MADDOCK & ASSOCIATES
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Employee Benefits Packet
For

Allied Steel
FABRICATORS, INC.
(425) 861 - 9558 REDMOND, WA

Enclosed is an outline of the employee benefit program brought to you by Allied Steel Fabricators and Maddock & Associates. The purpose of this packet is to give you a brief overview of the plans and assist you with enrollment. Maddock & Associates is your insurance advocate. Please call us at 800-875-4490 with your questions or benefits issues. We are here to help you! Your plan provides

- Medical & Prescription Drugs
- Dental
- Life & AD&D
- Voluntary Supplemental Life

Detailed benefit summaries and forms are available on-line at:

www.yourmedicalbenefits.com

Login: **alliedsteel** Password: **alliedsteel123**

ALLIED STEEL FABRICATORS, INC. EMPLOYEE BENEFITS ENROLLMENT

Your employer is pleased to offer you group medical, dental, vision and life insurance coverage. The purpose of this packet is to outline the plans, to advise you of the costs and to assist you with the enrollment. The required forms are attached. Below is a brief description of your plans. For full benefits and limitations please refer to the attached summaries. You will also to have 24-hour access to detailed plan summaries, provider directories, and important forms at the Maddock & Associates website, www.yourmedicalbenefits.com. YourMedicalBenefits LOGIN is **alliedsteel a**nd your PASSWORD is **alliedsteel123.**

ENROLLMENT FORMS

Anyone not enrolling at this time will NOT be eligible to enroll until September 1, 2013 unless they meet certain specific requirements, such as involuntary loss of other coverage through a spouse's employer, and apply immediately upon losing such coverage. Late entrant waiting periods apply to employees or dependents who do not enroll in the dental at this time unless they have the above enrollment exceptions

- **Aetna Enrollment Form** (Medical, Life)
  Complete this form (including beneficiary information) and sign the bottom of page 2.
  If you or any of your dependents (spouse or children) are not enrolling in the medical plan you must complete and sign the waiver section (Section F).

- **HSA Bank Enrollment:**
  Complete if you are enrolling in the HSA plan..

- **HSA Payroll Deduction Form:**
  Complete if you are enrolling in the HSA plan.

- **Met Life Enrollment Form** (Dental)

- **VSP Enrollment Form** (Vision)

- **Dearborn Life Voluntary Life Enrollment Form** (Voluntary Life)

2012/2013 BENEFIT SUMMARY

MEDICAL INSURANCE: Aetna. Each employee will choose between three medical insurance options, one of which is an HSA plan. You will receive the best benefits when you use an **Aetna Open Choice Preferred Provider**. Network providers can be found in the provider directory section of your website, www.yourmedicalbenefits.com, or www.aetna.com. ***Under providers, select Aetna Open Choice PPO.***

AETNA $1,000 VALUE PLAN : This plan has a $1000 annual deductible . The deductible is waived for the first four doctor office visits, and basic lab and x-ray. The first four office visits are covered at 100% after a $35 co-pay. Visits after the first four, complex imaging, and other services provided by Preferred physicians and Preferred hospitals are covered at **80%** after the deductible to a co-insurance maximum of $4,000. Non preferred providers are covered at 50% after a $2,000 deductible.

AETNA $2,500 SAVER PLAN : This plan has a $2,500 per person annual deductible. The deductible is waived for primary care office visits and basic lab and x-ray, which have a $15 co-pay. For other services (including specialist office visits and complex lab and x-ray) the plan pays **70%** after the deductible to a co-insurance maximum of $5,000 if you use Preferred physicians and Preferred hospitals. Non preferred providers are covered at 50% after a $5,000 deductible.

PRESCRIPTION DRUGS (Value & Saver Plans): Prescription Drugs are covered at a $20 co-pay for generic drugs, $40 for formulary brand name drugs and $70 for non formulary drugs. Mail order drugs are covered for up to a 90 day supply at a co-pay of $40 generic, $80 brand and $140 non formulary. A list of participating pharmacies and formulary drugs can be found on www.yourmedicalbenefits.com or at www.aetnanavigator.com.

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AETNA HSA $1,500 PLAN: This plan pays most benefits, at 80% after a $1,500 deductible for single coverage and $3,000 for family coverage for preferred providers. If you are insuring a family the entire family deductible must be met before benefits are paid to any individual family member. The deductible is waived for preventive care which is covered at 100%. The co-insurance maximum is $2,000 for single coverage and $4,000 for family coverage. Please see benefit summary for non-preferred provider deductibles and co-insurance levels.

HSA PRESCRIPTION DRUGS: For HSA plans, the deductible must be met before prescription drugs are covered. After deductible, prescription drugs are covered at a $20 co-pay for generic drugs, $40 for formulary brand name drugs and $70 for non formulary drugs. Mail order drugs are covered for up to a 90 day supply at a copay of $40 generic, $80 brand and $140 non formulary. A list of participating pharmacies and formulary drugs can be found on www.yourmedicalbenefits.com or at www.aetna.com.

HSA BANK ACCOUNT:: For employees who choose the HSA plans, Alllied Steel will contribute $43.34 per employee per month ($520/year) into a tax free account that can be used for medical expenses or retirement. In addition, employees can also contribute tax free up to $215.00 for single coverage or $477.50 for family coverage into this account. The funds in your HSA account can pay for medical, dental, and vision expenses or be used for retirement.

VISION: Vision Service Plan. VSP vision insurance covers an eye examination after a $10 co-payment and lenses and/or frames for a $25 co-payment. Benefits for an eye exam are available through the vision plan once every 12 months. Lenses and frames are available once every 24 months. A list of VSP providers can be found at www.vsp.com or www.yourmedicalbenefits.com. It is important to go to VSP providers, not Aetna, to get the best vision coverage. A plan summary is attached.

DENTAL INSURANCE: Met Life Dental Plan. This plan covers preventive care at 100%, restorative at 80% and major at 50%. There is a calendar year deductible of $50 per person which is waived for preventive benefits. The annual maximum is $2,000 per year. You may use the dentist of your choice, however, your out-of-pocket costs will almost always be lower if you use a preferred dentist. A plan summary is attached. Preferred dentists can be found at www.yourmedicalbenefits.com, or www.metlife.com.

LIFE INSURANCE: Aetna. Each employee enrolled in the medical plan will also receive $20,000 of group life and accidental death & dismemberment insurance. This policy pays $40,000 if death results from an accident.

VOLUNTARY LIFE INSURANCE: Dearborn National. Employees can purchase between $10,000 and $500,000 of voluntary life insurance. If you would like to enroll in the voluntary life plan for the first time, or increase your amount of life insurance please see you plan administrator for an enrollment form and health statement.

AETNA EMPLOYEE ASSISTANCE PLAN (EAP): This free service gives you free 24 hour access to nurses, counselors, attorneys and financial consultants to answer your questions or direct you to resources for your personal, legal or financial concerns.

SECTION 125 PLAN: Section 125 of the Internal Revenue Code allows employer to set up a plan that allows you to pay for you and your dependents portion of medical and dental premiums on a tax-free basis. The premium amount is deducted from the payroll before taxes are figured…so you use your money tax-free. A brief summary of how this works is attached. Participation is voluntary. All employees will be automatically enrolled in the Section 125 plan.
If you do not wish to have your dependent premiums taken on a pre-tax basis, you must notify your plan administrator within 30 days of the date you are eligible.

ELIGIBILITY: All employees working a minimum of 32 hours per week are eligible for coverage effective the first of the month following 90 days of employment.

COSTS: Allied Steel will pay $306.70 toward the employee premium for the medical, dental and vision plans. This is an annual cost of $3,680.40 per employee. At your option and expense you may elect to enroll your eligible dependents. Costs are outlined below. *The Child(ren) rates includes all unmarried dependent children to age 26.*

	Medical/Vision/Dental Value $1,000 Weekly Deduction	**Medical/Vision/Dental Saver $2,500 Weekly Deduction**	**Medical/Vision/Dental HSA $1,500 Weekly Deduction**
Employee	$30.12	$10.05	$26.74
Emp+Spouse	$154.97	$108.81	$134.50
Emp,Sp+Child(ren)	$209.30	$154.38	$183.07
Emp+Child	$97.73	$64.96	$86.04
Emp+Child(ren)	$97.77	$65.00	$86.08

The above summary is an overview only and is not a guarantee of benefits. For complete description of benefits and limitations see your benefit book.

FOR FURTHER INFORMATION feel free to contact any of the following:

Nancy Exe……..……..(425) 861-9558 X 230
Allied Steel Employee Benefit Website…..……...www.yourmedicalbenefits.com
Maddock & Associates…….....(800) 875-4490
Maddock & Associates Website…….……..www.medicalbenefits.com
Aetna ……..(800) 756-7039
Aetna website……www.aetna.com
Met Life Claims……..(800) 275-4638
Met Life Website……www.metlife.com
Vision Service Plan…….(800) 877-7195
Vision Service Website…….....www.vsp.com
Key Bank HSA – Kim Bao…….(425)313-3608

The above summary is an overview only and is not a guarantee of benefits. For complete description of benefits and limitations see your benefit book.

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GROUP MEDICAL COMPARISON FOR
ALLIED STEEL FABRICATORS,, INC.

