# short term disability insurance

life | **health**

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

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

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

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

## summary of benefits

### total disability benefit

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

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

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

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

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

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

## partial disability benefit

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

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

## mental illness limited benefit

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

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

Mental Illness means a psychiatric or psychological condition such as:

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

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

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

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

## waiver of premium

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

Waiver of Premium will continue until the earliest of the:

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

## limitations, adjustments and exclusions

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

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

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

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

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

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

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

### pre-existing condition limitation

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

### exclusions

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

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

# basic term life insurance

life | health

## ActOne Government Solutions

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

| | |
|---|---|
| **Employee Benefit** | $10,000 |

## benefit reduction schedule

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

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

## suicide exclusion

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

## accidental death and dismemberment rider (rider form series CRADBT00)

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

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

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

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

## limitations and exclusions

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

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

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

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

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

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

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

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

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

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

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

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

## waiver of premium rider (rider form series CRWPBT00)

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

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

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

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

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

## beneficiary designation

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

## conversion option

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

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

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

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

---

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

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

# Important disclosure information about traditional and PPO-based plans:

Aetna Choice® POS II

Aetna Health Network Only℠

Aetna Health Network Option℠

Aetna Open Access® Elect Choice® EPO

Aetna Open Access® Managed Choice®

Open Access Aetna Select℠

Open Choice® PPO

Traditional Choice® Indemnity

**Health insurance plans are offered and/or administered by Aetna Life Insurance Company (Aetna).**

## Table of contents


**We offer quality health plans....2**

**Features of a traditional or preferred provider organization (PPO)-based plan....2**

Not yet a member? ....3

Avoid unexpected bills ....3

Get a free printed directory ....3

Choose a primary care physician (PCP)....3

**Getting approval for some services....3**

No coverage, based on U.S. trade sanctions ....4

Coverage for transplants and other complex conditions....4

Clinical policy bulletins ....4

**What to do if you disagree with us....4**

You can file an appeal ....4

You can contact an independent review organization (IRO)....4

You can get a rush review ....4

**Member rights and responsibilities ....5**

Nondiscrimination policy for genetic testing....5

Your rights under the Employee Retirement Income Security Act of 1974 (ERISA)....5

Women's Health and Cancer Rights Act of 1998 (WHCRA)....5

Your right to enroll later....6

When you have a new dependent ....6

**Important information for certain states and plans ....6**

Colorado ....6

Delaware....6

Florida ....6

Georgia ....7

Hawaii ....8

Illinois....8

Indiana ....9

Iowa ....9

Kansas....9

Kentucky ....9

Louisiana....10

Michigan....10

North Carolina....10

Oklahoma....11

Rhode Island....11

Tennessee ....11

West Virginia....11


2268201-27-01 (5/23)

**Here is important disclosure information about our plans. It's followed by required content that varies by state.**

## We offer quality health plans

By following health plan accreditation standards of the National Committee for Quality Assurance (NCQA), we offer you quality health plans. Visit **Aetna.com/document-library/individuals-families-health-insurance/document-library/documents/2019Disclosures/NCQA-MED-Disclosures-FI-SI.pdf** to learn more about how we meet the NCQA accreditation and standards. You can also call us at the number on your member ID card to ask for a printed copy.

This document details how to:

### Understand your health plan

- Benefits and services included in, and excluded from, your coverage
- Prescription drug benefit
- Mental health and addiction benefits
- Care after office hours, urgent care, and emergency care

### Get plan information online and by phone

- How you can reach us
- Help for those who speak another language and for the hearing impaired
- Get information about how to file a claim
- Search our network for doctors, hospitals and other health care providers
- Accountable care organizations (ACOs)
- Our quality management programs, including goals and outcomes

### Know the costs and rules for using your plan

- What you'll pay
- Your costs when you go outside the network
- Precertification: getting approvals for services
- We study the latest medical technology
- How we make coverage decisions
- Complaints, appeals and external reviews

### Understand your rights and responsibilities

- Member rights and responsibilities
- Notice of Privacy Practices

## Features of a traditional or preferred provider organization (PPO)-based plan

If you're a member, not all of the information in this document applies to your specific traditional or PPO-based plan. Most information applies to all plans, but some does not. For example, not all plans have prescription drug or behavioral health benefits. There's also information that may only apply to a handful of states and plans. To be sure about which plan features apply to you, check your Summary of Benefits and Coverage plan documents. Can't find them? Ask your benefits administrator or call Member Services to have a copy of your plan documents mailed to you.

### How some plans pay

Providers set the rates to charge you. It may be higher (sometimes, much higher) than what your Aetna® plan allows. For some plans, your doctor may bill you for the dollar amount that the plan doesn't allow and no dollar amount above the allowed charge will count toward your deductible or out-of-pocket limits. This means you're fully responsible for paying everything above the amount the plan allows for a service or procedure. However, emergency care is always covered by your plan, and you don't have to get prior approval.


