

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

Take charge of your health

Aetna Affordable Health Choices®
Limited Benefits Insurance Plan*

Affordable coverage
Special discounts
Information and
tools to make
healthy decisions

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

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We want you to know®
 Aetna®



Good health is important to you and your

Make the easy ch

They say nothing is more important than your health

They're right. And that's what makes health insurance such an essential part of your life. It's time to take charge of your health and your health insurance needs.

At Aetna, we're here to help. Your employer is offering you Aetna Affordable Health Choices® limited benefits insurance plan. "Limited" means that the plan has a number of specific limits and other restrictions on visits, services and/or the dollar amounts covered under the plan in addition to the overall dollar limit of the policy. Once these limits have been reached, the plan will not pay any more towards the cost of the service in question, and you will be responsible for the remaining unpaid charges or expenses. Your Benefits Summary explains these visit and service limits, the overall annual benefit maximum, and other cost-sharing features of your plan, such as copayments and deductibles. Please read it carefully so that you understand the limits to what the plan will pay before you enroll.

Take charge of your health — enroll today!

We're here to help

When you enroll in the Aetna Affordable Health Choices limited benefits insurance plan, you're gaining a lot of advantages. Some of these are:

Easy to understand

Yes, insurance can be simple. We provide you with straightforward language and easy-to-understand benefits. If you have any questions, just call us or check us out on the web at www.src-web.com.

Easy to choose

We'll guide you through the process step by step. Aetna's participating provider network (PPO) offers you a wide selection of doctors and hospitals.

Easy to afford

You choose from the options available to you in your plan, and your premiums are simply deducted from your pay. As an Aetna member, you are also entitled to discounts.** It's one more way we help you maintain a healthy lifestyle.

Easy to manage

Thanks to easy-to-use web-based tools, you can get valuable health-related information and quickly locate Aetna network doctors in your area.

Find a doctor — DocFind makes it easy!

With our DocFind® online directory, you can customize your search by specialty and location. Looking for a pediatrician within your zip code? How about a doctor affiliated with a nearby hospital? It's all here — plus maps and directions to a doctor's office. DocFind even lets you search by a doctor's gender and languages spoken. Just visit www.aetna.com/docfind/custom/aahc.



choice today!

How it works

You'll like visiting a network doctor, but you'll also like knowing it's your choice

See a network doctor ... lower costs, hassle-free access

Visit any preferred provider without a referral. You'll have confidence knowing that anyone you choose measures up to our strict credentialing standards.

- Your plan may include an annual **deductible** (the amount of money you must pay for eligible expenses during each coverage year before the plan begins to pay benefits).
- Once your deductible is met, you'll pay a percentage of the remaining covered expenses. For some visits, services or other charges you may pay a **copay** (an initial amount of a medical provider's fee that you are responsible for paying each time you incur certain covered charges, usually paid when the charges are incurred).
- On average, you'll enjoy lower costs since network doctors have agreed to offer Aetna members negotiated fees (generally lower than the doctor's usual charges).
- Your network doctor will submit your claims for you.

See any doctor ... the choice is yours

It's all about your freedom to choose. Visit any licensed doctor or specialist — there are no network restrictions and no referrals. You may need to:

- Meet an annual deductible (generally higher than the deductible set for services received from a network doctor).
- Then pay a percentage of the remaining covered expense at the time of service. This percentage may be higher than you would pay in-network at a preferred provider. For some visits, services or other charges you may pay a copay.
- File your own claims.
- Pay the difference between the amount covered by your plan and the amount charged by the doctor. This can increase your out-of-pocket costs because the doctor has not agreed to negotiated fees with Aetna.

I want good health.
I like the plan.
I want to get started!

What do I do next?

- Read all the materials in your enrollment kit.
- Follow the step-by-step instructions and enroll today!

Language assistance

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

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



Coverage you need
Coverage you
can afford
Enroll today!

Discounts and programs to help maintain a healthy lifestyle

Your medical membership includes special programs* and discounts** with a wealth of features. These programs include savings on products and educational materials geared toward particular health needs. Here are a few of the ways we can help you maintain a healthy lifestyle:

Weight management discount program

You and your eligible family members can save on weight-loss programs and products from one of the largest weight management firms worldwide — Jenny Craig®. You'll get a sensible weight-loss plan, one-on-one weekly consultations and discounts on weight-loss products that fit your lifestyle.