CARRIER	CEHIT Aetna Value $1,000/80		CEHIT Aetna Saver $2,500/70		CEHIT Aetna HSA $1,500/80*	
COST SHARES	**In Network**	**Out of Network**	**In Network**	**Out of Network**	**In Network**	**Out of Network**
HSA Contribution	None		None		**$43.34/ Month ($,520/Year)**	
Deductible (Calendar Year)	$1,000/Person	$2,000/Person	$2,500/Person	5,000/Person	$1,500/Single Plan $3,000/Family Plan	$3,000/Single Plan $6,000/Family Plan
Coinsurance	80%	50%	70%	50%	80%	50%
Coinsurance Maximum (Excludes Deductible)	$4,000/Person N/A	$8,000/Person N/A	$5,000/Person N/A	Unlimited N/A	$2,000/Single Plan $4,000/Family Plan	$3,000/Single Plan $6,000/Family Plan
Office Visit Copays	$35 Copay	N/A	$15 Copay	N/A	N/A	N/A
Lifetime Limit	Unlimited		Unlimited		Unlimited	
PRESCRIPTIONS	**Aetna In Network Services**		**Aetna In Network Services**		**Aetna In Network Services**	
Generic	$20 Copay		$20 Copay		Deductible, then $20 Copay	
Preferred Brand	$40 Copay		$40 Copay		Deductible, then $40 Copay	
Non Preferred Brand	$70 Copay		$70 Copay		Deductible, then $70 Copay	
Specialty	N/A		N/A		N/A	
Mail-Order (90 day supply)	2 times pharmacy cost		2 times pharmacy cost		2 times pharmacy cost	
PROFESSIONAL CARE	**Aetna In Network Services**		**Aetna In Network Services**		**Aetna In Network Services**	
Preventive Office Visit	100%, Deductible Waived		100%, Deductible Waived		100%, Deductible Waived	
Physician Office Visits	Copay, DW,1st 4 vsts/yr, then Deduc & Coins		Copay, DW for Primary / 70% for Specialist		80%	
Mental Health	Same as Physician Office Visit		100%, DW (med mgmnt same as Specialist)		80%	
Chiropractic	Copay, Deductible Waived, 12 visits per year		Copay, Deductible Waived, 12 visits per year		80%, 12 visits per year	
Acupuncutre	Copay, Deductible Waived, 12 visits per year		Copay, Deductible Waived, 12 visits per year		80%, 12 visits per year	
Massage Therapy	80%, 30 visits per year (cmbnd rehabilitaion)		70%, 30 visits per year (cmbnd rehabilitaion)		80%, 30 visits per year (cmbnd rehabilitaion)	
DIAGNOSTIC CARE	**Aetna In Network Services**		**Aetna In Network Services**		**Aetna In Network Services**	
Lab & Xray	Copay, DW for Basic / 80% for Complex		Copay, DW for Basic / 70% for Complex		80%	
Preventive Mammography	100%, Deductible Waived		100%, Deductible Waived		100%, Deductible Waived	
Preventive Screening	100%, Deductible Waived		100%, Deductible Waived		100%, Deductible Waived	
FACILITY CARE	**Aetna In Network Services**		**Aetna In Network Services**		**Aetna In Network Services**	
Hospital	80%		70%		80%	
Emergency Room Copay	80%		70%		80%	
OTHER BENEFITS						
Life Insurance	**$20,000**					
Vision	**VSP - Exam every 12 months, lenses & frames every 24 months**					
Dental	**Met Life - $50 Deductible Waived for Preventive - 100% Preventive/80% Basic/50% Major**					

The above is a summary description of benefits. For complete details and limitations, see company brochure.

***HSA $1500 - If you are insuring dependents the entire $3,000 Family Deductible must be met before benefits are paid.**

Rates	*Weekly Costs*	*Weekly Cost*	*Weekly Cost*
Employee	$30.12	$10.05	$26.74
Emp +Spouse	$154.97	$108.81	$134.50
Emp,Spouse & Child(ren)	$209.30	$154.38	$183.07
Emp + Child	$97.73	$64.96	$86.04
Emp + Children	$97.77	$65.00	$86.08

aetna℠

Washington PPO
Cascade Employers Health Insurance Trust
Plan Effective Date: 08/01/2012

PPO Value $1,000 80/50 $35 (4-visit limit) (08/12)

PLAN FEATURES	IN-NETWORK	OUT-OF-NETWORK
Deductible (per calendar year)	$1,000 Per Member	$2,000 Per Member
Unless otherwise indicated, the Deductible must be met prior to benefits being payable. Member cost sharing for certain services, including member cost sharing for prescription drugs, as indicated in the plan, are excluded from charges to meet the Deductible. All covered expenses accumulate separately toward the preferred and non-preferred Deductible.		
Member Coinsurance (applies to all expenses unless otherwise stated)	20%	50%
Payment Limit (per calendar year, excludes deductible)	$4,000 Per Member	$8,000 Per Member
All covered expenses accumulate separately toward the preferred and non-preferred Payment Limit. Certain member cost sharing elements may not apply toward the Payment Limit. Amounts over allowable, copays, failure to precertify penalty, Rx (including self-injectables), emergency/urgent care and DME do not apply to the Payment Limit and continue to be payable after the maximum is reached.		
Lifetime Maximum (per member lifetime)	Unlimited	
Payment for Out-of-Network Care	Not Applicable	Professional: Aetna Market Fee Schedule* Facility: Aetna Facility Fee Schedule*
Primary Care Physician Selection	Not Applicable	Not Applicable
Referral Requirement	None	None
Certification Requirements Certification for certain types of Non-Preferred care must be obtained to avoid a reduction in benefits paid for that care. Certification for Hospital Admissions, Treatment Facility Admissions, Convalescent Facility Admissions, Home Health Care, and Hospice Care is required. Benefits will be reduced by $400 per occurrence if Certification is not obtained.		
PHYSICIAN SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Office Visits to Physicians	$35 copay; deductible waived	50% after deductible
The first four office visits per member per calendar year are paid with a copay for all types of visits combined (primary physician, specialist physician, etc). Any visits over this limit are covered at plan deductible and coinsurance. The four visit limit does not apply to preventive care or benefits that have their own limit.		
E-Visits to Physicians	$10 copay; deductible waived	Not Covered
An E-visit is an online internet consultation between a physician and an established patient about a non-emergency healthcare matter. This visit must be conducted through an Aetna authorized internet E-visit service vendor. Register at www.relayhealth.com.		
Pre-Natal Maternity	$0 copay; deductible waived	50% after deductible
Maternity - Delivery and Post-Partum Care	20% after deductible	50% after deductible
Walk-in Clinics	$35 copay; deductible waived	Not Covered

PPO Value $1,000 80/50 $35 (4-visit limit) (08/12)

Walk-in Clinics are network, free-standing healthcare facilities. They are an alternative to a physician's office visit for treatment of unscheduled, non-emergency illnesses and injuries and the administration of certain immunizations. It is not an alternative for emergency room services or the ongoing care provided by a physician. Neither an emergency room, nor an outpatient department of a hospital, shall be considered a Walk-in Clinic.		
Surgery (in physician's office)	20% after deductible	50% after deductible
Allergy Testing (given by a physician)	20% after deductible	50% after deductible
Allergy Treatment/Injections (not given by a physician)	20% after deductible	50% after deductible
PREVENTIVE CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Routine Adult Physical Exams / Immunizations Age and frequency schedules may apply.	$0 copay; deductible waived	50% after deductible
Well Child Exams / Immunizations Age and frequency schedules may apply	$0 copay; deductible waived	50% after deductible
Routine Gynecological Exams Includes Pap smear and related lab fees. Frequency schedule applies.	$0 copay; deductible waived	50% after deductible
Routine Mammograms For covered females age 40 and over or as recommended by provider. Frequency schedule applies.	$0 copay; deductible waived	50% after deductible
Women's Health Includes: Screening for gestational diabetes; HPV (Human Papillomavirus) DNA testing, counseling for sexually transmitted infections; counseling and screening for human immunodeficiency virus; screening and counseling for interpersonal and domestic violence; breastfeeding support, supplies and counseling; and contraceptive methods and counseling. Limitations may apply.	$0 copay; deductible waived	Member cost sharing is based on the type of service performed and the place of service where it is rendered
Routine Digital Rectal Exam	Included in Adult Routine Physical Exam	Included in Adult Routine Physical Exam
Prostate-Specific Antigen Test For covered males age 40 and over or as recommended by provider. Frequency schedule applies.	$0 copay; deductible waived	50% after deductible

Colorectal Cancer Screening For all members age 40 and over. Fecal Occult Blood Test (one per 12-month period), Sigmoidoscopy (one test per consecutive five year period), Double Contrast Barium Enema (one test per consecutive five year period). Preferred and Non-Preferred combined.	0%; deductible waived	50% after deductible
Colonoscopy for Members Age 50 and Over Limited to one colonoscopy every 10 consecutive year period. Preferred and Non-Preferred combined.	0%; deductible waived	50% after deductible
Colonoscopy for Members Up to Age 50	20% after deductible	50% after deductible
Routine Eye and Hearing Exams Covered only as a part of a routine physical.	Paid as part of a routine physical.	Paid as part of a routine physical.
DIAGNOSTIC PROCEDURES	**IN-NETWORK**	**OUT-OF-NETWORK**
Outpatient Diagnostic Laboratory and X-ray [except for Complex Imaging Services]	$35 copay; deductible waived	50% after deductible
Outpatient Complex Imaging Services Precertification required. Including, but not limited to, MRI, MRA, PET and CT Scans	20% after deductible	50% after deductible
EMERGENCY MEDICAL CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Urgent Care Provider	$50 copay; deductible waived	$50 copay; deductible waived
Non-Urgent Use of Urgent Care Provider	Not Covered	Not Covered
Emergency Room	20% after deductible	Paid as Preferred Care
Non-Emergency care in an Emergency Room	Not Covered	Not Covered
Emergency Ambulance	20% after deductible	Paid as Preferred Care
HOSPITAL CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient Coverage Including maternity	20% after deductible	50% after deductible
Transplants Precertification required. Transplants must be performed through an Institutes of Excellence or a National Medical Excellence Facility and are limited to $350,000 per member per lifetime.	20% after deductible	Not Covered
Outpatient Surgery Provided in an outpatient hospital department or a freestanding surgical facility.	20% after deductible	50% after deductible

PPO Value $1,000 80/50 $35 (4-visit limit) (08/12)

Outpatient Hospital Services other than Surgery Including but not limited to lab, x-ray, physical therapy, speech therapy, occupational therapy, spinal manipulation, dialysis and radiation therapy.	20% after deductible	50% after deductible

PPO Value $1,000 80/50 $35 (4-visit limit) (08/12)

MENTAL HEALTH SERVICES	IN-NETWORK	OUT-OF-NETWORK
Inpatient Mental Health	20% after deductible	50% after deductible
Outpatient Mental Health	$35 copay; deductible waived	50% after deductible
Residential Treatment Centers	20% after deductible	50% after deductible
ALCOHOL / DRUG ABUSE SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient Detoxification	20% after deductible	50% after deductible
Outpatient Detoxification	$35 copay; deductible waived	50% after deductible
Inpatient Rehabilitation	20% after deductible	50% after deductible
Outpatient Rehabilitation	$35 copay; deductible waived	50% after deductible
OTHER SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Skilled Nursing Facility Limited to 90 days per member per calendar year. Preferred and Non-Preferred combined.	20% after deductible	50% after deductible
Home Health Care Limited to 130 visits per member per calendar year. Preferred and Non-Preferred combined; 1 visit equals a period of 4 hours or less.	20% after deductible	50% after deductible
Infusion Therapy Provided in the home or physician's office	$35 copay; deductible waived	50% after deductible
Infusion Therapy Provided in an outpatient hospital department or freestanding facility	20% after deductible	50% after deductible
Inpatient & Outpatient Hospice Care	20% after deductible	50% after deductible
Outpatient Speech Therapy Limited to 20 visits per member per calendar year. Preferred and Non-Preferred combined.	20% after deductible	50% after deductible
Outpatient Physical, Occupational and Massage Therapy Limited to 30 visits per member per calendar year. Preferred and Non-Preferred combined.	20% after deductible	50% after deductible
Outpatient Chiropractic Therapy Limited to 12 visits per member per calendar year. Preferred and Non-Preferred combined	$35 copay; deductible waived	50% after deductible
Neurodevelopment Therapy For children age 6 and under. Limited to $1,500 per member per calendar year. Preferred and Non-Preferred combined.	20% after deductible	50% after deductible

