are payable under the policy. Successive Disabilities will be considered one period of disability, unless the disabilities are separated by the Insured's return to Active Service or any other occupation for at least 90 consecutive days. Any disability which begins after termination of coverage will not be considered a Successive Disability and will not be covered under this Policy.

partial disability benefit

A Partial Disability Benefit will be paid if an Insured becomes Partially Disabled due to a covered Accident or Sickness. Payment of the Partial Disability Benefit is subject to the following conditions:

1. The Elimination Period for Total Disability must be satisfied.
2. Partial Disability Benefits will be payable beginning the first day following cessation of Total Disability.
3. The Partial Disability must be the result of the same Accident or Sickness which caused Total Disability.
4. The Partial Disability Benefit will be payable for a maximum period of six consecutive months. However, the combined period of time for which benefits are payable for Total Disability and Partial Disability may not exceed the Maximum Disability Period stated on the Insurance Schedule.
5. The Partial Disability Benefit will be equal to 50% of the Disability Benefit. However, the sum of the Partial Disability Benefit, the salary earned while receiving Partial Disability Benefits, and income from all other sources may not exceed 100% of the Insured's pre-disability Monthly Compensation. In this event, the Minimum Disability Benefit, if any, stated on the Insurance Schedule will not be payable.

mental illness limited benefit

If an Insured is Totally Disabled due to a Mental Illness, regardless of the cause, Disability Benefits will be paid for the period up to the Maximum Mental Illness Disability Period shown on the Insurance Schedule provided the Insured is under the Regular Care and Attendance of a Physician and for the first 12 months after the date the Insured completes his or her Elimination Period, the Insured receives medical treatment (mental or medical examination alone not being considered treatment) from either:

1. A registered specialist in psychiatry;
2. A Physician administering treatment on the advice of a registered specialist in psychiatry who certifies that such treatment is medically necessary; or
3. A Physician, if in our opinion, a specialist in psychiatry is not required to certify that such treatment is medically necessary.

Mental Illness means a psychiatric or psychological condition such as:

1. Schizophrenia;
2. Depression;
3. Manic depressive or bipolar illness;
4. Anxiety;
5. Personality disorders;
6. Alcohol addiction;
7. Drug addiction; and/or
8. Adjustment disorders or other conditions, usually treated by a mental health provider or other qualified provider using psychotherapy, psychotropic drugs or other similar modalities used in the treatment of the above conditions.

The term Mental Illness does not apply to dementia, if due to:

1. Stroke;
2. Trauma;
3. Viral infection;
4. Alzheimer's disease; or
5. Other such conditions not listed above which are not usually treated by a mental health provider using psychotherapy, psychotropic drugs, or other similar modalities.

This benefit is limited to 50% of the Maximum Disability Benefit Period shown on the Schedule Page, with a minimum benefit period of 3 months. Lifetime maximum benefit is 12 months of disability payments.

waiver of premium

If the Insured becomes Totally Disabled due to a covered Accident or Sickness, the Insured's coverage will be continued without payment of premium. Waiver of Premium will begin the next premium due date following the Insured's satisfaction of the Elimination Period. Premium must be paid from the beginning of Total Disability to the date Waiver of Premium begins.

Waiver of Premium will continue until the earliest of the:

1. End of the Insured's Total Disability;
2. End of the Maximum Benefit Period;
3. End of the period for which benefits would otherwise be payable;
4. Date the policy terminates; or
5. Date the Insured's employment or relationship with you terminates as determined by you.

limitations, adjustments and exclusions

The sum of the Disability Benefits paid to the Insured and the payments the Insured is entitled to receive from the sources described below, may not exceed the percentage of Monthly Compensation shown on the Insurance Schedule:

1. Group or individual insurance coverage or like coverage for persons in a group
2. Federal Social Security Act (this includes benefits paid to the Insured and the Insured's dependents on account of the Insured's disability).
3. State or federal government disability or retirement plan or increases thereof which begin on or after the date of Total Disability;
4. Pension plan to which you or the Insured's employer contributes or makes payroll deductions;
5. Salary or wage continuance plans such as sick leave paid for by you or the Insured's employer which extend beyond the period stated in the Insurance Schedule;
6. Federal Old Age Benefits, or increases which begin on or after the date of Total Disability, under the Federal Social Security Act on the Insured's own behalf; and
7. Workers' Compensation or similar law.

With respect to any and all of the above sources, if a lump sum payment is received by the Insured or his or her dependents for a period previously paid by us, any resulting overpayment by the Company will be due to us on a lump sum basis. If the Insured has the option of taking retirement benefits on a monthly basis but chooses to receive retirement benefits on a lump sum basis, we may assume he or she is receiving retirement benefits based upon the lowest monthly retirement plan benefit available to him or her prior to lump sum withdrawal.

