Your 2018 Guide to Benefits

Summary Plan Descriptions for Retiree Health and Life Benefits

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We are pleased to provide you with the 2018 Guide to Benefits and Summary Plan Descriptions (SPDs) for Retiree Health and Life Benefits. This SPD can help you understand what benefits, rights and obligations you have under the plans we offer you and your dependents.

We offer a wide range of health, dental and other benefits that are outlined in the *Table of contents* section of this SPD. You'll want to read this SPD carefully. If you have questions, the *Contact information* section beginning on page 65 of this SPD can direct you to representatives or websites that will answer your questions. Three very helpful resources are:

- Aetna Human Resources, which will answer questions regarding benefits eligibility, plan options and enrollment. Just call **1-800-AETNA-HR (1-800-238-6247)** weekdays, 8 a.m. to 8 p.m. ET.
- Aetna One® Premier, an award-winning concierge service center, which will answer questions regarding plan resources, coverages or claims for the pre-Medicare plans. Just call **1-800-247-5485**, 8 a.m. to 6 p.m., your local time.
- Aetna Medicare Member Services will answer questions regarding plan resources, coverages or claims for the Aetna Medicare medical and pharmacy plans. Just call **1-888-972-3862**, 8 a.m. to 6 p.m., your local time.

In the event of a discrepancy, the language in the plan document or official group policy will govern. Also, this SPD contains a summary of current plan guidelines, which may be changed by the company at any time. For more information on the rights and protections that govern the plans, please see the *ERISA* section in this SPD.

We continue to listen to you, our retirees, to help in the development of the benefits we offer. You can provide your feedback by calling Aetna Human Resources at **1-800-AETNA-HR (1-800-238-6247)** weekdays, 8 a.m. to 8 p.m. ET.

We hope you find this SPD useful and that it provides you with the resources you need to learn more about the benefits plans we offer.

Thank you,
Your Aetna Benefits team

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Overview

Overview

This guide describes the main features of the plans and should not be considered a contract. The complete terms of the plans are in the plan documents and group insurance policies. The terms of the plan documents and group policies will govern.

The benefits described in this guide are effective only if you are and continue to be eligible for these benefits in accordance with the provisions of each applicable plan.

Eligibility

You

The following requirements must be met for you to be eligible for retiree benefits:

- You must have been a regular U.S. employee employed by a participating company.
- You must normally be scheduled to work 20 or more hours per week.
- You must be at least age 55 on the day you terminated employment.
- Aetna temporary employees, employees from an outside agency (for example, leased employees), and individuals designated by the company as independent contractors, career agents and brokers are not eligible for retiree life and health benefits.
- If you cancel retiree dental, medical or prescription drug coverage, you will not be eligible to re-enroll in this coverage in the future.

The following rules also apply:

- If you do not elect retiree coverage when your employment terminates, you will automatically be placed in deferred status (see *Deferring coverage* in this section). If you are over age 65 at retirement and do not elect coverage, deferral is not available to you, and you will lose eligibility.
- If you do not elect retiree health coverage by the end of your deferral period, you cannot elect it at a future date.
- You must participate in retiree health coverage in order for your eligible dependents to participate.

Your dependents

You may add coverage for an eligible dependent (including a spouse, domestic partner or child) at annual enrollment, or with a valid status change during the plan year (for example, you get married or your spouse loses employer coverage).

Your eligible dependents

You, the retiree, must be enrolled in a medical and/or dental plan in order to enroll any dependents in a medical and/or dental plan. Depending on the benefit, your eligible dependents may include:

- Your legal spouse
- Your partner
- Child(ren)

Spouse

Your spouse is eligible for coverage if:

- You are legally married or you are legally recognized as having a common-law marriage

This SPD applies to individuals who terminate in 2018. Different rules apply to terminations prior to 2018. If you terminated prior to 2018, refer to the SPD in effect at the time of your termination for the rules that apply to you.

Partner*

Your civil union partner is eligible for coverage if:

- Your civil union is legally recognized

Your domestic partner, of either the same or opposite sex, is eligible for coverage as a partner if you and your partner are:

- At least age 18
- Not legally married to another person or part of another partner relationship
- Intending to remain each other's sole partner indefinitely
- Residing together in the same principal residence and intend to do so indefinitely
- Emotionally committed to one another and share joint responsibilities for common welfare and financial obligations
- Not related by blood closer than what your resident state prohibits for a legal marriage
- Mentally competent to enter into contracts
- Not in the relationship solely for the purpose of obtaining benefits coverage

*In this guide, the term "partner" is intended to refer to both civil union and domestic partners, unless otherwise noted.

Child(ren)

Your child is eligible for coverage up to age 26 if she or he is:

- Your son, daughter, stepson, stepdaughter or foster child.
- Your lawfully adopted child.
- Any child placed with you for adoption.
- Any child over whom you have legal custody.
- A child of your partner (provided your partner is enrolled in the plan).
- Any child for whom you have been mandated to provide medical or dental coverage by a court or administrative agency under a Qualified Medical Child Support Order (QMCSO) and the child is otherwise eligible. If you are not currently enrolled, you must elect coverage for yourself and the child at the time of the QMCSO. If you are not eligible for coverage, or the child is not eligible for coverage, you will be responsible for obtaining other coverage for the child. Also see *Qualified Medical Child Support Order* on page 4.

If your spouse/partner works or worked for Aetna, only one of you may cover your eligible children.

Incapacitated or disabled children over age 26

- Incapacitated or disabled children may be permitted to continue coverage beyond age 26 if they were covered under an Aetna-sponsored plan prior to meeting the age limit, provided notification is received within 90 days of the date the child attains the age of 26.
- To enroll an incapacitated or disabled child over the age of 26, you must contact Aetna One Premier at **1-800-247-5485**. Request the *Continuation of Medical Coverage for Handicapped Child* form and *Attending Physician Statement* form. Complete and return both forms to Aetna One Premier within the requested time frame. Aetna has the right to require proof of continuation of coverage for the incapacitating/handicap condition. You will be contacted by the Clinical Team medical director when proof of continuation of coverage is required. Once you receive approval from Aetna One Premier, and obtain proof of prior medical coverage, contact Aetna Human Resources at **1-800-AETNA-HR (1-800-238-6247)** weekdays, 8 a.m. to 8 p.m. ET, for assistance with enrolling your dependent. If all criteria are met, coverage will begin at the same time as your coverage.

Qualified Medical Child Support Order

Certain judgments or court orders could require Aetna's retiree health plans to cover your child if they are eligible for coverage. This is known as a medical child support order. The company determines whether the court order is a Qualified Medical Child Support Order (QMCSO). The child also can gain eligibility for coverage if the company receives a National Medical Support Notice and determines it to be a QMCSO. In these situations, the company can take deductions from your pension checks to pay for the child's health coverage.

The plans cover the child from the date the order is approved until the date or age stated in the order, but not beyond the normal plan eligibility age. The child is added to coverage if you're already enrolled. If you're not already enrolled, you'll be assigned coverage. If you are not eligible for coverage, or the child is not eligible for coverage, you will be responsible for obtaining other coverage for the child.

Contact Aetna Human Resources at **1-800-AETNA-HR (1-800-238-6247)** weekdays, 8 a.m. to 8 p.m. ET, as soon as you are aware of any court proceedings that may affect your child's eligibility for coverage under the company's plans. Aetna Human Resources can also provide you with a copy of the procedures governing QMCSOs free of charge.

When spouse/partner is an Aetna employee

If you and your spouse/partner both work or worked at Aetna, special rules apply. You and your spouse/partner cannot be covered under more than one Aetna medical or dental plan (active employee and retiree benefits plans) at the same time.

Choosing coverage

When your spouse/partner later leaves Aetna, they may either:

- Choose coverage as a dependent under your retiree medical and/or dental coverage, if eligible, or
- Choose their own retiree medical and/or dental coverage, if eligible

If your spouse or partner chooses coverage as a dependent and defers commencement of their own retiree benefits, they may choose to end coverage as your dependent and begin their own retiree medical and/or dental coverage, per the deferral coverage rules on page 7. If you and your spouse/partner are both Aetna eligible retirees, you have these retiree health plan coverage options:

- You both can enroll for You Only coverage.
- One of you can enroll for You + Spouse/Dependent coverage, if you're both eligible for Medicare or both eligible for pre-Medicare.
- One of you can enroll for You Only coverage and the other can cover himself or herself and your eligible children by enrolling for You + Child(ren) coverage.
- You both can enroll for You + Child(ren) coverage if you're covering different children.
- One of you can enroll for You + Family coverage, if you're all eligible for Medicare or all are eligible for pre-Medicare.

Retiree health benefits eligibility for spouses/partners who are also Aetna employees			
Retiree (living)			
Spouse/partner retired from Aetna		**Spouse/partner active Aetna employee**	
Covered as your dependent under retiree plan OR	Covered as a retiree under retiree plan (if eligible)	Covered as your dependent under retiree plan* OR	Covered as an employee under active employee plan (if eligible)
Retiree (deceased)			
Spouse employed by Aetna before retiree death			
Spouse/partner retired from Aetna		**Spouse/partner active Aetna employee**	
Covered as your elevated dependent under retiree plan OR	Covered as a retiree under retiree plan (if eligible)	Covered as your elevated dependent under retiree plan* OR	Covered as an employee under active employee plan (if eligible)
Spouse employed by Aetna after retiree death			
Spouse/partner retired from Aetna		**Spouse/partner active Aetna employee**	
Covered as your elevated dependent under retiree plan OR	Covered as a retiree under retiree plan (if eligible)	Covered as your elevated dependent under retiree plan* OR	Covered as an employee under active employee plan (if eligible)

Note: You cannot participate in active employee benefits and retiree health benefits at the same time.

*Dependent cannot split health benefits between active and retiree (that is, cannot choose active dental and retiree health).

Deferring coverage

If your employment terminates after age 55, you can defer enrollment until you reach age 65. When you then enroll, you may purchase retiree health coverage at unsubsidized group rates. You may elect medical and dental, medical only, or dental only.

You will be eligible for the plan, if any, that is available at the time you elect coverage.

If you elect coverage for yourself, you may defer coverage for your eligible spouse/partner until they turn age 65. Children can be deferred until they reach age 26. Also, coverage for your spouse or partner and children may begin independently. You must elect coverage for yourself in order to enroll eligible dependents.

You may want to consider deferral if you have coverage through your spouse's plan or with a different employer or if you wish to seek coverage under a health care exchange. If you do not elect retiree health coverage when you reach age 65, you cannot elect it at a future date.

If you are rehired as an active Aetna employee after your termination/retirement and subsequently terminate employment again, you will be subject to the deferral rule in place at that time.

If you are over age 65 and/or eligible for Medicare, no deferral is available.

For all retirees: You must begin your coverage on the first day of the month in which you turn age 65 or, if your birthday falls on the first of the month, the first of the month **before** the month of your 65th birthday (in other words, your Medicare eligibility date).

If you do not begin coverage, you (and your eligible dependents) will lose the right to participate in retiree health benefits.

Re-entry rule

Current participants in the pre-Medicare retiree plans may drop coverage and return to deferred status at annual enrollment (only). Participants may remain deferred until they reach age 65. This option is not available to Medicare participants. See page 8 for more details on deferred status.

Important points to consider before taking action to drop coverage and return to deferred status	
Subsidy	• If you currently have a company subsidy, it will be preserved and may be used when you re-elect coverage, against plans offered at that time (if any). • No subsidies can increase or change due to this option.
Dependents	• If you cover dependents, they must also defer with you, even if they are enrolled in a Medicare plan. • If your dependents are enrolled in a Medicare plan, they will have to cancel it.
If you are a covered spouse/partner of a Medicare-eligible Aetna retiree	You may defer until you reach age 65, and your spouse/partner may continue their Aetna retiree Medicare plan.
If you are a covered dependent child of a Medicare-eligible Aetna retiree	This feature does not apply to you. You may continue your coverage in the pre-Medicare plan until you no longer qualify as an eligible dependent. Note: The retiree must be enrolled in the Medicare plan in order for you to continue enrollment.
Impact of returning to deferred status on dental	If you return to deferred status for medical coverage, you and your covered dependents must return to deferred status for dental coverage.

When to enroll

If you do not elect retiree coverage when your employment terminates, you will automatically be placed in deferral status. If you do not elect retiree health coverage by the end of your deferral period, you cannot elect it at a future date. If you are over age 65 and/or eligible for Medicare, no deferral is available.

If you want to enroll in an Aetna retiree Medicare plan, you must enroll during the 60 days prior to turning age 65 as indicated on your enrollment worksheet. You MUST enroll by calling Aetna Human Resources at **1-800-AETNA-HR (1-800-238-6247)**. You will be ineligible for retiree health benefits if you fail to enroll prior to turning age 65.

Please note that in order to comply with the Patient Protection and Affordable Care Act reporting requirements, we request Social Security numbers for you and your eligible dependents. Please have this information when you enroll.

When retiree health and dental coverage begins

If you elect coverage when your employment terminates

If you enroll in retiree health and/or dental coverage within 60 days of your termination of employment, your coverage takes effect retroactive to the first day of the month after your last day of active employment. If your termination of employment is on the first day of the month, your retiree coverage begins that day.

If you deferred coverage

If coverage is elected at the end of the deferral period, coverage begins on the first of the month in which the deferral period ends.

If you elect coverage before the end of the deferral period, coverage is effective on the first of the month in which you make the election, if your election is received on or before the 15th of the month. If your election is not received by the 15th of the month, it will begin on the first day of the following month.

If you return to work at Aetna following retirement

If you become employed by Aetna or a participating company as a regular employee after commencing Aetna retiree health coverage, regardless of the number of hours worked, your retiree health coverage, as well as coverage for any eligible dependents, will end. Your medical plan subsidy (if any) will be frozen until your re-retirement from Aetna. You will be eligible to enroll in active employee health benefits if you are scheduled to work 20 or more hours per week. (If you work fewer than 20 hours a week, you are not eligible for active employee health benefits.) You cannot participate in retiree health benefits while you are a regular Aetna employee.

If you are designated as a temporary employee (for example, employed by an outside temporary agency) and working for Aetna, you may continue to participate in retiree health coverage. If you are the spouse or partner of an Aetna retiree and are enrolled in Aetna retiree health benefits as a dependent of that person, you may continue your participation as long as you do not enroll in active employee health benefits.

When you later terminate your employment with Aetna, you may choose to elect or defer retiree health coverage according to the plan provisions in effect at that time.

At annual enrollment

For current retirees making new coverage choices during annual enrollment, your new coverage begins the following January 1.

For mid-year coverage changes

If you change your coverage due to a valid status change, your new coverage generally begins on the date of your status change — for example, on the date you move to a new address (if you move out of a plan service area). If you cancel coverage for yourself and/or for a dependent, then coverage generally ends on the last day of the month in which the status change occurred, unless it is the first day of the month. Then coverage ends the last day of the previous month.