Acupuncture Limited to 12 visits per member per calendar year. Preferred and Non-Preferred combined	$35 copay; deductible waived	50% after deductible
Jaw Joint Disorder Treatment (TMJ) Limited to $1,000 per member per calendar year; $5,000 lifetime maximum. Preferred and Non-Preferred combined.	20% after deductible	50% after deductible
Durable Medical Equipment Maximum benefit of $3,000 per member per calendar year. Preferred and Non-Preferred combined.	50% after deductible	50% after deductible
Diabetic Supplies not obtainable at a pharmacy	Covered same as any other medical expense	Covered same as any other medical expense
FAMILY PLANNING	**IN-NETWORK**	**OUT-OF-NETWORK**
Infertility Treatment Covered only for the diagnosis and surgical treatment of the underlying medical condition	Member cost sharing is based on the type of service performed and the place rendered	Member cost sharing is based on the type of service performed and the place rendered
Voluntary Sterilization - Vasectomy	Member cost sharing is based on the type of service performed and the place rendered	Member cost sharing is based on the type of service performed and the place rendered
Voluntary Sterilization - Tubal Ligation	0%; deductible waived	50% after deductible
PHARMACY - PRESCRIPTION DRUG BENEFITS	**PARTICIPATING PHARMACIES**	**NON-PARTICIPATING PHARMACIES**
Retail Up to a 30-day supply	$20 copay for generic drugs, $40 copay for brand name formulary drugs, and $70 copay for brand name non-formulary drugs	Not Covered
Mail Order Delivery 31-90 day supply	$40 copay for generic drugs, $80 copay for brand name formulary drugs, and $140 copay for brand name non-formulary drugs	Not Covered
Self-Injectables	Included in Pharmacy Plan. Must use Aetna Specialty Pharmacy Network.	Not Covered
Mandatory Generic with DAW override (MG w/DAW Override) - The member pays the applicable copay only, if the physician requires brand. If the member requests brand when a generic is available, the member pays the applicable copay plus the difference between the generic price and the brand price.		
Plan includes: Contraceptive drugs and devices obtainable from a pharmacy and diabetic supplies obtainable from a pharmacy.		

Plan excludes: Lifestyle/performance drugs
Precertification included and 90 day Transition of Care (TOC) for Precertification.
Formulary generic FDA-approved Women's Contraceptives covered 100% in network.

*Members may choose providers in our network (physicians and facilities) or may visit an out-of-network provider. Typically, members will pay substantially more money out of their own pocket if they choose to use an out-of-network doctor. The out-of-network provider will be paid based on Aetna's "recognized" charge". This is not the same as the billed charge from the doctor.

Aetna pays a percentage of the recognized charge, as defined in the member's plan. The member may have to pay the difference between the out-of-network provider's billed charge and Aetna's recognized charge, plus any coinsurance and deductibles due under the plan. Note that any amount the doctor bills the member above Aetna's recognized charge does not count toward the member's deductible or out-of-pocket maximums.
For out-of-network physicians and other out-of-network providers, the recognized charge is based on the Aetna Market Fee Schedule (also referred to as Aetna Out-of-Network Rates), which are Aetna's standard rates used to begin contract negotiations with providers who participate in our network. Since not all network doctors contract at standard rates, our payment to an out-of-network provider may be based on rates lower than we pay to providers in our network. For out-of-network hospitals and other out-of-network facilities the recognized charge is based on the Aetna Facility Fee Schedule.
This benefit applies when members choose to get care out-of-network. When members have no choice in the in the doctors they see (for example, an emergency room visit after a car accident), their deductible and coinsurance for the in-network level of benefits will be applied, and they should contact Aetna if their doctor asks them to pay more.

What's Not Covered

This plan does not cover all health care expenses and includes exclusions and limitations. Members should refer to their plan documents 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 documents may contain exceptions to this list based on state mandates or the plan design or rider(s) purchased.**

All medical or hospital services not specifically covered in, or which are limited or excluded in the plan documents;
Charges related to any eye surgery mainly to correct refractive errors;
Cosmetic surgery, including breast reduction;
Custodial care;
Dental care and X-rays;
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 such as IVF, ZIFT, GIFT, ICSA and other related services, unless specifically listed as covered in your plan documents;
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 and/or private nursing; and

Weight control services including surgical procedures, medical treatments, weight control/loss programs, dietary regimens and supplements, appetite suppressants and other medications; food or food supplements, exercise programs, excursive or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity, including Morbid Obesity, or for the purpose of weight reduction, regardless of the existence of comorbid conditions.

Pre-existing Conditions Exclusion Provision

This plan imposes a pre-existing conditions exclusion, which may be waived in some circumstances (that is, creditable coverage) and may not be applicable to you. A pre-existing conditions exclusion means that if you have a medical condition before coming to our plan, you might have to wait a certain period of time before the plan will provide coverage for that condition. This exclusion applies only to conditions for which medical advice, diagnosis or treatment was recommended or received or for which the individual took prescribed drugs within three months.

Generally, this period ends the day before your coverage becomes effective. However, if you were in a waiting period for coverage, the three month period ends on the day before the waiting period begins. The exclusion period, if applicable, may last up to three months from your first day of coverage, or, if you were in a waiting period, from the first day of your waiting period.

If you had less than three-months of creditable coverage immediately before the date you enrolled, your plan's pre-existing conditions exclusion period will be reduced by the amount (that is, number of days) of that prior coverage.

If you had no prior creditable coverage within the three-months prior to your enrollment date (either because you had no prior coverage or because there was more than a three-month gap from the date your prior coverage terminated to your enrollment date), we will apply your plan's pre-existing conditions exclusion.

In order to reduce or possibly eliminate your exclusion period based on your creditable coverage, you should provide us a copy of any Certificates of Creditable Coverage you have. Please contact your Aetna Member Services representative at 1-888-802-3862 if you need assistance in obtaining a Certificate of Creditable Coverage from your prior carrier or if you have any questions on the information noted above.

The pre-existing condition exclusion does not apply to pregnancy nor to children up to age 19. Note: For late enrollees, coverage will be delayed until the plan's next open enrollment unless the enrollee qualifies for a special enrollment period; the pre-existing exclusion, if applicable, will be applied from the individual's effective date of coverage.

This material is for informational purposes only and is not an offer or invitation to contract. An application must be completed to obtain coverage. Plan features and availability may vary by location and group size. Not all heath services are covered. See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Plan features are subject to change. With the exception of Aetna Rx Home Delivery, 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.

Certain services require precertification, or prior approval of coverage. Failure to precertify for these services may lead to substantially reduced benefits or denial of coverage. Some of the benefits requiring precertification may include, but are not limited to, inpatient hospital, inpatient mental health, inpatient skilled nursing, outpatient surgery, substance abuse (detoxification, inpatient and outpatient rehabilitation). When the Member's preferred provider is coordinating care, the preferred provider will obtain the precertification. Precertification requirements may vary.

If your plan covers outpatient prescription drugs, your plan may include a drug formulary (preferred drug list). A formulary is a list of prescription drugs generally covered under your prescription drug benefits plan on a preferred basis subject to applicable limitations and conditions. Your pharmacy benefit is generally not limited to the drugs listed on the formulary. The medications listed on the formulary are subject to change in accordance with applicable state law. For information regarding how medications are reviewed and selected for the formulary, formulary information, and information about other pharmacy programs such as precertification and step-therapy, please refer to Aetna's website at Aetna.com, or the Aetna Medication Formulary Guide. 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. In addition, in circumstances where your prescription plan utilizes copayments or coinsurance calculated on a percentage basis or a deductible, use of formulary drugs may not necessarily result in lower costs for the member. Members should consult with their treating physicians regarding questions about specific medications. Refer to your plan documents or contact Member Services for information regarding the terms and limitations of coverage.

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

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aetna℠

Washington PPO
Cascade Employers Health Insurance Trust
Plan Effective Date: 08/01/2012

PPO Saver $2,500 70/50 (08/12)

PLAN FEATURES	IN-NETWORK	OUT-OF-NETWORK
Deductible (per calendar year)	$2,500 Per Member	$5,000 Per Member
Unless otherwise indicated, the Deductible must be met prior to benefits being payable. Member cost sharing for certain services, including member cost sharing for prescription drugs, as indicated in the plan, are excluded from charges to meet the Deductible. All covered expenses accumulate separately toward the preferred and non-preferred Deductible.		
Member Coinsurance (applies to all expenses unless otherwise stated)	30%	50%
Payment Limit (per calendar year, excludes deductible)	$5,000 Per Member	Unlimited
All covered expenses accumulate separately toward the preferred and non-preferred Payment Limit. Certain member cost sharing elements may not apply toward the Payment Limit. Amounts over allowable, copays, failure to precertify penalty, Rx (including self-injectables), emergency/urgent care and DME do not apply to the Payment Limit and continue to be payable after the maximum is reached.		
Lifetime Maximum (per member lifetime)	Unlimited	
Payment for Out-of-Network Care	Not Applicable	Professional: Aetna Market Fee Schedule* Facility: Aetna Facility Fee Schedule*
Primary Care Physician Selection	Not Applicable	Not Applicable
Referral Requirement	None	None
Certification Requirements Certification for certain types of Non-Preferred care must be obtained to avoid a reduction in benefits paid for that care. Certification for Hospital Admissions, Treatment Facility Admissions, Convalescent Facility Admissions, Home Health Care, and Hospice Care is required. Benefits will be reduced by $400 per occurrence if Certification is not obtained.		
PHYSICIAN SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Office Visits to Non-Specialist Physicians	$15 copay; deductible waived	50% after deductible
Office Visits Specialist Physicians	30% after deductible	50% after deductible
E-Visits to Physicians	$10 copay; deductible waived	Not Covered
An E-visit is an online internet consultation between a physician and an established patient about a non-emergency healthcare matter. This visit must be conducted through an Aetna authorized internet E-visit service vendor. Register at www.relayhealth.com.		
Pre-Natal Maternity	$0 copay; deductible waived	50% after deductible
Maternity - Delivery and Post-Partum Care	30% after deductible	50% after deductible

PPO Saver $2,500 70/50 (08/12)

