BENEFITS SUMMARY

Aetna Voluntary Plans

Plan design and benefits insured and administered by Aetna Life Insurance Company (Aetna).

Unless otherwise indicated, all benefits and limitations are per covered person.

Inside this Benefits Summary:

IMPORTANT INFORMATION ABOUT THE BENEFITS YOU ARE BEING OFFERED: The Aetna Fixed Benefits Plan is a hospital confinement indemnity plan with other fixed indemnity benefits. This plan provides **LIMITED BENEFITS.** Benefits provided are supplemental and are not intended to cover all medical expenses. This plan pays you fixed dollar amounts regardless of the amount that the provider charges. You are responsible for making sure the provider's bills get paid. These benefits are paid in addition to any other health coverage you may have. This disclosure provides a very brief description of the important features of the benefits being considered. It is not an insurance contract and only the actual policy provisions will control. **THESE PLANS DO NOT COUNT AS MINIMUM ESSENTIAL COVERAGE UNDER THE AFFORDABLE CARE ACT. THESE ARE A SUPPLEMENT TO HEALTH INSURANCE AND ARE NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMUM ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES.**

IF YOU ARE ELIGIBLE FOR MEDICARE NOW OR IN THE NEXT 12 MONTHS, YOU SHOULD UNDERSTAND THAT:
- This IS NOT a Medicare Supplement Policy.
- This prescription drug benefit IS NOT creditable coverage under Medicare Part D.
You can get a free Guide to Health Insurance for People with Medicare at www.medicare.gov.

Aetna will pay benefits only for services provided while coverage is in force, and only for medically necessary, **covered** services. These benefits may be modified where necessary to meet state mandated benefit requirements.

If you or your spouse have a health saving account, please consult your tax advisor before you enroll about whether the Fixed Indemnity plan may affect it.

You can lower your medical expenses by seeing a participating provider in the Aetna Open Choice® PPO network. To locate a participating provider, call toll-free 1-800-772-1074 or visit www.aetna.com/dse/custom/avp. If your provider participates in your comprehensive medical plan's network, the medical plan's negotiated rate with that provider applies.

Group Fixed Indemnity coverage is not available if you live and work in **New Hampshire**. This policy does not meet **Massachusetts** Minimum Creditable Coverage standards.

Fixed Benefits Plan

Inpatient Hospital Stay -- daily benefit	
(Includes maternity)	
Plan pays per day in a private or semi-private room	$325
Plan pays per day in Intensive Care Unit (ICU)	$650
Maximum number of stays per coverage year	2 stays
Inpatient Hospital Stay - lump-sum benefit	
(Includes maternity)	
Plan pays per initial day of an inpatient stay	$250
Maximum number of days per coverage year	2 days
Inpatient surgical procedure	
Plan pays per day on which a surgical procedure is performed	$2,000
Maximum number of days per coverage year	2 days
Accident - additional benefit	
Plan pays per initial day of treatment for an accident	$300
Maximum number of days per coverage year	2 days
Emergency room	
Plan pays per day on which an emergency room visit occurs	$200
Maximum number of days per coverage year	2 days
Outpatient surgical procedure	
Plan pays per day on which a surgical procedure is performed	$500
Maximum number of days per coverage year	2 days
Outpatient doctors' office visits	
Includes doctors' service in the office, home, walk-in clinic, and urgent care clinic.	
Plan pays per day on which doctors' services are provided	$65
Maximum number of days per coverage year	7 days
Outpatient laboratory and x-ray services	
Plan pays per day on which lab or x-ray services are provided	$80
Maximum number of days per coverage year	3 days
Prescription drugs, equipment and supplies	
Plan pays per day on which a prescription drug, equipment or supply is obtained	$40
Maximum number of days per coverage year	12 days

To use your prescription benefit:

A) Present your Aetna identification (ID) card to the pharmacist.
B) Participating pharmacies will apply a discount.
C) You pay the amount charged by the pharmacy.
D) Submit a medical claim form to Aetna Voluntary to receive your fixed benefit payment.

To find a participating pharmacy, call toll-free **1-800-772-1074** or visit **www.aetna.com/dse/custom/avp**.

Services to prevent illness are covered under the applicable benefit (Outpatient doctors' office visits or Outpatient laboratory and x-ray services) listed in this Benefit Summary, the same as services to treat illness.

Fixed Benefits Plan Exclusions and Limitations

This plan has exclusions and limitations. Refer to the actual policy and booklet certificate to determine which services are covered and to what extent. The following is a partial list of services and supplies that are generally not covered. **However, the plan may contain exceptions to this list based on state mandates or the plan design purchased.**

- All medical or hospital services not specifically covered in, or which are limited or excluded in the plan documents.
- Cosmetic surgery, including breast reduction.
- Custodial care.
- Experimental and investigational procedures.
- Infertility services, including donor egg retrieval, artificial insemination and advanced reproductive technologies, and reversal of sterilization.
- Nonmedically necessary services or supplies.