2268201-27-01 (5/23)

aetna®

Plans pay for your health care depending on the plan that you, or your employer, chooses. Some plans pay for services by looking at what Medicare would pay and adjusting that amount up or down. Plans range from paying 90% of Medicare (that is 10% less than Medicare would pay) up to 300% of Medicare (the Medicare rate multiplied by three). Some plans pay for services based on what is called the "usual and customary" charge. These plans use information from FAIR Health, Inc., a not-for-profit company that reports how much providers charge for services in any ZIP code. You can call Member Services at the number on your member ID card to find out the method your plan uses to pay providers.

### Not yet a member?

For help understanding how a certain medical plan works, review the plan's Summary of Benefits and Coverage document.

### Avoid unexpected bills

To avoid a surprise bill, make sure you check your plan documents to see what's covered before you get health care. Also, make sure you get care from a provider who is part of your plan's network. This just makes sense because:

- We have negotiated lower rates for you
- Network doctors and hospitals won't bill you above our negotiated rates for covered services
- You have access to quality care from our national network

Visit **Aetna.com** to find providers who are part of your plan's network. There you can learn more about network care and how we pay out-of-network benefits when a plan allows them.

### Get a free printed directory

To get a free printed list of doctors and hospitals, call the toll-free number on your member ID card. If you're not yet a member, call **1-888-982-3862 (TTY: 711)**.

### Choose a primary care physician (PCP)

Most traditional or PPO-based plans don't require you to select a PCP. However, some employers may require you to do so. We strongly encourage you to choose one because your PCP can help coordinate your care and order tests and screenings. If it's an emergency, you don't have to call your PCP first. You may change your PCP at any time.

Members may choose an Ob/Gyn as their PCP. Ob/Gyns acting as your PCP will provide the same services and follow the same guidelines as any other PCP. You may also be able to choose a pediatrician for your child(ren)'s PCP. See your plan documents for details.

## Getting approval for some services

Usually, we will pay for care only if we have given an approval before you get it. Your plan documents list all the services that require you to get prior approval.

First, we check to see that you're still a member. And we make sure the service is medically necessary for your condition. We also make sure the service and place requested to perform the service are cost effective. Our decisions are based solely on the existence of coverage and the appropriateness of care and service, using nationally recognized guidelines. We may suggest a different treatment or place of service that is just as effective but costs less. We also look to see if you qualify for one of our care management programs. If so, one of our nurses may contact you. Precertification doesn't verify whether you have reached any plan dollar limits or visit maximums for the service requested. So, even if you get approval, the service may not be covered.


2268201-27-01 (5/23)

aetna®

### No coverage, based on U.S. trade sanctions

If U.S. trade sanctions consider you a "blocked person," the plan can't provide benefits or coverage to you. If you travel to a country sanctioned by the United States, the plan, in most cases, can't provide benefits or coverage to you. Also, if your health care provider is a blocked person or is in a sanctioned country, we can't pay for services from that provider. For example, if you receive care while traveling in another country and the health care provider is a blocked person or is in a sanctioned country, the plan can't pay for those services. For more information, visit **Treasury.gov/resource-center/sanctions/pages/default.aspx** to read about U.S. trade sanctions.

### Coverage for transplants and other complex conditions

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

### Clinical policy bulletins

We write a report about a product or service when we decide if it's medically necessary. We call the report a clinical policy bulletin (CPB). CPBs guide us in deciding whether to approve a coverage request. Your plan may not cover everything our CPBs say is medically necessary. Each plan is different, so check your plan documents. CPBs are not meant to advise you or your doctor on your care. Only your doctor can give you advice and treatment. Talk to your doctor about any CPB related to your coverage or condition.

You and your doctor can visit **Aetna.com/health-care-professionals/clinical-policy-bulletins.html** to read CPBs. No internet? Call the number on your Aetna member ID card and ask for a copy of a CPB for any product or service.

## What to do if you disagree with us

If you disagree with something we've done, you can talk to us on the phone. Or you can mail us a written complaint. The phone number is on your Aetna member ID card. You can also email us at **Aetna.com**.

Still not satisfied?

### You can file an appeal

Did we deny your claim? Directions on how to appeal our decision are in:

- The letter we sent you
- The Explanation of Benefits statement that says your claim was denied

The letter we sent you tells you:

- What we need from you
- How soon we will respond

If a denial is based on a medical judgment, you may be able to get an external review if you're not satisfied with your appeal. Some states have their own external review process, and you may need to pay a small filing fee to your state. In other states, external review is available but follows federal rules.

For help or to learn more:

- Go to **USA.gov/state-tribal-governments** and select your state's website.
- Call the phone number on your member ID card.