Walk-in Clinics	$15 copay; deductible waived	Not Covered
Walk-in Clinics are network, free-standing healthcare facilities. They are an alternative to a physician's office visit for treatment of unscheduled, non-emergency illnesses and injuries and the administration of certain immunizations. It is not an alternative for emergency room services or the ongoing care provided by a physician. Neither an emergency room, nor an outpatient department of a hospital, shall be considered a Walk-in Clinic.		
Surgery (in physician's office)	30% after deductible	50% after deductible
Allergy Testing (given by a physician)	30% after deductible	50% after deductible
Allergy Treatment/Injections (not given by a physician)	30% after deductible	50% after deductible
PREVENTIVE CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Routine Adult Physical Exams / Immunizations Age and frequency schedules may apply.	$0 copay; deductible waived	50% after deductible
Well Child Exams / Immunizations Age and frequency schedules may apply	$0 copay; deductible waived	50% after deductible
Routine Gynecological Exams Includes Pap smear and related lab fees. Frequency schedule applies.	$0 copay; deductible waived	50% after deductible
Routine Mammograms For covered females age 40 and over or as recommended by provider. Frequency schedule applies.	$0 copay; deductible waived	50% after deductible
Women's Health Includes: Screening for gestational diabetes; HPV (Human Papillomavirus) DNA testing, counseling for sexually transmitted infections; counseling and screening for human immunodeficiency virus; screening and counseling for interpersonal and domestic violence; breastfeeding support, supplies and counseling; and contraceptive methods and counseling. Limitations may apply.	$0 copay; deductible waived	Member cost sharing is based on the type of service performed and the place of service where it is rendered
Routine Digital Rectal Exam	Included in Adult Routine Physical Exam	Included in Adult Routine Physical Exam
Prostate-Specific Antigen Test For covered males age 40 and over or as recommended by provider. Frequency schedule applies.	$0 copay; deductible waived	50% after deductible

PPO Saver $2,500 70/50 (08/12)

Colorectal Cancer Screening For all members age 40 and over. Fecal Occult Blood Test (one per 12-month period), Sigmoidoscopy (one test per consecutive five year period), Double Contrast Barium Enema (one test per consecutive five year period). Preferred and Non-Preferred combined.	0%; deductible waived	50% after deductible
Colonoscopy for Members Age 50 and Over Limited to one colonoscopy every 10 consecutive year period. Preferred and Non-Preferred combined.	0%; deductible waived	50% after deductible
Colonoscopy for Members Up to Age 50	30% after deductible	50% after deductible
Routine Eye and Hearing Exams Covered only as a part of a routine physical.	Paid as part of a routine physical.	Paid as part of a routine physical.
DIAGNOSTIC PROCEDURES	**IN-NETWORK**	**OUT-OF-NETWORK**
Outpatient Diagnostic Laboratory and X-ray [except for Complex Imaging Services]	$15 copay; deductible waived	50% after deductible
Outpatient Complex Imaging Services Precertification required. Including, but not limited to, MRI, MRA, PET and CT Scans	30% after deductible	50% after deductible
EMERGENCY MEDICAL CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Urgent Care Provider	$50 copay; deductible waived	$50 copay; deductible waived
Non-Urgent Use of Urgent Care Provider	Not Covered	Not Covered
Emergency Room	30% after deductible	Paid as Preferred Care
Non-Emergency care in an Emergency Room	Not Covered	Not Covered
Emergency Ambulance	30% after deductible	Paid as Preferred Care
HOSPITAL CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient Coverage Including maternity	30% after deductible	50% after deductible
Transplants Precertification required. Transplants must be performed through an Institutes of Excellence or a National Medical Excellence Facility and are limited to $350,000 per member per lifetime.	30% after deductible	Not Covered
Outpatient Surgery Provided in an outpatient hospital department or a freestanding surgical facility.	30% after deductible	50% after deductible

PPO Saver $2,500 70/50 (08/12)

Outpatient Hospital Services other than Surgery Including but not limited to lab, x-ray, physical therapy, speech therapy, occupational therapy, spinal manipulation, dialysis and radiation therapy.	30% after deductible	50% after deductible
MENTAL HEALTH SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient Mental Health	30% after deductible	50% after deductible
Outpatient Mental Health	$0 copay; deductible waived	50% after deductible
Residential Treatment Centers	30% after deductible	50% after deductible
ALCOHOL / DRUG ABUSE SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient Detoxification	30% after deductible	50% after deductible
Outpatient Detoxification	$0 copay; deductible waived	50% after deductible
Inpatient Rehabilitation	30% after deductible	50% after deductible
Outpatient Rehabilitation	$0 copay; deductible waived	50% after deductible
OTHER SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Skilled Nursing Facility Limited to 90 days per member per calendar year. Preferred and Non-Preferred combined.	30% after deductible	50% after deductible
Home Health Care Limited to 130 visits per member per calendar year. Preferred and Non-Preferred combined; 1 visit equals a period of 4 hours or less.	30% after deductible	50% after deductible
Infusion Therapy Provided in the home or physician's office	30% after deductible	50% after deductible
Infusion Therapy Provided in an outpatient hospital department or freestanding facility	30% after deductible	50% after deductible
Inpatient & Outpatient Hospice Care	30% after deductible	50% after deductible
Outpatient Speech Therapy Limited to 20 visits per member per calendar year. Preferred and Non-Preferred combined.	30% after deductible	50% after deductible
Outpatient Physical, Occupational and Massage Therapy Limited to 30 visits per member per calendar year. Preferred and Non-Preferred combined.	30% after deductible	50% after deductible

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Outpatient Chiropractic Therapy Limited to 12 visits per member per calendar year. Preferred and Non-Preferred combined	$15 copay; deductible waived	50% after deductible
Neurodevelopment Therapy For children age 6 and under. Limited to $1,500 per member per calendar year. Preferred and Non-Preferred combined.	30% after deductible	50% after deductible
Acupuncture Limited to 12 visits per member per calendar year. Preferred and Non-Preferred combined	$15 copay; deductible waived	50% after deductible
Jaw Joint Disorder Treatment (TMJ) Limited to $1,000 per member per calendar year; $5,000 lifetime maximum. Preferred and Non-Preferred combined.	30% after deductible	50% after deductible
Durable Medical Equipment Maximum benefit of $3,000 per member per calendar year. Preferred and Non-Preferred combined.	50% after deductible	50% after deductible
Diabetic Supplies not obtainable at a pharmacy	Covered same as any other medical expense	Covered same as any other medical expense
FAMILY PLANNING	**IN-NETWORK**	**OUT-OF-NETWORK**
Infertility Treatment Covered only for the diagnosis and surgical treatment of the underlying medical condition	Member cost sharing is based on the type of service performed and the place rendered	Member cost sharing is based on the type of service performed and the place rendered
Voluntary Sterilization - Vasectomy	Member cost sharing is based on the type of service performed and the place rendered	Member cost sharing is based on the type of service performed and the place rendered
Voluntary Sterilization - Tubal Ligation	0%; deductible waived	50% after deductible
PHARMACY - PRESCRIPTION DRUG BENEFITS	**PARTICIPATING PHARMACIES**	**NON-PARTICIPATING PHARMACIES**
Retail Up to a 30-day supply	$20 copay for generic drugs, $40 copay for brand name formulary drugs, and $70 copay for brand name non-formulary drugs	Not Covered
Mail Order Delivery 31-90 day supply	$40 copay for generic drugs, $80 copay for brand name formulary drugs, and $140 copay for brand name non-formulary drugs	Not Covered

Self-Injectables	Included in Pharmacy Plan. Must use Aetna Specialty Pharmacy Network.	Not Covered
Mandatory Generic with DAW override (MG w/DAW Override) - The member pays the applicable copay only, if the physician requires brand. If the member requests brand when a generic is available, the member pays the applicable copay plus the difference between the generic price and the brand price.		
Plan includes: Contraceptive drugs and devices obtainable from a pharmacy and diabetic supplies obtainable from a pharmacy.		
Plan excludes: Lifestyle/performance drugs		
Precertification included and 90 day Transition of Care (TOC) for Precertification.		
Formulary generic FDA-approved Women's Contraceptives covered 100% in network.		

*Members may choose providers in our network (physicians and facilities) or may visit an out-of-network provider. Typically, members will pay substantially more money out of their own pocket if they choose to use an out-of-network doctor. The out-of-network provider will be paid based on Aetna's "recognized" charge". This is not the same as the billed charge from the doctor.

Aetna pays a percentage of the recognized charge, as defined in the member's plan. The member may have to pay the difference between the out-of-network provider's billed charge and Aetna's recognized charge, plus any coinsurance and deductibles due under the plan. Note that any amount the doctor bills the member above Aetna's recognized charge does not count toward the member's deductible or out-of-pocket maximums.

For out-of-network physicians and other out-of-network providers, the recognized charge is based on the Aetna Market Fee Schedule (also referred to as Aetna Out-of-Network Rates), which are Aetna's standard rates used to begin contract negotiations with providers who participate in our network. Since not all network doctors contract at standard rates, our payment to an out-of-network provider may be based on rates lower than we pay to providers in our network. For out-of-network hospitals and other out-of-network facilities the recognized charge is based on the Aetna Facility Fee Schedule.

This benefit applies when members choose to get care out-of-network. When members have no choice in the in the doctors they see (for example, an emergency room visit after a car accident), their deductible and coinsurance for the in-network level of benefits will be applied, and they should contact Aetna if their doctor asks them to pay more.

What's Not Covered

This plan does not cover all health care expenses and includes exclusions and limitations. Members should refer to their plan documents 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 documents may contain exceptions to this list based on state mandates or the plan design or rider(s) purchased.**

All medical or hospital services not specifically covered in, or which are limited or excluded in the plan documents;
Charges related to any eye surgery mainly to correct refractive errors;
Cosmetic surgery, including breast reduction;
Custodial care;
Dental care and X-rays;
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 such as IVF, ZIFT, GIFT, ICSA and other related services, unless specifically listed as covered in your plan documents;

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 and/or private nursing; and

Weight control services including surgical procedures, medical treatments, weight control/loss programs, dietary regimens and supplements, appetite suppressants and other medications; food or food supplements, exercise programs, excursive or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity, including Morbid Obesity, or for the purpose of weight reduction, regardless of the existence of comorbid conditions.

Pre-existing Conditions Exclusion Provision

This plan imposes a pre-existing conditions exclusion, which may be waived in some circumstances (that is, creditable coverage) and may not be applicable to you. A pre-existing conditions exclusion means that if you have a medical condition before coming to our plan, you might have to wait a certain period of time before the plan will provide coverage for that condition. This exclusion applies only to conditions for which medical advice, diagnosis or treatment was recommended or received or for which the individual took prescribed drugs within three months.

Generally, this period ends the day before your coverage becomes effective. However, if you were in a waiting period for coverage, the three month period ends on the day before the waiting period begins. The exclusion period, if applicable, may last up to three months from your first day of coverage, or, if you were in a waiting period, from the first day of your waiting period.

If you had less than three-months of creditable coverage immediately before the date you enrolled, your plan's pre-existing conditions exclusion period will be reduced by the amount (that is, number of days) of that prior coverage.

If you had no prior creditable coverage within the three-months prior to your enrollment date (either because you had no prior coverage or because there was more than a three-month gap from the date your prior coverage terminated to your enrollment date), we will apply your plan's pre-existing conditions exclusion.

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Introduction to Health Savings Accounts

A Health Savings Account (HSA) is an account that you can put money into to save for future medical expenses. There are certain advantages to putting money into these accounts, including favorable tax treatment. HSAs were signed into law by President Bush on December 8, 2003.