No benefit is paid for or in connection with the following stays or visits or services:

- Those received outside the United States
- Those for education, special education or job training, whether or not given in a facility that also provides medical or psychiatric treatment.

Terms defined

An ***Inpatient Hospital Stay*** (or "Stay") is a period during which you are admitted as an inpatient; and are confined in a hospital, non-hospital residential facility, hospice facility, skilled nursing facility, or rehabilitation facility; and are charged for room, board, and general nursing services. A Stay does not include time in the hospital because of custodial or personal needs that do not require medical skills or training. A Stay specifically excludes time in the hospital for observation or in the emergency room unless this leads to an Inpatient Stay.

A ***Negotiated Charge*** is the maximum amount that a preferred provider has agreed to charge for a covered visit, service, or supply. After your plan limits have been reached, the provider may require that you pay the full charge rather than the negotiated charge.

Other available benefits:

Vision Care

Eye Exams	Reimbursements of up to $250 every 12 months for an exam, frames, lenses, or contact lenses.

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

Vision Care Exclusions:

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

- Orthoptic vision training, subnormal vision aids, any associated supplemental testing.
- Medical and/or surgical treatment of the eyes or supporting structure.
- Any eye or vision examination, or any corrective eyewear, required by an employer as a condition of employment.

Dental	
Maximum benefit per coverage year	$750
Deductible per coverage year	$50
Preventive services (includes checkups and cleanings)	You are responsible for paying up to 20%† of the Recognized Charges. These services have no waiting period.
Basic services (includes fillings, oral surgery, and denture, crown and bridge repair)	You are responsible for paying up to 40%† of the Recognized Charges. You must be covered under the dental plan without interruption for 3 months before the plan begins to pay for these services.
Major services (includes Perio and Endodontics, crowns, bridges, and dentures)	You are responsible for paying up to 40%† of the Recognized Charges. You must be covered under the dental plan without interruption for 12 months before the plan begins to pay for these services.

† The percentage of the cost that you are responsible for paying a preferred provider is based on a ***Negotiated Charge***. A ***Negotiated Charge*** is the maximum amount that a preferred provider has agreed to charge for a covered visit, service, or supply. After your plan limits have been reached, the provider may require that you pay the full charge rather than the ***Negotiated Charge.***

The percentage of the cost that you are responsible for paying a non-preferred provider is based on a ***Recognized Charge.*** A ***Recognized Charge*** is the amount that Aetna recognizes as payable by the plan for a visit, service, or supply. For non-preferred providers (except inpatient and outpatient facilities and pharmacies), the ***Recognized Charge*** generally equals the 80th percentile of what providers in that geographic area charge for that service, based on the FAIR Health RV Benchmarks database from FAIR Health, Inc. This means that 80% of the charges in the database for geographic area are that amount or less – and 20% are more – for that service or supply. For preferred providers, the *Recognized Charge* equals the ***Negotiated Charge.*** A non-preferred provider may require that you pay more than the ***Recognized Charge,*** and this additional amount would be your responsibility.

The dental PPO network is not available in **Idaho, Hawaii, Montana, New Mexico** or **Puerto Rico**. To locate a preferred provider, call toll-free **1-800-772-1074** or visit **www.aetna.com/dse/custom/avp**.

In Texas, the Preferred Provider Organization (PPO) network is known as the Participating Dental Network (PDN).

Dental Exclusions:

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

The following charges are not covered under the dental plan, and they will not be recognized toward satisfaction of any deductible amount.

- Cosmetic procedures unless needed as a result of injury.
- Any procedure, service or supplies that are included as covered medical expenses under another group medical expense benefit plan.
- Prescribed drugs, pre-medication, analgesia or general anesthesia.
- Services provided for any type of temporomandibular (TMJ) or related structures, or myofascial pain.
- Charges in excess of the Recognized Charge, based on the 80th percentile of the FAIR Health RV Benchmarks.

Short Term Disability (STD)	
Benefit Period Benefit Amount	Weekly benefits for up to 6 months while you are disabled.
Benefit Amount	60% of base pay received from the employer that sponsors this program (includes reported tips, but not overtime) up to $150 maximum weekly benefit.
Waiting Period	Benefits begin after 7 days (plan pays immediately if hospitalized).