### You can contact an independent review organization (IRO)

An IRO will assign your case to one of its experts. The expert will be a doctor or other professional who specializes in the area referred to in your case or in your type of appeal. You should have a decision within 45 calendar days of the request. The IRO's decision is final and binding; we will follow its decision and you won't have to pay anything, unless there was a filing fee.

### You can get a rush review

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


2268201-27-01 (5/23)

# Member rights and responsibilities

We don't consider race, disability, religion, sex, sexual orientation, health, ethnicity, creed, age or national origin when giving you access to care. Federal law requires network providers to do the same.

### Nondiscrimination policy for genetic testing

We don't use the results of genetic testing to discriminate, in any way, against applicants or enrollees. Also, you choose if you want to tell us your race or ethnicity and preferred language. We'll keep that information private. We use it to help us improve your access to health care and to serve you better.

### Your rights under the Employee Retirement Income Security Act of 1974 (ERISA)

If you're a participant in an employer-funded group health plan, you're entitled to certain rights and protections under ERISA. Some of those rights are listed below. Your rights are outlined in more detail in your plan documents.

Below are some of your rights.

- Receive, free of charge, information about your plan and benefits.
- Upon written request to your plan administrator, examine copies of documents governing the operation of the plan, contracts, collective bargaining agreements, annual reports and more. The administrator may charge you a reasonable copy fee.
- Receive a copy of procedures used to determine a qualified domestic relation or medical child support order.
- Continue group health coverage for you, your spouse or dependents if there is a loss of coverage as the result of a qualifying event.
- Know why a claim was denied.
- Exercise your rights and take steps to enforce your rights, without discrimination or retribution.
- Get answers to your questions about the plan. Contact your plan administrator with questions about your plan. If they don't provide the information you asked for, you can get help from the nearest office of the Employee Benefits Security Administration, which is part of the U.S. Department of Labor. Look them up online or in your local telephone directory.

### Women's Health and Cancer Rights Act of 1998 (WHCRA)

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under WHCRA. For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses
- Treatment of physical complications of the mastectomy, including lymphedema

Benefits will be provided to a person who has already undergone a mastectomy as a result of breast cancer while covered under a different health plan. Coverage is provided according to your plan design and is subject to plan limitations, copays, deductibles, coinsurance and referral requirements, if any, as outlined in your plan documents.


2268201-27-01 (5/23)

aetna®

Please contact Member Services for more information. Or follow these links to learn more.
Fact sheet from the U.S. Department of Health and Human Services: **https://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/whcra_factsheet.html**
Pamphlet from the U.S. Department of Labor: **https://www.dol.gov/sites/default/files/ebsa/ about-ebsa/our-activities/resource-center/ publications/your-rights-after-a-mastectomy.pdf**

### Your right to enroll later

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

### When you have a new dependent

Getting married? Having a baby? If you chose not to enroll during the normal open enrollment period, you may enroll within 31 days after a life event. Examples of life events are marriage, divorce, birth, adoption, and placement for adoption. Talk to your benefits administrator for more information or to request special enrollment.

## Important information for certain states and plans

Here is additional disclosure content that varies by state.

### Colorado

**Network access plan**
Aetna keeps network access plans for its provider networks in Colorado. The plans describe how we monitor the networks to be sure they meet our members' health care needs. To get a copy of the plans, contact us at the number on your member ID card. Or, download them:

- Go to **Aetna.com**
- Scroll to the bottom of the page and select "Plan disclosures"
- Select "State-Specific Information"
- Scroll down to find "Colorado"

### Delaware

**Scalp hair prosthesis benefit**
Aetna plans cover the cost of a scalp hair prosthesis worn for hair loss suffered as a result of alopecia areata resulting from an autoimmune disease. The same limitations and guidelines that apply to other prostheses as outlined in your plan documents apply, but this benefit is limited to $500, per year.

### Florida

**Direct access to a network chiropractor and podiatrist**
You have direct access to a participating primary care chiropractic and podiatric provider of your choice and do not need a referral from your PCP to access the benefits covered under your health benefits plan.

**Direct access to a network dermatologist**
You have direct access to a participating primary care dermatologist provider of your choice and do not need a referral from your PCP to access the benefits covered under your health benefits plan.


2268201-27-01 (5/23)

## Georgia

**Get a free printed directory**

If you live in Georgia, you can call toll-free at **1-800-223-6857 (TTY: 711)** to confirm that the preferred provider in question is in the network and is accepting new patients.

**Georgia clarifies the prudent layperson standard.**

It now includes **mental** or physical conditions in need of emergency care.

**Explanation of what constitutes an emergency situation and emergency services**

Emergency situation

Any physical or mental condition of a recent onset and severity. Regardless of your diagnoses, the symptoms would be severe enough to lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that his or her condition, sickness or injury is of such a nature that failure to obtain immediate medical care could result in:

- placing the patient's health in serious jeopardy.
- serious impairment to bodily functions or
- serious dysfunction of any bodily organ or part.