Advantages of HSAs

Security – Your high deductible insurance and HSA protect you against high or unexpected medical bills.

Affordability – You should be able to lower your health insurance premiums by switching to health insurance coverage with a higher deductible.

Flexibility – You can use the funds in your account to pay for current medical expenses, including expenses that your insurance may not cover, or save the money in your account for future needs, such as:

- Health insurance or medical expenses if unemployed
- Medical expenses after retirement (before Medicare)
- Out-of-pocket expenses when covered by Medicare
- Long-term care expenses and insurance

Savings – You can save the money in your account for future medical expenses and grow your account through investment earnings.

Control – You make all the decisions about:

- How much money to put into the account
- Whether to save the account for future expenses or pay current medical expenses
- Which medical expenses to pay from the account
- Which company will hold the account
- Whether to invest any of the money in the account
- Which investments to make

Portability – Accounts are completely portable, meaning you can keep your HSA even if you:

- Change jobs
- Change your medical coverage
- Become unemployed
- Move to another state
- Change your marital status

Ownership – Funds remain in the account from year to year, just like an IRA. There are no "use it or lose it" rules for HSAs.

Tax Savings – An HSA provides you triple tax savings:
(1) tax deductions when you contribute to your account;
(2) tax-free earnings through investment; and,
(3) tax-free withdrawals for qualified medical expenses.

Who Can Have an HSA

Any adult can contribute to an HSA if they:

- Have coverage under an HSA-qualified "high deductible health plan" (HDHP)
- Have no other first-dollar medical coverage (other types of insurance like specific injury insurance or accident, disability, dental care, vision care, or long-term care insurance are permitted).
- Are not enrolled in Medicare.
- Cannot be claimed as a dependent on someone else's tax return.

Contributions to your HSA can be made by you, your employer, or both. However, the total contributions are limited annually. Contributions are pre-tax is contributed via payroll deduction or tax deductible is contributed directly to the bank. Contributions to the account must stop once you are enrolled in Medicare. However, you can keep the money in your account and use it pay for medical expenses tax-free.

High Deductible Health Plans (HDHPs)

You must have coverage under an HSA-qualified "high deductible health plan" (HDHP) to open and contribute to an HSA. Generally, this is health insurance that does not cover first dollar medical expenses. Federal law requires that the health insurance deductible be at least: 1,200 -- Self-only coverage $2,400 -- Family coverage. Since the minimum deductible increases annual, most insurance companies offer deductibles higher than the minimum.

In general, the deductible must apply to all medical expenses (including prescriptions) covered by the plan. However, plans can pay for "preventive care" services on a first-dollar basis (with or without a co-pay). "Preventive care" can include routine pre-natal and well-child care, child and adult immunizations, annual physicals, mammograms, pap smears, etc.

HSA Contributions

You can make a contribution to your HSA each year that you are eligible. For 2012, you can contribute up to $3,100 Self-only and $6,250 Family.

Catch-Up Contributions

Individuals age 55 and older can also make additional "catch-up" contributions. The maximum annual catch-up contribution is $1,000 per year.

Determining Your Contribution

Your eligibility to contribute to an HSA for each month is generally determined by the whether you have HDHP coverage on the first day of the month. Your maximum contribution for the year is the greater of:
(1) *the full contribution,* or (2) *the pro rated amount.*
The full contribution is the maximum annual contribution for the type of coverage you have on December 1.
The pro rated amount is 1/12 of the maximum annual contribution for the type of HDHP coverage you have times the number of months you have that type of coverage. If your contribution is greater than the pro rated amount, and you fail to remain covered by an HDHP for the entire following year, the extra contribution above the pro rated amount is included in income and subject to an additional 10 percent tax.

Using Your HSA

You can use the money in the account to pay for any "qualified medical expense" permitted under federal tax law. This includes most medical care and services, and dental and vision care, and also includes over-the-counter drugs such as aspirin.

You can generally not use the money to pay for medical insurance premiums, except under specific circumstances, including:

- Any health plan coverage while receiving federal or state unemployment benefits.
- COBRA continuation coverage after leaving employment with a company that offers health insurance coverage.
- Qualified long-term care insurance.
- Medicare premiums and out-of-pocket expenses, including deductibles, co-pays, and coinsurance for: Part A (hospital and inpatient services), Part B (physician and outpatient services), Part C (Medicare HMO and PPO plans), Part D (prescription drugs)

You can use the money in the account to pay for medical expenses of yourself, your spouse, or your dependent children. You can pay for expenses of your spouse and dependent children even if they are not covered by your HDHP.

Using Your HSA (Continued)

Any amounts used for purposes other than to pay for "qualified medical expenses" are taxable as income and subject to an additional 10% tax penalty. The penalty increases to 20% in 2011. Examples include:

- Medical expenses that are not considered "qualified medical expenses" under federal tax law (e.g., cosmetic surgery).
- Other types of health insurance unless specifically described above.
- Medicare supplement insurance premiums.
- Expenses that are not medical or health-related.

After you turn age 65, the 10% additional tax penalty no longer applies. If you become disabled and/or enroll in Medicare, the account can be used for other purposes without paying the additional 10% penalty.

What Happens to My HSA When I Die?

If your spouse becomes the owner of the account, your spouse can use it as if it were their own HSA. If you are not married, the account will no longer be treated as an HSA upon your death. The account will pass to your beneficiary or become part of your estate (and be subject to any applicable taxes).

Opening Your Health Savings Account

It is important that you open your HSA at the same date as you start your high deductible health insurance plan. Expenses incurred prior to you opening your HSA Bank Account do not qualify for tax free HSA reimbursement.

Need More Information about HSAs?

Treasury's web site has additional information about Health Savings Accounts, including answers to frequently asked questions, related IRS forms and publications, technical guidance, and links to other helpful web sites. Treasury's HSA website can be found through www.treas.gov (click on "Health Savings Accounts") or directly at the following address: http://www.treas.gov/offices/public-affairs/hsa/.

HSA Eligible Medical Expenses

An eligible expense is defined as those expenses paid for care as described in **Section 213 (d)** of the Internal Revenue Code. Below are two lists which may help determine whether an expense is eligible.

For more detailed information, please refer to **IRS Publication 502** titled, "Medical and Dental Expenses," Catalog Number 15002Q. Publications can be ordered directly from the IRS by calling 1-800-TAX FORM. If tax advice is required, you should seek the services of a competent professional.

HSA Eligible Medical Expenses

- Abdominal supports
- Abortion
- Acupuncture
- Air conditioner (when necessary for relief from difficulty in breathing)
- Alcoholism treatment
- Ambulance
- Anesthetist
- Arch supports
- Artificial limbs
- Autoette (when used for relief of sickness/disability)
- Birth Control Pills (by prescription)
- Blood tests
- Blood transfusions
- Braces
- Cardiographs
- Chiropractor
- Christian Science Practitioner
- Contact Lenses
- Contraceptive devices (by prescription)
- Convalescent home (for medical treatment only)
- Crutches
- Dental Treatment
- Dental X-rays
- Dentures
- Dermatologist
- Diagnostic fees
- Diathermy
- Drug addiction therapy
- Drugs (prescription)
- Elastic hosiery (prescription)
- Eyeglasses
- Fees paid to health institute prescribed by a doctor
- FICA and FUTA tax paid for medical care service
- Fluoridation unit
- Guide dog
- Gum treatment
- Gynecologist
- Healing services
- Hearing aids and batteries
- Hospital bills
- Hydrotherapy
- Insulin treatment
- Lab tests
- Lead paint removal
- Legal fees
- Lodging (away from home for outpatient care)
- Metabolism tests
- Neurologist
- Nursing (including board and meals)
- Obstetrician
- Operating room costs
- Ophthalmologist
- Optician
- Optometrist
- Oral surgery
- Organ transplant (including donor's expenses)
- Orthopedic shoes
- Orthopedist
- Osteopath
- Oxygen and oxygen equipment
- Pediatrician
- Physician
- Physiotherapist
- Podiatrist
- Postnatal treatments
- Practical nurse for medical services
- Prenatal care
- Prescription medicines
- Psychiatrist
- Psychoanalyst
- Psychologist
- Psychotherapy
- Radium Therapy
- Registered nurse
- Special school costs for the handicapped
- Spinal fluid test
- Splints
- Sterilization
- Surgeon
- Telephone or TV equipment to assist the hard-of-hearing
- Therapy equipment
- Transportation expenses (relative to health care)
- Ultra-violet ray treatment
- Vaccines
- Vasectomy
- Vitamins (if prescribed)
- Wheelchair
- X-rays

HSA Eligible Over-the-Counter Drugs with Prescription*

- Antacids
- Allergy Medications
- Pain Relievers
- Cold medicine
- Anti-diarrhea medicine
- Cough drops and throat lozenges
- Sinus Medications and Nasal sprays
- Nicotine medications and nasal sprays
- Pedialyte
- First aid creams
- Calamine lotion
- Wart removal medication
- Antibiotic ointments
- Suppositories and creams for hemorrhoids
- Sleep aids
- Motion sickness pills

HSA Ineligible Medical Expenses

- Advancement payment for services to be rendered next year
- Athletic Club membership
- Automobile insurance premium allocable to medical coverage
- Boarding school fees
- Bottled Water
- Commuting expenses of a disabled person
- Cosmetic surgery and procedures
- Cosmetics, hygiene products and similar items
- Funeral, cremation, or burial expenses
- Health programs offered by resort hotels, health clubs, and gyms
- Illegal operations and treatments
- Illegally procured drugs
- Maternity clothes
- Non-prescription medication
- Premiums for life insurance, income protection, disability, loss of limbs, sight or similar benefits
- Scientology counseling
- Social activities
- Special foods and beverages
- Specially designed car for the handcapped other than an autoette or special equipment
- Stop-smoking programs
- Swimming pool
- Travel for general health improvement
- Tuition and travel expenses a problem child to a particular school
- Weight loss programs

HSA Ineligible Over-the-Counter Drugs

- Toiletries (including toothpaste)
- Acne treatments
- Lip balm (including Chapstick or Carmex)
- Cosmetics (including face cream and moisturizer)
- Suntan lotion
- Medicated shampoos and soaps
- Vitamins (daily)
- Fiber supplements
- Dietary supplements
- Weight loss drugs for general well being
- Herbs

**** Effective January 1, 2011, you must have a prescription from a Doctor to use your HSA funds tax free to pay for over-the-counter drugs.***

Health insurance may not be purchased with HSA Funds. There are three (3) situations which are exceptions whereby HSA funds can be used to pay for:

1) A health plan during any period of continuation coverage required under any Federal law

2) A qualified long-term care insurance contract

3) A health plan during a period in which the individual is receiving unemployment compensation under any Federal or State Law.

aetna℠

Washington PPO
Cascade Employers Health Insurance Trust
Plan Effective Date: 08/01/2012

PPO HSA HDHP $1,500 80/50 (08/12)