Hearing discount program

Receive a discount** on hearing exams and services with HearPO® at participating locations nationwide.

Oral health care discounts

Receive savings on products and services to help improve dental and overall health.

Aetna pharmacy management

In addition to prescription discounts, we help protect your health by providing information to help control certain medical conditions.

Aetna Natural Products and ServicesSM program

Professional services** offered at reduced rates — from natural therapy professionals, which include acupuncturists, chiropractors, massage therapists and nutritional counselors.

Discounts on health-related products*

including over-the-counter vitamins, herbal and nutritional supplements and natural products.

Fitness program

Enjoy discounted rates on memberships at participating health clubs contracted with GlobalFit™ as well as savings on home exercise equipment.

Aetna VisionSM Discounts

Receive discounts** on eyewear, contact lenses, LASIK eye surgery and eye care accessories. Participating optical centers include Sears Optical®, LensCrafters®, Target Optical® and many Pearle Vision® locations.

To learn more about these programs and discounts, go to www.aetna.com/docfind/custom/aahc or call the Member Services number at 1-888-772-9682.

* These discount programs are rate-access programs and may be in addition to any plan benefits. Discount and other similar health programs offered hereunder are not insurance. Program features are not guaranteed under the plan contract and may be discontinued at any time. Program providers are solely responsible for the products and services provided hereunder. Aetna does not endorse any vendor, product or service associated with these programs. It is not necessary to be a member of an Aetna plan to access the program participating providers.

** Discounts are from the provider's usual fee for the service (retail price). These discount programs are not insured benefits, but provide access to discount programs maintained by Aetna Inc. and its affiliates.

This material is for information only. Providers are independent contractors and are not agents of Aetna. Provider participation may change without notice. Aetna does not provide care or guarantee access to health services. Health insurance plans contain exclusions and limitations. Discount programs provide access to discounted prices and are not insured benefits. Not all health services are covered. See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by location and are subject to change. Aetna receives rebates from drug manufacturers that may be taken into account in determining Aetna's Preferred Drug List. Rebates do not reduce the amount a member pays the pharmacy for covered prescriptions.

Policy form numbers issued in OK include: GR-9/GR-9N, GR-29/GR-29N.

**Aetna Affordable Health Choices®
limited benefits insurance plan***

Questions and Answers

Membership information you need to know

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

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

How do benefit limits work?

This plan has limits on the amount of money it will pay. Some limits may be overall maximums, and some may be limits on particular kinds of charges. After a particular limit or maximum is reached, the plan will not pay any more for that benefit. Your Benefits Summary, found in this enrollment kit, explains these limits, maximums, and other features of your plan, such as copays and deductibles. Please read it carefully so that you understand what your plan will pay before you enroll.

Who can enroll?

All employees employed for at least 90 days and working on average a minimum of 25 hours per week are eligible to enroll. If you are an eligible employee, you can also enroll your eligible dependents. Dependent age and status requirements may vary by state.

When does coverage begin?

Coverage is effective on the Saturday following the day they receive a check with a deduction.

When do maximums and deductibles reset?

Annual deductibles, maximums, and limits add up throughout the coverage year, then reset and begin again on the anniversary date of your coverage year, January 2.

Will I get ID cards?

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

How do I file a claim?

Claim forms are available from www.aetna.com/docfind/custom/aahc, by calling SRC toll free at **1-888-772-9682**, or by writing to Strategic Resource Company, Attn: Claims Department, PO Box 23759, Columbia, SC 29224-3759.



**You have a limited
time to enroll.**

**Just hired?
You have 90 days from
the date you become
eligible to enroll.**

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

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

Cut out your temporary member identification along the dotted line.

