The following documents were developed and intended for use as a complete enrollment package. By distributing, posting printing, downloading, or viewing the enrollment package, you agree that the components may not be modified, omitted or used independently of one another. Your distribution, posting, printing, downloading, or viewing also memorializes your agreement that Aetna Inc. is not responsible for any miscommunication resulting from the separation of these documents.

Aetna Voluntary Plans

Questions and Answers

Membership information you need to know

If you do not enroll now, you cannot enroll until the next open enrollment, unless you have a qualifying life event.

Open enrollment begins November 28, 2011 and ends January 1, 2012.

Just hired? You have 31 days from the date you are hired to enroll.

How do I decide if this plan is right for me?

Please read the information in this enrollment kit, including your Benefits Summary, which explains some of the benefits, limitations, features, and exclusions of this plan. Consider the amount you will pay in premiums, as shown on the Enrollment/Change Request form, and compare this plan to any other medical coverage options you may have. If you have any questions or need additional information, please call us toll free at **1-888-772-9682**.

How do benefit limits work?

Limits put a cap or ceiling on what the plan will pay. Some benefits have a limit on the dollar amount and others on the number of services, or both. The plan will not pay for a service or supply once you have reached a limit on either the dollar amount or the number of services for that service or supply. Because there are limits on what is paid for certain kinds of services or visits, you may not be covered for some services or visits even though you have not reached your overall maximum. Your Benefits Summary, found in this enrollment kit, explains these limits, maximums, and other features of your plan, such as copays and deductibles. Please read it carefully so that you understand what your plan will pay before you enroll.

Who can participate?

The following two classes are eligible to participate; Class 1: Core benefits eligible employees during their 90 day Core Medical waiting period; Class 2: Non-Core benefits eligible employees are eligible to participate. If you are an eligible employee, you can also enroll your eligible dependents. Your eligible dependents are your lawful spouse and your children from birth until age 26, through any age if handicapped and unable to earn a living, or until they can no longer be legally declared as dependents. Dependent age and status requirements may vary by state.

When does coverage begin?

Coverage is effective on the first day of the pay period following the pay period in which a deduction occurs.

When do maximums and deductibles reset?

Annual deductibles, maximums, and limits add up throughout the coverage year, then reset and begin again on the anniversary date of your coverage year, January 7.

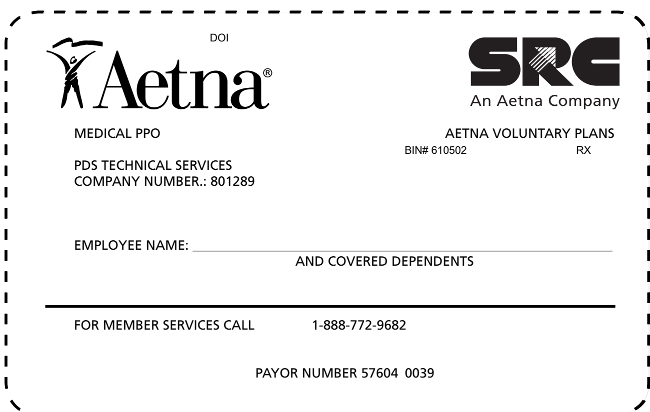
Will I get ID cards?

If you choose coverage, you will get plastic member identification (ID) cards. Until you get your plastic IDs, please use the temporary member ID at lower right. This ID is valid after you enroll and your coverage begins.

How do I file a claim?

Claim forms are available from **www.aetna.com/docfind/custom/aahc**, by calling SRC toll free at **1-888-772-9682**, or by writing to Strategic Resource Company, Attn: Claims Department, P.O. Box 14079, Lexington, KY 40512-4079.

Cut out your temporary member identification along the dotted line.


DOI

Aetna®

SRC An Aetna Company

MEDICAL PPO

AETNA VOLUNTARY PLANS

BIN# 610502 RX

PDS TECHNICAL SERVICES
COMPANY NUMBER.: 801289

EMPLOYEE NAME: ____________________
AND COVERED DEPENDENTS

FOR MEMBER SERVICES CALL 1-888-772-9682

PAYOR NUMBER 57604 0039

Aetna Voluntary Plans

Aetna Life Insurance Company

Missed Premium Payment Coupon

Company name	Group number	Today's date (mm/dd/yyyy)
PDS Technical Services	801289	
Member name (last, first, middle initial)	**Member daytime telephone number**	**Member Social Security number**

Payment will be applied to the oldest gap in coverage within the last 45 days from the postmark on your mailed payment. To find out what gaps in coverage you may have, please call us toll free at 1-888-772-9682.

______________________ X $ __________________________ = $ ________________________

Number of pay periods missed — Amount of deduction per pay period — **Full premium payment due**

Instructions: Make a copy of this page. Complete the payment coupon. Cut along the dotted line. Mail coupon with your full amount, made payable to ***SRC/Aetna***, to:

SRC Missed Premiums
P.O. Box 534739
Atlanta, GA 30353-4739

What if I miss a payroll deduction?
Your coverage will not begin until you have your first payroll deduction. Each payroll deduction pays for coverage for one payroll period. If you miss a payroll deduction after your coverage begins, you will not have coverage during the time that payroll deduction would cover, unless you pay the full missed premium directly to SRC.

Will my insurance be canceled if I don't make up a missed premium?
Once your coverage has begun, it will not be canceled because you do not make up a missed premium. However, no claims will be paid for losses or covered expenses that occur during the period for which premium is unpaid.

How do I pay my missed premium?
To pay by personal check, **cashier's check, or money order,** make payable to **SRC/Aetna** and send with a completed copy of the coupon above to: SRC Missed Premiums, P.O. Box 534739, Atlanta, GA 30353-4739. You can get additional payment coupons from **www.aetna.com/src**, or by calling **1-888-772-9682.**

Can I pick which missed premiums I wish to pay?
No. Your missed premium payment will always be applied to the oldest gap in coverage within the last 45 days (from the postmark on your mailed payment). You cannot choose to cover a later gap in coverage if you have an earlier gap within the past 45 days from the date your payment is postmarked. To find out what gaps in coverage you may have, please call toll free **1-888-772-9682**, Monday through Friday, 8 a.m. to 8 p.m. Eastern Time.

How long do I have to pay a missed premium?
You may pay for a gap in coverage that is up to 45 days old, from the date your payment is postmarked.

Can I pay just a part of a missed premium?
No. You must pay the full premium deduction that was missed in your paycheck, for all coverage you have. We cannot accept partial payments.

If I become ineligible or my employment ends, can I continue coverage with missed premium payments?
No. If your coverage terminates, you may not continue coverage by paying missed premiums. There may be other ways you can continue coverage, such as state continuation of coverage or COBRA, if eligible.

www.aetna.com/docfind/custom/aahc

HEALTH CARE PROVIDER: The person listed on the front of this card has been enrolled under a limited major medical plan sponsored by the employer listed on the front of this card. Covered members are entitled to benefits under the applicable plan, subject to exclusions and limitations. This card does not guarantee coverage. For verification of coverage, filing a claim or for questions other than the discount programs, contact us at the number printed on the front of this card or mail us at the address below

INSURED: Network physicians, hospitals, and other health care providers are independent contractors and are neither agents nor employees of Aetna Life Insurance Company.

EMERGENCY URGENT CARE: Call your local emergency hotline (ex.911) or go to the nearest emergency facility. For AETNA VISION DISCOUNTS call 1-800-793-8616. For LASIK call 1-800-422-6600. For CONTACTS DIRECT call 1-800-391-5367.

Strategic Resource Company
P.O. Box 14079
Lexington, KY 40512-4079

Notice to members concerning health care services: *Your share of the payment for health care services may be based on the agreement between your health plan and your provider. Under certain circumstances, this agreement may allow your provider to bill you for amounts up to the provider's regular billed charges.*

More questions?
*To get help in any language, call toll free **1-888-772-9682** Monday through Friday, 8 a.m. to 8 p.m. Eastern Time.*

¿Tiene más preguntas?
*Si necesita ayuda en cualquier idioma, llame sin cargo al **1-888-772-9682** de lunes a viernes de 8 a.m. a 8 p.m., hora del Este.*

Insurance Plans are underwritten by Aetna Life Insurance Company. Plans are administered by Strategic Resource Company (SRC). Health insurance plans contain exclusions and limitations. Information is believed to be accurate as of the production date; however, it is subject to change. For OK residents only, policy forms issued include GR-9/GR-9N and GR-29/GR-29N.

You *can* get affordable health insurance coverage at group rates!