Coverage for employee only; coverage is not available if you work in **California, Hawaii, New Jersey, New York, Rhode Island or Puerto Rico.**

Short Term Disability Exclusions:

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

- Attempted suicide, while sane or insane, or intentional self-inflicted injury or sickness, unless as the result of a medical condition.
- Commission of or attempt to commit an act which is a felony in the jurisdiction in which the act occurred.
- Substance abuse.
- Occupational injury or sickness.
- Disability insurance plans/policies contain certain reductions and waiting periods, which may affect the payable benefit.

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Term Life and Accidental Death Insurance	
Employee term life benefit	$10,000
Employee accidental death benefit	$20,000
Optional dependents coverage	$5,000 in term life for spouse. $5,000 for children from birth through 6 months of age. $1,000 for infants from 15 days through 6 months of age.

Benefits paid to the beneficiary of your choice; benefits reduced to $7,500 when employee is 65 years of age $5,000 when employee is 70 years of age. Coverage for spouse terminates at age 70. Accidental death benefit, when applicable, pays in addition to term life benefit.

Term Life and Accidental Death Exclusions:

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

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.

Questions and answers about the Fixed Benefits Plan

The Fixed Benefits Plan is a fixed indemnity plan. How does a fixed indemnity plan work?

Fixed indemnity plans have no copays, deductibles, or coinsurance. A fixed indemnity plan pays a fixed amount per day or other period, with limits on the number and types of services. Once you have used up your number of services, the plan will no longer pay for that kind of service. Payments under the Fixed Benefits Plan can be used for any purpose you choose.

Because the plan pays a fixed amount, you may owe the provider more than the plan pays. If you choose a preferred (in network) provider, then you may pay less, because the provider may accept payment for the negotiated charge. Before you enroll in the plan, please read the benefits chart in the previous pages carefully to understand what this plan will pay.

How does this fixed indemnity plan differ from a traditional comprehensive medical plan?

The Fixed Benefits Plan is intended to supplement, not substitute for, comprehensive medical coverage. Unlike most major medical plans, this plan does not have catastrophic coverage or a limit on your out-of-pocket expenses. This means that you may have large out-of-pocket costs if you have a serious or chronic medical condition. Because comprehensive medical plans provide more coverage, they cost more. They typically satisfy the Affordable Care Act's mandate to maintain Minimum Essential Coverage, but the Fixed Benefits Plan does not.

Can I have the Fixed Benefits Plan if I already have comprehensive health insurance?

Yes, the Fixed Benefits Plan can supplement other health insurance. The Fixed Benefits Plan will pay the specified benefit whether or not your other health insurance pays anything for the service. The Fixed Benefits plan does not coordinate benefits with other coverage. If the provider participates in your underlying health plan's network, the provider may bill you for the rate the provider has negotiated with the health plan and the Aetna discounted rate cannot be guaranteed.

Does this fixed indemnity plan have COBRA continuation coverage?

Unlike a traditional health plan, this fixed indemnity plan does not offer COBRA continuation coverage.

What will I pay up front when I go to a healthcare provider?

A provider may require that you pay all charges in advance, and it would be up to you to submit a claim for benefits under the plan. Remember that you are responsible for making sure the provider's bill gets paid, even when the fixed benefit is less than provider's charges.

How do I submit a claim for benefits?

You can assign your benefits to your provider and your provider will submit the claim. In that case, benefits will be paid to your provider. If the benefits are more than what you owe the provider, the difference will be paid to you.

If you want benefits to be paid to you, you can submit the claim to Aetna yourself (unless you already assigned the benefits to your provider). Be sure to include the diagnosis codes (you may need to ask your provider for them). Do not sign box 26 on the claim form unless you want us to pay the benefits to your provider. Claim forms are available at **www.aetna.com/voluntary/employees/materials-forms.html**, or by calling Customer Service at the toll-free number on your ID card.

What should I do in case of an emergency?

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

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

Please call us. We want you to understand these benefits before you decide to enroll. You may reach one of our Customer Service representatives Monday through Friday, 8 a.m. to 6 p.m., by calling toll free **1-800-772-1074**. We're here to answer questions before and after you enroll.

Important information about your benefits

Search our network for doctors, hospitals and other health care providers

Here's how you can find out if your health care provider is in our network. Log in to **www.aetna.com/voluntary** and follow the path to find a doctor, or call us at the toll-free number on your Aetna ID card. If you would like a printed list of doctors, contact Member Services at the toll-free number on your Aetna ID card. Our online directory is more than just a list of doctors' names and addresses. It also includes information about where the physician attended medical school, board certification status, language spoken and gender. You can even get driving directions to the office. If you don't have Internet access, call Member Services to ask about this information.

Complaints and appeals

Please tell us if you are not satisfied with a response you received from us or with how we do business. Call Member Services to file a verbal complaint or to ask for the address to mail a written complaint. You can also e-mail Member Services through the secure member website. If you're not satisfied after talking to a Member Services representative, you can ask us to send your issue to the appropriate department.