When retiree health and dental coverage ends

Your coverage can continue as long as your plan is available and as long as you continue paying your share of the cost for coverage.

You may cancel coverage at any time by calling Aetna Human Resources at **1-800-AETNA-HR (1-800-238-6247)** weekdays, 8 a.m. to 8 p.m. ET. If you or your eligible dependents cancel retiree health or dental coverage, you and/or your dependents may not re-elect health or dental coverage, as applicable, in the future.

When your covered child attains the age of 26, the child's coverage is automatically terminated, and the child is notified of the opportunity to continue coverage under COBRA (Consolidated Omnibus Budget Reconciliation Act).

If your plan becomes unavailable, you will be provided with a replacement plan, unless the company decides to eliminate the health and dental plans.

In the event of your death, your eligible dependents may continue coverage while the plan remains in effect. Eligible children may continue coverage until they are no longer eligible. Your spouse or partner (if eligible) can continue coverage until:

- Death
- Obtainment of other health insurance coverage

Coverage for a surviving spouse or partner may continue at remarriage or entry into a new partnership, but a surviving spouse or partner may never add a dependent.

Coordination with Medicare and other coverage

If both you and your spouse/partner are retired and also are covered by your spouse's/partner's group plan, the Aetna Medicare Plan (PPO/PPO with ESA) will be primary for both you and your spouse/partner. If you are covered under another group plan by a spouse or partner who is actively employed, that plan will be considered primary for you, and the Aetna Medicare Plan (PPO/PPO with ESA) will be considered secondary. CMS requirements do not allow you to be enrolled in two Medicare Advantage plans or prescription drug plans (PDPs) at the same time. If you are currently enrolled in a Medicare Advantage plan under a spouse or partner, you automatically will be disenrolled from that Medicare Advantage plan when you enroll in the Aetna Medicare Plan (PPO/PPO with ESA).

The Medicare prescription drug program doesn't coordinate benefits with other Medicare Part D coverage. If you're eligible for Medicare, you cannot participate in Medicare Part D through Aetna and through another PDP at the same time.

Paying for retiree health and dental coverage

Your monthly premiums (if you currently pay for coverage)

When you enroll in or change your benefits, you will be sent a confirmation letter from Aetna Human Resources.

This confirmation will display your monthly premiums for all benefits for which you share in the cost of coverage. You may pay for your benefits through direct debit. The system withdraws your monthly benefits payment automatically from your checking or savings account. You can enroll in direct debit directly on the Retiree Health Access website at **retireehealthaccess.net/aetna** or by calling Aetna Human Resources at **1-800-AETNA-HR (1-800-238-6247)** weekdays, 8 a.m. to 8 p.m. ET. If you are not enrolled in direct debit, you will receive a monthly bill for your coverage. Your payment is due the first of the month for that month. Important: If you do not pay the required premium for coverage in the time and manner required, your coverage will be terminated. If your coverage is terminated, you will no longer be eligible for retiree group health benefits.

Imputed income

Imputed income is the difference in the company's premium cost incurred when you add any medical and/or dental coverage for your dependents who do not qualify for pre-tax benefits. This difference will be taxable to you as income and be reported on your W-2, Box 1, as part of wages. Consult your tax advisor for more information about imputed income.

Subsidy eligibility

If you initially retired from Aetna after January 1, 2007, you are eligible to receive retiree medical benefits and/or coverage at unsubsidized group rates, provided you meet the eligibility requirements described in this section.

If you initially retired from Aetna prior to January 1, 2007, and returned to work at Aetna, per the plan rules in place at the time of your initial retirement, you may have earned a retiree subsidy that was frozen upon your rehire. See below for more details.

Rehire and effect on retiree medical subsidy

The following rule applies only for retirees first rehired on or after January 1, 2008. If you were rehired at any time prior to January 1, 2008, different rules apply (see below).

If you returned to work at Aetna on or after January 1, 2008, as a regular employee, you are eligible to maintain your previously earned subsidy as of your rehire date. While working at Aetna, you will be eligible to enroll in the active employee health plan(s) if you work 20 or more hours per week. You cannot participate in Aetna retiree health benefits while you are a regular Aetna employee.

The following will apply to your retiree medical subsidy, if any:

- If you are receiving a retiree medical subsidy at the time you return to work at Aetna, your current subsidy will be maintained until you later terminate your employment with Aetna. Your current subsidy will be available when you recommence your retiree health benefits.
- If you had previously deferred your Aetna retiree health enrollment, you will retain your earned retiree medical subsidy, if any. The subsidy will be calculated using your current age and prior service as of the date of your rehire, and that is the subsidy percentage that will be available when you later terminate your employment with Aetna.

In either case, when you later terminate your employment with Aetna, you may elect or defer coverage according to the rules in place at that time. If you choose to defer your retiree health benefits, the previously calculated subsidy percentage will be the subsidy available upon later enrollment.

The following rule applies if you returned to work anytime prior to January 1, 2008, and:

- Your latest termination of employment date, prior to returning to work, was prior to January 30, 2003; and
- Your rehire date was after January 30, 2003; and
- You were not considered an active employee on January 30, 2003

If you returned to work at Aetna as a regular employee working 20 or more hours per week, you are eligible to maintain your previously earned subsidy as of your rehire date. While working at Aetna, you will be eligible to enroll in the active employee health plan(s).

The following rule applies if you returned to work anytime prior to January 1, 2008, and:

- Your latest termination of employment date, prior to returning to work, was after January 30, 2003

If you returned to work at Aetna as a regular employee working 20 or more hours per week, you were treated as all other active, regular employees working 20 or more hours per week. You were subject to the elimination of the retiree medical subsidy. If your subsequent termination is on or after January 1, 2007, you will be eligible for unsubsidized group rates upon election of retiree medical benefits.

Subsidy cap – retiree medical – effective March 1, 1994

Company contributions to retiree medical coverage are capped for employees who retired on or after March 1, 1994. The amount of the cap is linked to Medicare coverage eligibility. Annual cap amounts for retiree medical coverage (for those subject to the cap and eligible for a subsidy) are $4,235 for pre-Medicare retirees and $1,025 for Medicare-eligible retirees.

The following example is for a Medicare-eligible retiree who is affected by the subsidy cap, has self-only coverage in a medical plan and is eligible for an adjusted subsidy of 50 percent.

Please note that this example is provided for illustration purposes only. Actual costs for Aetna and the retiree will vary depending on medical inflation, plan enrollment and other factors affecting plan experience and costs.

Monthly total cost	$256.10
Monthly capped plan cost	$85.42
Aetna's share of premium based on capped plan cost ($85.42 x 0.50)	$42.71
Total retiree contribution to premium ($256.10 – $42.71)	$213.39

Acquired employees: retiree medical, dental and life coverage

Former NYLCare employees

Some NYLCare employees who joined Aetna as a result of the acquisition of NYLCare were eligible to receive retiree medical, dental and life insurance from NYLCare.

If you were eligible to receive retiree benefits from NYLCare, then NYLCare will notify you. You are not eligible to receive retiree health and dental benefits from Aetna if you are eligible to receive them from NYLCare.

Former U.S. Healthcare employees

If you were a former U.S. Healthcare employee who had a VEBA account established under the U.S. Healthcare Retiree Health Benefits Plan and you terminated your employment with Aetna, if you were at least age 60 with 10 or more completed years of service when you left Aetna, your retiree medical plan cost will be 100 percent subsidized using the funds in your VEBA account. Once your VEBA account is exhausted, you may be eligible to continue your retiree benefits at an unsubsidized rate.

Additional acquisition companies

If you terminated employment with Aetna on or after January 1, 2016, the following requirements must be met in order for you to be eligible for retiree benefits:

- You must have been a regular U.S. employee employed by a participating company.
- You must have been normally scheduled to work 20 or more hours per week.
- You must have been at least age 55 on the day you terminated employment.

Other plan rules

Coordination of benefits

When you or a dependent is covered by another plan

If you or a dependent is covered by another medical and/or dental plan, Aetna requires information about the other plan in order to process your claim. If Aetna Member Services does not have information about your other plan on file, the service center will request it from you at the time your claim is submitted.

The information you provide will remain on file for 12 months. After this, Aetna will ask you to validate the information. For further information, call Member Services at the toll-free number on your member ID card.

Definition of coordination of benefits

Some people are covered under multiple health plans. For instance, if you're married and your spouse works for a different company, each of you can choose to cover the other under your respective plans.

Most health plans have coordination of benefits rules to ensure that when multiple plans are involved, the insurance companies don't overpay or duplicate payments for covered health care services.

When coordination is needed

Coordination of benefits is needed when you and/or your dependents have coverage under:

- More than one company-provided health plan — for example, if both spouses are working
- A university-sponsored student plan and a company plan
- Medicare and a company plan
- An individually purchased plan and a company plan

How coordination rules work

If a health care expense is covered by two plans, one plan is the "primary" plan and has first responsibility for the expense. When the primary plan has paid its normal benefits, the other or "secondary" plan can make an additional payment based on its provisions.

When Aetna plans are primary (pre-Medicare plans)

When Aetna's plan is primary, it pays full benefits according to its rules. After you've received an Explanation of Benefits from the Aetna plan, you can submit any remaining expenses to the secondary plan.

When Aetna plans are secondary (pre-Medicare plans)

When the Aetna plan pays benefits as the secondary plan, the primary plan pays its benefits first. Then, the Aetna plan determines whether or not any additional benefit is payable.

Other rules for Medicare plans

If you and/or your dependent(s) are covered under the Aetna Medicare Plan (PPO or PPO with ESA [extended service area]), the plan is your (and any Medicare-eligible dependent[s]) primary plan, processing all claims first. If both you and your dependent(s) are not actively employed, but are also covered by your spouse's/partner's group plan (which is not a Medicare Advantage plan), the Aetna Medicare Plan (PPO or PPO with ESA) is primary for both you and your spouse/partner. If either you or your spouse/partner is actively employed and is also covered by the employer's group plan, that plan will be considered primary, and the Aetna Medicare Plan (PPO or PPO with ESA) will be considered secondary.

You can only be in one Medicare Advantage plan and/or one Medicare Part D plan at a time. For example, you cannot be enrolled in Aetna's Medicare Plan with a Medicare prescription drug plan (PDP) and another Medicare Advantage plan or Medicare PDP through another carrier at the same time. If you enroll in another Medicare Advantage plan or Medicare PDP through another carrier, Aetna's Medicare Plan (PPO or PPO with ESA) and/or Medicare PDP election will be terminated, and you will lose eligibility for Aetna coverage in the future.

If you're eligible for Medicare and you are enrolled in the Medicare-eligible Traditional Choice® Indemnity plan (exception basis only), Medicare is your primary medical coverage. The Traditional Choice Indemnity plan pays benefits as follows:

- If Medicare covers the entire expense, the medical plan doesn't pay any benefits.
- If Medicare doesn't cover the entire expense, the medical plan pays the difference up to the total dollar amount the plan would have paid if it were primary.

Prescription drug coverage: Medicare eligible

If you're eligible for Medicare and you enroll in the Aetna Medicare Rx® Standard (PDP) plan or Aetna Medicare Rx Plus® (PDP) plan, you're enrolling in Medicare Part D. You can't be enrolled in more than one Medicare Part D plan at the same time.

Subrogation rights

The plan may seek recovery of medical expenses paid to treat an accident or injury to you or your covered dependent(s) that was or may have been caused by someone else. This subrogation provision ensures that duplicate payments are not made for the same medical expenses. Under the plan's subrogation, the plan reserves the right to recover from the responsible party the cost of medical benefits paid when another party is, or may be, responsible for causing the accident or injury to you or your covered dependent(s). The plan also may recover the cost of medical expenses from you if you recover expenses from the other party.

The plan also has an automatic lien against you, and may recover the full cost of medical expenses from you, if you receive any recovery from another party. These recovery rights shall be imposed upon any recovery, whether by settlement, judgment or otherwise, and may be enforced upon any party who possesses funds or proceeds representing the amount of benefits paid by the plan.

These recovery rights are first priority rights, and the plan is not required to reduce their recovery amount for any reason, including payment of attorneys' fees or if the settlement is insufficient to fully compensate you.

The plan has contracted with an external vendor to provide subrogation and reimbursement services to the plan. Plan participants are required to cooperate with this process and to provide all requested information to the external vendor. Participants who fail to provide information to the vendor will be reported to the plan.

Failure to provide requested information, failure to assist the plan in pursuit of its subrogation rights, or failure to reimburse the plan from any settlement or recovery may result in termination of health benefits or the institution of court proceedings.

By accepting benefits under the plan, plan participants agree to reimburse the plan for the medical expenses paid by the plan if they recover these expenses from a responsible party.

More details about the plan's subrogation rights can be found in the Subrogation/Right of Recovery provision in the Summary of Coverage/Booklet. If you have questions about subrogation rights, please call Member Services at the toll-free number on your medical ID card and ask to be connected to the Subrogation Department.

Recovery of overpayment

If a benefits payment is made to or on behalf of any person that exceeds the benefits amount such person is entitled to receive, the plan has the right to:

- Require the return of the overpayment on request, or
- Reduce by the amount of the overpayment any future benefits payment made to or on behalf of that person or another person in their family

This right to recovery does not affect any other right of recovery the plan may have with respect to such overpayment.

Health benefits

Health benefits

Medical plan options

Eligible retirees are offered different medical plan options based on Medicare eligibility and home ZIP code.

- If you *are not* eligible for Medicare, you will be offered the pre-Medicare plan(s) available in your home ZIP code.
- If you *are* eligible for Medicare, you will be offered the Medicare-eligible plan(s) available in your home ZIP code.

You may need to choose two medical plan options if some family members are eligible for Medicare and some are not. Family members who are not eligible for Medicare must enroll in the same medical plan.

For example: If you are eligible for Medicare and your spouse and child are not eligible for Medicare, you would choose a Medicare-eligible option for yourself and a pre-Medicare option for both your spouse and child.

- Remember, if you choose to waive your coverage, you and your dependents lose eligibility and neither you nor your dependents will be permitted to re-enroll in the future.
- If an eligible dependent(s) chooses to waive or drop coverage, they will only be permitted to re-enroll in the future at annual enrollment or with a valid status change.
- For plan details, refer to the Summary of Benefits and Coverage and Summary of Benefits, which are available at annual enrollment, or you can obtain them by going to the Retiree Health Access website at **retireehealthaccess.net/aetna** or by calling Aetna Human Resources at **1-800-AETNA-HR (1-800-238-6247)** weekdays, 8 a.m. to 8 p.m. ET.
- Visit the Aetna Navigator® website on **aetna.com** to access a suite of online resources to help you use your plan and find in-network providers.