			
MEDICAL PPO		BIN# 610502 RX	
DECISIONHR, INC. COMPANY NO.: 800504		An Aetna Company AETNA AFFORDABLE HEALTH CHOICES® PPO	
EMPLOYEE NAME: _____ AND COVERED DEPENDENTS _____			
FOR MEMBER SERVICES CALL		1-888-772-9682	
PAYOR NUMBER 57604 0039			

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Aetna Life Insurance Company

Company name DecisionHR, Inc.	Group number 800504	Today's date (mm/dd/yyyy)
Member name (last, first, middle initial)	Member daytime telephone number	Member Social Security number

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

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

**Strategic Resource Company
Attn: Missed Premium Department
PO Box 23759
Columbia, SC 29224-3759**

_____ X \$ _____ = \$ _____
Number of pay periods missed Amount of deduction per pay period Full premium payment due

What if I miss a payroll deduction?

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

Will my insurance be canceled if I don't make up a missed premium?

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

How do I pay my missed premium?

To pay by **personal check, cashier's check, or money order**, make payable to **SRC/Aetna** and send with a completed copy of the coupon above to: Strategic Resource Company, Attn: Missed Premium Department, PO Box 23759, Columbia, SC 29224-3759.

You can get additional payment coupons from **www.src-web.com**, or by calling **1-888-772-9682**.

Can I pick which missed premiums I wish to pay?

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

How long do I have to pay a missed premium?

You may pay for a gap in coverage that is up to 45 days old, from the date your payment is postmarked.

Can I pay just a part of a missed premium?

No. You must pay the full premium deduction that was missed in your paycheck, for all coverage you have. We cannot accept partial payments.

If I become ineligible or my employment ends, can I continue coverage with missed premium payments?

No. If your coverage terminates, you may not continue coverage by paying missed premiums. There may be other ways you can continue coverage, such as state continuation of coverage or COBRA, if eligible.

www.aetna.com/docfind/custom/aahc

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

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

EMERGENCY URGENT CARE: Call your local emergency hotline (ex.911) or go to the nearest emergency facility. For AETNA VISION DISCOUNTS call 1-800-792-8616. For LASIK call 1-800-422-6600. For CONTACTS DIRECT call 1-800-391-5367.

Strategic Resource Company
P.O. Box 23759
Columbia, SC 29224-3759

More questions?

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

¿Tiene más preguntas?

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

Insurance Plans are underwritten by Aetna Life Insurance Company. Plans are administered by Strategic Resource Company (SRC). Aetna Affordable Health Choices® is a registered service mark of Aetna Inc. Health insurance plans contain exclusions and limitations. Material is subject to change. For OK residents only, policy forms issued include GR-9/GR-9N and GR-29/GR-29N.





BENEFITS SUMMARY

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

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

IMPORTANT DISCLOSURE: This plan has a number of specific limits and other restrictions on visits, services and/or the dollar amounts covered under the plan in addition to the overall dollar limit of the policy. Once these limits have been reached, the plan will not pay any more towards the cost of the service in question and you will be responsible for the remaining unpaid charges or expenses. This Benefits Summary explains these visit and service limits, the overall annual benefit maximum, and other cost sharing features of your plan, such as copayments and deductibles. Please read it carefully so that you understand the limits to what the plan will pay before you enroll.

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

Group limited benefit medical plans are not available to residents of New Hampshire.

Prime Care Option 2

Coverage for Outpatient Charges	Preferred Provider (in network)	Non-Preferred Provider (out of network)
Doctors' office visits		
Maximum benefit per coverage year	5 visits	Same as preferred
Copay/deductible for each visit	\$10 copay	\$10 deductible
Percentage of remaining charges you pay	None (plan pays 100% up to benefit maximum)	20%
Preventive visits		
Maximum benefit per coverage year	\$100	Same as preferred
Copay for each visit	\$15	None
Percentage of remaining charges you pay	None (plan pays 100% up to benefit maximum)	50%
Emergency room visits		
Maximum benefit per coverage year	\$1,000	Same as preferred
Deductible per coverage year	\$100	Same as preferred
Percentage of remaining charges you pay	None (plan pays 100% up to benefit maximum)	Same as preferred
Diagnostic & surgical services		
Maximum benefit per coverage year	\$400 or 5 services, whichever is used up first	Same as preferred
Copay/deductible for each visit	\$15 copay	\$15 deductible
Percentage of remaining charges you pay	None (plan pays 100% up to benefit maximum)	20%