PLAN FEATURES	IN-NETWORK	OUT-OF-NETWORK
Deductible (per calendar year)	$1,500 Individual $3,000 Family	$3,000 Individual $6,000 Family
Unless otherwise indicated, the Deductible must be met prior to benefits being payable. All covered expenses accumulate separately toward the preferred and non-preferred Deductible. The Individual Deductible can only be met when a member is enrolled for self only coverage with no dependent coverage. The Family Deductible can be met by a combination of family members or by any single individual within the family. Once the Family Deductible is met, all family members will be considered as having met their Deductible for the remainder of the calendar year.		
Member Coinsurance (applies to all expenses unless otherwise stated)	20%	50%
Payment Limit (per calendar year, excludes deductible)	$2,000 Individual $4,000 Family	$3,000 Individual $6,000 Family
All covered expenses accumulate separately toward the preferred and non-preferred Payment Limit. Certain member cost sharing elements may not apply toward the Payment Limit. Amounts over allowable and failure to precertify do not apply to the Payment Limit and continue to be payable after the maximum is reached. The Individual Payment Limit can only be met when a member is enrolled for self only coverage with no dependent coverage. The Family Payment Limit can be met by a combination of family members or by any single individual within the family. Once the Family Payment Limit is met, all family members will be considered as having met their Payment Limit for the remainder of the calendar year.		
Lifetime Maximum (per member lifetime)	Unlimited	
Payment for Out-of-Network Care	Not Applicable	Professional: Aetna Market Fee Schedule* Facility: Aetna Facility Fee Schedule*
Primary Care Physician Selection	Not Applicable	Not Applicable
Referral Requirement	None	None
Certification Requirements Certification for certain types of Non-Preferred care must be obtained to avoid a reduction in benefits paid for that care. Certification for Hospital Admissions, Treatment Facility Admissions, Convalescent Facility Admissions, Home Health Care, and Hospice Care is required. Benefits will be reduced by $400 per occurrence if Certification is not obtained.		
PHYSICIAN SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Office Visits to Physicians	20% after deductible	50% after deductible
E-Visits to Physicians	20% after deductible	Not Covered
An E-visit is an online internet consultation between a physician and an established patient about a non-emergency healthcare matter. This visit must be conducted through an Aetna authorized internet E-visit service vendor. Register at www.relayhealth.com.		
Pre-Natal Maternity	$0 copay; deductible waived	50% after deductible
Maternity - Delivery and Post-Partum Care	20% after deductible	50% after deductible

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Walk-in Clinics	20% after deductible	Not Covered
Walk-in Clinics are network, free-standing healthcare facilities. They are an alternative to a physician's office visit for treatment of unscheduled, non-emergency illnesses and injuries and the administration of certain immunizations. It is not an alternative for emergency room services or the ongoing care provided by a physician. Neither an emergency room, nor an outpatient department of a hospital, shall be considered a Walk-in Clinic.		
Surgery (in physician's office)	20% after deductible	50% after deductible
Allergy Testing (given by a physician)	20% after deductible	50% after deductible
Allergy Treatment/Injections (not given by a physician)	20% after deductible	50% after deductible
PREVENTIVE CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Routine Adult Physical Exams / Immunizations Age and frequency schedules may apply.	$0 copay; deductible waived	50% after deductible
Well Child Exams / Immunizations Age and frequency schedules may apply	$0 copay; deductible waived	50% after deductible
Routine Gynecological Exams Includes Pap smear and related lab fees. Frequency schedule applies.	$0 copay; deductible waived	50% after deductible
Routine Mammograms For covered females age 40 and over or as recommended by provider. Frequency schedule applies.	$0 copay; deductible waived	50% after deductible
Women's Health Includes: Screening for gestational diabetes; HPV (Human Papillomavirus) DNA testing, counseling for sexually transmitted infections; counseling and screening for human immunodeficiency virus; screening and counseling for interpersonal and domestic violence; breastfeeding support, supplies and counseling; and contraceptive methods and counseling. Limitations may apply.	$0 copay; deductible waived	Member cost sharing is based on the type of service performed and the place of service where it is rendered
Routine Digital Rectal Exam	Included in Adult Routine Physical Exam	Included in Adult Routine Physical Exam
Prostate-Specific Antigen Test For covered males age 40 and over or as recommended by provider. Frequency schedule applies.	0%; deductible waived	50% after deductible

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Colorectal Cancer Screening For all members age 40 and over. Fecal Occult Blood Test (one per 12-month period), Sigmoidoscopy (one test per consecutive five year period), Double Contrast Barium Enema (one test per consecutive five year period). Preferred and Non-Preferred combined.	0%; deductible waived	50% after deductible
Colonoscopy for Members Age 50 and Over Limited to one colonoscopy every 10 consecutive year period. Preferred and Non-Preferred combined.	0%; deductible waived	50% after deductible
Colonoscopy for Members Up to Age 50	20% after deductible	50% after deductible
Routine Eye and Hearing Exams Covered only as a part of a routine physical.	Paid as part of a routine physical.	Paid as part of a routine physical.
DIAGNOSTIC PROCEDURES	**IN-NETWORK**	**OUT-OF-NETWORK**
Outpatient Diagnostic Laboratory and X-ray [except for Complex Imaging Services]	20% after deductible	50% after deductible
Outpatient Complex Imaging Services Precertification required. Including, but not limited to, MRI, MRA, PET and CT Scans	20% after deductible	50% after deductible
EMERGENCY MEDICAL CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Urgent Care Provider	20% after deductible	20% after deductible
Non-Urgent Use of Urgent Care Provider	Not Covered	Not Covered
Emergency Room	20% after deductible	Paid as Preferred Care
Non-Emergency care in an Emergency Room	Not Covered	Not Covered
Emergency Ambulance	20% after deductible	Paid as Preferred Care
HOSPITAL CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient Coverage Including maternity	20% after deductible	50% after deductible
Transplants Precertification required. Transplants must be performed through an Institutes of Excellence or a National Medical Excellence Facility and are limited to $350,000 per member per lifetime.	20% after deductible	Not Covered
Outpatient Surgery Provided in an outpatient hospital department or a freestanding surgical facility.	20% after deductible	50% after deductible

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Outpatient Hospital Services other than Surgery Including but not limited to lab, x-ray, physical therapy, speech therapy, occupational therapy, spinal manipulation, dialysis and radiation therapy.	20% after deductible	50% after deductible
MENTAL HEALTH SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient Mental Health	20% after deductible	50% after deductible
Outpatient Mental Health	20% after deductible	50% after deductible
Residential Treatment Centers	20% after deductible	50% after deductible
ALCOHOL / DRUG ABUSE SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient Detoxification	20% after deductible	50% after deductible
Outpatient Detoxification	20% after deductible	50% after deductible
Inpatient Rehabilitation	20% after deductible	50% after deductible
Outpatient Rehabilitation	20% after deductible	50% after deductible
OTHER SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Skilled Nursing Facility Limited to 90 days per member per calendar year. Preferred and Non-Preferred combined.	20% after deductible	50% after deductible
Home Health Care Limited to 130 visits per member per calendar year. Preferred and Non-Preferred combined; 1 visit equals a period of 4 hours or less.	20% after deductible	50% after deductible
Infusion Therapy Provided in the home or physician's office	20% after deductible	50% after deductible
Infusion Therapy Provided in an outpatient hospital department or freestanding facility	20% after deductible	50% after deductible
Inpatient & Outpatient Hospice Care	20% after deductible	50% after deductible
Outpatient Speech Therapy Limited to 20 visits per member per calendar year. Preferred and Non-Preferred combined.	20% after deductible	50% after deductible
Outpatient Physical, Occupational and Massage Therapy Limited to 30 visits per member per calendar year. Preferred and Non-Preferred combined.	20% after deductible	50% after deductible

Outpatient Chiropractic Therapy Limited to 12 visits per member per calendar year. Preferred and Non-Preferred combined	20% after deductible	50% after deductible
Neurodevelopment Therapy For children age 6 and under. Limited to $1,500 per member per calendar year. Preferred and Non-Preferred combined.	20% after deductible	50% after deductible
Acupuncture Limited to 12 visits per member per calendar year. Preferred and Non-Preferred combined	20% after deductible	50% after deductible
Jaw Joint Disorder Treatment (TMJ) Limited to $1,000 per member per calendar year; $5,000 lifetime maximum. Preferred and Non-Preferred combined.	20% after deductible	50% after deductible
Durable Medical Equipment Maximum benefit of $3,000 per member per calendar year. Preferred and Non-Preferred combined.	50% after deductible	50% after deductible
Diabetic Supplies not obtainable at a pharmacy	Covered same as any other medical expense	Covered same as any other medical expense
Contraceptive drugs and devices not obtainable at a pharmacy Includes coverage for contraceptive visits	Covered same as any other medical expense	Covered same as any other medical expense
FAMILY PLANNING	**IN-NETWORK**	**OUT-OF-NETWORK**
Infertility Treatment Covered only for the diagnosis and surgical treatment of the underlying medical condition	Member cost sharing is based on the type of service performed and the place rendered	Member cost sharing is based on the type of service performed and the place rendered
Voluntary Sterilization - Vasectomy	Member cost sharing is based on the type of service performed and the place rendered	Member cost sharing is based on the type of service performed and the place rendered
Voluntary Sterilization - Tubal Ligation	0%; deductible waived	50% after deductible
PHARMACY - PRESCRIPTION DRUG BENEFITS	**PARTICIPATING PHARMACIES**	**NON-PARTICIPATING PHARMACIES**
Prescription drug calendar year deductible (must be satisfied before any prescription drug benefits are paid).	Plan deductible includes prescription drugs and must be met before pharmacy copays apply.	Not Applicable
Retail Up to a 30-day supply	$20 copay for generic drugs, $40 copay for brand name formulary drugs, and $70 copay for brand name non-formulary drugs	Not Covered

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Mail Order Delivery 31-90 day supply	$40 copay for generic drugs, $80 copay for brand name formulary drugs, and $140 copay for brand name non-formulary drugs	Not Covered
Self-Injectables	Included in Pharmacy Plan. Must use Aetna Specialty Pharmacy Network.	Not Covered
Mandatory Generic with DAW override (MG w/DAW Override) - The member pays the applicable copay only, if the physician requires brand. If the member requests brand when a generic is available, the member pays the applicable copay plus the difference between the generic price and the brand price.		
Plan includes: Contraceptive drugs and devices obtainable from a pharmacy and diabetic supplies obtainable from a pharmacy.		
Plan excludes: Lifestyle/performance drugs		
Precertification included and 90 day Transition of Care (TOC) for Precertification.		
Formulary generic FDA-approved Women's Contraceptives covered 100% in network.		

*Members may choose providers in our network (physicians and facilities) or may visit an out-of-network provider. Typically, members will pay substantially more money out of their own pocket if they choose to use an out-of-network doctor. The out-of-network provider will be paid based on Aetna's "recognized" charge". This is not the same as the billed charge from the doctor.