Notice regarding Women's Health and Cancer Rights Act

Under this health plan, coverage will be provided to a person who is receiving benefits for a medically necessary mastectomy and who elects breast reconstruction after the mastectomy for:

1. Reconstruction of the breast on which a mastectomy has been performed
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance
3. Prostheses
4. Treatment of physical complications of all stages of mastectomy, including lymphedemas

This coverage will be provided in consultation with the attending physician and the patient, and will be subject to the same annual deductibles and coinsurance provisions that apply for the mastectomy.

If you have any questions about our coverage of mastectomies and reconstructive surgery, please contact the Member Services number on your ID card.

Statement of Rights under the Newborns' and Mothers' Health Protection Act

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not 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 delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (for example, your physician, nurse midwife or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that you, your physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, you may be required to obtain precertification for any days of confinement that exceed 48 hours (or 96 hours). For information on precertification, contact your plan administrator.

Pre-Medicare plan options

Your medical plan choices depend on the availability of certain plans in your area (based on your home ZIP code).

- Aetna HealthFund® HSA 80
- Aetna HealthFund® HRA 80

Preventive care services

Each medical plan pays 100 percent of eligible, routine preventive care services received from an in-network provider, not subject to the deductible. The plan pays 50 percent of routine preventive care services received from an out-of-network provider, subject to the deductible if out of network is available in your plan. For out-of-network specialists, you pay coinsurance after meeting the deductible.

Some examples of preventive care services are:

- Physical exam
- Well-baby and well-child care
- Scheduled immunizations for children
- Ob/gyn office visit, including important health screenings such as mammograms and Pap smears
- Prostate screening tests
- Routine eye exam
- FDA-approved tobacco-cessation medications, including both prescription and over the counter

These services are not preventive if you receive them as part of a visit to diagnose, monitor or treat an illness or injury. A list of covered preventive services is available by calling Aetna One Premier at **1-800-247-5485**.

Aetna HealthFund HSA 80

The Aetna HealthFund HSA 80 plan combines the protection of a health insurance plan with a tax-advantaged Health Savings Account (HSA) that you can use to pay for qualified health expenses now, or save for future health costs.

The HSA plan has three parts:

1. The savings account — You can put money in this account on a tax-advantaged basis and use it to pay for qualified out-of-pocket expenses, or you can save it for later. PayFlex® administers the HSAs.
2. The deductible — This is the amount you pay out of your own pocket for covered expenses before the medical plan starts to pay. The HSA 80 has a separate in-network deductible and an out-of-network deductible. In-network covered expenses will be applied to satisfy the in-network deductible, and out-of-network covered expenses will be applied to satisfy the out-of-network deductible.
3. The medical plan — The plan covers most of your expenses after the deductible has been met.

Like a traditional bank savings account, an HSA earns interest and is protected by the Federal Deposit Insurance Corporation (FDIC), so your money can grow over time. And, because contributions to this account are free from federal and most state and local taxes, you'll see some tax advantages. Also, any money left in the account at the end of the year rolls over to the next year and continues to earn interest.

Since you own your HSA, you keep any accumulated balance in your account — even if you change health plans. In addition, once your account reaches $1,000, HSA investment funds are available to you. For additional information, call Aetna One Premier at **1-800-247-5485** or visit the PayFlex portal via Aetna Navigator at **aetna.com**.

If you choose to place funds in an investment account, your HSA becomes two linked accounts — a cash account and an investment account.

Establishing your HSA

Please note that after you newly enroll in the HSA 80 plan, it typically takes between two to four weeks from the date your medical coverage is effective for your account to be established at PayFlex. You will receive a letter in the mail from PayFlex notifying you when your HSA is established and ready for your use. Eligible expenses incurred on or after the date your HSA is established are eligible for tax-free distribution.

Your contribution

Once your account is established, you and your family members can contribute. And you can change your contribution anytime during the year — even if you haven't had a qualified status change.

Who can contribute?

According to IRS rules, you can contribute to your account as long as you are not covered under any other health plan that is not a high-deductible health plan (HDHP). For example, if you have coverage under an HDHP, and also are covered under the non-HDHP of your spouse's employer, you will not be able to make contributions to an HSA. Likewise, if you are enrolled in a Health Care Flexible Spending Account (FSA), or if your medical expenses can be reimbursed by your spouse's FSA, then you will not be able to contribute to an HSA.

You also cannot participate in an HSA if you are enrolled in Medicare Part A and/or Part B.

If you decide to contribute, you can do so on an after-tax basis in the following ways:

- Mail your check with an HSA deposit slip, which is available on the PayFlex portal accessed through Aetna Navigator or by calling the PayFlex service center at **1-855-806-1070**.

- Electronic funds transfer (EFT) — Money can be transferred from a linked checking or savings account to an HSA on a one-time or recurring basis, subject to certain limitations.

  -To sign up for an EFT, or for more information, visit the PayFlex portal accessed through Aetna Navigator. Note: You may be able to get a tax benefit for this deposit when you file your annual tax return — ask your tax advisor.

- Roll over an amount from an IRA or another HSA. You may elect a one-time HSA funding distribution from your IRA into your HSA. You should contact your financial services agent and/or tax advisor to complete this type of rollover. Because the account is yours, Aetna is not involved in the process. The IRA rollover amount will count toward your annual contribution limit. Rollovers from another HSA with a different bank or trustee will not count against the annual contribution limit. To obtain a *Request to Rollover/Transfer Funds* form, go to the PayFlex portal via Aetna Navigator at **aetna.com** or call the PayFlex service center at **1-855-806-1070**.

Your annual contribution cannot exceed IRS limits

The total amount of contributions from all sources to your 2018 HSA cannot be more than $3,450 per individual and $6,900 per family. However, you're allowed to contribute up to an additional $1,000 per year in catch-up contributions if you're age 55 or older. To avoid exceeding your total allowable contribution, you can set up goal limit reminders by logging in to your PayFlex account via Aetna Navigator or on **payflex.com**.

Determining your contribution

- Your eligibility to contribute to an HSA each month is generally determined by whether or not you have HDHP coverage on the first day of the month.
- Your maximum contribution for the year is the greater of: (1) the full annual contribution, or (2) the prorated amount.
- Individuals who are eligible as of December 1, 2018, are allowed the full 2018 annual contribution. The full annual contribution is the maximum annual contribution for the type of coverage (self-only or family) you have on December 1 (plus catch-up contributions, if age 55 or older by year end), regardless of the number of months you were an eligible individual in the year.

If you are no longer an eligible individual on that date, both the HSA contribution and catch-up contribution apply pro rata based on the number of months of the year you were an eligible individual. The prorated amount is 1/12 of the maximum annual contribution for the type of HDHP coverage you have times the number of months you have that type of coverage. If your contribution is greater than the prorated amount, and you fail to remain covered by an HDHP for the entire following year, the extra contribution above the prorated amount is included in income and subject to tax penalties and/or IRS fees.

If you have a spouse who is age 55 or older and not enrolled in Medicare, they will need to open a separate HSA to qualify for their own catch-up contribution.

Contribution examples

If you first have family coverage on July 1, 2018, and keep coverage through December 31, 2018, you are allowed the full $6,900 family contribution to an HSA for 2018. If you fail to remain covered for all of 2019, $3,450 would be included in your income and subject to an additional tax.

If you have family coverage from January 1, 2018, until June 30, 2018, and then cease having coverage, you're allowed an HSA contribution of 6/12 of $6,900 or $3,450 for 2018.

If you have family coverage from January 1, 2018, until June 30, 2018, and have self-only coverage from July 1, 2018, to December 31, 2018, you are allowed an HSA contribution of 6/12 of $6,900 plus 6/12 of $3,450, or $5,175 for 2018.

Remember to consider contributions from all sources when calculating your maximum contribution for the year.

Your account earns interest

HSA contributions earn interest that is free from federal and most state and local taxes, with no minimum balance required. HSA participants are able to view interest earned on their HSAs (within a specified period) by going to the PayFlex portal. You can access PayFlex directly at **payflex.com** or through Aetna Navigator.

Ways to use your PayFlex HSA

1. Save the money for future qualified expenses (even in retirement) and pay current eligible expenses out of your own pocket. Any balance you haven't used by the end of the calendar year rolls over to the following year. Also, your account will continue to earn interest — free of federal taxes — as long as you have money in it.
2. Pay for certain qualified expenses from the account in a number of ways, including:

   PayFlex MasterCard® debit card — You will automatically receive the debit card shortly after your enrollment. When you use the PayFlex debit card, your expense is automatically paid from your account. When you use your debit card, there's no need to provide documentation to substantiate the amount, but you should keep all receipts for expenses paid through your HSA for federal tax or audit purposes.

   Auto pay — You have the option to set up automatic payment for the amount due for your health care claims. You can set this up online by expense type (for example, medical and/or dental. If you have automatic payment turned on, the amount due for your claim will be automatically taken out of your HSA and sent to you.

   The amount paid from your account is the amount reported to PayFlex by your Aetna health plan.

   Note: If you have automatic payment turned off, you can use the connected claims feature. It lets you choose how you want to handle your out-of-pocket expenses.

   Connected claims — With connected claims, you can link your health care claims to your PayFlex account. Then you can easily pay yourself back for an eligible out-of-pocket expense or pay your doctor.

   Online bill payment — Online bill payment gives you the ability to pay medical expenses directly from your HSA. Once enrolled, you can monitor, manage and schedule payments online, anytime. Payments can be on a one-time or recurring basis.

   Any of these options will help you pay your out-of-pocket costs quickly and easily — and you don't have to complete any forms or wait for reimbursement. To sign up or for more information, go to the PayFlex portal on Aetna Navigator.

Important:

- You cannot borrow against future contributions. You must have sufficient funds available in your HSA at the time you make a request for withdrawal. If you anticipate large expenses early in the plan year, you may need to pay for them out of your own pocket.
- Be sure to check the PayFlex portal via Aetna Navigator to confirm the deposit, as occasionally the contributions are not available until the next business day.
- You also can pay for non-qualified expenses from the account. If you are under the age of 65 and not disabled, any withdrawals that the Internal Revenue Service (IRS) considers as "non-qualified expenses" are considered taxable income. They may be subject to income tax and an additional 20 percent penalty.*
- You can also set up goal limit reminders to confirm that you are not exceeding your IRS allowed limit by logging in to your PayFlex account from Aetna Navigator. When you use your account, some fees and penalties may apply.

*You can find more information on the IRS website at **irs.gov**, but you should consult your tax advisor to learn about the rules in your state. Generally, a domestic partner does not qualify as a dependent. To see a full explanation of the "qualified expenses" that are allowed by the IRS, see Publication 502 at **irs.gov**.

The deductible: You pay, then you can use your account

Your deductible is the amount you pay out of your own pocket for covered expenses before the medical plan starts to pay. The HSA 80 plan has a separate in-network deductible and an out-of-network deductible. In-network covered expenses will be applied to satisfy the in-network deductible, and out-of-network covered expenses will be applied to satisfy the out-of-network deductible.

Once you've met your deductible — either by paying out of your own pocket or through your HSA — you move to the next stage, the medical plan.

If you are enrolled with dependents, there are individual cost-share limits that make sure no individual's costs are higher than the limit allowed by the Affordable Care Act (ACA). The individual limits apply separately to you and each of your covered dependents. The plan will begin to pay once you or one of your covered family members hits the individual deductible. Once someone hits the individual out-of-pocket limit, their health care costs are covered at 100 percent for the rest of the plan year.

For 2018, the embedded individual deductible limit is $3,000 for the HSA 80 plan.

The medical plan: The majority of your costs are covered

Once you meet your deductible, your medical plan picks up most of the eligible medical and prescription drug costs. You pay a percentage of the costs (called "coinsurance"), and your share is less when you use health care professionals in the Aetna network.

There is a maximum limit to the amount you have to pay for covered services (called an "out-of-pocket limit") with HSA plans. If you reach that amount, the medical plan pays 100 percent of your covered medical and pharmacy expenses for the rest of the year. In-network and out-of-network medical expenses accumulate to separate in-network and out-of-network limits.

If you use doctors who are out of network, Aetna pays a percentage of the amount for that service. That amount is based on what we consider to be a "reasonable" rate. That could be a percentage of what Medicare pays or, if no Medicare rate is available, what we determine the market rate to be. If the doctor's fee is more than that amount, you may have to pay the difference.

How you access care and pay your doctors

You can use in-network or out-of-network doctors. But, your out-of-pocket costs will be lower if you use an in-network doctor. In general, if you use in-network doctors, you don't need to make a payment at the time you receive services. Your in-network doctor will typically submit the claim to Aetna and send you a bill for the amount you owe.

You can set up automatic payments, which automatically sends you the amount due for your claim if dollars are available in your HSA. Or, you can withdraw money from your HSA to pay for part or all of your qualified expenses using your PayFlex MasterCard debit card or online bill payment. You also can choose to pay for your covered health care expenses out of pocket and save your HSA balance to help pay future health-related expenses.

Aetna HealthFund HRA 80

The Aetna HealthFund Health Reimbursement Arrangement (HRA) 80 plan lets you see any doctor you want, without a referral. In-network preventive care is generally covered at 100 percent.

The HRA has three parts:

1. The fund: Aetna contributes
   After you enroll in the HRA 80 plan, Aetna will establish a fund to help you pay for your out-of-pocket health expenses, and contribute $400 for individual coverage or $800 for family coverage. Deposits to the fund are prorated for enrollments that occur during the year with 1/12 of the total maximum deposited for each month of coverage in the year.

   For instance, an individual who enrolls in the plan on July 1 will be credited with $200 to the fund. Also, you don't pay taxes on the amount in your fund. As you and your family receive certain eligible services, the HRA fund automatically pays the full negotiated cost and reduces your deductible at the same time. Because the fund covers the full amount, you do not have any out-of-pocket costs (unless the cost for the services exceeds your fund balance).

   If you stay with the HRA plan next year and do not use all the money in the fund, the balance rolls over into the next year's fund, with no cap. However, if you stop participating in the HRA plan, the fund is forfeited (you give up the money).

2. The deductible: You pay, the fund helps
   When your fund pays for your covered medical and prescription drug expenses, that amount also counts toward your deductible — the amount you pay out of your own pocket for covered expenses before the medical plan starts to pay. If you have used up your fund and your deductible is not met, then you must pay 100 percent of your covered medical and prescription expenses until you meet your deductible. For certain preventive care and chronic and preventive drugs, the deductible is waived. Once you've met your deductible, you move to the next stage — the medical plan.

   Note: If you enroll in an HRA plan with dependents, there is an individual limit within the family deductible. Once someone meets the individual deductible, the plan will begin to pay benefits for that individual.