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Coverage for Inpatient Charges	Preferred Provider (in network)	Non-Preferred Provider (out of network)
Maximum benefit per coverage year (Not all inpatient charges are paid up to the annual maximum. Carefully review the limit on other hospital services.)	\$10,000	Same as preferred
Limit on other hospital services per coverage year <i>Once this limit has been reached, this benefit will no longer pay for many hospital-billed charges. The plan will continue to pay for room and board and inpatient professional services until the maximum benefit per coverage year is reached.</i>	\$1,000	Same as preferred
Deductible per coverage year		
Individual	\$250	Same as preferred
Family	\$500	Same as preferred
Percentage of remaining charges you pay	20%	40%

Coverage for Prescription Drug Charges	Preferred Provider (in network)	Non-Preferred Provider (out of network)
Maximum benefit per month	\$50	Same as preferred
Amount you pay for each prescription		
Generic drugs	\$10 copay	50%
Brand-name drugs	\$20 copay	50%

To use your prescription benefit at a preferred pharmacy:
 A) Present your Aetna Affordable Health Choices[®] identification (ID) card to the pharmacist.
 B) You receive a discount at the point of sale and pay the applicable copay (and any balance over your maximum benefit).
 C) There are no claims to file.

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

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

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



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If you live in an area that does not have a preferred health care provider, you will be considered **out-of-area** and receive benefits for eligible expenses as if you were using a preferred provider. Please note that if you travel to an area that has a preferred health care provider but use a non-preferred health care provider, you will not be eligible for preferred provider benefits. However, if you have a life-threatening medical emergency and use a non-preferred provider, you can call member services within two business days of the medical emergency treatment and your claim for the covered expenses will be treated as if presented by a preferred provider. Call member services Monday through Friday between 8 a.m. and 8 p.m. ET, at **1-888-772-9682**.

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



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Terms defined

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

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

In many instances, the plan requires that a deductible is met before a benefit is paid. A **deductible** is the amount of money you must pay for eligible expenses before the plan begins to pay benefits. A deductible may be per service, per visit, per supply or per coverage year. All covered expenses accumulate toward both the preferred and non-preferred deductible per coverage year.

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

Other hospital services are charges for certain services and supplies billed by a hospital in addition to those charges for room occupancy. These charges may be significant and may include, but are not limited to: pharmacy; medical and surgical supplies and devices; lab and x-rays; and operating and recovery room expenses. They do not include charges for services such as surgeon, physician and anesthesiologist services, private duty nursing, or special duty nursing.

Inpatient professional services are charges for surgeon, physician and anesthesiologist services, private duty nursing, or special duty nursing.

Inpatient charges are charges billed by a hospital or provider when you are admitted as an inpatient and charged for room and board. Inpatient charges are comprised of: room and board charges (daily room rate), professional charges billed by a provider (such as charges by a physician who does not work directly for the hospital), and hospital charges other than room and board.

Outpatient charges are charges billed at doctors' offices, free-standing clinics and facilities, and pharmacies. They also include charges at a hospital when you are not admitted as an inpatient, and you are not billed for room and board charges.

A **negotiated charge** is the maximum amount that a preferred provider has agreed to charge for the visit, service, or supply. You should not have to pay more than your portion of the negotiated charge, subject to your plan limits. After your plan limits have been reached, the provider may require that you pay the full charge rather than the negotiated charge.

A **recognized charge** is the amount that Aetna recognizes that a visit, service, or supply should cost, whether from a preferred or non-preferred provider. A non-preferred provider may require that you pay more than the recognized charge, and this additional amount would be your responsibility.



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

Preventive visits are charges for routine doctor exams for reasons other than to diagnose or treat an injury or disease. Examples include, but are not limited to: physical exams, gynecological exams, mammograms, certain cancer screenings, and bone mass density measurements. Included as a part of the exam are x-rays, lab and other tests given in connection with the exam; and materials for the administration of immunizations for infectious disease and testing for tuberculosis. Your plan may or may not offer a preventive visit(s) benefit. Please refer to the benefits chart in this Benefits Summary. Some federal and state laws mandate certain preventive exams that are to be covered by, or in addition to, this benefit if offered under your plan. If a preventive visit(s) benefit is not offered under your plan (see the benefits chart), these federal and/or state mandates will be covered by other benefits under your plan. Please refer to the plan documents for more information.