**Emergency services**

Physical or mental health care services, including stabilization, rendered after the recent onset of a medical or traumatic condition, sickness or injury exhibiting severe symptoms. This includes a mental health condition or substance use disorder. Regardless of your diagnoses, the symptoms would be severe enough to lead a prudent layperson possessing an average knowledge of medicine and health to believe that his or her condition, sickness or injury is of such a nature that failure to obtain immediate medical care could result in:

- placing the patient's health in serious jeopardy.
- serious impairment to bodily functions or
- serious dysfunction of any bodily organ or part.

**Direct access to network an obstetrician-gynecologist (Ob/Gyn)**

Women who are members have direct access to the participating primary Ob/Gyn provider of their choice and don't need a referral from their PCP for:

- A routine well-woman exam (including a Pap smear, when appropriate)
- An unlimited number of visits for gynecological problems
- An unlimited number of visits for follow-up care

**Direct access to a network dermatologist**

You have direct access to the participating dermatologist provider of your choice and do not need a referral from your primary care physician to access dermatologic benefits covered under your health plan.

**How to nominate an out-of-network doctor for network benefits**

If you prefer to receive care from a doctor who isn't in the network, just call Member Services at the number on your member ID card (you'll get that card after you enroll). You can nominate a specific doctor to serve as a network doctor for you and your covered family members.

The doctor must agree to accept the plan's compensation rates. The doctor must also adhere to the plan's policies and quality assurance requirements. And the doctor must meet all other reasonable criteria, just like all the doctors in our network. If the doctor agrees, you will pay the same network cost sharing for that doctor's services as you pay for other network doctors.

We will adjust your premium to add the doctor to the network. The amount will depend on whether you have single or family coverage. Member Services representatives can tell you how much extra you'll pay. Talk to your employer or benefits administrator to find out exact pricing and other information.

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 phone number on your member 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.

**How to nominate an out-of-network doctor for network benefits**



2268201-27-01 (5/23)

If you prefer to receive care from a doctor who isn't in the network, just call Member Services at the number on your member ID card (you'll get that card after you enroll). You can nominate a specific doctor to serve as a network doctor for you and your covered family members.

The doctor must agree to accept the plan's compensation rates. The doctor must also adhere to the plan's policies and quality assurance requirements. And the doctor must meet all other reasonable criteria, just like all the doctors in our network. If the doctor agrees, you will pay the same network cost sharing for that doctor's services as you pay for other network doctors. We will adjust your premium to add the doctor to the network. The amount will depend on whether you have single or family coverage. Member Services representatives can tell you how much extra you'll pay. Talk to your employer or benefits administrator to find out exact pricing and other information.

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 phone number on your member 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.

## Hawaii

### Get a free printed directory

If you live in Hawaii, you may contact the Hawaii Insurance Division and the Office of Consumer Complaints at **808-586-2790**.

### Informed consent

You have the right to be fully informed before making any decision about any benefit, treatment, or nontreatment. Your provider will do all of the following actions listed below.

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

## Illinois

### Illinois law requires certain health plan disclosures

Illinois law requires health plans to provide the following information each year to enrollees and to prospective enrollees upon request: (1) a complete list of participating health care providers in the health care plan's service area; (2) a description of the service area; (3) the covered benefits and services with all exclusions, exceptions and limitations; (4) the precertification and other utilization review procedures and requirements; (5) a description of the process for the selection of a primary care physician, any limitation on access to specialists, and the plan's standing referral policy; (6) a description of the emergency coverage and benefits, including any restrictions on emergency care services

(7) out-of-area coverage and benefits, if any; (8) the enrollee's financial responsibility for copayments, deductibles, premiums and any other out-of-pocket expenses; (9) 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; (10) 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; (11) 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; (12) 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.


2268201-27-01 (5/23)

aetna®

## Indiana

### Filing a complaint

Visit the complaint section of Indiana's state website at **IN.gov/idoi/2547.htm** to learn how you can file a complaint.

## Iowa

### Coverage decisions

A "coverage decision" is defined as a final adverse decision because a product or service was not deemed medically necessary. This definition does not include a denial of coverage for a service or treatment specifically listed in a plan or evidence of coverage documents as excluded from coverage, or a denial of coverage for a service or treatment that has already been received and for which the enrollee has no financial liability.

## Kansas

### Kansas law requires plans to provide certain information

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

## Kentucky

### A provider's right to join the network

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

### Direct access to a network chiropractic provider

You have direct access to the participating primary chiropractic provider of your choice. You don't need a referral from your primary care physician to access chiropractic benefits covered under your benefits plan.