3. The medical plan: The majority of your costs are covered
   Once you meet your deductible, your medical plan picks up most of the eligible medical and prescription drug costs. You pay a percentage of the costs (called "coinsurance"), and your share is less when you use doctors and health care professionals in the Aetna network.

   Also, if you use out-of-network doctors, Aetna will pay a percentage of the amount it considers "recognized charges" for that service. If the doctor's fee is more than that amount, you may have to pay the difference.

   To learn about what is meant by "recognized," call Aetna One Premier at **1-800-247-5485**.

How you access care and pay your doctors

- You can use in-network or out-of-network doctors. But your out-of-pocket costs will be lower if you use an in-network doctor.
- In general, if you use in-network doctors, you don't need to make a payment at the time you receive services. Your in-network doctor will submit the claim to Aetna and send you a bill for any amount you owe.

Note: If your fund has grown over the years and the balance exceeds your deductible, you may have remaining dollars in your fund. This money will be used to help pay the coinsurance for covered expenses you are required to pay. Should the HRA plan be terminated by the company, any unused funds in your account will be forfeited.

Maximums for pre-Medicare plans

Coinsurance limit for medical

The coinsurance limit is the maximum medical coinsurance you pay for covered expenses in a calendar year. The coinsurance limit excludes the cost of prescription drugs. If your coinsurance payments reach the individual coinsurance limit, the plan will pay 100 percent of the recognized charge for covered expenses for that individual for the remainder of the calendar year.

There's also an annual family coinsurance limit. Once the total coinsurance payments for all covered family members reaches the family limit, the plan will pay 100 percent of the recognized charge for all covered family members for the remainder of the calendar year.

Out-of-pocket maximums

The out-of-pocket maximum is a combination of the deductible and the coinsurance limit for medical expenses. The out-of-pocket maximum does include prescription drug expenses.

Traditional Choice® Indemnity — out of network (closed group)

Aetna closed the Traditional Choice Indemnity plan to new entrants on January 1, 2018. If you are a member of this closed group, you can receive covered medical care from any licensed provider, health care professional or facility for covered services. You need to obtain coverage approval from Member Services prior to receiving certain medical services. To do so, call Aetna One Premier at **1-800-247-5485**. Not doing so may result in substantially reduced benefits or denial of coverage.

Pre-Medicare prescription drug program

After you enroll in medical coverage, you'll receive a member ID card in the mail. You must present this card when filling a prescription at a participating retail pharmacy to receive benefits and avoid having to file a claim. You can fill short-term prescriptions (up to a 30-day supply) at a participating retail pharmacy.

Self-injectable and certain specialty medications (up to a 30-day supply) may be purchased for the first time at a participating retail pharmacy or through Aetna Specialty Pharmacy®. Subsequent refills must be obtained through Aetna Specialty Pharmacy. Aetna Specialty Pharmacy serves members who need self-injectable medications and other medications that require special handling, storage or shipping. A list of these covered specialty medications (called Aetna specialty care Rx medications) is available by calling the number on your Aetna member ID card.

The Mandatory Generic with Dispense as Written (DAW) provision applies to all pre-Medicare prescription drug programs. This means if a health care professional prescribes a covered brand-name drug where a generic drug equivalent is available, and specifies "dispense as written," you will pay the cost share for the brand-name drug (that is, the coinsurance or copayment). If your health care professional does not specify if the drug should be a brand name or generic, and you request a covered brand-name drug when a generic drug equivalent is available, you will be responsible for the cost difference between the brand-name drug and the generic drug equivalent. You also will pay the applicable brand-name drug cost share (that is, the coinsurance or copayment).

Pre-Medicare prescription drug benefits

All of your Aetna pre-Medicare medical options include prescription drug coverage.

Covered expenses, including prescription drugs, are subject to the medical plan deductible before the coinsurance listed below is effective.

There continue to be certain "contractually excluded drugs" that are not covered by your prescription drug plan. These medications include, but are not limited to, those that are cosmetic in nature, used for weight reduction and those that are considered experimental drugs.

There is no out-of-network coverage for prescription drug expenses.

If you have any questions about what's covered, contact Aetna One Premier at **1-800-247-5485** for information about prescription drug coverage under your plan.

New Maintenance Choice® program

Beginning January 1, 2018, Aetna implemented a new Maintenance Choice program for retirees who take maintenance medications (any prescription that is filled more than twice). After the first fill of a maintenance drug at retail, you will receive a letter that describes the program and what you need to do. The program allows you to fill maintenance medications with a 90-day supply via mail order and/or at any CVS Pharmacy® for the same cost.

Prescription drug coverage* under the HSA 80, HRA 80 and Traditional Choice Indemnity plans		
Amount you pay	**Participating retail pharmacy (up to a 30-day supply)**	**Aetna Rx Home Delivery®/CVS (up to a 90-day supply)**
Type of drug	**Coinsurance/copay**	**Coinsurance/copay**
Generic**	10%	$30
Preferred brand name	30%	$60
Nonpreferred brand name	40%	$75
Specialty medications***		
– Preferred brand name	10% $20 minimum/$85 maximum	N/A
– Nonpreferred brand name	20% $35 minimum/$100 maximum	N/A

*Once the deductible is met, you pay coinsurance when you purchase a prescription from a participating provider.

**Subject to mandatory generic requirement.

***Certain self-injectable drugs and other specialty medications may be purchased for the first time at a retail pharmacy or through Aetna Specialty Pharmacy. Additional refills must be obtained through Aetna Specialty Pharmacy.

Replacement of lost or stolen medications

For lost or stolen medications, you are authorized a one-time override per benefits year, provided you submit a police report that documents the medication theft or loss. Until the police report is received, you are authorized to receive a seven-day supply of medication if the prescription can be filled as a partial fill by law**.**

If the fill cannot be partially filled, a one-day supply of the prescription will be honored. Your deductible/coinsurance applies to both the partial fill and the replacement fill.

Medicare-eligible plan options

- Aetna Medicare℠ Plan (PPO) with Rx Standard (PDP)
- Aetna Medicare Plan (PPO) with an Extended Service Area (ESA) with Rx Standard (PDP)
- Aetna Medicare Plan (PPO) with Medicare Rx Plus (PDP)
- Aetna Medicare Plan (PPO) with ESA with Medicare Rx Plus (PDP)
- Aetna Medicare Rx® Standard (PDP)
- Aetna Medicare Rx Plus® (PDP)

If you reside outside of the U.S., this plan is available to you:

- Traditional Choice Indemnity plan with no Rx (enrollment by exception only)

Summaries of Benefits for all plans are available at **retireehealthaccess.net/aetna**.

If you or an eligible dependent becomes Medicare eligible either due to turning age 65 or disability status, you must notify Aetna Human Resources at **1-800-AETNA-HR (1-800-238-6247)** weekdays, 8 a.m. to 8 p.m. ET. Call as soon as you are aware of the Medicare eligibility, as you or your dependent(s) no longer qualify for the pre-Medicare plans and must enroll in Medicare-eligible plans. Failure to do so may result in penalties and/or a break in coverage.

Aetna Medicare plans (PPO/PPO with ESA)

How the Aetna Medicare plans (PPO/PPO with ESA) work

The Aetna Medicare plans (PPO or PPO with ESA) are Medicare Advantage plans and are available to Medicare-eligible retirees and their eligible dependents who are also eligible for Medicare.

The plan offerings are based on your home ZIP code. With either plan, Aetna pays Medicare Part A and B claims through an insured plan, although the deductibles are different from traditional Medicare. These plans offer you health coverage and cover many services that traditional Medicare Parts A and B do not cover. Some of those services include:

- 100 percent coverage (deductible waived) for eligible preventive care (such as your annual physical, mammogram and prostate exams) when you use an in-network provider. For ESA plans, preventive care is covered at 100 percent whether you use an in-network or out-of-network provider.
- A member maximum out-of-pocket limit versus no limit in Medicare Parts A and B.
- A comprehensive set of services and programs designed to help you optimize your health coverage:

  -Hearing aid reimbursements

  -Health-related products and services

  -Disease management

  -Health risk assessment tools
- No referrals for covered services.

The plans do include frequency limitations on certain preventive services, including routine physical exams, screenings and immunizations. With both of the Aetna Medicare plans (PPO/PPO with ESA), you may obtain care from in-network or out-of-network providers. When you use an in-network provider, however, you know they will accept your plan and payment.

You are free to visit any out-of-network doctor or hospital that is licensed, is eligible to receive payment from Medicare and agrees to accept the Aetna Medicare Plan (PPO/PPO with ESA).

Here's how the plans work:

- You must pay an Aetna plan deductible each plan year. However, you are not responsible for separate Medicare Part A and Part B deductibles, since this plan replaces Medicare.
- The plan then pays a share of the Medicare-allowable rates for covered services.
- You pay the remaining portion of charges, called coinsurance, up to the out-of-pocket maximum.
- Once you reach the annual out-of-pocket maximum, the plan pays 100 percent of most covered expenses for the rest of the plan year.

With the Aetna Medicare (PPO) plans, you can use out-of-network providers, but your share of the cost will be higher when you do. Your medical care provider submits claims directly to Aetna for payment.

After the deductible has been met, Aetna pays the appropriate amount, and the provider bills you for the appropriate coinsurance. Under this plan, Aetna is the primary payer of your claims.

The Aetna Medicare PPO with ESA is offered to those participants who live in an area where the Aetna Medicare provider network does not meet Centers for Medicare & Medicaid Services (CMS) requirements for employers to offer the traditional PPO option in those areas. Therefore, this plan offers you the option to use Aetna Medicare network providers where available but does not penalize you for using out-of-network providers. You will pay the same coinsurance or copay for either type of provider.

Note: CMS requirements do not allow you to be enrolled in two Medicare Advantage plans at the same time. If you are currently enrolled in a Medicare Advantage plan under a spouse or partner, you automatically will be disenrolled from that Medicare Advantage plan when you enroll in the Aetna Medicare Plan (PPO/PPO with ESA).

Medicare-eligible Traditional Choice Indemnity plan (closed group)

Aetna closed the Traditional Choice Indemnity plan to new entrants on January 1, 2014. If you are a member of this closed group, you can receive covered medical care from any licensed provider.

The plan benefits are coordinated with Medicare based on the maintenance of benefits provision. When coordinating with Medicare, Medicare pays first, and the Traditional Choice Indemnity plan pays next. If Medicare pays the same amount or more than the Traditional Choice Indemnity plan, the plan will pay no additional benefits. However, if Medicare pays less than the Traditional Choice Indemnity plan, the plan pays the difference between what Medicare paid and what the plan would have paid on a calendar-year basis, if it was the primary plan.

Aetna Medicare Part D prescription drug program

The Aetna Medicare Part D prescription drug program offers two options:

- Aetna Medicare Rx Standard (PDP)
- Aetna Medicare Rx Plus (PDP)

Both plans have an annual deductible. Generally, the plans cover necessary drugs and medicines prescribed by your or your covered dependent's doctor on an outpatient basis. The plans do not cover some drugs and medicines. To qualify as a federally sponsored Medicare Part D plan, Aetna's prescription drug plans must have a formulary, which is a government-approved list of covered drugs. Each plan has its own formulary. Certain prescription drugs are excluded by CMS and are not covered by Aetna prescription drug plans.

You may contact Aetna Medicare Member Services at **1-888-97-AETNA (1-888-972-3862)** for more information on the specifics of each plan and the list of covered prescription drugs.

Both Aetna Medicare Part D prescription drug plans include some important features to help you get maximum value and quality.

For short-term prescriptions (up to 30 days)

You can fill short-term prescriptions (up to a 30-day supply) at a participating retail pharmacy.

For maintenance medications (31 – 90 days)

You can order up to a 90-day supply of maintenance prescription drugs using the Aetna Rx Home Delivery mail-order program. While Aetna Rx Home Delivery offers the convenience of a 90-day supply sent to your home, you can also obtain a 90-day supply at a retail pharmacy for the same copay.

Maintenance medications are those you take continuously to treat a chronic condition, such as thyroid problems or heart disease. Using this program may save you time. For more information, contact Aetna Rx Home Delivery at **1-888-RX-AETNA (1-888-792-3862)**.

When your doctor prescribes a new maintenance medication, you may want to ask for a second prescription for a 30-day supply of that drug, in addition to the ongoing prescription. The short-term prescription, filled at your participating local retail pharmacy, will serve your needs while you're waiting for your mail-order prescription to arrive.

90-day supply available at retail pharmacies

Under the Aetna Medicare prescription drug plans, you may obtain up to a 90-day supply of your medication through a participating retail pharmacy for allowed prescription drugs. The same benefit applies to Aetna Rx Home Delivery and retail pharmacies for a 90-day supply.

Creditable coverage (Medicare Part D)

If you or a covered dependent is eligible for Medicare or will soon be eligible, you're also eligible for Medicare prescription drug coverage (Part D).

If you are participating in an Aetna-offered Medicare prescription plan, you don't need to enroll in Medicare Part D since Aetna's Medicare prescription drug program coverage is creditable, which means that your coverage is as good as Medicare Part D standard coverage. If your prescription drug program coverage wasn't creditable, you would need to enroll in Medicare Part D when you're first eligible, even if you're still working. If you don't enroll, you may be subject to a late enrollment penalty.

How the program works with Medicare Part D

If you're enrolled in one of the Medicare-eligible medical plans, except the Traditional Choice Indemnity (no Rx) plan, your Medicare prescription drug coverage is included. The Medicare prescription drug plan automatically processes your prescription drug expenses. You don't need to file a claim.

The Aetna Medicare prescription drug program doesn't coordinate benefits with other Medicare Part D coverage.

Note: If you're eligible for Medicare, you can't participate in Medicare Part D through Aetna and through another prescription drug plan at the same time.

If you enroll in Medicare Part D through another prescription drug plan, your Medicare prescription drug coverage and your Medicare medical coverage with Aetna will end, and you will lose eligibility for Aetna coverage in the future.

You have the choice of enrolling in Medicare medical coverage separately from prescription coverage outside of the Aetna retiree plans; however, CMS limits your choices. If you are enrolled in Aetna's group Medicare prescription drug coverage, and later join a Medicare Advantage plan through another carrier, your coverage in Aetna's prescription drug plan will end. In this circumstance, you can only join a private fee-for-service Medicare Advantage plan.

Medicare Parts A, B, C and D

Brief summary of Medicare

Medicare has four parts:

- Medicare Part A: (hospital insurance) pays some of the costs of hospitalization, limited skilled nursing home care and hospice care. Part A is financed by payroll taxes; participants usually pay no premiums.
- Medicare Part B: (Medicare insurance) primarily covers physicians' services, most outpatient hospital services and certain related services. Long-term nursing home care is not currently covered. A monthly premium is charged for Part B coverage.
- Medicare Part C: (Medicare Advantage plans) includes managed care plans, PPO plans, private fee-for-service plans and medical savings accounts. These plans were formerly called Medicare+Choice. A monthly premium is charged for Part C coverage.
- Medicare Part D: (outpatient prescription drug plan) is prescription drug coverage. Participants must be covered by Part A and/or Part B to be eligible to elect a Medicare Part D plan. A monthly premium is charged for Part D coverage.