If you don't agree with a denied claim, you can file an appeal. To file an appeal, follow the directions in the letter or explanation of benefits statement that explains that your claim was denied. The letter also tells you what we need from you and how soon we will respond.

We protect your privacy

We consider personal information to be private. Our policies protect your personal information from unlawful use. By "personal information," we mean information that can identify you as a person, as well as your financial and health information.

Personal information does not include what is available to the public. For example, anyone can access information about what the plan covers. It also does not include reports that do not identify you.

When necessary for your care or treatment, the operation of our health plans or other related activities, we use personal information within our company, share it with our affiliates and may disclose it to: your doctors, dentists, pharmacies, hospitals and other caregivers, other insurers, vendors, government departments and third-party administrators (TPAs). We obtain information from many different sources —particularly you, your employer or benefits plan sponsor if applicable, other insurers, health maintenance organizations or TPAs, and health care providers.

These parties are required to keep your information private as required by law. Some of the ways in which we may use your information include: Paying claims, making decisions about what the plan covers, coordination of payments with other insurers, quality assessment, activities to improve our plans and audits.

We consider these activities key for the operation of our plans. When allowed by law, we use and disclose your personal information in the ways explained above without your permission. Our privacy notice includes a complete explanation of the ways we use and disclose your information. It also explains when we need your permission to use or disclose your information.

We are required to give you access to your information. If you think there is something wrong or missing in your personal information, you can ask that it be changed. We must complete your request within a reasonable amount of time. If we don't agree with the change, you can file an appeal.

If you'd like a copy of our privacy notice, call **1-800-772-1074** or visit us at **www.aetna.com.**

If you require language assistance, please call Member Services at 1-888-772-9682 and an Aetna representative will connect you with an interpreter. If you're deaf or hard of hearing, use your TTY and dial 711 for the Telecommunications Relay Service. Once connected, please enter or provide the Aetna telephone number you're calling.

Si usted necesita asistencia lingüística, llame a Servicios al Miembro al 1-888-772-9682, y un representante de Aetna le conectará con un intérprete. Si usted es sordo o tiene problemas de audición, use su TTY y marque 711 para el Servicio de Retransmisión de Telecomunicaciones (TRS). Una vez conectado, por favor entrar o proporcionar el número de teléfono de Aetna que está llamando.

NOTICE TO TEXAS EMPLOYERS: THIS IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE. THE EMPLOYER DOES NOT BECOME A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM BY PURCHASING THIS POLICY, AND IF THE EMPLOYER IS A NON-SUBSCRIBER, THE EMPLOYER LOSES THOSE BENEFITS WHICH WOULD OTHERWISE ACCRUE UNDER THE WORKERS' COMPENSATION LAWS. THE EMPLOYER MUST COMPLY WITH THE WORKERS' COMPENSATION LAW AS IT PERTAINS TO NON-SUBSCRIBERS AND THE REQUIRED NOTIFICATIONS THAT MUST BE FILED AND POSTED.

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

ATTENTION MISSOURI RESIDENTS: An optional rider for elective abortion has not been purchased by the group contract holder pursuant to VAMS section 376.805. An enrollee who is a member of a group health plan with coverage for elective abortions has the right to exclude and not pay for coverage for elective abortions if such coverage is contrary to his or her moral, ethical or religious beliefs. Your plan sponsor does not include coverage for elective abortions.

This material is for information only and is not an offer or invitation to contract. Insurance plans contain exclusions and limitations. Providers are independent contractors and are not agents of Aetna. Provider participation may change without notice. Aetna does not provide care or guarantee access to health services. Not all health services are covered. See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Policies may not be available in all states, and rates and benefits may vary by location. Aetna receives rebates from drug manufacturers that may be taken into account in determining Aetna's Preferred Drug List. Rebates do not reduce the amount a member pays the pharmacy for covered prescriptions.
Information is believed to be accurate as of the production date; however, it is subject to change. For more information about Aetna plans, refer to **www.aetna.com**.

Financial Sanctions Exclusions Clause
If coverage provided by this policy violates or will violate any US economic or trade sanctions, the coverage is immediately considered invalid. For example, Aetna companies cannot make payments or reimburse for health care or other claims or services if it violates a financial sanction regulation. This includes sanctions related to a blocked person or entity, or a country under sanction by the United States, unless permitted under a valid written Office of Foreign Assets Control (OFAC) license. For more information on OFAC, visit
http://www.treasury.gov/resource-center/sanctions/Pages/default.aspx.

Policy forms issued in Oklahoma and Idaho include GR-96172, GR-96173, GR-9/9N, GR-29/29N, GR-23.