Aetna Voluntary Plans
Limited Benefits Insurance Plan*

Cannot be turned down for affordable coverage

Special discounts

Information and tools to make a healthy decision

Insurance plans are underwritten by Aetna Life Insurance Company (Aetna). Plans are administered by Strategic Resource Company (SRC).

*Except in NY, this plan is filed as a major medical plan that contains an annual benefit maximum and a number of additional coverage limitations and exclusions.

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Is the Aetna Voluntary Limited Benefits Plan right for you?

Think about the following questions …

- Have you ever skipped a visit with your doctor because you didn't have insurance?
- Have you let an illness go untreated until you were too sick to go to work?
- Do you rely on emergency room visits to get care because, without insurance, you don't have a family doctor?
- Do you buy over-the-counter medicines instead of seeing a doctor or having a prescription filled?
- Do you want to visit the same doctor who knows your medical history and can provide treatment that is right for you?

If you answered "yes" to any of these questions and most of your medical expenses are for minor illnesses and injuries, then the Aetna Limited Benefits Plan may be right for you! If you have a chronic illness or expect to have significant medical needs in the next year, however, you may want to consider other health insurance options.

Six reasons why you should enroll in the Aetna Voluntary Limited Benefits Plan …

1. **Affordable coverage** — Coverage at lower group rates from a top health insurance provider, Aetna.
2. **Guaranteed acceptance** — You cannot be turned down for coverage during your enrollment period.
3. **Aetna ID card and network discounts** — Carrying an Aetna ID card gives you access to discounts from participating medical providers that typically range from 30 to 50 percent.*
4. **No claims to file** — Network providers submit claims on your behalf, so you can pay just your portion of the cost at the time of service.
5. **Discounts and programs** — Access to services and discounts you can use every day are included in the plan at no extra charge (check out the back panel).
6. **Professional customer service** — Trained customer service representatives, toll-free numbers, multilingual services, online access to forms and additional information, all designed to make it easy for you.

*Aetna network data.

Hi, I'm Cindy

Your employer is giving you the opportunity to enroll in the Aetna Voluntary Limited Benefits Plan. I'm here to explain the plan in more detail. The Aetna Voluntary Plan is a limited benefits insurance plan created for employees without medical benefits.

This plan helps with the costs of everyday health care — things like doctor's office visits, prescriptions, and short hospital stays. It is not a traditional health plan (such as a major medical plan), which would be more comprehensive and would cover larger medical expenses resulting from major illnesses or accidents.

Let's take a few minutes and look at some important things you should know before you enroll in the plan.

All insurance is not alike — let's take a look!

Traditional health insurance and Aetna's Voluntary Limited Benefits Plan are both designed to help you get access to the health care you need while reducing your out-of-pocket expenses. But there are some important differences. Let's look at how traditional insurance and the Aetna Limited Benefits Plan are different and the same.

	Traditional health insurance	Aetna Limited Benefits Plan
Health needs covered	All situations including serious and chronic illnesses, and extensive hospital stays	Minor illnesses and short hospital stays
Benefit maximums	No annual maximum High or unlimited lifetime maximums	Annual maximums
Limitations	Few limits on specific types of services	Limits including dollar amounts per visit or service, or limits on number of visits
Discounts on medical fees	Yes	Yes
Office visit copays	Yes	Yes
Pharmacy discounts	Yes	Yes
Cost of coverage	Higher	Lower

Here are some insurance terms you need to know

Let me explain some of the terms you may see to help you better understand how your plan works.

Deductible — The amount you must pay for eligible expenses before the plan begins to pay benefits. A deductible may be per service, per visit, per supply or per coverage year.

Copay — A fixed amount that you must pay for a medical service after you have met any deductible. In some cases, you may be responsible for paying a copay as well as a percentage of the remaining charges.

Inpatient Charges — Charges while you stay as an inpatient at a hospital or other inpatient facility, including hospital room and board charges (daily room rate), inpatient professional services, and other hospital services.

Outpatient Charges — Charges for services and supplies provided at doctors' offices, free-standing clinics and outpatient facilities. They also include charges at a hospital when you are not admitted as an inpatient, including emergency room charges.

Benefits Summary — Overview of your particular plan's benefits. It explains how much the plan will pay for specific types of services, and lists exclusions and limitations of the plan. **Please read it carefully before you enroll.**

Understanding how the Aetna Voluntary Limited Benefits Plan works

The following is a general example of how an Aetna limited medical benefits plan works. Your plan works the same way, but may contain different **copays, deductibles** or limit amounts. Always refer to your **Benefits Summary** for what your specific plan pays.

The column on the left shows what the plan will pay for **outpatient charges**. The column on the right shows what the plan will cover if you go into the hospital, which is also known as **inpatient charges.**

This example is based on using preferred, in-network providers.

The graph shows the maximum overall benefit per coverage year.

Amount available for room and board and inpatient professional services not billed by the hospital.

This part of the total benefit is a dollar amount available for outpatient charges.

May include:

- Visits to the doctor
- Visits to free-standing clinics
- Lab and diagnostic services
- Outpatient surgery
- Outpatient supplies
- Hospital services when not admitted as an inpatient, including emergency room charges

(Refer to your Benefits Summary for the dollar amount on outpatient charges.)

Prescription drugs

Refer to the Benefits Summary for details.

This part of the total benefit is a dollar amount for hospital services other than room and board. (Refer to your Benefits Summary for the dollar amount limit on other hospital services.)

You pay:

- $100 deductible
- 20% of the negotiated charges in-network up to the maximum benefit of your plan
- Any charges over the limits on outpatient charges and other other hospital services or the overall maximum

If the cost of services exceeds the limits of the plan, then you are responsible for the excess amount.

Language assistance

If you need assistance in any language, please call Member Services at **1-888-772-9682**.

Su necesita asistencia en cualquier idioma, por favor llame a Servicios al Cliente al **1-888-772-9682**.

Take a look at how the plan pays for some common health care services and saves you money

These examples show what you would pay with and without insurance.

How using a network provider can stretch your benefit dollars

The term "in-network" or "preferred provider" describes doctors, hospitals, and other health care professionals who work with Aetna to charge lower prices for medical services — usually 30 to 50 percent lower. This can save you a significant amount of money. Out-of-network providers have not contracted with Aetna for negotiated (lower) rates, so the amount you are charged may be higher than it would be if you saw an in-network provider.

And remember, while you should always seek the closest hospital emergency room for a medical emergency, you can reduce your out-of-pocket expenses even more by visiting in-network walk-in clinics or urgent care centers for non-emergency care.

Always check to see whether your doctor is in the network

Aetna's DocFind® online directory helps you find a doctor or medical specialist in your area. For example, you can look for a pediatrician in your zip code or a doctor affiliated with a nearby hospital. It also includes maps and directions to a doctor's office — and even lets you search by a doctor's gender and languages spoken. Just visit **www.aetna.com/docfind/custom/aahc** or call **1-888-772-9682**.

Doctor's office visit*

Sue went to a doctor to be treated for an illness. The doctor ordered X-rays and two prescriptions. **The total charges for her treatment were $450.**

	Without insurance	With the Aetna Voluntary Limited Benefits Plan				
		Nonpreferred provider (out of network)		Preferred provider (in network)		
	Billed charges	Plan pays	Sue pays	Negotiated network charge	Plan pays	Sue pays
Doctor's office visit	$150	$112	$42	$70	$55	$15
Generic drug prescription**	$30	$20	$10	$5	$0	$5
Brand drug prescription**	$120	$35	$85	$20	$0	$20
Radiological examination	$150	$0	$150	$45	$0	$45
Totals	**$450**	**$163**	**$287**	**$140**	**$55**	**$85**

By using the Aetna Voluntary Limited Benefits Plan with an in-network doctor, Sue lowered the amount she paid out of pocket from $450 to $85, **which saved her $365**.

Short hospital stay*

Tonya had minor surgery that required a two-day stay in the hospital. **The total inpatient charges were $10,500.**

	Without insurance	With the Aetna Voluntary Limited Benefits Plan				
		Non-preferred provider (out of network)		Preferred provider (in network)		
	Billed charges	Plan pays	Tonya pays	Negotiated network charge	Plan pays	Tonya pays
BILL FROM THE HOSPITAL						
Room and board (2 days)	$3,200	$1,800	$1,400	$1,920	$1,456	$464
Other Hospital Services†	$3,800	**$1,000†**	$2,800	$2,280	$1,000†	$1,280
BILLS FROM INPATIENT PROFESSIONALS						
Anesthesiologist's bill	$800	$480	$320	$480	$384	$96
Surgeon's bill	$2,700	$1,620	$1,080	$1,620	$1,296	$324
Totals	**$10,500**	**$4,900**	**$5,600**	**$6,300**	**$4,136**	**$2,164**

By using the Aetna Voluntary Limited Benefits Plan with in-network providers, Tonya was able to lower her medical bill from $10,500 to $2,164 for an **out-of-pocket cost savings of $8,336**.