With respect to items (2) and (6) only, unless the Insured shows proof to us that payments under these applicable programs or acts have been applied for but will not be paid, we:

1. Will assume each Insured who is covered under the Federal Social Security Act is receiving such payments; and
2. May require the Insured to reapply (but not more frequently than annually) once a Social Security denial has been received and all appeals have been pursued. Failure to reapply for benefits when required by us will result in our estimation of payment under those acts.

Benefits will not be reduced due to a cost of living increase in Social Security if the increase takes place while benefits are payable.

After application or reapplication has been made for the above applicable income sources, in lieu of our estimating other income, the Insured may complete a reimbursement agreement provided by us. The agreement will allow us to provide benefits without estimation of other income and require the Insured to reimburse us for any overpayment as the result of retroactive awards.
The Disability Benefits payable will never be less than the Minimum Disability Benefit amount shown on the Insurance Schedule.

pre-existing condition limitation

There will be no Disability Benefit payable for a Pre-existing Condition until the Insured has been continuously covered under the policy for 12 months, and has returned to performing the duties of his or her occupation for 30 continuous days after the first 12 months of coverage.

exclusions

The policy does not cover any loss, fatal or non-fatal, which occurs as a result of:

1. An intentionally self-inflicted injury while sane or insane;
2. Any act of war, declared or undeclared;
3. The Insured's commission of a felony;
4. The Insured operating, learning to operate or having any duty in the operation of any device or vehicle intended or designed for flight in the air including boarding, alighting or descending therefrom;
5. Accident or Sickness arising out of and in the course of any occupation, either full-time or part-time, for wage or profit. This exclusion applies even if Workers' Compensation is not paid for the on-the-job injury; or
6. An Accident sustained or Sickness contracted while in the service of the armed forces of any country.

basic term life insurance

life | health

ActOne Government Solutions

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.

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 Boon to verify coverage.

Who do I contact?

Vision providers must send their bills to Boon (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:** **www.aetna.com/dse/custom/bn**

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

Aetna Resources For Living℠

Employee Assistance Program
To access services:
1-800-599-7158 / TTY: 711
resourcesforliving.com
Username: MY123EAP
Password: MY123EAP

Boon Group - Med Premier

Aetna Resources For Living is an employer sponsored program, available at no cost to you and all members of your household. That includes dependent children up to age 26, whether or not they live at home.

Services are confidential and available 24 hours a day, 7 days a week.

Emotional well-being support

You can access up to 3 counseling sessions per issue each year. You can also call us 24 hours a day for in-the-moment emotional well-being support.

Counseling sessions are available face to face or online with televideo. Services are free and confidential. We're always here to help with a wide range of issues including:

- Relationship support
- Stress management
- Work/life balance
- Family issues
- Grief and loss
- Depression
- Anxiety
- Substance misuse and more
- Self-esteem and personal development

Daily life assistance

Competing day-to-day needs can make it tough to know where to start. Call us for personalized guidance. We'll help you find resources for:

- Child care, parenting and adoption
- Summer programs for kids
- School and financial aid research
- Care for older adults
- Caregiver support
- Special needs
- Pet care
- Home repair and improvement
- Household services and more

We also offer carekits related to growing families, child care, caregiving and more.

aetna™

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Online resources

Your member website offers a full range of tools and resources to help with emotional wellbeing, work/life balance and more. You'll find:

- Articles and self-assessments
- Adult care and child care provider search tool
- Stress resource center
- Video resources
- Live and recorded webinars
- Mobile app

Discount Center
Find deals on brand name products and services including electronics, entertainment, gifts and flowers, travel, fitness, nutrition and more.

Other services

Identity theft services — One hour fraud resolution phone consultation or coaching about ID theft prevention and credit restoration. Services include a free emergency kit for victims.

Legal services

You can get a free 30-minute consultation with a participating attorney for each new legal topic related to:

- General
- Family
- Criminal law
- Elder law and estate planning
- Divorce
- Wills and other document preparation
- Real estate transactions
- Mediation services

If you opt for services beyond the initial consultation you can get a 25 percent discount.

*Services must be related to the employee and eligible household members. Work-related issues are not covered. Discount does not include flat legal fees, contingency fees and plan mediator services.

Financial services

Simply call for a free 30-minute consultation for each new financial topic related to:

- Budgeting
- Retirement or other financial planning
- Mortgages and refinancing
- Credit and debt issues
- College funding
- Tax and IRS questions and preparation

You can also get a 25 percent discount on tax preparation services.

*Services must be for financial matters related to the employee and eligible household members.

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Hable con un médico matriculado por teléfono o video desde cualquier lugar

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Find the lowest-cost prescriptions in your area

Ahorre dinero
Encuentre los medicamentos recetados más baratos disponibles en su área

Find a pharmacy nearby
Locate a pharmacy near you to pick up prescriptions from your doctor visit*

*Medicine is prescribed when medically necessary

Encuentre una farmacia cercana
Localice una farmacia cercana para retirar los medicamentos recetados que le indicaron en su visita al médico*

*Los medicamentos se recetan únicamente cuando es médicamente necesario.