Questions and answers:

How do benefit limits work?

This plan has limits on the amount of money it will pay per coverage year. These limits differ for each type of charge and, depending on your plan design as explained in the benefits chart in the previous pages above, may be a maximum number of visits or services, a maximum dollar amount, or both. Because there are limits on what is paid for certain kinds of services or visits, you may not be covered for some services or visits even though you have not reached your overall maximum. **Before you enroll in the plan, please read the benefits chart in the previous pages carefully to understand these limits and consider what effects they may have.**

Will the plan always pay up to the maximum benefits per coverage year?

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

How does this limited benefits insurance plan differ from a traditional major medical health plan?

This limited benefits insurance plan, like a traditional major medical health plan, covers a range of health care services both in and out of the hospital. However, this limited benefits insurance plan places limits on how much it will pay or how many services or visits it will cover. Once you have used up the overall maximums or limits on specific benefits, the plan will not pay any more. And unlike most major medical plans, this limited benefits insurance plan does not have catastrophic coverage or a limit on your out-of-pocket expenses. This means that you may have considerable out-of-pocket costs if you have a serious or chronic medical condition that requires hospitalization or continuing outpatient care.



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What are my rights for childbirth?

The Newborns' and Mothers' Health Protection Act (NMHPA) states that group health plans and health insurers generally may not limit the benefits for a hospital stay connected to childbirth to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section, for either the mother or newborn child. However, it generally does not prohibit the mother's or newborn's doctor from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable) after consulting with the mother. In any case, plans and insurers may not require that a doctor get authorization from the plan or issuer for prescribing a length of stay up to 48 hours (or 96 hours). This act does not change the benefit maximum, limits or deductibles of your plan. The state in which you live, you work, or your plan was underwritten may have additional mandated rights regarding childbirth. Please refer to the plan documents.

What are my rights for reconstructive surgery after a mastectomy?

The Women's Health and Cancer Rights Act (effective 1998) states that any health plan that provides medical benefits for a medically necessary mastectomy must also provide coverage for reconstruction of the same breast, reconstruction of the other breast to achieve symmetry, prostheses, and treatment of physical complications of all stages of mastectomy including lymphedema. 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. This act does not change the benefit maximum, limits or deductibles of your plan. The state in which you live, you work, or your plan was underwritten may have additional mandated rights regarding a mastectomy. Please refer to the plan documents.

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

Please call us. We want you to understand these benefits before you decide to enroll. You may reach one of our Customer Service representatives Monday through Friday, 8 a.m. to 8 p.m. Eastern Time, by calling toll free **1-888-772-9682**. We're here to answer questions before and after you enroll.

When you enroll in medical coverage, you also receive:

Aetna VisionSM Discounts*

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

Prescription drug discount program*

The prescription drug discount program gives you and your family access to over 55,000 retail pharmacies nationwide including major pharmacy chains and independent pharmacies (Aetna Region Network Profile - 3/10/06). To locate a participating pharmacy, call **1-888-772-9682** or visit www.aetna.com/docfind/custom/aahc.

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



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Other available coverage:

Term Life and Accidental Death Insurance

Employee term life benefit	\$20,000
Employee accidental death benefit	\$20,000
Optional dependents coverage	\$2,500 in term life for dependents over 6 months of age \$500 for children from birth through 6 months of age

Benefits paid to the beneficiary of your choice; benefits reduced by 50% when you reach age 70.



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Exclusions and Limitations

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

Medical Pre-existing Condition Limitation:

For the first 365 days after an insured person enrolls, the plan will not pay for medical expenses for pre-existing conditions. Pre-existing conditions are those conditions for which the insured person received diagnosis, care or treatment within 180 days before that person enrolled in the plan.

The plan will reduce the pre-existing condition period by the number of days of "prior creditable coverage" as of the enrollment date. "Creditable coverage" means prior medical coverage as defined in the Federal Health Insurance Portability and Accountability Act of 1996. Please provide us with a copy of any certificates of creditable coverage or, if you need help in obtaining one or have questions about creditable coverage, please contact member services at **1-888-772-9682**.