Notice the savings for using an in-network doctor or hospital. If you use a health care provider who is not in Aetna's network, you may be responsible for the entire difference between what the provider bills you and what the Aetna plan pays, which can be large.

*These are general examples meant to illustrate how the Aetna Voluntary Limited Benefits Plan could save you money. The examples may not be specific to your plan. Your plan may not pay the same amounts, and you may not need the same services. The amount of network discounts applied will vary based on negotiated provider rates. The amount the plan pays will vary based on plan design. These examples assume that annual deductibles have not been satisfied and inner plan limits are applied to certain services, which are reflected in the columns showing what the person owes.

**Presumes $35 monthly benefit, with $10 copay for generic, $20 for branded.

†Illustrates limit on Other Hospital Services of $1,000. Other Hospital Services are certain charges billed by a hospital when you are admitted as an inpatient, other than those charges for room and board. They do not include charges billed by medical professionals for services provided during an inpatient stay, such as surgeon's fees. Please read your enrollment information carefully for further details.

Your Aetna Voluntary Limited Benefits Plan also includes a variety of discount programs

Aetna Book℠ Discounts

Access to a 10 percent discount on any book or DVD online purchase from the **MayoClinic.com** Bookstore.

Aetna Fitness℠ discount program

Access to preferred rates on gym memberships and discounts on at-home weight-loss programs, home fitness options, and one-on-one health coaching services through GlobalFit™.

Aetna Hearing℠ discount program

Access to discounts of about 25 percent on hearing devices and hearing exams from HearPO®.

Aetna Natural Products and Services℠ discount program

Access to reduced rates on services from participating providers for acupuncture; chiropractic care; massage therapy and dietetic counseling; and discounts on over-the-counter vitamins, herbal and nutritional supplements, and natural products.

Aetna Vision℠ discount program

Access to discounts on vision exams, lenses and frames when using the EyeMed Select Network and discounts on LASIK surgery.

Aetna Weight Management℠ discount program

Access to discounts on Jenny Craig® weight-loss programs and products and access to a 30 percent discount on monthly membership dues for eDiet, an online diet, fitness and healthy living website.

Oral health care discount program

Access to discounts on oral health care products including xylitol mints, mouth rinses, gum, candies and toothpaste from Epic, and exclusive savings on Waterpik® dental water jets and sonic toothbrushes.

Zagat discounts

Access to a 30 percent discount on a one-year online subscription fee to Zagat.com that allows a 25 percent discount on all purchases at the Zagat online store, which lists 40,000 restaurants, nightspots, hotels and attractions around the world.

For more information on these discount programs go to ***www.aetna.com/docfind/custom/aahc***.

Medical exclusions and limitations

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.

Medical pre-existing condition limitation:

This plan imposes a pre-existing condition exclusion. This means that if you have a medical condition before coming to our plan, you might have to wait a certain period of time before the plan will provide coverage for that condition. This exclusion applies only to conditions for which medical advice, diagnosis, care or treatment was recommended or received within the 180 days prior to your enrollment in this plan. Generally, this 180-day period ends on the day before the medical plan waiting period begins (for example, on your date of hire). The pre-existing condition exclusion does not apply to pregnancy or to children under 19 years of age including a newborn child or a child who is enrolled in the plan within 30 days after birth, adoption or placement for adoption.

This exclusion may last up to 365 days from the first day of your waiting period. However, you can reduce the length of this exclusion period by the number of days of your prior "creditable coverage." Most prior health coverage is creditable coverage and can be used to reduce the pre-existing condition exclusion period if you have not experienced a break in coverage of at least 63 days. To reduce the 365-day exclusion period by your creditable coverage, you should give us a copy of any certificates of creditable coverage you have. If you do not have a certificate but you have had prior health coverage, we will help you obtain a certificate from your prior plan or insurer. There are also other ways to show you have had creditable coverage. Please contact us at **1-888-772-9682** if you need help demonstrating creditable coverage.

Medical exclusions:

- All medical or hospital services not specifically covered in, or which are limited or excluded in the plan documents
- Any eye surgery mainly to correct refractive errors
- Cosmetic surgery, including breast reduction
- Custodial care
- Dental care and X-rays, unless medically necessary to repair an injury to the mouth, jaw or teeth resulting from an accident
- Donor egg retrieval
- Experimental and investigational procedures
- Hearing aids
- Immunizations for travel or work
- Infertility services, including, but not limited to, artificial insemination and advanced reproductive technologies
- Nonmedically necessary services or supplies
- Orthotics
- Over-the-counter medications and supplies
- Reversal of sterilization
- Services for the treatment of sexual dysfunction or inadequacies, including therapy, supplies or counseling
- Special duty nursing
- Treatment of alcoholism, drug abuse and mental/ behavioral disorders (except where state mandated)

This material is for information only. 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. Health insurance plans contain exclusions and limitations. Discount programs provide access to discounted prices and are NOT insured benefits. The member is responsible for the full cost of the discounted 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 and are subject to change. Aetna receives rebates from drug manufacturers that may be taken into account in determining Aetna's Preferred Drug List. Rebates do not reduce the amount a member pays the pharmacy for covered prescriptions. Information is believed to be accurate as of the production date; however, it is subject to change.

Policy Forms issued in Oklahoma: GR-9/GR-9N, GR-29/GR-29N.

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www.aetna.com/src

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The Affordable Care Act prohibits health plans from applying dollar limits below a specific amount on coverage for certain benefits. This year, if a plan applies a dollar limit on the coverage it provides for certain benefits in a year, that limit must be at least $1,250,000.

Your health coverage, offered by Aetna Life Insurance Company, does not meet the minimum standards required by the Affordable Care Act described above. Your coverage has an annual limit of:

Medical Coverage Limits: Option 1

Most this plan will pay overall per coverage year	**$5,000**
Most this plan will pay per coverage year for:	
Outpatient charges	**$500**
Hospital services other than daily room charge	**$500**
Most this plan will pay per month for prescriptions	**$35**

This means that your health coverage might not pay for all of the health care expenses you incur. For example, a stay in a hospital costs around $1,853 per day. At this cost, your insurance would only pay for 2 days.

Medical Coverage Limits: Option 2

Most this plan will pay overall per coverage year	**$10,000**
Most this plan will pay per coverage year for:	
Outpatient charges	**$1,000**
Hospital services other than daily room charge	**$1,000**
Most this plan will pay per month for prescriptions	**$35**

This means that your health coverage might not pay for all of the health care expenses you incur. For example, a stay in a hospital costs around $1,853 per day. At this cost, your insurance would only pay for 5 days.

Your health plan has requested that the U.S. Department of Health and Human Services waive the requirement to provide coverage for certain key benefits of at least $1,250,000 this year. Your health plan has stated that meeting this minimum dollar limit this year would result in a significant increase in your premiums or a significant decrease in your access to benefits. Based on this representation, the U.S. Department of Health and Human Services has waived the requirement for your plan until December 30, 2012.

If you are concerned about your plan's lower dollar limits on key benefits, you and your family may have other options for health care coverage. For more information, go to: www.HealthCare.gov.

If you have any questions or concerns about this notice, contact SRC, an Aetna company, at 1-888-772-9682.

In addition, for plans offered in states with a Consumer Assistance Program (CAP), you can contact your state's CAP. For more information, go to: www.HealthCare.gov/law/provisions/cap/index.html

BENEFITS SUMMARY

Aetna Voluntary Plans limited benefits insurance plan

(Except in New York, this plan is filed as a major medical plan that contains an annual benefit maximum and a number of additional coverage limitations and exclusions.)

Plan design and benefits provided by Aetna Life Insurance Company (Aetna) and administered by Aetna or Strategic Resource Company (SRC).

Unless otherwise indicated, all benefits and limitations are per covered person. Where a benefit is expressed as a percentage, the lower of the negotiated charge(s) or the recognized charge(s) will be the basis of payment.

Inside this Benefits Summary:

• Medical

PLEASE READ CAREFULLY BEFORE DECIDING WHETHER THIS PLAN IS RIGHT FOR YOU:

• This plan will not pay more than the overall maximum benefit in a coverage year.
• This plan also limits what it will pay for particular kinds of services in addition to the overall annual maximum benefit.
• Once any of these limits have been reached, the plan will not pay any more towards the cost of the service in question, and your health care providers can bill you for what the plan does not pay. Many illnesses cost much more to treat than this plan will cover.
• This Benefits Summary explains these limits, the overall annual maximum benefit, and other cost sharing features of your plan, such as copayments and deductibles. See the full plan for more information.