Medicare enrollment

You are responsible for applying for Medicare Parts B and D when you are eligible. If you do not apply when you are eligible, a surcharge may be added to your Medicare premiums when you do enroll. Your local Social Security office can give you information on how to enroll in Medicare.

When you or your spouse/partner reaches age 65 and/or becomes eligible for Medicare, Medicare becomes your primary payer of claims. With the Aetna Medicare Plan (PPO/PPO with ESA), the process is more streamlined because the Aetna Medicare Plan (PPO/PPO with ESA) will be primary payer for Medicare Part A and B claims.

As a retiree, you purchase Medicare Part B coverage. When you make an office visit, the doctor delivers the service and then submits a claim to Aetna. After the deductible, Aetna pays the claim and then your provider bills you for the appropriate coinsurance.

You also will be eligible to enroll in a Medicare Part D prescription drug plan. As an Aetna retiree, you can elect one of the Medicare-eligible medical plans and/or one of the Medicare Part D plans available under the Aetna retiree health plan if:

- You retire and are age 65 or over
- You or your spouse/partner is retired and turns 65
- You, your spouse/partner or eligible dependent becomes eligible for Medicare due to disability

Approximately three months prior to becoming eligible for Medicare at age 65, Aetna Human Resources will send you information regarding our choices as a Medicare-eligible participant. If you don't receive the information from Aetna Human Resources, please call **1-800-AETNA-HR (1-800-238-6247)** weekdays, 8 a.m. to 8 p.m. ET.

When you or your covered spouse or partner becomes eligible for Medicare, you must enroll in coverage. If you want coverage through Aetna's retiree health benefits program, you must call Aetna Human Resources to enroll at least 30 days prior to your Medicare-eligible date.

Important: If you or your eligible dependent does not contact Aetna Human Resources within the time frame designated on your *Enrollment Worksheet & Materials* (in general, 30 days prior to your or your dependent's Medicare-eligible date), you will be defaulted into the coverage listed on your enrollment worksheet. If you are defaulted to "No Medical or Prescription Drug coverage," you will lose your right to enroll in the future.

- If applicable, you'll remain in your current dental plan.
- If you were age 65 or older when you terminated employment and did not elect Aetna retiree medical and/or dental coverage at that time, you are not eligible for retiree medical and/or dental coverage in the future.

Your prescription drug and/or Aetna Medicare plan (PPO/PPO with ESA) coverage takes effect on one of the following dates:

- The first of the month in which you or your spouse/partner becomes Medicare eligible, if you contact Aetna Human Resources to enroll before your initial coverage effective date
- The first of the preceding month if you or your spouse/partner turns age 65 on the first of the month, if you contact Aetna Human Resources to enroll before your initial coverage effective date
- The first of the month following the date you enroll through Aetna Human Resources

You must call Aetna Human Resources at **1-800-AETNA-HR (1-800-238-6247)** weekdays, 8 a.m. to 8 p.m. ET to enroll. You will need to provide the following information:

- Data required by the Centers for Medicare & Medicaid Services (CMS), which includes health plan selection and personal information such as your name, Social Security number, address, telephone number and date of birth. You also are required to provide this same information for dependents enrolling in coverage.
- Medicare Part A and Part B effective dates.
- The Medicare claim number, which can be found on your Medicare card or letter of verification from the Social Security Administration.
- Other information, such as end-stage renal disease eligibility or whether or not you have other medical coverage in place.
- Timing of enrollment (first of the month following the enrollment date, or first of the month you are Medicare eligible, whichever is later).
- Please also have your dependents' Social Security numbers on hand when you enroll, because health care reform requires these to be collected.

A confirmation statement of your elections will be mailed to you.

If you have Medicare-eligible dependents, they each will need to register for a member account on Aetna Navigator at **aetna.com** under their own names to view enrollment and claims records.

Note: If you and/or your dependent were enrolled in Aetna retiree medical benefits prior to enrolling in Aetna retiree Medicare medical/pharmacy benefits, deductibles and out-of-pocket expenses will not be carried over to your new plan selections. All deductibles and other expenses will be reset to zero.

Medicare Part D rules

If you were eligible to enroll in Medicare Part D prescription drug coverage during the enrollment period and did not, or you canceled your Medicare Part D coverage at any time and did not re-enroll in another plan within 63 days, a one percent per month penalty for each month you were not enrolled will be added to your premiums at the time you enroll in coverage.

You may postpone enrollment in Medicare Part D and join in any future year without penalty, if you have proof of existing creditable coverage.

You must maintain coverage in either Aetna's retiree medical plan or Aetna's retiree Medicare Part D plan to be eligible for medical and/or prescription coverage in the future.

Under the Aetna retiree medical plan, all participants who are Medicare eligible within a family have to be enrolled in the same medical and/or prescription drug plan.

If you are an Aetna Medicare Advantage plan member and have a limited income, you may qualify for helpful programs like Low Income Subsidy (LIS) for Medicare prescription drug coverage (also called "extra help"). LIS is a Medicare program to help people with limited income and resources pay for Medicare prescription drug program costs.

My Advocate is Aetna's contracted partner whose mission is to ensure every eligible person receives the social program benefits to which they are entitled. They can help you apply for state Medicaid health insurance and maintain Part D LIS coverage. The services are free, and your Medicare Advantage coverage is not affected by enrolling for this coverage status.

My Advocate identifies Aetna Medicare Advantage members (Medicare Advantage PPO) who could potentially qualify for Medicaid but are not currently enrolled. If identified, you'll get informational materials and a phone call about a week or two later. The caller will state that they are calling on behalf of Aetna Medicare.

In order to determine if you qualify for these programs, the representative will need to ask for financial information.

Please contact Aetna Human Resources at **1-800-AETNA-HR (1-800-238-6247)** weekdays, 8 a.m. to 8 p.m. ET for questions or assistance with an enrollment.

Dental

Aetna provides eligible retirees and their eligible dependents with the opportunity to participate in a dental preferred provider organization (PPO) plan. You also have an opportunity to participate in a dental maintenance organization (DMO®) plan if you live in a network service area. You can review the plans available to you each year at annual enrollment.

For plan details, refer to the Summary of Benefits, which you can obtain by going to the Retiree Health Access website at **retireehealthaccess.net/aetna** or by calling **1-800-AETNA-HR (1-800-238-6247)** weekdays, 8 a.m. to 8 p.m. ET. This information is also provided to you at annual enrollment.

Remember: If you choose to waive your coverage, you lose eligibility and cannot enroll in the future. You may be able to make changes to your dental plan if you experience a qualified benefits status change. The specific dental plan options available to you will depend on your home ZIP code.

How dental options vary

The PPO and DMO options vary in these ways:

- Choice of providers
- Deductibles
- Coinsurance and/or copayment amounts
- Annual and lifetime maximum amounts
- Coverage provided for certain dental services
- Process for filing claims

Cost of dental coverage

The cost for dental coverage each plan year depends on the option you choose and the number of dependents you cover. There is no subsidy for dental coverage. Dental group rates are offered to eligible retirees and their dependents.

Once enrolled in the dental plan, you pay the deductible and the copayment when applicable.

Changing your dental plan option

After you enroll, you can change your option only:

- If you move and your current option is no longer available
- If your eligibility for the dental plan changes
- During annual enrollment
- If the option is no longer offered
- If the contract between Aetna and the dental plan insurer ends

How a dental PPO plan works

Dental PPOs have networks of participating dentists that provide dental care at negotiated rates.

You receive benefits whether you use in-network or out-of-network providers. But you pay less if you use in-network providers, because your cost is calculated using discounted fees that Aetna has negotiated with your dentist. In-network providers also file claims for you and allow time for the plan to pay first.

How a DMO plan works

A DMO plan provides prepaid benefits for most dental care needs, with no bills or claims forms.

If you live in the DMO's service area, as defined by your ZIP code, you're eligible to join the DMO. You need to choose a dentist from a list of providers in the service area when you enroll.

You must receive care from your selected dentist, or be referred by your dentist to another in-network provider, to receive full benefits from a DMO. If you receive care from a dentist not approved by the DMO, you won't receive full benefits coverage.

Member Services can provide you with information about DMO benefits, services and claims procedures. Use the number on your Aetna member ID card.

For dental plan details, refer to the Summary of Benefits, which you can obtain by going to the Retiree Health Access website at **retireehealthaccess.net/aetna** or by calling **1-800-AETNA-HR (1-800-238-6247)** weekdays, 8 a.m. to 8 p.m. ET. This information is also available at annual enrollment.

How to file medical and dental claims

Aetna Inc. delegates to Aetna Life Insurance Company the discretionary authority to review and make initial benefits determinations.

Note: The procedures described in this section do not apply to the Aetna Medicare Plan (PPO or PPO with ESA [extended service area]), Aetna Medicare Rx Standard (PDP), Aetna Medicare Rx Plus (PDP) or any combination of these plans. Claims and appeal procedures for these plans are separately provided to participants each year. If you have any questions, contact the number on your Aetna member ID card.

If you use an in-network provider, they will generally file claims for you. If you use an out-of-network provider, you may have to file your own claims. Remember to follow these steps when filing a pre-Medicare or Traditional Choice Indemnity medical claim or a PPO or DMO dental claim:

1. Get a *Medical Benefits Request* form or *Dental Benefits Request* form from Aetna Navigator at **aetna.com** or by calling Aetna One Premier at **1-800-247-5485**.
2. Complete the employee portion of the *Medical* or *Dental Benefits Request* form each time you submit a bill for reimbursement.

   For medical bill reimbursement requests that include any treatment over $50 or any surgery, have the doctor complete the provider's section of the form, unless the doctor's bill clearly indicates exactly what services were rendered.

   For dental claims, your dentist must complete the reverse side of the form. Sometimes, dentists may complete a preprinted form of their own instead of completing the reverse side of the claim form. In that case, the preprinted form should be attached to your claim form.

   You may submit more than one bill per claim form.
3. Sort forms and receipts by family member and attach the appropriate receipts to each form. When it's not necessary for your doctor/dentist to complete their portion of the *Medical* or *Dental Benefits Request* form, be sure each receipt shows the nature of the illness or injury, the type of treatment, and the date it was administered. If any of the information is missing, write it on the receipt and sign your name.
4. Make copies of all bills, receipts and forms for your records. Send completed forms, bills and receipts to the applicable address below:

   Pre-Medicare and Traditional Choice Indemnity claims

   Aetna
   PO Box 981106
   El Paso, TX 79998-1106

   Dental claims

   Aetna
   PO Box 14094
   Lexington, KY 40512-4094

   Send all claims to the PO box. Do not send claims by certified or overnight mail as there may be a delay in receipt.
5. All claims should be filed promptly. The deadline for filing a claim is 90 days from the date of the service. If through no fault of your own, you are not able to meet the filing deadline, your claim will be accepted if you file as soon as possible. (However, claims filed more than two years after the deadline will not be accepted unless you are legally incapacitated.)

If your claim is denied

If you do not receive the benefit you believe you are entitled to receive, you have the right to appeal the decision. For details, see the *ERISA* section of this guide.

No legal action can be brought to recover benefits after three years from the deadline for filing claims.

Long-term care insurance

Aetna no longer offers long-term care coverage to retirees. If you were previously enrolled in one of the following long-term care (LTC) insurance programs, the terms and conditions of coverage provided under your existing Certificate of Coverage do not change:

- If you are enrolled in LTC insurance through The Prudential Insurance Company of America (Prudential) between January 1, 2009, and June 3, 2013, you can contact Prudential at **1-800-732-0416**.
- If you were enrolled in the Aetna LTC insurance program prior to January 1, 2009, and remain enrolled, you can call Aetna's contact center at **1-800-537-8521** with questions.
- If you are enrolled in LTC insurance through Genworth, you can contact Genworth with your questions at **1-800-416-3624**.

Retiree Life insurance

Retiree Life insurance

If you are eligible, you can participate in Aetna's Retiree Life insurance coverage. Any questions you have regarding the plan, policy, or claims and appeal process should be directed to Aetna Human Resources at **1-800-AETNA-HR (1-800-238-6247)** weekdays, 8 a.m. to 8 p.m. ET.

For questions related to Paid-Up Life Insurance, call the Aetna Life Service Center at **1-800-523-5065.**

Eligibility for Retiree Life insurance

Terminating employees must meet the following criteria in order to be eligible for a $5,000 company-paid Retiree Life insurance benefit.

If you were last hired prior to January 1, 2002:

- By Aetna, or
- By a company Aetna acquired prior to January 1, 2002,
- And attained age 35 no later than December 31, 2001,

you may be eligible for a $5,000 company-paid Retiree Life insurance benefit if you retire after you have completed 10 years of service and have attained age 45, and your attained age and completed years of service total 65 points. If you do not meet all of these requirements, you will not be eligible for a Retiree Life insurance benefit.

Aetna temporary employees, employees from an outside agency (for example, leased employees), individuals designated by the company as independent contractors, career agents and brokers, and non-resident alien employees are not eligible for retiree life benefits.

Effect of rehire on Retiree Life insurance

If you return to work at Aetna as a regular employee working 20 or more hours per week, you will be eligible to enroll in the active employee life insurance benefits, and your Retiree Life insurance benefit will end. When you later terminate your employment with Aetna, your Retiree Life insurance benefit will be available in the amount that was in effect on the day before returning to active employment.

If you return to work at Aetna as a regular employee working fewer than 20 or more hours per week or as a temporary employee, your Retiree Life insurance remains in effect.

Accelerated death benefit

If you have a life expectancy of 18 months or less, you can request an accelerated benefit from the Retiree Life insurance plan.

You'll receive up to 75 percent of your life insurance coverage benefit. Once you receive the accelerated benefit, your total benefit is reduced by the amount you receive.

To request an accelerated benefit, contact the Life Service Center at **1-800-523-5065** or **1-888-584-2983 (TTY:1-860-273-5198)**.

The accelerated death benefit feature isn't available if you assign your benefits.

Life insurance in force at retirement

Your Basic Term Life coverage ends on the day your employment terminates. You may convert your Basic Life insurance within 31 days of loss of coverage by contacting Aetna One Premier at **1-800-247-5485.**

As an active employee, you may have purchased Supplemental Term Life insurance for yourself, Spouse/Partner Supplemental Term Life insurance and/or Child(ren) Term Life insurance. You may be eligible to convert any of these Supplemental Term Life coverages to a whole-life policy at group rates different than the active employee group rates. Or, you may choose to port your Supplemental Term Life coverages. Requested amounts over $500,000 require Evidence of Insurability. A maximum of $1 million coverage can be ported.