### Directory information, financial incentives and wait times

Kentucky law requires Aetna to provide, upon enrollment and upon request, the following information: (1) a current participating provider directory with information on access to primary care providers and available providers; (2) general information on the type of financial incentives between contracted participating providers including any incentives and bonuses; and (3) our standard customary waiting times for appointments for urgent and routine care. Our customary wait times are for routine care (within 7 days); preventive care (within 8 weeks); symptomatic, urgent care (within 3 days) and urgent complaint (same day or within 24 hours) and emergency care (immediately or referred to an emergency room.)

Additionally, upon request, we will make available information about the provider network, including hospital affiliations and whether a particular network provider is board certified and whether a provider is currently accepting new patients. Members may contact Member Services at the phone number on their member ID card for more information; all others, contact your benefits administrator.


2268201-27-01 (5/23)

**Definition of "emergency medical condition"**

An emergency medical condition is a medical condition that manifests itself with 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

**You may receive care at a network hospital by a provider who is not in your plan's network**

Health care services may be provided to you at a network health care facility by facility-based physicians who are not in your health plan. You may be responsible for payment of all or part of the fees for those out-of-network services, in addition to applicable amounts due for copayments, coinsurance, deductibles, and noncovered services. Specific information about in-network and out-of-network facility-based-physicians can be found at the website address of your health plan or by calling the customer service telephone number of your health plan.

**Women's Health and Cancer Rights Act of 1998**

Any health benefit plan delivered or issued for delivery in this state shall include coverage, on no less than an annual basis, for preventive cancer screenings for an insured or enrollee who was previously diagnosed with breast cancer, completed treatment for breast cancer, underwent a bilateral mastectomy, and was subsequently determined to be clear of cancer.

## Michigan

**Get a free printed directory**

Michigan members may contact the Michigan Office of Financial and Insurance Services at **517-284-8800** to verify participating providers' licenses and access information on formal complaints and disciplinary actions filed or taken against a health care provider in the preceding three years. For more information on your health plan, call **1-800-208-8755 (TTY: 711)** or refer to your plan documents.

## North Carolina

**Obstetrician-gynecologist (Ob/Gyn) visits**

Any female member who is 13 or older may visit any participating OB/Gyn for:

- A routine well-woman exam (including a Pap smear, when appropriate)
- An unlimited number of visits for gynecological problems
- An unlimited number of visits for follow-up care

**Members may be able to pay in-network cost sharing for out-of-network services**

If you cannot get a medically necessary service or supply through a participating doctor or hospital without unreasonable delay, or you can't find a participating doctor who can provide the service or supply, you can get the service or supply from a nonparticipating provider. You must precertify the service or supply first. Once precertified, we will cover the service or supply at the in-network benefit level. That means your share of the costs — the copayment, coinsurance, and/or deductible, if applicable — will be at the in-network level. This is also true for medical emergencies. Medical emergencies do not require precertification.


2268201-27-01 (5/23)

aetna®

## Oklahoma

### Filing claims

Aetna network doctors and other health care providers will file claims for you. However, you may need to file a claim for covered out-of-network services. Go to **Aetna.com/individuals-families/using-your-aetna-benefits/find-form.html** to download and print a claim form. You can also call the phone number on your member ID card to ask for a claim form. The claim form includes complete instructions including what documentation to send with it. We determine how and whether a claim is paid based on the terms and conditions of the health coverage plan and our internal coverage policies.

### Oklahoma Breast Cancer Patient Protection Act

In addition to the benefits provided under the Women's Health and Cancer Rights Act of 1998, the Oklahoma Breast Cancer Patient Protection Act requires plans to provide the following benefits:

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

## Rhode Island

### All Payer Claims Database (APCD)

The Rhode Island All Payer Claims Database (APCD) provides reports about health care quality, cost and reforms. Policymakers will use it to help them make better decisions regarding health care quality. All health insurers in Rhode Island send information to the APCD. All information sent to the APCD is anonymous. To maintain your privacy, we will not send any of the following to the APCD: your name, address, telephone number, email address, Social Security number, or any other information that could identify you.

You can exclude your information from the APCD. To do so, go to **RIAPCD-OptOut.com** or call Rhode Island Health Insurance Consumer Support toll-free at **1-855-747-3224.**

Questions?

- Email: Rhode Island All Payer Claims Database at Contact Us: **Department of Health (ri.gov)**
- Phone: Rhode Island Health Insurance Consumer Support toll-free at **1-855-747-3224**

## Tennessee

### Routine vision care

You're covered for routine vision exams from participating providers without a referral from your primary care physician. Copayments may apply. For routine eye exams, you can visit a participating optometrist or ophthalmologist without a referral, once every 12 months. A contact lens fitting exam is not covered.

## West Virginia

### Contraceptive drugs and devices

Plans that include prescription drug benefits must have a rider that covers birth control products that are approved by the U.S. Food and Drug Administration. Religious employers are allowed to opt out of this coverage. If that happens, members covered under the contract can get their own birth control rider directly from us. Talk to your plan administrator to see if this impacts you.