If you have a pre-existing condition, this plan may not pay for the coverage of this condition for up to the first 365 days of coverage. For more information on pre-existing condition limitations, please see "Exclusions and Limitations" in this summary or refer to the plan documents.

Aetna will pay benefits only for expenses incurred while this coverage is in force, and only for the medically necessary treatment of injury or disease. The coverage displayed in this Benefits Summary reflects certain mandate(s) of the state in which this policy was written. However, certain federal laws or other mandate(s) in the state you live and/or work could also affect how this coverage pays.

Group limited benefit medical coverage is not available if you live and work in **New Hampshire**.
This limited health plan does not meet **Massachusetts** Minimum Creditable Coverage standards.

This health insurance issuer believes this plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). Being a grandfathered health plan means that your plan does not include certain consumer protections of the Affordable Care Act. Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at **1-888-772-9682.** You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at **1-866-444-3272** or **www.dol.gov/ebsa.**

Medical: Option 1

Plan Features	**Preferred Provider** (In network. Percentages refer to Negotiated Charge.)	**Non-Preferred Provider** (Out of network. Percentages refer to Recognized Charge.)
Maximum benefit per coverage year (Not all charges are paid up to the annual maximum. Carefully review the following limits.)	$5,000	Same as preferred
Limit on Other Hospital Services per coverage year	$500	Same as preferred
Once this limit has been reached, this benefit will no longer pay for many hospital-billed charges. The plan will continue to pay for room and board and Inpatient Professional Services until the maximum benefit per coverage year is reached.		
Limit on outpatient charges per coverage year	$500	Same as preferred
Once this limit is reached, this benefit will no longer pay for outpatient charges.		
Deductible per coverage year		
Individual	$100	$200
Family (when 2 individual deductibles are met)	$200	$400
Percentage of remaining charges you pay (applies to all expenses unless otherwise stated)		
Inpatient charges	20%	40%
Outpatient charges	20%	40%
Physician office visits		
Copay/deductible for each visit	$15 copay	$15 deductible per visit
Percentage of remaining charges you pay (annual deductible does not apply)	None (plan pays 100% up to benefit maximum)	20%

Coverage for Prescription Drug Charges	**Preferred Provider** (In network. Percentages refer to Negotiated Charge.)	**Non-Preferred Provider** (Out of network. Percentages refer to Recognized Charge.)
Maximum benefit per month (This does not count towards any other benefit limits or maximums.)	$35	Same as preferred
Amount you pay for each prescription		
Generic drugs	$10 copay	20%
Brand-name drugs	$20 copay	20%

To use your prescription benefit at a preferred pharmacy:
A) Present your Aetna identification (ID) card to the pharmacist.
B) You receive a discount at the point of sale and pay the applicable copay (and any balance over your maximum benefit).

To use your prescription benefit at a non-preferred pharmacy:
A) Pay the full amount charged by the pharmacy.
B) Submit a claim form to Aetna Pharmacy Management (www.AetnaPharmacy.com) for reimbursement.

When you get a covered prescription at a non-preferred pharmacy, you pay the full price and must send in a claim form for reimbursement. When you get a covered prescription at a preferred pharmacy, you pay the discounted price and do not have to send in a claim form. To find a preferred pharmacy, log on to **www.AetnaPharmacy.com.**

Covers only medical prescriptions, except for dental prescriptions issued in connection with treatment resulting from a covered accident.

Medicare Part D Notice: This prescription drug benefit does not meet the criteria for Medicare Part D coverage; it does not match up to the plan offered under Medicare Part D.

Sometimes the plan will treat a service from a non-preferred provider as if that provider were a preferred provider for purposes of determining your copay, coinsurance and deductible. The plan will do this when you have a medical emergency or there is not a preferred provider in your area. You remain responsible, however, for any amount that a non-preferred provider may bill you above the recognized charge. Please note that if you travel to an area that has a preferred provider but use a non-preferred health care provider, you will not be eligible for preferred provider benefits.

If you get emergency care from a non-preferred provider, call us within two business days after you start receiving treatment. Member services is available Monday through Friday between 8 a.m. and 8 p.m. Eastern Time, at **1-888-772-9682.**

To find out whether a provider is in Aetna's network (a **preferred provider**), call **1-888-772-9682** or use DocFind at **www.aetna.com/docfind/custom/aahc.**

Group limited benefit medical coverage is not available if you live and work in **New Hampshire**.
This limited health plan does not meet **Massachusetts** Minimum Creditable Coverage standards.

This health insurance issuer believes this plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). Being a grandfathered health plan means that your plan does not include certain consumer protections of the Affordable Care Act. Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at **1-888-772-9682.** You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at **1-866-444-3272** or **www.dol.gov/ebsa.**

Medical: Option 2

Plan Features	**Preferred Provider** (In network. Percentages refer to Negotiated Charge.)	**Non-Preferred Provider** (Out of network. Percentages refer to Recognized Charge.)
Maximum benefit per coverage year (Not all charges are paid up to the annual maximum. Carefully review the following limits.)	$10,000	Same as preferred
Limit on Other Hospital Services per coverage year	$1,000	Same as preferred
Once this limit has been reached, this benefit will no longer pay for many hospital-billed charges. The plan will continue to pay for room and board and Inpatient Professional Services until the maximum benefit per coverage year is reached.		
Limit on outpatient charges per coverage year	$1,000	Same as preferred
Once this limit is reached, this benefit will no longer pay for outpatient charges.		
Deductible per coverage year		
Individual	$100	$200
Family (when 2 individual deductibles are met)	$200	$400
Percentage of remaining charges you pay (applies to all expenses unless otherwise stated)		
Inpatient charges	20%	40%
Outpatient charges	20%	40%
Physician office visits		
Copay/deductible for each visit	$15 copay	$15 deductible per visit
Percentage of remaining charges you pay (annual deductible does not apply)	None (plan pays 100% up to benefit maximum)	20%

Coverage for Prescription Drug Charges	Preferred Provider (In network. Percentages refer to Negotiated Charge.)	Non-Preferred Provider (Out of network. Percentages refer to Recognized Charge.)
Maximum benefit per month (This does not count towards any other benefit limits or maximums.)	$35	Same as preferred
Amount you pay for each prescription		
Generic drugs	$10 copay	20%
Brand-name drugs	$20 copay	20%

To use your prescription benefit at a preferred pharmacy:
A) Present your Aetna identification (ID) card to the pharmacist.
B) You receive a discount at the point of sale and pay the applicable copay (and any balance over your maximum benefit).

To use your prescription benefit at a non-preferred pharmacy:
A) Pay the full amount charged by the pharmacy.
B) Submit a claim form to Aetna Pharmacy Management (www.AetnaPharmacy.com) for reimbursement.

When you get a covered prescription at a non-preferred pharmacy, you pay the full price and must send in a claim form for reimbursement. When you get a covered prescription at a preferred pharmacy, you pay the discounted price and do not have to send in a claim form. To find a preferred pharmacy, log on to **www.AetnaPharmacy.com.**

Covers only medical prescriptions, except for dental prescriptions issued in connection with treatment resulting from a covered accident.

Medicare Part D Notice: This prescription drug benefit does not meet the criteria for Medicare Part D coverage; it does not match up to the plan offered under Medicare Part D.

Sometimes the plan will treat a service from a non-preferred provider as if that provider were a preferred provider for purposes of determining your copay, coinsurance and deductible. The plan will do this when you have a medical emergency or there is not a preferred provider in your area. You remain responsible, however, for any amount that a non-preferred provider may bill you above the recognized charge. Please note that if you travel to an area that has a preferred provider but use a non-preferred health care provider, you will not be eligible for preferred provider benefits.

If you get emergency care from a non-preferred provider, call us within two business days after you start receiving treatment. Member services is available Monday through Friday between 8 a.m. and 8 p.m. Eastern Time, at **1-888-772-9682.**

To find out whether a provider is in Aetna's network (a **preferred provider**), call **1-888-772-9682** or use DocFind at **www.aetna.com/docfind/custom/aahc.**

When you enroll in medical coverage, you also receive:

Aetna Vision℠ Discounts*

Aetna Vision℠ Discounts uses the nationwide EyeMed Select Network of vision care providers to offer you and your family glasses, contact lenses, nonprescription sunglasses, contact lens solutions and other eye care accessories at discounted prices. Plus, you can receive discounts on eye exams and LASIK eye surgery. For exams and eyewear call **1-800-793-8616**. For contacts call **1-800-391-5367**. For LASIK customer service call **1-800-422-6600**. You can also locate a local provider by visiting **www.aetna.com/docfind/custom/aahc**. This discount arrangement may not be available to **Illinois** residents.