Or you may be eligible to convert coverage for yourself, your spouse/partner and your child(ren) to individual whole life insurance policies without providing evidence of good health. For details, call Aetna One Premier at **1-800-247-5485.**

Naming beneficiaries

You need to name one or more primary beneficiaries for every Aetna Retiree Life insurance plan in which you participate. If you die and don't have a beneficiary on file, or if your primary and contingent beneficiaries have died before you, the benefit will be paid according to the plan's rules.

To check whom you have named as a beneficiary or to add and update beneficiaries, contact Aetna Human Resources at **1-800-AETNA-HR (1-800-238-6247)** weekdays, 8 a.m. to 8 p.m. ET.

How to file a life insurance claim

If you have questions about how to file a life insurance claim, please contact Aetna Human Resources at **1-800-AETNA-HR (1-800-238-6247)** weekdays, 8 a.m. to 8 p.m. ET.

Your beneficiary will need to provide a certified death certificate and any additional required information to the Aetna Life Insurance Company in order for them to process the claim. Payment will be made to the last beneficiary on record.

Your beneficiary has the right to appeal a claim if it is denied.

COBRA

COBRA

Eligibility

36-month continuation

If your dependent loses medical or dental coverage due to one of the following events, they are eligible to purchase COBRA (Consolidated Omnibus Budget Reconciliation Act) continuation coverage for up to 36 months from the date of the event. Qualifying events are:

- Death of the covered retiree
- Divorce or legal separation from the retiree
- A child ceasing to be considered an eligible dependent under the plan
- Cessation of dependent's coverage due to a covered retiree's entitlement to (enrollment in) Medicare

If the company's benefits plans change during the period that you, your spouse or partner, your dependent child, or your partner's child is continuing COBRA coverage, the COBRA coverage will change accordingly.

Cost of COBRA coverage

For the coverage you or a dependent elects to continue, you will be charged the full group cost, plus a two percent administrative fee. If you elect coverage, your first payment must be paid within 45 days of your election.

COBRA (Consolidated Omnibus Budget Reconciliation Act)

If you or your covered dependent lose coverage for any reason (divorce, child ages out of the plan, etc.), you are eligible for continuation of coverage under COBRA. COBRA provides you with an opportunity to continue medical and/or dental coverage for up to 18 months (extendable to 36 months for certain events), if you had previous coverage. The cost is the full company premium rate plus an additional 2 percent administrative fee (102 percent of the total premium). Any retiree who has and loses health coverage at Aetna will receive a COBRA notification letter, as required by law.

Your responsibilities

You have a 60-day period to elect COBRA coverage. The 60-day period starts from the later of the date your coverage ends or the date of your notice of COBRA rights. If the COBRA Unit does not receive your election within the 60-day period, your COBRA rights to continue medical and/or dental coverage are waived. If you elect coverage, your first premium payment must be paid within 45 days of your election.

If you divorce or legally separate, or a dependent's eligibility ends, you or your dependent must notify the plan administrator, Retiree Unit, in writing within 60 days of the event, or any COBRA continuation rights will be lost. Use the PayFlex address below.

Early termination of COBRA coverage

Coverage under COBRA will terminate early for you or your dependents if any of these situations occur:

- You do not pay the required premium for coverage within the grace period (31 days)
- You obtain coverage under another group health care plan that does not contain any applicable exclusions or limitations with respect to pre-existing conditions you or an eligible dependent may have
- You become entitled to Medicare; however, your covered dependents still may be eligible to continue coverage under COBRA for up to 36 months
- When the company stops providing group health benefits under the plan
- The Social Security Administration determines that you or a dependent is longer disabled

Mailing address for COBRA documents

PayFlex Systems USA, Inc.
PO Box 953374
St. Louis, MO 63195-3374

ERISA

ERISA

As an eligible retiree or beneficiary covered by or participating in certain plans described in this guide, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). The intent of this guide is to meet ERISA's summary plan description requirements for these plans. However, in the event of any discrepancy between the official plan documents and this guide, the plan documents will govern.

Plans that are subject to ERISA

The following benefits are subject to ERISA:

- Medical
- Dental
- Retiree Life insurance

For plans subject to ERISA, you are entitled to certain rights and protections as described in the statement of ERISA rights that follows.

Your ERISA rights

Receiving information about your plan and benefits

As a participant in (or beneficiary of) any plan subject to ERISA, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974. ERISA provides that all plan participants shall be entitled to:

- Examine, without charge, at the plan administrator's office and at other specified locations, such as work sites, all documents governing the plan, including insurance contracts, plan documents and a copy of the latest annual report (Form 5500 series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration (EBSA).
- Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts, copies of the latest annual report (Form 5500 series) and plan documents. The administrator may charge a reasonable fee for copies.
- Receive each year (as required by law) a summary of the plan's annual financial report.
- Receive a copy of the procedures used by the plan for determining a Qualified Domestic Relations Order (QDRO) or a Qualified Medical Child Support Order (QMCSO).

Continuing group health plan coverage

You have the right to continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review the *COBRA* section of this guide and the documents governing the plan for the rules governing your COBRA continuation coverage rights.

There may be a reduction or elimination of exclusionary periods of coverage for pre-existing conditions under your group health plan if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage or when your COBRA continuation coverage ceases, if you request it before losing coverage, or up to 24 months after losing coverage.

Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in the plan.

Prudent actions by plan fiduciaries

ERISA also imposes these obligations upon the plan fiduciaries (the people who are responsible for the operation of the employee benefits plan):

- The fiduciaries must operate the plan prudently, in your interest, and in the interest of other participants and beneficiaries.
- You cannot be fired, disciplined or discriminated against in any way with the intention of interfering with or preventing you from obtaining a benefit or exercising your rights under ERISA.
- If your benefits claim is denied, in whole or in part, you must receive a written explanation for the denial. You have the right to have the plan administrator review and reconsider your claim.

Enforcing your rights

Under ERISA, there are steps you can take to enforce these rights. For example:

- If your benefits claim is denied or ignored, in whole or in part, you have the right to know why this was done, to obtain documents relating to the decision without charge and to appeal any denial, all within certain time schedules.
- If you request materials from the plan and don't receive them within 30 days, you may file suit in a federal court. In such case, unless there were reasons beyond the plan's control, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive them.
- If you have a claim for benefits that is denied or ignored, in whole or in part, you may file a suit in a state or federal court after you have exhausted the plan's claims denial and appeal procedures.
- If you disagree with the plan's decision, or the lack thereof, concerning the qualified status of a domestic relations order or a medical child support order, you may file a suit in a federal court.
- If the plan fiduciaries misuse the plan's money or you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or file a suit in a federal court. The court will decide who will pay court costs and legal fees. If you're successful, the court may order the company or person you have sued to pay those costs and fees. If you lose, the court may order you to pay these costs and fees (if, for example, it finds your claim frivolous).

Assistance with your questions

If you have questions about your plan, contact the plan administrator.

If you have any questions about your rights under ERISA, contact the nearest area office of the Employee Benefits Security Administration (EBSA), U.S. Department of Labor, listed in the telephone directory, or you may write to:

Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Ave. NW
Washington, DC 20210

You also may obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the EBSA at **1-866-444-3272.**

Claims and appeal procedures

Information on how to file an initial claim for benefits is described in the section of this SPD applicable to the particular benefit. This section describes the maximum time frames for deciding a claim, appealing a denied claim, deciding an appeal and requesting external review (if applicable).

Note: The procedures described in this section do not apply to the Aetna Medicare Plan (PPO or PPO with ESA [extended service area]), Aetna Medicare Rx Standard (PDP), Aetna Medicare Rx Plus (PDP) or any combination of these plans. Claims and appeal procedures for these plans are separately provided to participants each year. If you have any questions, contact the number on your Aetna member ID card.

For all pre-Medicare plan options and the Medicare-eligible Traditional Choice Indemnity plan, the following procedures apply. (Note: Participants in the Medicare-eligible Traditional Choice Indemnity plan are not eligible for the voluntary external review.)

You may file claims for benefits and appeal adverse benefits determinations either yourself or through an authorized representative. An "authorized representative" means a person you authorize, in writing, to act on your behalf. A court order giving a person authority to submit claims on your behalf will also be recognized, except that in the case of a claim involving urgent health care, a health care professional with knowledge of your condition may always act as your authorized representative. Any reference to "you" in this section includes you and your authorized representative.

Initial claims decisions

If your claim for benefits is wholly or partially denied, you will receive written notice of the denial within a certain number of days. The time frames may be extended for an additional number of days if special circumstances require an extension of time for processing your claim. In that case, you will receive an extension notice that explains the special circumstances and indicates the date on which the plan expects to make a determination.

The extension notice will be provided to you before the end of the initial time frame for providing notice of a denied claim. If there is not sufficient information to decide your claim, you will be given a period of time to provide the requested information before a decision is made. The maximum time frames are described in the chart that follows.

Initial claims decisions				
	Medical claims			Other claims
Event	Urgent care[1]	Pre-service[2]	Post-service	
Notice of incomplete claim	24 hours	N/A	N/A	N/A
	(but may extend initial claim decision as described below)			
Time frame to provide additional information if requested by plan	Not less than 48 hours	45 days	45 days	N/A
Initial claim decision (measured from receipt of initial claim)	24 hours[3]	15 days, plus one 15-day extension[4]	30 days, plus one 15-day extension	90 days, plus one additional 90-day extension period
Information included in notice of an adverse benefits determination	• The specific reason for the denial • Reference to the specific plan provisions on which the denial is based • A description of any additional information necessary to correct the claim and an explanation of why such information is necessary • A description of the plan's claims review procedures and the time limits applicable to such procedures, including a statement of your right to bring a civil action under Section 502(a) of ERISA if the claim is denied on review • In the case of a denied claim for group health benefits, (i) a copy of any internal rule, guideline or protocol that was relied upon in denying your claim (or a statement that you may request a copy free of charge), (ii) if the denial is based on a plan exclusion or limit (for example, medical necessity or experimental treatment), an explanation of any scientific or clinical judgment for the determination, applying the terms of the plan to your medical circumstances (or a statement that you may request a copy of such explanation free of charge), and (iii) in the case of denial of a claim involving urgent care, a description of the expedited review process			

[1]"Urgent care" means any "pre-service claim" for medical care or treatment for which the application of the time periods for making non-urgent care determinations could seriously jeopardize your life, your health or your ability to regain maximum function, or, in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that could not be adequately managed without the care or treatment that is the subject of the claim.

[2]If your plan requires you to obtain advance approval of a non-urgent service, supply or procedure before a benefit will be payable, the claim is considered a pre-service claim.

[3]Notice may be given orally by deadline, with written notice three days after oral notice.

[4]For pre-service claims that name a specific claimant, medical condition, and service or supply for which approval is requested and that are submitted to a plan representative for handling benefits matters, but that otherwise fail to follow the plan's procedures for filing pre-service claims, you will be notified of the failure within five days (within 24 hours in the case of an urgent care claim) and of the proper procedures to be followed. The notice may be oral unless you request written notification.

Additional rules for group health plans: ongoing course of treatment

If you have received preauthorization for an ongoing course of treatment, you will be notified in advance if the preauthorized course of treatment is intended to be terminated or reduced so that you will have an opportunity to appeal the decision and receive a decision on the appeal before the termination or reduction takes effect. If the course of treatment involves urgent care and you request an extension of the course of treatment at least 24 hours before its expiration, you will be notified of the decision within 24 hours after receipt of the request.

Appealing a denied claim

If your claim has been denied, you may submit a request for review of the denied claim, and a decision will be rendered, in accordance with the time frames in the chart that follows. The time frames for deciding an appeal may be extended for an additional number of days if special circumstances require an extension of time for processing your claim. In that case, you will receive an extension notice that explains the special circumstances and indicates the date on which the plan expects to make a determination. The extension notice will be provided to you before the end of the initial time frame for deciding the appeal.

Your request must be submitted in writing (see exception for urgent care claims) and include reasons for requesting the review.

You may also submit written comments, documents, records and other information relating to your claim, even if the comments were not submitted in connection with the initial claim. You may also request that the plan provide you, free of charge, copies of all documents, records and other information relevant to the claim.

Expedited process for appeals of urgent care claims: If your claim involves urgent care, an expedited appeal may be initiated by a telephone call to the phone number included in your denial, or to Member Services. Aetna's Member Services phone number is on your Aetna member ID card. You may appeal urgent care claims denials either orally or in writing. All necessary information, including the appeal decision, will be shared between you and the plan by telephone, facsimile or other similar method. You will be notified of the decision no later than 36 hours after the appeal is received.

Exhaustion of internal appeal processes

Generally, you are required to complete all appeal processes of the plan before being able to obtain external review or bring an action in litigation. However, if the plan or its designee does not strictly adhere to all claims determination and appeal requirements under applicable federal law, you are considered to have exhausted the plan's appeal requirements ("deemed exhaustion") and may proceed with external review or may pursue any available remedies under §502(a) of ERISA or under state law, as applicable. There are limits, though, on what sends a claim or appeal straight to external review. Your claim or internal appeal may not go straight to external review if:

- A rule violation was minor and is not likely to influence a decision or harm you
- It was for a good cause or was beyond the plan's or its designee's control
- It was part of an ongoing good faith exchange between you and the plan

Appeals				
	Medical claims			Other claims
Event	Urgent care	Pre-service	Post-service	
Deadline for filing an appeal (measured from receipt of adverse benefits determination)	180 days *(See Expedited appeal process)*	180 days	180 days	60 days
Appeal decision (measured from receipt of appeal)	36 hours	15 days	30 days	60 days, plus one 60-day extension
Deadline for filing a second-level appeal (measured from receipt of level-one appeal decision)	ASAP	60 days	60 days	N/A
Second-level appeal decision (measured from receipt of appeal)	36 hours	15 days	30 days	N/A
Deadline for requesting external review (measured from date of receipt of appeal decision)	(See *external review procedures* that follow)	123 days		N/A
Information included in notice of an adverse benefits determination	• The specific reason for the denial • Reference to the specific plan provisions on which the denial is based • A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim for benefits • A statement describing any voluntary appeal procedures, including external review • A statement of your right to bring a civil action under Section 502(a) of ERISA • In the case of a denied claim for group health benefits, (i) a copy of any internal rule, guideline or protocol that was relied upon in denying your claim (or a statement that you may request a copy free of charge), (ii) if the denial is based on a plan exclusion or limit (for example, medical necessity or experimental treatment), an explanation of any scientific or clinical judgment for the determination, applying the terms of the plan to your medical circumstances (or a statement that you may request a copy of such explanation free of charge), and (iii) information regarding voluntary alternative dispute resolution options			

Additional rules for health claims: voluntary external review

The external review process gives you the opportunity to receive review of an adverse benefits determination conducted pursuant to applicable law. "External review" is a review of an eligible adverse benefits determination by an independent review organization/external review organization (ERO) or by the state insurance commissioner, if applicable.