Aetna pays a percentage of the recognized charge, as defined in the member's plan. The member may have to pay the difference between the out-of-network provider's billed charge and Aetna's recognized charge, plus any coinsurance and deductibles due under the plan. Note that any amount the doctor bills the member above Aetna's recognized charge does not count toward the member's deductible or out-of-pocket maximums.

For out-of-network physicians and other out-of-network providers, the recognized charge is based on the Aetna Market Fee Schedule (also referred to as Aetna Out-of-Network Rates), which are Aetna's standard rates used to begin contract negotiations with providers who participate in our network. Since not all network doctors contract at standard rates, our payment to an out-of-network provider may be based on rates lower than we pay to providers in our network. For out-of-network hospitals and other out-of-network facilities the recognized charge is based on the Aetna Facility Fee Schedule.

This benefit applies when members choose to get care out-of-network. When members have no choice in the in the doctors they see (for example, an emergency room visit after a car accident), their deductible and coinsurance for the in-network level of benefits will be applied, and they should contact Aetna if their doctor asks them to pay more.

What's Not Covered

This plan does not cover all health care expenses and includes exclusions and limitations. Members should refer to their plan documents 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 documents may contain exceptions to this list based on state mandates or the plan design or rider(s) purchased.**

All medical or hospital services not specifically covered in, or which are limited or excluded in the plan documents;

Charges related to any eye surgery mainly to correct refractive errors;

Cosmetic surgery, including breast reduction;

Custodial care;

Dental care and X-rays;

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 such as IVF, ZIFT, GIFT, ICSA and other related services, unless specifically listed as covered in your plan documents;

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 and/or private nursing; and

Weight control services including surgical procedures, medical treatments, weight control/loss programs, dietary regimens and supplements, appetite suppressants and other medications; food or food supplements, exercise programs, excursive or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity, including Morbid Obesity, or for the purpose of weight reduction, regardless of the existence of comorbid conditions.

Pre-existing Conditions Exclusion Provision

This plan imposes a pre-existing conditions exclusion, which may be waived in some circumstances (that is, creditable coverage) and may not be applicable to you. A pre-existing conditions exclusion means that if you have a medical condition before coming to our plan, you might have to wait a certain period of time before the plan will provide coverage for that condition. This exclusion applies only to conditions for which medical advice, diagnosis or treatment was recommended or received or for which the individual took prescribed drugs within three months.

Generally, this period ends the day before your coverage becomes effective. However, if you were in a waiting period for coverage, the three month period ends on the day before the waiting period begins. The exclusion period, if applicable, may last up to three months from your first day of coverage, or, if you were in a waiting period, from the first day of your waiting period.

If you had less than three-months of creditable coverage immediately before the date you enrolled, your plan's pre-existing conditions exclusion period will be reduced by the amount (that is, number of days) of that prior coverage.

If you had no prior creditable coverage within the three-months prior to your enrollment date (either because you had no prior coverage or because there was more than a three-month gap from the date your prior coverage terminated to your enrollment date), we will apply your plan's pre-existing conditions exclusion.

In order to reduce or possibly eliminate your exclusion period based on your creditable coverage, you should provide us a copy of any Certificates of Creditable Coverage you have. Please contact your Aetna Member Services representative at 1-888-802-3862 if you need assistance in obtaining a Certificate of Creditable Coverage from your prior carrier or if you have any questions on the information noted above.

The pre-existing condition exclusion does not apply to pregnancy nor to children up to age 19. Note: For late enrollees, coverage will be delayed until the plan's next open enrollment unless the enrollee qualifies for a special enrollment period; the pre-existing exclusion, if applicable, will be applied from the individual's effective date of coverage.

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This material is for informational purposes only and is not an offer or invitation to contract. An application must be completed to obtain coverage. Plan features and availability may vary by location and group size. Not all heath services are covered. See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Plan features are subject to change. With the exception of Aetna Rx Home Delivery, 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.

Certain services require precertification, or prior approval of coverage. Failure to precertify for these services may lead to substantially reduced benefits or denial of coverage. Some of the benefits requiring precertification may include, but are not limited to, inpatient hospital, inpatient mental health, inpatient skilled nursing, outpatient surgery, substance abuse (detoxification, inpatient and outpatient rehabilitation). When the Member's preferred provider is coordinating care, the preferred provider will obtain the precertification. Precertification requirements may vary.

If your plan covers outpatient prescription drugs, your plan may include a drug formulary (preferred drug list). A formulary is a list of prescription drugs generally covered under your prescription drug benefits plan on a preferred basis subject to applicable limitations and conditions. Your pharmacy benefit is generally not limited to the drugs listed on the formulary. The medications listed on the formulary are subject to change in accordance with applicable state law. For information regarding how medications are reviewed and selected for the formulary, formulary information, and information about other pharmacy programs such as precertification and step-therapy, please refer to Aetna's website at Aetna.com, or the Aetna Medication Formulary Guide. 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. In addition, in circumstances where your prescription plan utilizes copayments or coinsurance calculated on a percentage basis or a deductible, use of formulary drugs may not necessarily result in lower costs for the member. Members should consult with their treating physicians regarding questions about specific medications. Refer to your plan documents or contact Member Services for information regarding the terms and limitations of coverage.

Aetna Rx Home Delivery refers to Aetna Rx Home Delivery, LLC, a subsidiary of Aetna, Inc., that is a licensed pharmacy providing mail-order pharmacy services. Aetna's negotiated charge with Aetna Rx Home Delivery may be higher than Aetna Rx Home Delivery's cost of purchasing drugs and providing mail-order pharmacy services.

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

Plans are provided by Aetna Life Insurance Company.

While this information is believed to be accurate as of the print date, it is subject to change. For more information about Aetna plans, refer to www.aetna.com.

Aetna Navigator® — our secure member website

When you need up-to-date information about your health insurance plan or want information about a particular health condition, here's where you'll find it!

Aetna members can turn to Aetna Navigator, our secure member website that provides you with a single source for online health and benefits information. It's convenient, and easy to use:

1. Go to **www.aetna.com**.
2. Click on Member Log In.
3. Register as a new user, or log in using your secure user name and password.
4. Find a wealth of credible health care information and self-service functions — available to you anytime of the day or night — from wherever you have Internet access.

Our secure website lets you:

- View information about who is covered on your plan
- Find doctors, pharmacies or hospitals on our DocFind® online provider directory
- Check the status of a claim or review an Explanation of Benefits (EOB)
- Contact Member Services with benefits questions (also available in Spanish)

Use Aetna Navigator's online tools to manage your benefits and help you make more informed health decisions:

- **Hospital Comparison Tool** — helps you decide where to receive care for specific procedures, conditions and diagnoses. You can compare hospitals based on four factors you consider important:
  1. Number of patients treated per year
  2. Complication rates
  3. Mortality rates
  4. Length of stay
- **Price-A-Drug℠ tool*** — helps you estimate the cost of prescriptions before you buy
- **Estimate the Cost of Care tool** — provides average in- and out-of-network costs for certain procedures based on a geographic area
- **Pharmacy benefits summary** — allows you to locate retail pharmacies; order prescriptions through Aetna's mail-order pharmacy, Aetna Rx Home Delivery®; search and learn about medications; and review the medications available on Aetna's formulary

*If Included in your plan.

Use it to talk to your doctors with ease

The Personal Health Record can help you team up with your doctors. You can share your Personal Health Record online with individual doctors by making it available through a secure website many doctors already use. You also can print your Health Summary to share at office visits or to help you fill out medical forms when you see a new doctor.

Stay safe and healthy with alerts and reminders

Your Personal Health Record helps you get the care you need. If you're due for a checkup or other important screening, you might see a reminder when you log in. You may also receive a message if there's an alternative treatment that may improve your care. And, if you give Aetna permission, you can get e-mails telling you that a new alert or reminder is in your secure Personal Health Record.

Portability ensures your personal health records go where you go

Aetna's relationship with Microsoft provides our members portability of their personal health information. You can transfer a copy of your Aetna Personal Health Record from Aetna Navigator directly to Microsoft HealthVault at **www.healthvault.com/personal**. Your information will be stored on this secure, web-based consumer health platform and remains available if you change jobs or health plans.

You can also print and save a PDF copy of your health record for your own files through the same Navigator location.

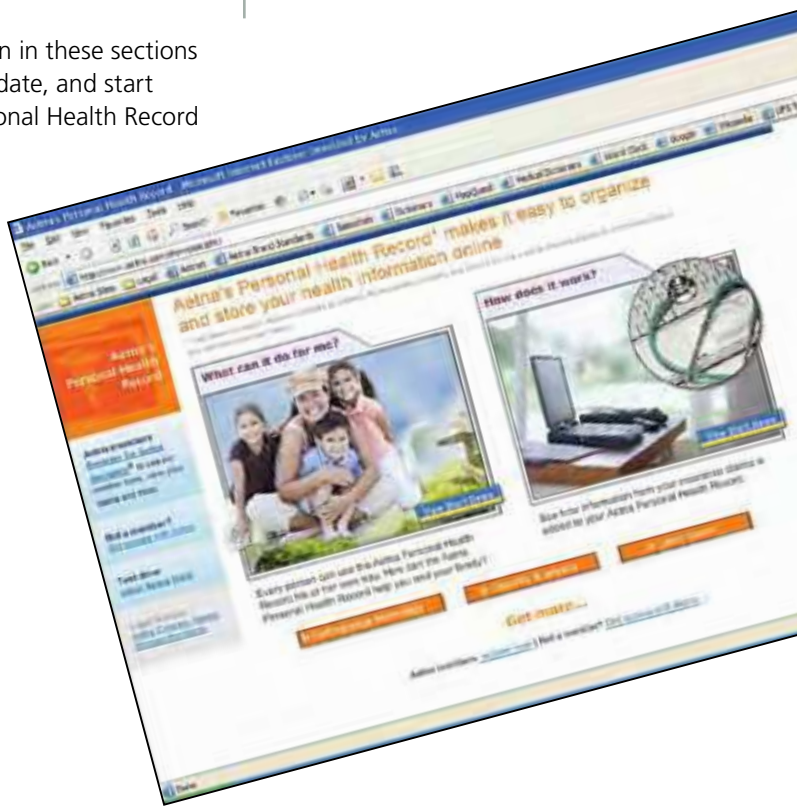
Print your personalized Emergency Card

You can print an Emergency Information Card that pulls information from several sections of your Personal Health Record. It provides first responders with your emergency contact's name and phone number, your insurance details, any medications you are taking, allergies if you have any, and information about whether you have a living will or have designated your organs for donation. All this detail in a printout that folds and fits in your wallet.

Be sure the information in these sections is accurate and up-to-date, and start using your Aetna Personal Health Record today!