Prescription drug discount program*

The prescription drug discount program gives you and your family access to over 59,000 retail pharmacies nationwide including major pharmacy chains and independent pharmacies (Aetna Network Pharmacy Database - 3/20/08). To locate a participating pharmacy, call **1-888-772-9682** or visit **www.aetna.com/docfind/custom/aahc**.

*Discount programs provide access to discounted prices and are not insured benefits.

Medical Exclusions and Limitations

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.**

Medical Pre-existing Condition Limitation:

This plan imposes a pre-existing condition exclusion. This means that if you have a medical condition before coming to our plan, you might have to wait a certain period of time before the plan will provide coverage for that condition. This exclusion applies only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received within the 180 days prior to your enrollment in this plan. Generally, this 180-day period ends on the day before the medical plan waiting period begins (for example, on your date of hire). The pre-existing condition exclusion does not apply to pregnancy or to members under 19 years of age including a newborn child or a child who is enrolled in the plan within 30 days after birth, adoption, or placement for adoption.

This exclusion may last up to 365 days from the first day of your waiting period. However, you can reduce the length of this exclusion period by the number of days of your prior "creditable coverage." Most prior health coverage is creditable coverage and can be used to reduce the pre-existing condition exclusion period if you have not experienced a break in coverage of at least 63 days. To reduce the 365-day exclusion period by your creditable coverage, you should give us a copy of any certificates of creditable coverage you have. If you do not have a certificate but you have had prior health coverage, we will help you obtain a certificate from your prior plan or insurer. There are also other ways to show you have had creditable coverage. Please contact us at **1-888-772-9682** if you need help demonstrating creditable coverage.

Medical Exclusions:

- All medical or hospital services not specifically covered in, or which are limited or excluded in the plan documents.
- Any eye surgery mainly to correct refractive errors.
- Cosmetic surgery, including breast reduction.
- Custodial care.
- Dental care and X-rays, unless medically necessary to repair an injury to the mouth, jaw or teeth resulting from an accident.
- Donor egg retrieval.
- Experimental and investigational procedures.
- Hearing aids.
- Immunizations for travel or work.
- Infertility services, including, but not limited to, artificial insemination and advanced reproductive technologies.
- Nonmedically necessary services or supplies.
- Orthotics.
- Over-the-counter medications and supplies.
- Reversal of sterilization.
- Services for the treatment of sexual dysfunction or inadequacies, including therapy, supplies, or counseling.
- Special duty nursing.
- Treatment of alcoholism, drug abuse and mental/behavioral disorders (except where state mandated).

Terms defined

A service or supply is ***medically necessary*** if it is determined by Aetna to be appropriate for the diagnosis, care or treatment of the disease or injury involved. See the plan documents for the complete definition.

A ***copayment*** (or ***copay***) is a fixed amount that you must pay for a medical service after you have met any deductible. In some cases, you may be responsible for paying a copay as well as a percentage of the remaining charges.

In many instances, the plan requires that a deductible is met before a benefit is paid. A **deductible** is the amount you must pay for eligible expenses before the plan begins to pay benefits. A deductible may be per service, per visit, per supply or per coverage year.

Once the ***family deductible*** per coverage year is met, all family members will be considered to have met their deductible. You will have met your **family deductible** when two covered family members have each fully paid their own deductibles in a coverage year.

Inpatient charges are all charges incurred when you are admitted as an inpatient at a hospital or other inpatient facility, including hospital room and board charges (daily room rate), Inpatient Professional Services, and Other Hospital Services.

> ***Other Hospital Services*** are charges for certain services and supplies billed by a hospital when you are admitted as an inpatient, other than those charges for room and board. These charges may be significant and may include, but are not limited to: pharmaceutical, medical and surgical supplies and devices; lab tests and x-rays; and operating and recovery room expenses.
>
> ***Inpatient Professional Services*** are charges billed by surgeons, physicians, radiologists, pathologists and anesthesiologists for services provided during an inpatient stay.

Outpatient charges are charges billed for services and supplies provided at doctors' offices, free-standing clinics and outpatient facilities. They also include charges at a hospital when you are not admitted as an inpatient, including emergency room charges.

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.

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.

Percentage of remaining charges you pay refers to the percentage of **Negotiated** or **Recognized Charges** you pay after you have fulfilled the deductible and/or copay and before the benefit maximum is reached. This is also known as member coinsurance. A non-preferred provider may require that you pay more than the **Recognized Charge**, and this additional amount would also be your responsibility. Once the applicable benefit maximum has been reached, you will be responsible for 100% of the remaining balance.

Wellness visits are those visits to the doctor for services that are not for the purpose of diagnosing or treating an injury or disease. Some common types of wellness visits are annual physical exams, gynecological exams, well-baby or well-child visits, mammograms, some cancer screenings, and bone mass density measurements. Included as part of the wellness visit are x-rays, lab and other tests, and materials for the administration of immunizations and testing for tuberculosis.

Your plan might not offer a wellness visit(s) benefit. Please refer to the benefits chart in this Benefits Summary. Some federal and state laws mandate certain preventive exams that are to be covered by, or in addition to, this benefit if offered under your plan. If a wellness visit(s) benefit is not offered under your plan (see the benefits chart), these mandates will be covered by other benefits under your plan. Please refer to the plan documents for more information.

Questions and answers

How do benefit limits work?
Limits put a cap or ceiling on what the plan will pay. Some benefits have a limit on the dollar amounts and others on the number of services, or both. The plan will not pay for a service or supply once you have reached a limit on either the dollar amounts or the number of services for that service or supply. Because there are limits on what is paid for certain kinds of services or visits, you may not be covered for some services or visits even though you have not reached your overall maximum. **Before you enroll in the plan, please read the benefits chart in the previous pages carefully to understand these limits and consider what effects they may have.**

Will the plan always pay up to the maximum benefits per coverage year?
No. How much the plan pays depends on the type and amount of the health care you receive. Some types of charges may have limits that are reached before the overall maximum they are a part of is reached. This means that the plan may no longer pay for certain types of charges you continue to have, even though the overall maximum benefit has not been reached. Please read the benefits chart in the previous pages carefully to understand what types of charges may be limited before the overall maximums in question are reached.

How does this limited benefits insurance plan differ from a traditional major medical health plan?
There are important differences in what the plan will pay and what the premium costs. Both types of plans cover many types of services and supplies. However, this limited benefits insurance plan has a lower maximum benefit and places limits on how much it will pay for categories of services or supplies. Once you have used up the overall maximums or limits on specific benefits, the plan will not pay any more. And unlike most major medical plans, this limited benefits insurance plan does not have catastrophic coverage or a limit on your out-of-pocket expenses. This means that you may have large out-of-pocket costs if you have a serious or chronic medical condition. Because traditional major medical health plans provide more coverage, they cost more.

What will I pay up front when I go to a healthcare provider?
A preferred doctor, hospital or other healthcare provider may require you to pay charges for which you are responsible in advance. This could include your copay, deductible, percentage of charges the plan does not pay (coinsurance), charges for services excluded under the plan, and charges in excess of your coverage limits. A non-preferred provider may require that you pay all charges in advance, and it would be up to you to submit a claim for reimbursement for any charges the plan may pay.

What are my rights for childbirth?
Under the Newborns' and Mothers' Health Protection Act (NMHPA), your plan will treat your hospital stay for the first 48 hours after a vaginal delivery (or 96 hours after cesarean section) as **medically necessary**. Your plan's overall benefit maximum, limits and deductibles will determine how much the plan will pay. The state in which you live, you work, or your plan was underwritten may have additional mandated rights regarding childbirth. Please refer to the plan documents.

What are my rights for reconstructive surgery after a mastectomy?
Under the Women's Health and Cancer Rights Act, your plan will consider as **medically necessary** post-mastectomy reconstruction of the same breast, or reconstruction of the other breast to achieve symmetry, prostheses, and treatment of physical complications of all stages of mastectomy including lymphedema. Your plan's overall benefit maximum, limits and deductibles will determine how much the plan will pay. The state in which you live, you work, or your plan was underwritten may have additional mandated rights regarding a mastectomy. Please refer to the plan documents.