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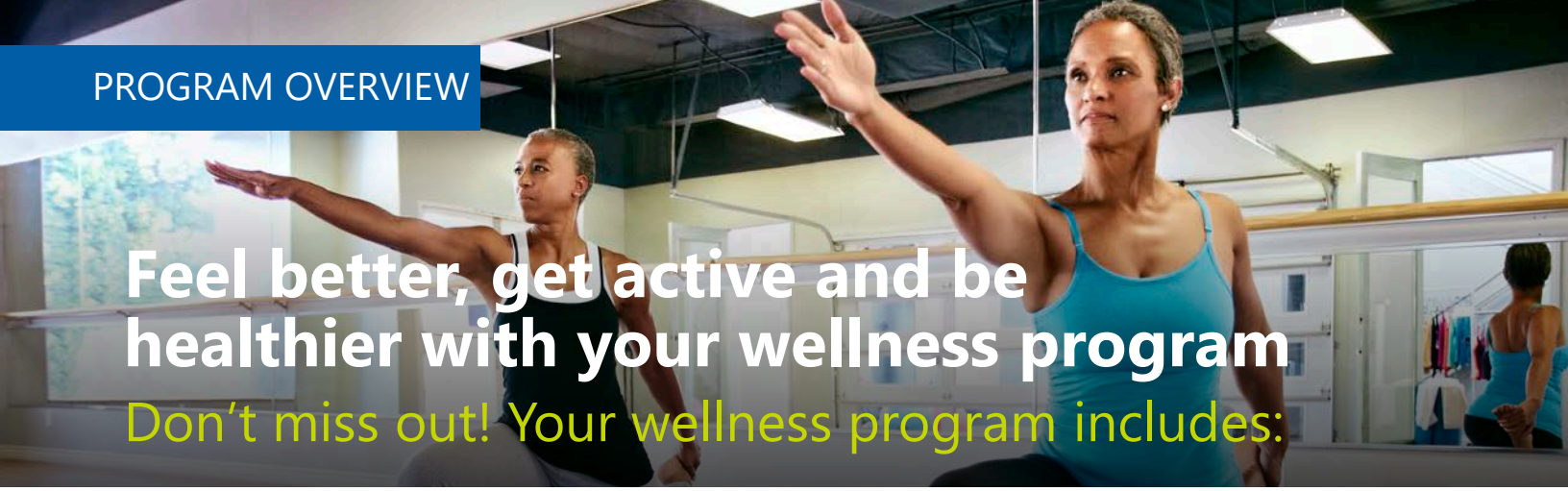
PROGRAM OVERVIEW



Feel better, get active and be healthier with your wellness program

Don’t miss out! Your wellness program includes:

Lifestyle and condition coaching:

Ready to do something good for yourself? Now, it’s easier than ever. This personalized coaching program can help you reach your health goals. You can learn to eat better, get more active and take charge of your health. You choose how to use the program. You can go at your own pace with online digital coaching. Or you can work with a coach in live, group coaching sessions or one to one over the phone.

MyActiveHealth website:

Managing your health can be challenging. But the tools that help you don’t have to be. That’s why we’ve made it easy to track your activity, get wellness advice, find healthy recipes and more. Whatever gets you closer to achieving your health goals. You’ll find it online at MyActiveHealth.com/MedPremier

ActiveHealth app:

Always on the go? No problem. The ActiveHealth app is ready for you wherever you are. Just search for “ActiveHealth” in your app store and download the app.

Health Actions:

Small actions matter — especially when it comes to staying at your best health. You’ll get notifications from ActiveHealth with important steps to take to help you achieve your best health. We call these Health Actions. Track them online on MyActiveHealth.com/MedPremier

Maternity support:

Pregnancy is an exciting time in your life. You may have a lot of questions or need support. Even if you’re an experienced mom. This program includes support and resources just for you. You can even call and speak to a nurse coach if you want.

Case management:

Your health should be front and center. That’s true whether you’re managing a chronic condition or recovering from an injury. Or maybe you’re dealing with another challenge. We’ll pair you with an experienced nurse. Your nurse coach can help take care of the details of whatever you’re facing. That leaves you free to focus on getting better.

You can get started today. Call **877-518-0768**
or log on **MyActiveHealth.com/MedPremier**

ActiveHealth MANAGEMENT

Services are provided by ActiveHealth Management, Inc. Our programs, care team and care managers do not provide diagnostic or direct treatment services. We assist you in getting the care you need, and our program is not a substitute for the medical treatment and/or instructions provided by your health care providers.

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.