Your request will be eligible for external review if the claim decision involves medical judgment and the following are satisfied:

- The plan or its designee does not strictly adhere to all claims determination and appeal requirements under federal law (except for minor violations).
- The standard levels of appeal have been exhausted.
- The appeal relates to a rescission, defined as a cancellation or discontinuance of coverage, which has retroactive effect.

An adverse benefits determination based upon your eligibility is not eligible for external review.

If, upon the final standard level of appeal, the coverage denial is upheld and it is determined that you are eligible for external review, you will be informed in writing of the steps necessary to request an external review.

An independent review organization refers the case for review by a neutral, independent clinical reviewer with appropriate expertise in the area in question. The decision of the independent external expert reviewer is binding on you and the plan unless otherwise allowed by law.

Process for requesting an external review

You must complete all of the levels of standard appeal described in this section before you can request external review, other than in a case of deemed exhaustion. Subject to verification procedures that the plan may establish, your authorized representative may act on your behalf in filing and pursuing this voluntary appeal.

You may file a voluntary appeal for external review of any adverse benefits determination that qualifies as set forth below.

- The notice of adverse benefits determination you receive will describe the process to follow if you wish to pursue an external review and will include a copy of the *Request for External Review* form.
- You must submit the *Request for External Review* form within 123 calendar days of the date you received the adverse benefits determination notice. If the last filing date would fall on a Saturday, Sunday or federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday or federal holiday. You also must include a copy of the notice and all other pertinent information that supports your request.
- If you file a voluntary appeal, any applicable statute of limitations will be tolled while the appeal is pending. The filing of a claim will have no effect on your rights to any other benefits under the plan. However, the appeal is voluntary, and you are not required to undertake it before pursuing legal action.
- If you choose not to file for voluntary review, the plan will not assert that you have failed to exhaust your administrative remedies because of that choice.

Preliminary review

Within five business days following the date of receipt of the request, the plan will provide a preliminary review determining: you were covered under the plan at the time the service was requested or provided, the determination does not relate to eligibility, you have exhausted the internal appeal processes (unless deemed exhaustion applies), you have provided all paperwork necessary to complete the external review, and you are eligible for the external review.

Within one business day after completion of the preliminary review, the plan will issue you a notification in writing. If the request is complete, but not eligible for external review, such notification will include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number **1-866-444-3272**). If the request is not complete, such notification will describe the information or materials needed to make the request complete, and the plan will allow you to perfect the request for external review within the 123 calendar days filing period or within the 48-hour period following receipt of the notification, whichever is later.

Referral to ERO

The plan will assign an ERO accredited, as required under federal law, to conduct the external review. The assigned ERO will timely notify you in writing of the request's eligibility and acceptance for external review, and will provide an opportunity for you to submit in writing within ten business days following the date of receipt, additional information that the ERO must consider when conducting the external review. Within one business day after making the decision, the ERO will notify you and the plan.

The ERO will review all of the information and documents timely received. In reaching a decision, the assigned ERO will review the claim and not be bound by any decisions or conclusions reached during the plan's internal claims and appeal processes. In addition to the documents and information provided, the assigned ERO, to the extent the information or documents are available and the ERO considers them appropriate, will consider the following in reaching a decision:

i. Your medical records

ii. The attending health care professional's recommendation

iii. Reports from appropriate health care professionals and other documents submitted by the plan, you or your treating provider

iv. The terms of your plan to ensure that the ERO's decision is not contrary to the terms of the plan, unless the terms are inconsistent with applicable law

v. Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the federal government, national or professional medical societies, boards, and associations

vi. Any applicable clinical review criteria developed and used by the plan, unless the criteria are inconsistent with the terms of the plan or with applicable law

vii. The opinion of the ERO's clinical reviewer or reviewers after considering the information described in this notice, to the extent the information or documents are available and the clinical reviewer or reviewers consider them appropriate

The assigned ERO will provide written notice of the final external review decision within 45 days after the ERO receives the request for the external review. The ERO will deliver the notice of final external review decision to you and the plan. A "final external review decision" is a determination by an ERO at the conclusion of an external review.

After a final external review decision, the ERO will maintain records of all claims and notices associated with the external review process for six years. An ERO will make such records available for examination by the claimant, plan, or state or federal oversight agency upon request, except where such disclosure would violate state or federal privacy laws.

Upon receipt of a notice of a final external review decision reversing the adverse benefits determination, the plan immediately must provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

Expedited external review

The plan must allow you to request an expedited external review at the time you receive:

A. An adverse benefits determination if the adverse benefits determination involves a medical condition for which the time frame for completion of an expedited internal appeal would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function and you have filed a request for an expedited internal appeal

B. A final internal adverse benefits determination, if you have a medical condition where the time frame for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, or if the final internal adverse benefits determination concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but have not been discharged from a facility

Immediately upon receipt of the request for expedited external review, the plan will determine whether the request meets the reviewability requirements set forth above for standard external review. The plan will immediately send you a notice of its eligibility determination.

Referral of expedited review to ERO

Upon a determination that a request is eligible for expedited, external review following preliminary review, the plan will assign an ERO. The ERO will render a decision as expeditiously as your medical condition or circumstances require, but in no event more than 72 hours after the ERO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned ERO must provide written confirmation of the decision to you and the plan.

If your claim is denied

If you do not receive the benefit you believe you are entitled to receive, you have the right to appeal the decision.

Aetna Inc. delegates to Aetna Life Insurance Company the discretionary authority to review and make final benefits determination for appeals of medical and dental claims denials.

Where to send claims appeals

Pre-Medicare, Traditional Choice Indemnity and dental benefits appeals

Address claims appeals to:

Aetna
Attn: National Account CRT
PO Box 14463
Lexington, KY 40512
Fax: **1-859-425-3379**

Medicare Part C claim appeals

Address claim appeals to:

Aetna Medicare Grievance and Appeal Unit
PO Box 14067
Lexington, KY 40512

Medicare Part D claim appeals

Address claim appeals to:

Aetna Medicare Grievance and Appeal Unit
PO Box 14579
Lexington, KY 40512

Send all appeals to the PO Box or fax number. Do not send appeals by certified or overnight mail as there may be a delay in receipt.

All other claims appeals

Address claims appeals to:

ERISA Appeals Committee, REAG
c/o Aetna Corporate Compensation and Benefits
151 Farmington Avenue
Hartford, CT 06156

Administrative details

Plan sponsor

Aetna Inc.
151 Farmington Avenue
Hartford, CT 06156

Address inquiries to:

Plan Sponsor
Aetna Corporate Compensation and Benefits, REAG
151 Farmington Avenue
Hartford, CT 06156

Plan administrator

Aetna Inc.
Address inquiries to:

Plan Administrator
Aetna Corporate Compensation and Benefits, REAG
151 Farmington Avenue
Hartford, CT 06156

If you are on COBRA continuation, address COBRA inquiries to:

Individual Billing Administration and COBRA Services
PO Box 14391
Lexington, KY 40512-4391
1-888-678-7835

The plan administrator has the authority to construe and interpret the plans, and has the sole right to make rules and procedures necessary or proper for the administration of the plans and the transaction of business, including but not limited to, determining eligibility for benefits. The plan administrator's decisions are final and binding, and the plan administrator may delegate its powers to any person or entity.

Plan year

Retiree records relating to plans are kept on a plan-year basis. The plan year for all ERISA benefits plans is January 1 through December 31.

Employer identification number (EIN)

Refer to this number to obtain plan information from the U.S. Department of Labor or Internal Revenue Service: 23-2229683. For periods prior to December 13, 2000, the EIN to use is 06-0843808.

Agent for service of legal process

Person to contact in legal matters:

Executive Vice President and General Counsel
Aetna Inc.
151 Farmington Avenue
Hartford, CT 06156

Plan amendment

The company retains the right to amend or terminate some or all of its benefits at any time, with or without notice.

Plan name	Plan number	Plan type	Funding method/third-party administrator (if applicable)
Aetna Inc. Life and Accident Insurance Benefits Plan	511	Welfare plan providing life and accident benefits	Insured and administered by Aetna Life Insurance Company
Aetna Inc. Medical/ Dental Benefits Plan for Inactive Employees	513	Welfare plan that includes the following: • Pre-Medicare plans	All of the pre-Medicare plan options are self-insured by the company and administered by insurance subsidiaries of Aetna Life Insurance Company.
		• Medicare plans - Medicare plan options (other than the Traditional Choice Indemnity plan)	All of the Medicare plan options (other than the Traditional Choice Indemnity plan) are insured and administered by insurance subsidiaries of Aetna Life Insurance Company.
		- Traditional Choice Indemnity plan	The Traditional Choice Indemnity plan option is self-insured by the company and administered by insurance subsidiaries of Aetna Life Insurance Company. The prescription drug coverage provided under the Traditional Choice Indemnity plan is insured and administered by insurance subsidiaries of Aetna Life Insurance Company.
		• Dental plans (PPO and DMO)	Insured and administered by insurance subsidiaries of Aetna Life Insurance Company

Privacy notices

Disclosure of protected health information to Aetna as plan sponsor

The medical and dental plans (referred to as HIPAA or the HIPAA plans) are subject to federal privacy regulations issued under the Health Insurance Portability and Accountability Act of 1996. This section describes certain limitations on the disclosure of protected health information by the HIPAA plans to Aetna, as plan sponsor, and the measures Aetna will take to safeguard this information. For more information on the privacy practices of the HIPAA plans, please refer to the *Notice of Privacy Practices*. You can print a paper copy of this notice from the Retiree Health Access website at **retireehealthaccess.net/aetna**.

What plans are subject to the Privacy Rules?

- Medical plan
- Dental plan

For the plans that are subject to the Privacy Rules, you are entitled to certain rights and protections as described in the statement that follows. (Note: Other benefits described in this guide, such as life insurance benefits, are not subject to the Privacy Rules.)

What is "protected health information"?

"Protected health information" is information about you, including demographic information collected from you, that can reasonably be used to identify you and that relates to your past, present or future physical or mental health condition. Protected health information is also information about the provision of heath care or the payment for that care.

How may Aetna, as plan sponsor, use and disclose protected health information?

In its role as plan sponsor, Aetna will use or disclose only that amount of your protected health information that is minimally necessary for the purpose of carrying out the plan administrative functions for the HIPAA plans in a manner consistent with the Privacy Rules. These "plan administrative" functions include activities described below.

Payment

Aetna may use and disclose protected health information for such payment-related activities:

- Determining eligibility
- Claims payment
- Claims-related activities, such as utilization review and management, medical necessity review, appropriateness of care review, and coordination of care
- Complaints, appeals and external review requests
- Obtaining payment under stop-loss insurance
- Billing for premiums and determining contributions

Health care operations

Aetna may use and disclose protected health information in a number of additional ways to support the operations of its HIPAA plans, including the following:

- Quality assessment and improvement
- Performance measurement and outcomes assessment
- Preventive health and disease management
- Underwriting and administration of stop-loss policies
- Risk management, auditing and investigation of fraud or other unlawful conduct
- Due diligence in connection with the sale or transfer of assets to a potential successor in interest
- Other general and administrative activities, including data and information systems, management, and member services

Many of these activities will be carried out through relationships with affiliates and third-party vendors. In its role as plan sponsor, Aetna may have access to protected health information maintained by such affiliates and vendors, whether through auditing activities, ongoing monitoring and management of vendor relationships, or otherwise in the ordinary course of business.

Protected health information also may be used and disclosed in a number of additional situations permitted by the Privacy Rules, as described in the section of the Notice of Privacy Practices entitled *Other Permitted or Required Uses and Disclosures of Protected Health Information.* This section addresses such matters as disclosures in response to litigation, disclosures to health oversight officials (for example, the Department of Labor) and disclosures in connection with disasters or threats to health and safety.

Protected health information will not be used or disclosed by Aetna, as the plan sponsor, for the purpose of employment-related actions or decisions or in connection with any other benefits plans of Aetna, unless authorized by the member.

Please refer to *Aetna as insurer or administrator of the HIPAA plans and other exceptions to protected health information restrictions* on page 63 for a description of the additional ways in which certain Aetna affiliates may use and disclose protected health information when acting as an insurer or administrator of the health plans.

Certification from Aetna as plan sponsor

The HIPAA plans will disclose protected health information to Aetna, as plan sponsor, only upon receipt of a certification that Aetna agrees to comply with these conditions:

- Not to use or further disclose the information other than as described previously or as required by law
- Ensure that any agents, including a subcontractor to whom Aetna provides protected health information received from the HIPAA plans, agree to the same restrictions and conditions that apply to Aetna with respect to such information
- Not to use or disclose the protected health information for employment-related actions or decisions, or in connection with any other benefits plans of Aetna, unless authorized by the member
- To report to the HIPAA plans any use or disclosure of the protected health information that is inconsistent with the uses or disclosure allowed for in the guide
- Make protected health information available to members in accordance with 45 C.F.R. §164.524
- Make protected health information available to members for purposes of amendment, incorporate any such amendments and permit members to file a rebuttal statement if there is any dispute regarding the amendment of protected health information in accordance with 45 C.F.R. §164.526
- Make available the information required to provide members an accounting of certain Aetna disclosures of their protected health information in accordance with 45 C.F.R. §164.528
- Make Aetna's internal practices, books and records relating to the use and disclosure of protected health information received from the HIPAA plans available to the U.S. Secretary of Health and Human Services for purposes of determining the HIPAA plans' compliance with the Privacy Rules
- If feasible, return or destroy all protected health information received from the HIPAA plans that Aetna still maintains in any form, and retain no copies of such information when no longer needed for the purposes for which disclosure was made; if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible
- Ensure that the separation described on the following page is established

Separation between Aetna and the HIPAA plans

The following are the employees or classes of employees or other workforce members of Aetna, as plan sponsor, who may be given access to protected health information received from the HIPAA plans or a health insurance issuer of the HIPAA plans:

- Employees within Aetna's Compensation and Benefits Unit (or any successor business unit), their supervisors and superiors who have been designated as having administration responsibilities with respect to the HIPAA plans, and contractors working for this unit
- Other employees or associates of Aetna who may serve on a HIPAA plan appeals committee or are otherwise involved in complaints, appeals and external review requests
- Internal and external advisors to Aetna's Compensation and Benefits Unit, including attorneys, accountants, actuaries and auditors

The persons identified in the preceding paragraphs will have access to the amount of protected health information minimally necessary to discharge their lawful duties in accordance with the Privacy Rules and solely to perform the plan administrative functions that Aetna performs for the HIPAA plans.