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 8 p.m. Eastern Time, by calling toll free **1-888-772-9682**. We're here to answer questions before and after you enroll.

THIS LIMITED HEALTH BENEFITS PLAN DOES NOT PROVIDE COMPREHENSIVE MEDICAL COVERAGE. IT IS A BASIC OR LIMITED BENEFITS POLICY AND IS NOT INTENDED TO COVER ALL MEDICAL EXPENSES. THIS PLAN IS NOT DESIGNED TO COVER THE COSTS OF SERIOUS OR CHRONIC ILLNESS. IT CONTAINS SPECIFIC DOLLAR LIMITS THAT WILL BE PAID FOR MEDICAL SERVICES WHICH MAY NOT BE EXCEEDED. IF THE COST OF SERVICES EXCEEDS THOSE LIMITS, THE BENEFICIARY AND NOT THE INSURER IS RESPONSIBLE FOR PAYMENT OF THE EXCESS AMOUNTS. THE SPECIFIC DOLLAR LIMITS ARE DESCRIBED IN THIS BENEFITS SUMMARY.

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 CO-PAYMENTS, COINSURANCE, DEDUCTIBLE, AND NON-COVERED 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.

ATTENTION MASSACHUSETTS RESIDENTS: As of January 1, 2009, the Massachusetts Health Care Reform Law requires that Massachusetts residents, eighteen (18) years of age and older, must have health coverage that meets the Minimum Creditable Coverage standards set by the Commonwealth Health Insurance Connector, unless waived from the health insurance requirement based on affordability or individual hardship. For more information call the Connector at 1-877-MA-ENROLL (1-877-623-6765) or visit the Connector website (www.mahealthconnector.org). THIS HEALTH PLAN, ALONE, DOES NOT MEET MINIMUM CREDITABLE COVERAGE STANDARDS. If you have questions about this notice, you may contact the Division of Insurance by calling 617-521-7794 or visiting its website at www.mass.gov/doi.

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. Aetna receives rebates from drug manufacturers that may be taken into account in determining Aetna's Preferred Drug List. Rebates do not reduce the amount a member pays the pharmacy for covered prescriptions. Discount programs provide access to discounted prices and are not insured benefits. Information is believed to be accurate as of the production date; however, it is subject to change.

Insurance plans are underwritten by Aetna Life Insurance Company (referred to as "Aetna") and administered by Aetna or Strategic Resource Company (SRC, an Aetna company).

For OK residents only, policy forms issued include GR-9/GR-9N and GR-29/GR-29N.

How to enroll

Aetna Voluntary Plans

Read the materials in this enrollment kit and ask questions. If you or your family need to know more, or don't completely understand something, please call us toll free at **1-888-772-9682** or visit **www.aetna.com/src**. We're here to answer questions before and after you enroll.

Fill out your Enrollment/Change Request form. Then follow the instructions below to **enroll, online or by telephone,** using the information you wrote on the form. **You do not need to give this form to your employer.** If you are currently enrolled, and do not wish to make changes, you do not need to do anything to continue your existing coverage.

To enroll online:

A ▸ Go to **www.aetna.com/src.**

B ▸ Click on ***Log In***, which will take you to the account access page.

C ▸ Select ***Log In*** from the menu. Enter the user name and password.

User name: **801289**
Password: **4559**

D ▸ Choose ***Enrollment*** from the panel on the left. Then follow the online instructions to enroll or decline.

E ▸ When complete, print a copy of the Confirmation page for your records. Your Confirmation Number is proof of successful enrollment. **Do not hand anything in to your employer.**

To enroll by telephone:

A ▸ For each type of coverage, **circle the number** that matches the level of coverage you want.

Medical
You may enroll in only one medical option. Coverage is not available if you live and work in New Hampshire.

No coverage **0**

Option 1
Yourself only **1**
Yourself plus one........................... **2**
Yourself and family......................... **3**

Option 2
Yourself only **4**
Yourself plus one........................... **5**
Yourself and family......................... **6**

B ▸ Write down the number you circled above.
This is the Benefit Code you will need when you call. ______ Medical

C ▸ Next, call **1-800-977-6974** to enroll. Follow the instructions you hear on the phone. Your access code is **4559**.

D ▸ Listen for your Confirmation Number at the end of your call. Write it here: ______________________
The number is proof of successful enrollment. If you enroll your dependent(s), please stay on the phone to give your dependent information to a Customer Service representative, Monday through Friday, 8 a.m. to 8 p.m. ET. If enrolling outside of these times, please call again later to give your information.

E ▸ Keep your completed Enrollment/Change Request form and this enrollment guide for your records. **Do not hand anything in to your employer.**

How to make changes

You may make changes to your enrollment at any time before the end of your enrollment period by following the enrollment instructions on the front of this guide.

If your enrollment period is over, you will need a Qualifying Life Event (QLE) to make changes. You must make your changes within 30 days of the QLE.

- You will need a QLE to add or increase coverage.
- However, if you drop Medical coverage for yourself or a dependent because of a QLE, it is important that you tell Customer Service at **1-888-772-9682** about the QLE so that you will be offered the chance to enroll in continuation coverage.

For a list of QLEs, please see the back of your Enrollment/Change Request form or call **1-888-772-9682.**

Make changes by filling out an Enrollment/Change Request form.

Then follow the instructions below to **make changes, online or by telephone,** using the information you wrote on the form. **You do not need to give this form to your employer.**

To make changes online:

A ▸ Go to **www.aetna.com/src.**

B ▸ Click on ***Log In***, which will take you to the account access page.

C ▸ Select ***Log In*** from the menu. Enter the user name and password.

User name: **801289**
Password: **4559**

D ▸ Choose ***Enrollment*** from the panel on the left. Then follow the online instructions to make changes.

E ▸ After you have made your changes, print a copy of the Confirmation page for your records. Your Confirmation Number is proof that your changes are successful. **Do not hand anything in to your employer.**

To make changes by telephone:

A ▸ Call **1-800-977-6974** to make changes. Follow the instructions you hear on the phone. Your access code is **4559**.

B ▸ Listen for your Confirmation Number at the end of your call. Write it here: ______________________
Your changes have not been made until you get a Confirmation Number. If you enroll your dependent(s), please stay on the phone to give your dependent information to a Customer Service representative, Monday through Friday, 8 a.m. to 8 p.m. ET. If enrolling outside of these times, please call again later to give your information.

C ▸ Keep your completed Enrollment/Change Request form and this guide for your records. **Do not hand anything in to your employer.**

Insurance plans are underwritten by Aetna Life Insurance Company (referred to as "Aetna") and administered by Aetna or Strategic Resource Company (SRC, an Aetna company). Information is believed to be accurate as of the production date; however, it is subject to change. For OK residents only, policy forms issued include GR-9/GR-9N, GR-29/GR-29N, GR96172, and GR96173.

12.03.396.1 PDSTech (11/11)

Aetna Voluntary Plans

(formerly Aetna Affordable Health Choices®)
Enrollment/Change Request

PDS Technical Services
801289

Insurance plans are underwritten by Aetna Life Insurance Company (referred to as "Aetna") and administered by Aetna or Strategic Resource Company (SRC, an Aetna company).

Instructions: Read and fill out the Enrollment/Change Request (all pages).
IF YOU ARE NOT CHANGING YOUR EXISTING COVERAGE, YOU DO NOT NEED TO COMPLETE THIS ENROLLMENT/CHANGE REQUEST.

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. ☐ **Decline** this opportunity to participate.
I am currently enrolled and I want to…	☐ **Make changes to** my current coverage choices (add, increase, drop, decrease) as selected below. All of my other coverage choices will remain the same as previously elected. *(If outside of an open enrollment, see "Making Changes Outside of an Open Enrollment.")* ☐ **Update** my personal and/or my dependent information. ☐ **Drop all** of my current coverage choices.

Your payroll deductions will be taken before taxes are taken.

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

Coverage type	Coverage level	Weekly cost
Medical *You may enroll in one medical option only.*	☐ No Medical	
	Option 1	
	☐ Yourself only	$ 28.46
	☐ Yourself plus one	$ 72.73
	☐ Yourself and family	$ 103.59
	Option 2	
	☐ Yourself only	$ 39.77
	☐ Yourself plus one	$ 101.43
	☐ Yourself and family	$ 144.44

Group limited benefit medical coverage is not available if you live and work in New Hampshire.

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 reverse side of this Enrollment/Change Request.

Your signature	Today's date (MM/DD/YYYY)	Do you have a disability which affects your ability to communicate or read? ☐ Yes ☐ No If "Yes," please indicate the nature of your disability. ___________________________

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)

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

If your deductions are taken before taxes are taken out of your pay, you can change 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, drop or decrease 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.