2268201-27-01 (5/23)

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

We provide free aids/services to people with disabilities and to people who need language assistance.

If you need a qualified interpreter, written information in other formats, translation or other services, call the number on your ID card.

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

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

(CA HMO customers: PO Box 24030 Fresno, CA 93779)

**1-800-648-7817, TTY: 711**

Fax: 859-425-3379 (CA HMO customers: **860-262-7705**)

Email: **CRCoordinator@aetna.com**

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



2268201-27-01 (5/23)

# Notice of Privacy Practices

Office Key 128

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

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

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

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

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

This notice became effective on **October 9, 2018**.

**How Aetna Uses and Discloses Personal Information**

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

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

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

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

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

**Additional Reasons for Disclosure**

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

- **Plan Administration** – to your employer, when we have been informed that appropriate language has been included in your plan documents, or when summary data is disclosed to assist in bidding or amending a group health plan.
- **Research** – to researchers, provided measures are taken to protect your privacy.
- **Business Partners** – to persons who provide services to us and assure us they will protect the information.
- **Industry Regulation** – to state insurance departments, boards of pharmacy, U.S. Food and Drug Administration, U.S. Department of Labor and other government agencies that regulate us.
- **Workers' Compensation – to comply with workers' compensation laws.**
- **Law Enforcement** – to federal, state, and local law enforcement officials.
- **Legal Proceedings** – in response to a court order or other lawful process.
- **Public Welfare** – to address matters of public interest as required or permitted by law (e.g., child abuse and neglect, threats to public health and safety, and national security).
- **As Required by Law** – to comply with legal obligations and requirements.
- **Decedents** – to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death, or as authorized by law; and to funeral directors as necessary to carry out their duties.
- **Organ Procurement** – to respond to organ donation groups for the purpose of facilitating donation and transplantation.

**Required Disclosures**: We **must** use and disclose your personal information in the following manner:

- To you or someone who has the legal right to act for you (your personal representative) in order to administer your rights as described in this notice; and
- To the Secretary of the Department of Health and Human Services, as necessary, for HIPAA compliance and enforcement purposes.

**Disclosure to Others Involved in Your Health Care**

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

If you are a minor, you also may have the right to block parental access to your health information in certain circumstances, if permitted by state law. You can contact us using the toll-free Customer Service number at **1-866-292-3374** – or have your provider contact us.

**Uses and Disclosures Requiring Your Written Authorization**

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

**Your Legal Rights**

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

- You have the right to ask us to communicate with you in a certain way or at a certain location. For example, if you are covered as an adult dependent, you might want us to send health information to a different address from that of your subscriber. We will accommodate reasonable requests.
- You have the right to ask us to restrict the way we use or disclose health information about you in connection with health care operations, payment, and treatment. We will consider, but may not agree to, such requests. You also have the right to ask us to restrict disclosures to persons involved in your health care.
- You have the right to ask us to obtain a copy of health information that is contained in a "designated record set" – medical records and other records maintained and used in making enrollment, payment, claims adjudication, medical management, and other decisions. We may ask you to make your request in writing, may charge a reasonable fee for producing and mailing the copies and, in certain cases, may deny the request.
- You have the right to ask us to amend health information that is in a "designated record set." Your request must be in writing and must include the reason for the request. If we deny the request, you may file a written statement of disagreement.
- You have the right to ask us to provide a list of certain disclosures we have made about you, such as disclosures of health information to government agencies that license us. Your request must be in writing. If you request such an accounting more than once in a 12-month period, we may charge a reasonable fee.
- You have the right to be notified following a breach involving your health information.
- You have the right to know the reasons for an unfavorable underwriting decisions. Previous unfavorable underwriting decisions may not be used as the basis for future underwriting decisions unless we make an independent evaluation of the basic facts. Your genetic information cannot be used for underwriting purposes.
- You have the right with very limited exceptions, not to be subjected to pretext interviews.[1]

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

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

**Aetna's Legal Obligations**

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

**Safeguarding Your Information**

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

---

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

[1] We do not participate in pretext interviews.

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

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

# Non-Discrimination Notice

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

Aetna provides free aids/services to people with disabilities and to people who need language assistance. If you need a qualified interpreter, written information in other formats, translation or other services, call 1-866-292-3374.