Medical Exclusions:

- All medical or hospital services not specifically covered in, or which are limited or excluded in the plan documents.
- Any eye surgery mainly to correct refractive errors.
- Cosmetic surgery, including breast reduction.
- Custodial care.
- Dental care and X-rays, unless medically necessary to repair an injury to the mouth, jaw or teeth resulting from an accident.
- Donor egg retrieval.
- Experimental and investigational procedures.
- Hearing aids.
- Immunizations for travel or work.
- Infertility services, including, but not limited to, artificial insemination and advanced reproductive technologies.
- Nonmedically necessary services or supplies.
- Orthotics.
- Over-the-counter medications and supplies.
- Reversal of sterilization.
- Services for the treatment of sexual dysfunction or inadequacies, including therapy, supplies, or counseling.
- Special duty nursing.
- Any treatment, drug service or supply intended to decrease or increase body weight, control weight or treat obesity, including morbid obesity, regardless of the existence of comorbid conditions.



BENEFITS SUMMARY

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

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

Term Life Exclusions:

- Suicide or attempted suicide (while sane or insane).

Accidental Death Benefit Exclusions:

- Use of alcohol, intoxicants, or drugs, except as prescribed by a physician.
- Suicide or attempted suicide (while sane or insane).
- An intentionally self-inflicted injury.
- A disease, ptomaine or bacterial infection except for that which results directly from an injury.
- Medical or surgical treatment except for that which results directly from an injury.
- Voluntarily inhalation of poisonous gases.
- Commission of or attempt to commit a criminal act.

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

This material is for information only and is not an offer or invitation to contract. Insurance plans contain exclusions and limitations. Providers are independent contractors and are not agents of Aetna. Provider participation may change without notice. Aetna does not provide care or guarantee access to health services. Not all health services are covered. See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by location. Aetna receives rebates from drug manufacturers that may be taken into account in determining Aetna's Preferred Drug List. Rebates do not reduce the amount a member pays the pharmacy for covered prescriptions. Discount programs provide access to discounted prices and are not insured benefits. Material is subject to change.

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

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

Important Disclosure Information

For Aetna Affordable Health ChoicesSM Plans

Plan of Benefits

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

Cost Sharing

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

How Aetna Compensates Your Health Care Provider

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

Participating providers in our network are compensated in various ways:

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

Advance Directives

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

There are three types of advance directives:

- Living will - spells out the type and extent of care you want to receive.
- Durable power of attorney - appoints someone you trust to make medical decisions for you.

- Do-not-resuscitate order - states that you don't want to be given CPR if your heart stops or if you stop breathing.

You can create an advance directive in several ways:

- Get an advance medical directive form from a health care professional. Certain laws require health care facilities that receive Medicare and Medicaid funds to ask all patients at the time they are admitted if they have an advance directive. You don't need an advance directive to receive care. But we are required by law to give you the chance to create one.
- Ask for an advance directive form at state or local offices on aging, bar associations, legal service programs, or your local health department.
- Work with a lawyer to write an advance directive.
- Create an advance directive using computer software designed for this purpose.

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

After-Hours Care

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

Behavioral Health Provider Safety Data Available

For information regarding our Behavioral Health provider network safety data, please go to Aetna.com and review the quality and patient safety links posted:

www.aetna.com/docfind/quality.html#jcaho. You may select the quality checks link for details regarding our providers' safety reports.

Claims Payment for Nonparticipating Providers and Use of Claims Software

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

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

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

Technology Review

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

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

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

Medically Necessary

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

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

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

Clinical Policy Bulletins

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

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

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

Filing a Complaint or Appeal

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

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

About Coverage Decisions

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

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

External Review

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

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

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

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

Member Rights & Responsibilities

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

www.aetna.com

Member Services

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

Interpreter/Hearing Impaired

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

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

Multilingual hotline - 1-888-982-3862

(140 languages are available.)

You must ask for an interpreter.)

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

Quality Management Programs

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

Privacy Notice

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

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

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

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

To obtain a hard copy of our Notice of Privacy Practices which describes in greater detail our practices concerning use and disclosure of personal information, please write to Strategic Resource Company (SRC), Post Office Box 23759, Columbia, SC 29224.