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 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)

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 ☐ 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 ☐ 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 ☐ Child ☐ Other (Specify): ____________________

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

CONDITIONS OF ENROLLMENT Applicant acknowledgments and agreements

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 by Aetna Life Insurance Company (referred to as "Aetna") 151 Farmington Avenue, Hartford, CT 06156 and administered by Aetna or Strategic Resource Company (SRC, an Aetna company), 221 Dawson Road, Columbia, SC 29223.
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 HIV/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 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 member(s) and will govern in the event they conflict with any benefits comparison, summary or other description of the plan.
5. I understand and agree that with the exception of Aetna Rx Home Delivery®, all participating providers and vendors are independent contractors and are neither agents nor employees of Aetna. Aetna Rx Home Delivery, LLC, is a subsidiary of Aetna Inc. The availability of any particular provider cannot be guaranteed and provider network composition is subject to change. Notice of the change shall be provided in accordance with applicable state law.
6. **Misrepresentation:** Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any intentional misrepresentation of material fact or conceals, for the purpose of misleading, information concerning any fact material thereto may commit a fraudulent insurance act, which may be a crime and may subject such person to criminal and civil penalties.

Important Disclosure Information

For Aetna Affordable Health Choices® Plans

Plan of Benefits

Your plan of benefits will be determined by your plan sponsor and underwritten by the Aetna Life Insurance Company, 151 Farmington Avenue, Hartford, Connecticut, 06156. The benefits and main points of the Group Policy for persons covered under your plans of benefits will be set forth in the Booklet-Certificate which will be provided to you at a later date.

Cost Sharing

You are responsible for any copayments, coinsurance and deductibles for covered services. These obligations are paid directly to the provider or facility at the time the service is rendered. Copayment, coinsurance and deductible amounts are listed in your benefits summary and plan documents.

How Aetna Compensates Your Health Care Provider

All the physicians are independent practicing physicians that are neither employed nor exclusively contracted with Aetna. Individual physicians and other providers are in the network by either directly contracting with Aetna* and/or affiliating with a group or organization that contract with us.

Participating providers in our network are compensated in various ways:

- Per individual service or case (fee for service at contracted rates).
- Per hospital day (per diem contracted rates).

Advance Directives

An advance directive is a legal document that states your wishes for medical care. It can help doctors and family members determine your medical treatment if, for some reason, you can't make decisions about it yourself.

There are three types of advance directives:

- Living will - spells out the type and extent of care you want to receive.
- Durable power of attorney - appoints someone you trust to make medical decisions for you.
- Do-not-resuscitate order - states that you don't want to be given CPR if your heart stops or if you stop breathing.

You can create an advance directive in several ways:

- Get an advance medical directive form from a health care professional. Certain laws require health care facilities that receive Medicare and Medicaid funds to ask all patients at the time they are admitted if they have an advance directive. You don't need an advance directive to receive care. But we are required by law to give you the chance to create one.
- Ask for an advance directive 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 advance directive.
- Create an advance directive using computer software designed for this purpose.

Advanced Directives and Do Not Resuscitate Orders. American Academy of Family Physicians, March 2005.
(Available at **http://familydoctor.org/003.xml?printxml**)

After-Hours Care

You may call your doctor's office 24 hours a day, 7 days a week if you have medical questions or concerns. You may also consider visiting participating Urgent Care facilities.

Behavioral Health Provider Safety Data Available

For information regarding our Behavioral Health provider network safety data, please go to **www.aetna.com** and review the quality and patient safety links posted: **www.aetna.com/docfind/quality.html#jcaho**. You may select the quality checks link for details regarding our providers' safety reports.

Claims Payment for Nonparticipating Providers and Use of Claims Software

If your plan includes coverage for out-of-network services, and you obtain coverage under this portion of your plan, you should be aware that Aetna generally determines payment for an out-of-network provider by referring to (i) commercially available data reflecting the customary

* Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies.

We want you to know®

amount paid to most providers for a given service in that geographic area or (ii) by accessing other contractual arrangements. If such data is not commercially available, our determination may be based upon our own data or other sources. Aetna may also use computer software (including ClaimCheck®) and other tools to take into account factors such as the complexity, amount of time needed and manner of billing. You may be responsible for any charges Aetna determines are not covered under your plan.

Technology Review

Aetna reviews new medical technologies, behavioral health procedures, pharmaceuticals and devices to determine which ones should be covered by our plans. And we even look at new uses for existing technologies to see if they have potential. To review these innovations, we may:

- Study medical research and scientific evidence on the safety and effectiveness of medical technologies.
- Consider position statements and clinical practice guidelines from medical and government groups, including the federal Agency for Health care Research and Quality.
- Seek input from relevant specialists and experts in the technology.
- Determine whether the technologies are experimental or investigational.

You can find out more on new tests and treatments in our Clinical Policy Bulletins. You can find the bulletins at **www.aetna.com**, under the "Members and Consumers" menu.

Medically Necessary

"Medically necessary" means that the service or supply is provided by a physician or other health care provider exercising prudent clinical judgment for the purpose of preventing, evaluating, diagnosing or treating an illness, injury or disease or its symptoms, and that provision of the service or supply is:

- In accordance with generally accepted standards of medical practice;
- Clinically appropriate in accordance with generally accepted standards of medical practice in terms of type, frequency, extent, site and duration, and considered effective for the illness, injury or disease;
- Not primarily for the convenience of you, or for the physician or other health care provider; and
- Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the illness, injury or disease.

For these purposes **"generally accepted standards of medical practice"** means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, or otherwise consistent with physician specialty society recommendations and the views of physicians practicing in relevant clinical areas and any other relevant factors.

Clinical Policy Bulletins

Aetna's CPBs describe Aetna's policy determinations of whether certain services or supplies are medically necessary or experimental or investigational, based upon a review of currently available clinical information. Clinical determinations in connection with individual coverage decisions are made on a case-by-case basis consistent with applicable policies.

Aetna's CPBs do not constitute medical advice. Treating providers are solely responsible for medical advice and for your treatment. You should discuss any CPB related to your coverage or condition with your treating provider.

While Aetna's CPBs are developed to assist in administering plan benefits, they do not constitute a description of plan benefits. Each benefit plan defines which services are covered, which are excluded, and which are subject to dollar caps or other limits. You and your providers will need to consult the benefit plan to determine if there are any exclusions or other benefit limitations applicable to this service or supply.

Filing a Complaint or Appeal

Aetna is committed to addressing your coverage issues, complaints and problems. If you have a coverage issue or other problem, call Member Services at the toll free number on your ID card. If Member Services is unable to resolve your issue to your satisfaction, it will be forwarded to the appropriate department for handling.

If you are dissatisfied with the outcome of your initial contact, you may file an appeal. Your appeal will be decided in accordance with the procedures applicable to your plan and applicable state law. Refer to your plan documents for further details regarding your plan's appeal procedure.

About Coverage Decisions

Sometimes we receive claims for services that may not be covered by your health benefits plan or that aren't in line with the terms of your plan. It can be confusing - even to your doctors. Our job is to make coverage decisions based on your specific benefits plan. If a claim is denied, we'll send you a letter to let you know. If you don't agree you can file an appeal. To file an appeal, follow the directions in the letter that explains that your claim was denied. Our

appeals decisions will be based on your plan provisions and any state and federal laws or regulations that apply to your plan. You can learn more about the appeal procedures for your plan from your plan documents.

External Review

Aetna established an external review process to give you the opportunity of requesting an objective and timely independent review of certain coverage denials. Once the applicable appeal process has been exhausted, you may request an external review of the decision if the coverage denial, for which you would be financially responsible, involves more than $500* and is based on lack of medical necessity or on the experimental or investigational nature of the proposed service or supply. Standards may vary by state, if a state-mandated external review process exists and applies to your plan.

An Independent Review Organization (IRO) will assign the case to a physician reviewer with appropriate expertise in the area in question. After all necessary information is submitted, an external review generally will be decided within 30 calendar days of the request.

Expedited reviews are available when your physician certifies that a delay in service would jeopardize your health. Once the review is complete, the plan will abide by the decision of the external reviewer. The cost for the review will be borne by Aetna (except where state law requires you to pay a filing fee as part of the state mandated program).

Certain states mandate external review of additional benefit or service issues; some may require a filing fee. In addition, certain states mandate the use of their own external review process for medical necessity and experimental/ investigational coverage decisions. For further details regarding your plan's appeal process and the availability of an external review process, call the Member Services toll-free number on your ID card. You may obtain an external review request form from Member Services. You also may call your state insurance or health department or consult their website for additional information regarding state mandated external review procedures.