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

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

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

# Availability of Language Assistance Services

TTY: 711

| |
|---|
| For language assistance in your language call 1-866-292-3374 at no cost. (English) |
| Para obtener asistencia lingüística en su idioma, llame sin cargo al 1-866-292-3374. (Spanish) |
| 欲取得以您的語言提供的語言協助，請撥打1-866-292-3374，無需付費。(Chinese) |
| Pour une assistance linguistique dans votre langue, appeler le 1-866-292-3374 sans frais. (French) |
| Para sa tulong sa inyong wika, tumawag sa 1-866-292-3374 nang walang bayad. (Tagalog) |
| Hilfe oder Informationen in deutscher Sprache erhalten Sie kostenlos unter der Nummer 1-866-292-3374. (German) |
| للمساعدة اللغوية بلغتك الرجاء الاتصال على الرقم المجاني 1-866-292-3374. (Arabic) |
| Pou jwenn asistans nan lang pa w, rele nimewo 1-866-292-3374 gratis. (French Creole) |
| Per ricevere assistenza nella sua lingua, può chiamare gratuitamente il numero 1-866-292-3374. (Italian) |
| 日本語で援助をご希望の方は1-866-292-3374（フリーダイアル）までお電話ください。(Japanese) |
| 본인의 언어로 통역 서비스를 받고 싶으시면 비용 부담 없이1-866-292-3374번으로 전화하 주십시오. (Korean) |
| برای راهنمایی به زبان شما با شماره 1-866-292-3374 بدون هیچ هزینه ای تماس بگیرید. (Persian) |
| Aby uzyskać pomoc w swoim języku, zadzwoń bezpłatnie pod numer 1-866-292-3374. (Polish) |
| Para obter assistência no seu idioma, ligue gratuitamente para o 1-866-292-3374. (Portuguese) |
| Чтобы получить помощь с переводом на ваш язык, позвоните по бесплатному номеру 1-866-292-3374. (Russian) |
| Để được hỗ trợ ngôn ngữ bằng ngôn ngữ của bạn, hãy gọi miễn phí đến số 1-866-292-3374. (Vietnamese) |

# PRESCRIPTION DRUG COVERAGE AND MEDICARE

**Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with your employer's plan and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area.**

Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

**There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:**

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. Your employer has determined that the prescription drug coverage offered by your employer's plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

### When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year **from October 15th to December 7th**.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

### What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current coverage through your employer's plan will not be affected.

### When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with your employer and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

### For More Information About This Notice Or Your Current Prescription Drug Coverage

Contact the person listed below for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Boon changes. You also may request a copy of this notice at any time.

### For More Information About Your Options Under Medicare Prescription Drug Coverage

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans. For more information about Medicare prescription drug coverage:

- Visit **www.medicare.gov**
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help.
- Call **1-800-MEDICARE (1-800-633-4227)**. TTY users should call **1-877-486-2048**.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at **www.socialsecurity.gov**, or call them at **1-800-772-1213 (TTY 1-800-325-0778)**.

# 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 toward your or your dependents' other coverage). However, you must request enrollment within 30 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 "30 days" after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact the benefits administrator.

# WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

If you are receiving covered benefits for a Mastectomy, you should know that your Plan complies with the Women's Health and Cancer Rights Act of 1998 (WHCRA).

The Act provides for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same copays, deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan as stated in the Plan Summary provided with these materials.

If you would like more information on WHCRA benefits, contact the benefits administrator.

# NEWBORN'S ACT DISCLOSURE

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

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

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

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

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

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

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

**If you live in one of the following states, you may be eligible for assistance from Medicaid in paying for your employer health plan premiums. The following list of states is current as of Jul. 31, 2024. Contact your State for more information on eligibility –**

**ALABAMA** | Medicaid
Website: http://myalhipp.com/
Phone: 1-855-692-5447

**ALASKA** | Medicaid
The AK Health Insurance Premium Payment Program
Website: http://myakhipp.com/
Phone: 1-866-251-4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx

**ARKANSAS** | Medicaid
Website: http://myarhipp.com/
Phone: 1-855-MyARHIPP (855-692-7447)

**CALIFORNIA** | Medicaid
Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp
Phone: 916-445-8322
Fax: 916-440-5676
Email: hipp@dhcs.ca.gov

**COLORADO** | Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Health First Colorado Website: https://www healthfirstcolorado.com/
Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711
CHP+: https://hcpf.colorado.gov/child-health-plan-plus
CHP+ Customer Service: 1-800-359-1991/ State Relay 711
Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/
HIBI Customer Service: 1-855-692-6442

**FLORIDA** | Medicaid
Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html
Phone: 1-877-357-3268

**GEORGIA** | Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
Phone: 678-564-1162, Press 1
GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization- act-2009-chipra
Phone: 678-564-1162, Press 2

**INDIANA** | Medicaid
Website: https://www.in.gov/medicaid/ or http://www.in.gov/fssa/dfr/
Family and Social Services Administration
Phone: 1-800-403-0864, Member Services Phone: 1-800-457-4584

**IOWA** – Medicaid & CHIP (Hawki)
Medicaid Website: https://hhs.iowa.gov/programs/welcome-iowa-medicaid
Medicaid Phone: 1-800-338-8366
Hawki Website: https://hhs.iowa.gov/programs/welcome-iowa-medicaid/iowa-health-link/hawki
Hawki Phone: 1-800-257-8563
HIPP Website: https://hhs.iowa.gov/programs/welcome-iowa-medicaid/fee-service/hipp
HIPP Phone: 1-888-346-9562