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

State Variations

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

Georgia

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

Members have direct access to the participating primary Ob/Gyn provider of their choice and do not need a referral from their PCP for a routine well-woman exam, including a Pap smear when appropriate and an unlimited number of visits for gynecologic problems and follow-up care.

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

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

Consumer Choice Option

The Consumer Choice Option is available for Georgia residents enrolled in certain Aetna managed care plans. Under this benefit option, with certain restrictions required by law and an additional monthly premium cost, members of certain Aetna managed care plans may nominate an out-of-network provider to provide covered services for themselves and their covered family members. Your benefits and any applicable copayments will be the same as for in-network providers. The out-of-network provider must agree to accept the Aetna compensation, to adhere to the plan's quality assurance requirements, and to meet all other reasonable criteria required by the plan of its in-network participating providers. It is possible the provider you nominate will not agree to participate.

This option is available for an increased premium in addition to the premium you would otherwise pay. Your increased premium responsibility will vary depending on whether you have a single plan or family coverage, and on the type of insurance, riders, and coverage. Exact pricing and any additional information can be obtained by calling 1-888-772-9682. Please have your Aetna member ID card available when you call.

www.aetna.com

Hawaii

Informed Consent

Members have the right to be fully informed prior to making any decision about any treatment, benefit, or nontreatment.

Your provider will:

- discuss all treatment options, including the option of no treatment at all;
- ensure that persons with disabilities have an effective means of communication with the provider and other members of the managed care plan; and
- discuss all risks, benefits, and consequences of treatment and non-treatment.

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

Insurance Division Telephone Number:

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

Illinois

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

Illinois law requires health plans to provide the following information annually to enrollees and to prospective enrollees upon request: a complete list of participating health care providers in the health care plan's service area and a description of the following terms of coverage:

1. The service area;
2. The covered benefits and services with all exclusions, exceptions and limitations;
3. The pre-certification and other utilization review procedures and requirements;

4. A description of the process for the selection of a PCP, any limitation on access to specialists, and the plan's standing referral policy;
5. The emergency coverage and benefits, including any restrictions on emergency care services;
6. The out-of-area coverage and benefits, if any;
7. The enrollee's financial responsibility for copayments, deductibles, premiums, and any other out-of-pocket expenses;
8. The provisions for continuity of treatment in the event a health care provider's participation terminates during the course of an enrollee's treatment by the provider;
9. The appeals process, forms, and time frames for health care services appeals, complaints, and external independent reviews, administrative complaints, and utilization review complaints, including a phone number to call to receive more information from the health care plan concerning the appeals process; and
10. A statement of all basic health care services and all specific benefits and services to be provided to enrollees by a State law or administrative rule.

Additionally, upon written request, the health plan will provide enrollees with a description of the financial relationship between the health plan and any health care provider, including, if requested, the percentage of copayments, deductibles, and total premiums spent on health care related expenses and the percentage of copayments, deductibles and total premiums spent on other expenses, including administrative expenses.

Kansas

Kansas law permits you to have the following information upon request:

1. A complete description of the health care services, items and other benefits to which the insured is entitled in the particular health plan which is covering or being offered to such person;
2. A description of any limitations, exceptions or exclusions to coverage in the health benefit plan, including prior authorization policies, restricted drug formularies or other provisions which restrict access to covered services or items by the insured;
3. A listing of the plan 's participating providers, their business addresses and telephone numbers, their availability, and any limitation on an insured's choice of provider;
4. Notification in advance of any changes in the health benefit plan which either reduces the coverage or benefits or increases the cost to such person; and

5. A description of the grievance and appeal procedures available under the health benefit plan and an insured's rights regarding termination, disenrollment, non-renewal or cancellation of coverage.

Kentucky

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

Emergency Medical Condition Definition

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

Louisiana

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

Maryland

Behavioral Health Care Expense Form

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

Michigan

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

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

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

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

Intractable Pain Coverage

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

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

Texas

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

Health Insurance Portability and Accountability Act

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

Special Enrollment Rights

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

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

Request for Certificate of Creditable Coverage

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

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

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