Member Rights & Responsibilities

You have the right to receive a copy of our Member Rights and Responsibilities Statement. This information is available to you online at **www.aetna.com/about/MemberRights/**. You can also obtain a printed copy by contacting Member Services at the number on your ID card.

Member Services

To request additional information regarding benefits, copayments or other charges, or how to file a claim, complaint or appeal, or if you have any other questions, you can contact Member Services at the toll-free number on your ID card.

Interpreter/Hearing Impaired

When you require assistance from an SRC representative, call us during regular business hours at the number on your ID card. Our representatives can:

- Answer benefits questions
- Find care outside your area
- Advise you on how to file complaints and appeals
- Connect you to behavioral health services (if included in your plan)
- Find specific health information

Multilingual hotline - 1-888-982-3862
(140 languages are available.
You must ask for an interpreter.)
TDD 1-800-628-3323 (hearing impaired only)

Quality Management Programs

Call Aetna to learn about the specific quality efforts we have under way in your local area. Ask Member Services for the phone number of your regional Quality Management office. If you would like information about Aetna Behavioral Health's Quality Management Program, ask Member Services for the phone number of your Care Management Center Quality Management office.

Privacy Notice

Aetna considers personal information to be confidential and has policies and procedures in place to protect it against unlawful use and disclosure. By "personal information," we mean information that relates to your physical or mental health or condition, the provision of health care to you, or payment for the provision of health care to you. Personal information does not include publicly available information or information that is available or reported in a summarized or aggregate fashion but does not identify you.

When necessary or appropriate for your care or treatment, the operation of our health plans, or other related activities, we use personal information internally, share it with our affiliates, and disclose it to health care providers (doctors, dentists, pharmacies, hospitals and other caregivers), payors (health care provider organizations, employers who sponsor self-funded health plans or who share responsibility for the payment of benefits, and others who may be financially responsible for payment for the

services or benefits you receive under your plan), other insurers, third party administrators, vendors, consultants, government authorities, and their respective agents. These parties are required to keep personal information confidential as provided by applicable law. Participating network providers are also required to give you access to your medical records within a reasonable amount of time after you make a request.

Some of the ways in which personal information is used include claims payment; utilization review and management; medical necessity reviews; coordination of care and benefits; preventive health, early detection, and disease and case management; quality assessment and improvement activities; auditing and anti-fraud activities; performance measurement and outcomes assessment; health claims analysis and reporting; health services research; data and information systems management; compliance with legal and regulatory requirements; formulary management; litigation proceedings; transfer of policies or contracts to and from other insurers, HMOs and third party administrators; underwriting activities; and due diligence activities in connection with the purchase or sale of some or all of our business. We consider these activities key for the operation of our health plans. To the extent permitted by law, we use and disclose personal information as provided above without your consent. However, we recognize that you may not want to receive unsolicited marketing materials unrelated to your health benefits. We do not disclose personal information for these marketing purposes unless you consent. We also have policies addressing circumstances in which you are unable to give consent.

To obtain a hard copy of our Notice of Privacy Practices which describes in greater detail our practices concerning use and disclosure of personal information, please write to Strategic Resource Company (SRC), Post Office Box 14079, Lexington, KY 40512-4079.

You can also visit our Internet site at www.aetna.com/docfind/custom/aahc/. You can link directly to the Notice of Privacy Practices by Plan Type, by selecting the "Privacy Notices" link at the bottom of the page, and selecting the link that corresponds to your specific plan.

State Variations

In some states, Aetna provides additional consumer disclosures in documents also posted on our website at **www.aetna.com/docfind/custom/aahc/**.

Georgia

Members can call 1-888-772-9682 (toll-free) to confirm that the preferred provider in question is in the network and/or accepting new patients.

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.

Members also have direct access to the participating dermatologist provider of their choice and do not need a referral from their primary care physicians to access dermatologic benefits covered under their health plan.

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 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.

Consumer Choice Option

The Consumer Choice Option is available for Georgia residents enrolled in certain Aetna managed care plans. Under this benefit 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 provider to provide covered services for themselves and their covered family members. Your benefits and any applicable copayments will be the same as for in-network providers. The out-of-network provider 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 it's in-network participating providers. It is possible the provider you nominate will not agree to participate.

This option is 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. Exact pricing and any additional information can be obtained by calling 1-888-772-9682. Please have your Aetna member ID card available when you call.

Hawaii

Informed Consent

Members have the right to be fully informed prior to 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; and
- discuss all risks, benefits, and consequences of treatment and non-treatment.

Your provider will also discuss with you and your immediate family both living wills and durable powers of attorney in relation to medical treatment.

Insurance Division Telephone Number:

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

Illinois

While every provider listed in the provider directory contracts with Aetna to provide primary care services, not every provider listed will be accepting new patients. Although Aetna has identified those providers who were not accepting patients as known to Aetna at the time the Provider Directory was created, the status of the physician's practice may have changed. For the most current information regarding the status of any physician's practice, please contact either the selected physician or call Member Services at the toll-free number on your ID card.

Illinois law requires health plans to provide the following information annually to enrollees and to prospective enrollees upon request: a complete list of participating health care providers in the health care plan's service area and 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 pre-certification 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; and
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.

Additionally, upon written request, the health plan will provide enrollees with 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 the insured is entitled in the particular health plan which is covering or being offered to such person;
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 which restrict access to covered services or items by the insured;
3. A listing of the plan 's participating providers, their business addresses and telephone numbers, their availability, and any limitation on an insured's choice of provider;
4. Notification in advance of any changes in the health benefit plan which either reduces the coverage or benefits or increases the cost to such person; and
5. A description of the grievance and appeal procedures available under the health benefit plan and an insured's rights regarding termination, disenrollment, non-renewal or cancellation of coverage.

Kentucky

Any 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.

Emergency Medical Condition Definition

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.

Louisiana

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

Maryland

Behavioral Health Care Expense Form

To obtain a copy of the Behavioral Health Care Expense Form, please call the number located on the back of your ID card.

Michigan

Contact the Michigan Department of Consumer and Industry Services at 1-517-373-0220 to verify participating providers' licenses or to access information on formal complaints and disciplinary actions filed or taken against participating providers.

Upon request, pursuant to Michigan law, the following information can be supplied to you:

1. date of provider certification by applicable nationally recognized board or other organization;
2. names of licensed facilities where providers have privileges;

3. prior authorization requirements and limitations including medication formulary restrictions;
4. information about financial relationships between providers and the health plan.

Intractable Pain Coverage

Aetna provides benefits for the evaluation and treatment of intractable pain when it is determined to be medically necessary and otherwise eligible by Aetna. Intractable pain means "a pain state in which the cause of the pain cannot be removed or otherwise treated and which, in the generally accepted practice of allopathic or osteopathic medicine, no relief of the cause of the pain or cure of the cause of the pain is possible or none has been found after reasonable efforts, including, but not limited to, evaluation by the attending physician and by one or more other physicians specializing in the treatment of the area, system, or organ of the body perceived as the source of the pain."

To obtain this and further information on the health plan, you may call Member Services at 1-888-772-9682.

Texas

Please refer to the plan design for a brief description of the services and benefits covered under your particular plan, as well as those services and benefits that are excluded. After enrollment, you can refer to your plan documents for a more complete description of your covered services and benefits and the exclusions under your plan. For information on whether a specific service is covered or excluded, please contact Member Services at the toll-free number on your ID card.

Health Insurance Portability and Accountability Act

The following information is provided to inform you of certain provisions contained in the Group Health Plan, and related procedures that may be utilized by you in accordance with Federal law.

Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 31 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption or placement for adoption. To request special enrollment or obtain more information, contact your benefits administrator.

Request for Certificate of Creditable Coverage

If you are a member of an insured plan sponsor or a member of a self insured plan sponsor who have contracted with us to provide Certificates of Prior Health Coverage, you have the option to request a certificate.

This applies to you if you are a terminated member, or are a member who is currently active but who would like a certificate to verify your status. As a terminated member, you can request a certificate for up to 24 months following the date of your termination. As an active member can request a certificate at any time. To request a Certificate of Prior Health Coverage, please contact Member Services at the telephone number on your ID card.

If you need this material translated into another language, please call Member Services at 1-888-772-9682.
Si usted necesita este documento en otro idioma, por favor llame a Servicios al Miembro al 1-888-772-9682.

Health benefits and health insurance plans are underwritten by Aetna Life Insurance Company and administered by Strategic Resource Company.