**KANSAS** | Medicaid
Website: https://www.kancare.ks.gov/
Phone: 1-800-792-4884
HIPAA Phone: 1-800-967-4660

**KENTUCKY** | Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP)
Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx
Phone: 1-855-459-6328
Email: KIHIPP.PROGRAM@ky.gov
KCHIP Website: https://kynect.ky.gov
Phone: 1-877-524-4718

**KENTUCKY** | Medicaid (continued)
Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms

**LOUISIANA** | Medicaid
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp
Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

**MAINE** | Medicaid
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US
Phone: 1-800-442-6003
TTY: Maine relay 711
Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 1-800-977-6740
TTY: Maine relay 711

**MASSACHUSETTS** | Medicaid & CHIP
Website: https://www.mass.gov/masshealth/pa
Phone: 1-800-862-4840 TTY: 711
Email: masspremassistance@accenture.com

**MINNESOTA** | Medicaid
Website: https://mn.gov/dhs/healthcare-coverage/
Phone: 1-800-657-3672

**MISSOURI** | Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

**MONTANA** | Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084
Email: HHSHIPPProgram@mt.gov

**NEBRASKA** | Medicaid
Website: http://www.ACCESSNebraska.ne.gov
Phone: 1-855-632-7633
Lincoln: 402-473-7000
Omaha: 402-595-1178

**NEVADA** | Medicaid
Medicaid Website:
https://dhcfp.nv.gov
Medicaid Phone: 1-800-992-0900

**NEW HAMPSHIRE** | Medicaid
Website:
https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program
Phone: 603-271-5218
Toll free number for the HIPP program: 1-800-852-3345, ext. 15218
Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov

**NEW JERSEY** | Medicaid & CHIP
Medicaid Website:
http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Phone: 800-356-1561
CHIP Premium Assistance Phone: 609-631-2392
CHIP Website: http://www.njfamilycare.org/ index.html
CHIP Phone: 1-800-701-0710 (TTY 711)

**NEW YORK** | Medicaid
Website:
https://www.health.ny.gov/health_care/medicaid/
Phone: 1-800-541-2831

**NORTH CAROLINA** | Medicaid
Website: https://medicaid.ncdhhs.gov/
Phone: 919-855-4100

**NORTH DAKOTA** | Medicaid
Website:
https://www.hhs.nd.gov/healthcare
Phone: 1-844-854-4825

**OKLAHOMA** | Medicaid and CHIP
Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

**OREGON** | Medicaid
Website: http://healthcare.oregon.gov/Pages/index.aspx
Phone: 1-800-699-9075

**PENNSYLVANIA** | Medicaid & CHIP
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html
Phone: 1-800-692-7462
CHIP Website:
https://www.dhs.pa.gov/CHIP/Pages/CHIP.aspx
CHIP Phone: 1-800-986-KIDS (5437)

**RHODE ISLAND** | Medicaid and CHIP
Website: http://www.eohhs.ri.gov/
Phone: 855-697-4347, or 401-462-0311 (Direct RIte Share Line)

**SOUTH CAROLINA** | Medicaid
Website: https://www.scdhhs.gov
Phone: 1-888-549-0820

**SOUTH DAKOTA** | Medicaid
Website: http://dss.sd.gov
Phone: 1-888-828-0059

**TEXAS** | Medicaid
Website:
https://www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program
Phone: 1-800-440-0493

**UTAH** | Medicaid & CHIP
Utah's Premium Partnership for Health Insurance (UPP) Website:
https://medicaid.utah.gov/
Email: upp@utah.gov
Phone: 1-888-222-2542
Adult Expansion Website:
https://medicaid.utah.gov/expansion/
Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/

**UTAH** | Medicaid & CHIP (continued)
CHIP Website:
http://health.utah.gov/chip

**VERMONT** | Medicaid
Website: https://dvha.vermont.gov/members/medicaid/hipp-program
Phone: 1-800-250-8427

**VIRGINIA** | Medicaid & CHIP
Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select
https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs
Medicaid/CHIP Phone: 1-800-432-5924

**WASHINGTON** | Medicaid
Website: https://www.hca.wa.gov/
Phone: 1-800-562-3022

**WEST VIRGINIA** | Medicaid and CHIP
Website: https://dhhr.wv.gov.bms/
http://mywvhipp.com/
Medicaid Phone: 304-558-1700
CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

**WISCONSIN** | Medicaid & CHIP
Website:
https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm
Phone: 1-800-362-3002

**WYOMING** | Medicaid
Website:
https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/
Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since Jul. 31, 2024, or for more information on special enrollment rights, contact either:

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

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