Any employee or workforce member identified above who violates these restrictions will be subject to disciplinary actions under Aetna's Code of Conduct. Aetna will report any such breach to the HIPAA plans, cooperate with the HIPAA plans to investigate any such breach, take appropriate disciplinary action and take appropriate action to mitigate the harmful effect of the breach. Any person who becomes aware of a potential breach should report the matter to AlertLine at **1-888-891-8910**.

Aetna as insurer or administrator of the HIPAA plans and other exceptions to protected health information restrictions

Aetna is one of the nation's leading providers of health care and related group benefits, and certain affiliates of Aetna have been engaged by the HIPAA plans to perform these insurance and administrative services on behalf of the HIPAA plans.

For example, Aetna HMOs may be offered as a health plan option to Aetna employees in their service areas. Likewise, Aetna Life Insurance Company serves as the self-funded benefits administrator for most of the Aetna health and dental plans. As such, one of Aetna's affiliates will act as the insurer or administrator for most components of the HIPAA plans. As more fully described in Aetna's *Notice of Privacy Practice*s, the employees and other workforce members of Aetna and its affiliates engaged in such operations will have more extensive access to member-protected health information than described previously for Aetna when acting in its role as a plan sponsor. The restrictions on the use and disclosure of protected health information described in this section of the guide do not apply to the business relationships described in this paragraph. For a description of the limitation of the uses and disclosures of protected health information by an affiliate of Aetna when acting as an insurer of benefits administrator, please refer to Aetna's *Notice of Privacy Practices* found on the Retiree Health Access website at **retireehealthaccess.net/aetna**.

The foregoing restrictions do not apply to protected health information disclosed to Aetna pursuant to a valid authorization from the individual who is the subject of the information or to protected health information that has been summarized in conformity with the Privacy Rules that is used for obtaining premium bids from health plans or modifying, amending or termination of the HIPAA plans.

Contact information

Telephone numbers and contact information

Keeping track of the range of benefits programs Aetna provides can be a challenge. Use this guide to help you quickly find the benefits resources and information you need. The guide also details the information you will need to have available when you call or visit the websites.

For general information, call Aetna Human Resources at **1-800-AETNA-HR (1-800-238-6247)** weekdays, 8 a.m. to 8 p.m. ET, or visit the Retiree Health Access website at **retireehealthaccess.net/aetna**, available 24 hours a day, 7 days a week. This website exclusively serves Aetna retirees and employees who are on long-term disability prior to January 1, 2017, and provides you with direct access to many of the websites below. It also includes other up-to-date information.

For information about	Call/online resource	Call weekdays (except as noted below) between	Information/PIN required
Retiree health • Your retiree health plans • Updating your personal information, such as mailing address, marriage, divorce • Requesting materials (forms, summaries of benefits, plan documents) • Medical and dental deductions (billing) • Whether your eligibility for Medicare has changed • Reporting the death of a retiree/spouse	**Aetna Human Resources** **1-800-AETNA-HR (1-800-238-6247)** Select the prompt for pension or retiree and LTD health benefits. **Retiree Health Access** **retireehealthaccess.net/aetna**	8 a.m. – 8 p.m. ET	Have your user ID and password handy when you call or use the website.

For information about	Call/online resource	Call weekdays (except as noted below) between	Information/PIN required
Medical • How your medical plan works • Eligible dependents • ID cards • Payment of medical claims • Finding preferred providers/facilities • Coordination of supplemental plans with your Aetna medical plan • How to access your Health Savings Account (HSA) • Checking provider acceptance of Aetna Medicare open plans	Use the phone number of the plan you are enrolled in:		Have your member ID card handy when you call.
	Aetna One Premier Pre-Medicare plans and Aetna Traditional Choice Indemnity plan **1-800-247-5485**	8 a.m. – 6 p.m. (your local time)	
	Aetna Medicare Member Services Aetna Medicare plans (PPO/PPO with ESA) **1-888-97-AETNA (1-888-972-3862)**	8 a.m. – 6 p.m. (your local time)	
	PayFlex service center **1-855-806-1070**	For assistance with your Aetna HSA, 24 hours a day, 7 days a week	
	Aetna Navigator **aetna.com**		Have your user name and password handy when you use the website.

For information about	Call/online resource	Call weekdays (except as noted below) between	Information/PIN required
Prescription drugs • Rx coverage • Formulary (what drugs are and are not covered) • Medicare Part D coverage • Specialty drug coverage (what drugs are covered) • Payment of Rx claims • Denial of Rx claims	Use the phone number of the plan you are enrolled in: **Aetna One Premier** Pre-Medicare plans and Aetna Traditional Choice Indemnity plan **1-800-247-5485** **Aetna Medicare Member Services** Aetna Medicare Rx Plus (PDP) and Aetna Medicare Rx Standard (PDP) **1-888-97-AETNA (1-888-972-3862)** **Aetna Navigator** **aetna.com**	8 a.m. – 6 p.m. (your local time) 8 a.m. – 6 p.m. (your local time)	Have your member ID card handy when you call. Have your user name and password handy when you use the website.

For information about	Call/online resource	Call weekdays (except as noted below) between	Information/PIN required
Mail-order drugs • How mail-order delivery works • Receiving up to a 90-day supply of certain drugs directly at your home address • Ordering refills by mail, over the phone or online if you pay by check or credit card • Note: If you need to submit a new order for mail-order prescription drugs (as a first-time or returning user), call the Member Services number on your ID card and request a mail-order pharmacy order form.	**Aetna Rx Home Delivery** **1-888-792-3862** **Aetna Navigator** **aetna.com**	7 a.m. – 11 p.m. ET, Monday – Friday 8 a.m. – 9:30 p.m. ET, Saturday 8 a.m. – 6 p.m. ET, Sunday Note: Pharmacists are available 24 hours a day, 7 days a week, to answer questions and provide emergency assistance.	Have your prescription number available when you call to reorder. Have your user name and password handy when you use the website.
Self-injectable drugs and specialty medications	**Aetna Specialty Pharmacy** **1-866-782-ASRX** **(1-866-782-2779)** **TDD: 1-877-833-2779**	8 a.m. – 7 p.m. ET • Dedicated team of patient care coordinators, pharmacists and registered nurses is available to address all therapy support needs. • Clinical representatives are also available 24 hours a day, 7 days a week to provide assistance.	Have your member ID card handy when you call.

For information about	Call/online resource	Call weekdays (except as noted below) between	Information/PIN required
Dental • How your dental plan works • ID cards • Finding a preferred provider • Payment of dental claims • Denial of dental claims	**Aetna One Premier** **1-800-247-5485** **Aetna Navigator** **aetna.com**	8 a.m. – 6 p.m. (your local time)	Have your member ID card handy when you call. Have your user name and password handy when you use the website.
Life insurance • Confirmation of life insurance coverage • Adding or changing a beneficiary • Beneficiary information • Reporting the death of a retiree	**Aetna Human Resources** **1-800-AETNA-HR (1-800-238-6247)** Select the prompt for pension or retiree and LTD health benefits.	8 a.m. – 8 p.m. ET	Have your user ID and password handy when you call.
Aetna 401(k) Plan • Checking 401(k) account balance • Managing investments (change elections, transfer funds, reallocate balances and rebalance account) • Changing beneficiary • Withdrawing money from the plan • Repaying loans and checking outstanding balance • Initiating rollovers	**Aetna Human Resources** **1-800-AETNA-HR (1-800-238-6247)** and select the 401(k) menu option for automated account information 24 hours a day, 7 days a week. **aetna.voya.com**	8 a.m. – 8 p.m. ET, excluding stock market holidays **Note:** Tools and forms available online.	Have your Social Security number and Voya Financial® PIN handy when you call or use the website.

For information about	Call/online resource	Call weekdays (except as noted below) between	Information/PIN required
Pension • Aetna's pension plan • Commencing your pension • Validating/changing beneficiary • Payment/direct deposit • Deductions from pension check • Changing tax withholding • Updating your personal information/mailing address • Requesting materials (forms, plan documents) • Reporting the death of a retiree/spouse	**Aetna Human Resources** **1-800-AETNA-HR (1-800-238-6247)** Select the prompt for pension information. **Your Benefit Resources** **ybr.com/aetna**	8 a.m. – 8 p.m. ET	Have your user ID and password handy when you call or use the website.

For information about	Call/online resource	Call weekdays (except as noted below) between	Information/PIN required
Equity-based awards and ESPP shares • Transacting shares • History for tax reporting purposes • 1099 information • Online modeling, reports and statements • **Note:** View equity awards and Employee Stock Purchase Plan shares (including grant expiration dates) online.	**UBS Financial Services** **1-800-AETNA-HR** **(1-800-238-6247)** Select the prompt "For more options," and then "Stock options" or call UBS OneSource directly at: **1-888-793-7631** **ubs.com/onesource/aet**	3 a.m. – 11 p.m. ET	Have your Social Security number and participant ID handy when you call. You also will be asked to answer two security questions. For the website: log-in ID is your Aetna ID (with preceding A). If you don't recall your Aetna ID, you may call UBS. PIN is the last four digits of your Social Security number (until you change it).
Life insurance/ pre-retirement • Career agents life insurance • Converted/ported coverage • Paid-up life insurance	**Aetna Life Service Center** **1-800-523-5065** **Ported Supplemental Term Life** **1-800-882-8395**	8 a.m. – 7 p.m. ET	Have your Social Security number handy when you call.
Aetna Foundation® • Aetna Employee Giving Campaign • Employee and retiree giving programs	**CyberGrants** **1-888-254-4059** Select "Need Support?" and then select "I still have a question." **cybergrants.com/ aetna/aero**	8 a.m. – 8 p.m. ET	Aetna employee ID number, hire date, termination date, date of birth.

Other helpful information, tools and resources

Resource	Call/online resource	Information/PIN required
Aetna Informed Health® Line Gives plan members access to registered nurses, 24 hours a day, 7 days a week	**1-800-556-1555**	
Aetna Navigator Online tool to help you manage your Aetna medical, dental and Rx plan, including: • Find a doctor, pharmacy or facility • Review claims • Order medications • See coverage and benefits - Price-A-Drug℠ tool - Estimate the cost of care	**aetna.com**	Have your user ID and password handy when you use the website.
Claim appeals		
Medical and dental benefits appeals Appeals of self-insured medical and dental claims denials are reviewed by Aetna Life Insurance Company. For insured benefits, appeals are reviewed by the applicable insurance carrier.	Call the Member Services number on your ID card for the appeals address.	
All other claims appeals	Address other claims appeals to: ERISA Appeals Committee, REAG c/o Aetna Corporate Compensation and Benefits 151 Farmington Avenue Hartford, CT 06156	

Resource	Call/online resource	Information/PIN required
DocFind® Search for doctors, dentists, pharmacies, hospitals, facilities and other health care professionals by inputting information such as your ZIP code, city or county and selecting the name of your Aetna plan.	**aetna.com/docfind**	
Medicare* General information about Medicare, 24 hours a day, 7 days a week *Please contact Aetna Medicare Member Services first for an issue related to your Aetna Medicare plans.	**1-800-633-4227** **medicare.gov**	Have your user ID and password handy when you use the website.
Social Security General information about Social Security *Social Security Handbook*	**1-800-772-1213** TTY: **1-800-325-0778** **socialsecurity.gov** **socialsecurity.gov** Type "Social Security Handbook" in the search bar, then choose the "Social Security Handbook."	

Appendix

Making changes between annual enrollments

During the plan year, you can change your coverage only if you have a qualified benefits status change. Any change must be necessary and consistent with the change in status, and must be made within 31 days following that change in status.

Note: Changes to medical and dental are effective the date of the qualified benefits status change; however, cancellations take effect on the first of the month following the event. If the cancellation occurs on the first of the month, then coverage will end the last day of the prior month.

Retiree benefits status changes

Medical and/or dental		
Type of change	**Medical**	**Dental**
Retiree gains a dependent child*	N/A	Add dependent child to coverage within 31 days.
Retiree's covered dependent(s) dies	Remove from coverage. Allow medical plan coverage.	Remove from coverage. Allow medical plan coverage.
Retiree marries	Not eligible	Not eligible
Retiree gets divorced or legally separated (including ending domestic partnership)	Remove spouse or partner from coverage within 31 days. Allow medical plan change.	Remove child(ren) of partner from coverage within 31 days.
Retiree's dependent child is newly eligible due to Qualified Medical Child Support Order	N/A	Add dependent child to coverage within 31 days. Retiree in a deferred status must elect coverage in order to cover newly eligible child. Allow medical plan coverage.
Retiree dependent child loses eligibility due to age	N/A	Remove dependent child from coverage within 31 days.
Retiree's dependent loses health plan coverage	Add certified dependent to coverage within 31 days. Allow medical plan coverage.	Add eligible dependent child(ren) within 31 days. Allow medical plan coverage.
Retiree moves into or out of health plan service area	May change plans within 31 days.	May change plans within 31 days.

*See definition of child(ren) in *Overview* section of this SPD.

Non-Discrimination 1557 Notice

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 **1-800-247-5485**.

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**), **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).

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

Availability of Language Assistance Services

TTY: 711

To access language services at no cost to you, call 1-800-247-5485 .

Para acceder a los servicios de idiomas sin costo, llame al 1-800-247-5485. (Spanish)

如欲使用免費語言服務，請致電 1-800-247-5485 。(Chinese)

Afin d'accéder aux services langagiers sans frais, composez le 1-800-247-5485 . (French)

Para ma-access ang mga serbisyo sa wika nang wala kayong babayaran, tumawag sa 1-800-247-5485 . (Tagalog)

Um auf für Sie kostenlose Sprachdienstleistungen zuzugreifen, rufen Sie 1-800-247-5485 an. (German)

للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء الاتصال على الرقم 1-800-247-5485 . (Arabic)

Pou jwenn sèvis lang gratis, rele 1-800-247-5485 . (French Creole-Haitian)

Per accedere ai servizi linguistici, senza alcun costo per lei, chiami il numero 1-800-247-5485. (Italian)

言語サービスを無料でご利用いただくには、1-800-247-5485 までお電話ください。(Japanese)

무료 언어 서비스를 이용하려면 1-800-247-5485 번으로 전화해 주십시오. (Korean)

برای دسترسی به خدمات زبان به طور رایگان، با شماره 1-800-247-5485 تماس بگیرید. (Persian-Farsi)

Aby uzyskać dostęp do bezpłatnych usług językowych proszę zadzwonoć 1-800-247-5485 . (Polish)

Para acessar os serviços de idiomas sem custo para você, ligue para 1-800-247-5485. (Portuguese)

Для того чтобы бесплатно получить помощь переводчика, позвоните по телефону 1-800-247-5485 . (Russian)

Nếu quý vị muốn sử dụng miễn phí các dịch vụ ngôn ngữ, hãy gọi tới số 1-800-247-5485 . (Vietnamese)