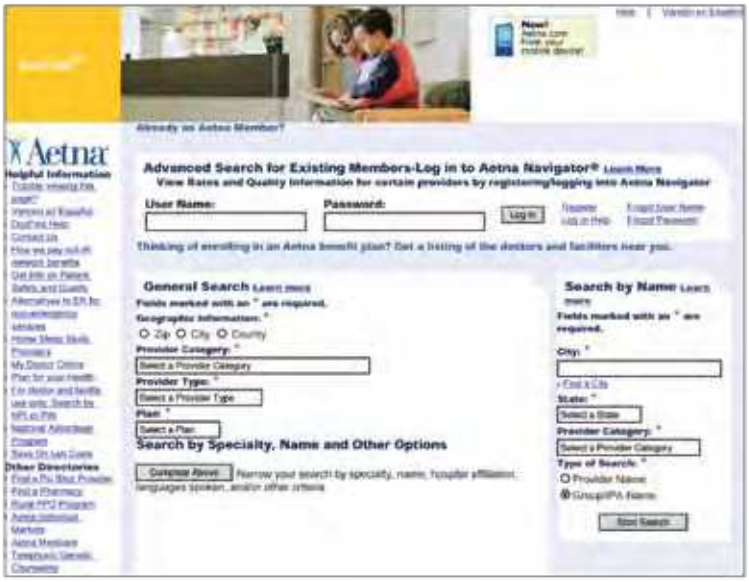
It's easy to get started.

Visit your Personal Health Record today or use our Walk Me Through guide to explore how this resource works on your own. Visit **www.aetna.com/showcase/phr/** for answers to the most common questions from our members.



How will I find a doctor or specialist?

Start your search at **www.aetna.com** (or, if you are already a member, log in to Aetna Navigator). Click on Find a Doctor. Use the simple online instructions to perform a general search. You also may search for a particular physician by name, specialty or other options.



How to find your Washington plan

When performing a search in DocFind, you will be asked to select a plan name. Some of the names of our Washington plans appear by their network names. Here is a quick reference to identify your plan:

Medical plan name as it appears in DocFind	Common plan names
Open Choice® PPO	PPO
	VALUE
	SAVER
	HDHP
	HSA

Dental plan name as it appears in DocFind	Common plan names
Dental Maintenance Organization (DMO)	DMO
Dental PPO/PDN with PPO II Network	PPO
Freedom-of-Choice* Choose the plan based on current election DMO or PPO	

*All family members must be enrolled on the same plan

RelayHealth®

Visit your doctor online with webVisit®

Aetna's latest innovative health care benefit in partnership with RelayHealth* offers members "webVisits." Now you can communicate effectively and securely online with your doctor to seek non-urgent medical care. You pay any required copays or deductibles through the system as if you had made an office visit.

webVisit is easy to use:

1. Enter the RelayHealth website for non-urgent medical care.
2. Complete a questionnaire.
3. Submit it directly and confidentially to your doctor.
4. Once your doctor reviews your questionnaire, you will get a diagnosis, instructions and information — just like at an actual visit.

Simply register on the RelayHealth website at **https://www.relayhealth.com/Patients/Registration.aspx** to get started.

Once registered, log in at your convenience to take advantage of the many features available to registered members, in addition to the webVisit service:

- Consult with your doctor
- Make and/or cancel appointments
- Obtain referrals
- Request lab and test results
- Order prescription refills
- Send a note to your doctor's office

What's the difference between the online RelayHealth site and e-mailing my doctor?

e-mail	webVisit
▪ May not be secure or HIPAA (Health Insurance Portability and Accountability Act)-compliant. ▪ Free form — you may not know the medical questions to address so your doctor can diagnose your ailment. ▪ Non-chargeable — eligibility needs to be determined, and you must submit a claim.	▪ HIPAA-compliant — secure and authenticated with user log-in. ▪ Clinically structured questionnaire focuses on your symptoms to help your doctor determine an accurate diagnosis. ▪ Reimbursable — checks eligibility in real time, collects copayment and submits claim automatically. **A few things to note before you get started:** ▪ You must have an established relationship with a doctor before webVisit can be used. ▪ Your doctor must be a member of Aetna's network and be registered as a participating provider in the RelayHealth physician network — participating providers are identified on DocFind through Aetna Navigator — our secure member website.

webVisit through RelayHealth links you with your doctor, Aetna health plan and pharmacy in a single secure network.

*Employees need to do nothing as this service will be automatically added to their coverage. Plan sponsors offering traditional plans can customize the copay required for an online visit (webVisit). This service includes plans that have health funds when the fund limit is exhausted. Physicians will be paid for services provided according to the terms of their contract.
As always, a member's financial responsibility depends on the terms of his or her plan, which may vary. Check your service area for availability.

A convenient solution for care on the go

Informed Health® Line

Access to a registered nurse — 24/7!

With Aetna's Informed Health Line, you can talk to a registered nurse anytime, day or night. Just call our 24-hour toll-free number (available upon enrollment). While only your doctor can diagnose, prescribe or give medical advice, the Informed Health Line nurses can provide information on thousands of health topics. They can also tell you how to ask the right questions and describe health symptoms more effectively during your next visit to your doctor. Remember, always contact your doctor first with any questions or concerns regarding your health care needs.

Walk-in clinics

Looking for a convenient way to get medical care? Consider a walk-in clinic. It's a convenient alternative to the doctor's office. If you aren't feeling well and have trouble getting an appointment with your doctor, it's your answer to non-emergency care right away.

And walk-in clinics are not just for when you are sick. You might be surprised by the full spectrum of services available at a walk-in clinic, many of which are staffed by physician assistants and nurse practitioners. They offer:

- Treatment for minor burns, stings or bites, strains, and cuts
- Care for earaches, flu and cold symptoms, sinus infections, and allergies
- Physicals and pediatric and gynecologic services
- Flu shots and other vaccinations
- X-ray and lab services

Urgent care

For care that is not minor, such as fractures, sprains or other urgent injuries, we contract with urgent care centers to offer you an economical alternative to visiting an emergency room. Urgent care sites are staffed with physicians to handle urgent medical needs, whereas walk-in clinics are staffed by nurse practitioners to care for minor ailments. And just like walk-in clinics, some urgent care centers offer evening and weekend hours with no appointments needed.

Check your Plan Design and Benefits Summary to get more information about coverage and costs to visit a walk-in clinic or urgent care center. To find the closest clinic or care center near you, simply log in to Aetna Navigator, select DocFind and follow the easy online instructions.

Prevention programs — helping you and your family stay healthy

Aetna Health Connections disease management program conditions and content		
Vascular ■ Heart failure ■ Diabetes — adult and pediatric ■ Coronary artery disease (CAD) ■ Peripheral artery disease (PAD) ■ Hypertension — adult and pediatric (high blood pressure) ■ Cerebrovascular disease/stroke (CVA) ■ Hyperlipidemia (high cholesterol) **Pulmonary** ■ Asthma — adult and pediatric ■ Chronic obstructive pulmonary disease (COPD)	**Orthopedic/ Rheumatologic** ■ Osteoporosis ■ Osteoarthritis (OA)* ■ Rheumatoid arthritis (RA) ■ Chronic lower back pain **Gastrointestinal** ■ Gastro esophageal reflux disease (GERD) ■ Peptic ulcer disease ■ Inflammatory bowel disease (IBD) (Crohn's disease) ■ Chronic hepatitis **Neuro-Geriatric** ■ Geriatrics ■ Migraines ■ Seizures ■ Parkinsonism	**Cancer** ■ General cancer ■ Breast cancer ■ Lung cancer ■ Lymphoma/Leukemia ■ Prostate cancer ■ Colorectal cancer **Renal** ■ Chronic kidney disease ■ End-stage renal failure **Other** ■ Weight management — adult and pediatric ■ Cystic fibrosis — adult and pediatric ■ HIV ■ Hypercoagulable state ■ Sickle cell disease — adult and pediatric ■ Depression**

*Not scored by Clinical Stratification and Identification (CSID) process.
**Addressed as a comorbid condition.

Find out what's covered and what requirements apply.

Getting to know your Aetna prescription drug plan

Know what drugs are covered

You and your doctor can choose from hundreds of quality, cost-effective drugs. Your plan covers brand-name and generic drugs on the Aetna Preferred Drug List. (You may also see this called a "formulary.") It was developed based on advice from many different health care specialists. And all drugs on it are approved by the U.S. Food and Drug Administration (FDA).

Your plan also covers many drugs that are not on this list. Remember though, you'll often pay less for drugs on our list.

To see this list or learn about medication alternatives, go to **www.aetna.com/formulary**.

Understand precertification and how it helps you

Some drugs need precertification before your plan will cover them. This simply means we need to approve them first for you. Doing this helps make sure the drug is being used at the right dose, for the right reasons. This helps keep you safe. It can also help you find another drug that costs less and is just as effective — something you could talk about with your doctor.

Your doctor will contact us by phone, fax or e-mail. If your request is not approved and you still want the drug, you will have to pay the full price of the prescription.

All decisions are made based on FDA guidelines and current medical findings. Learn more about this at **www.aetna.com/formulary**.

Start your Aetna plan with peace of mind

New plans often come with new rules. We want to help make the change easier. Once your plan starts, you don't have to worry about getting approval for most covered drugs for your first 90 days.

In your first 90 days:

- If you need a covered drug that normally needs approval first, you'll be able to get that drug without the approval.
- For clinical reasons, some drugs will still need to be approved first, even in your first 90 days. This may be because of questions about dosing, quantity or other health concerns.

After 90 days:

- You will need approval for any new drugs your doctor prescribes that would normally require precertification.
- Any prescription you filled during the first 90 days will still be covered as long as you get the drug at the same strength and quantity as originally prescribed.
- If you doctor changes the dosage of your medication, you may then need to get it approved first. This will happen if the dosage is more than what the FDA recommends.

Specialty Pharmacy Medications

With your new Aetna Specialty CareRx℠ benefit, you can get your first fill at a retail pharmacy. In order to receive coverage, your second fill and all other refills will need to come from a participating specialty pharmacy.

For a full list of specialty pharmacy medications, please visit **www.aetnaspecialtycarerx.com.**

Mandatory generic

Under this provision, the member pays the applicable copay only if the physician requires brand (and generic is available). If the member requests brand when a generic is available, the member pays the applicable copay plus the difference between the generic price and the brand price.

Over-the-counter drugs may be an option

Many health conditions can be treated safely with drugs you can get without a prescription. We call these drugs "over the counter" because you can buy them at your local stores. You don't have to go to a pharmacy.

These drugs have been approved by the FDA as safe and effective, and they often have the same active ingredients as an original prescription version. Always talk to your doctor before taking over-the-counter drugs.

Your plan does not cover prescription drugs if a similar drug is available over the counter. This includes drugs like Claritin® and Prilosec® 20 mg. Please ask your doctor what will work best for you.

Limitations and exclusions

Drugs that are not covered under the standard prescription drug benefits program include, but are not limited to:

- Drugs used for weight loss, including the treatment of obesity
- Over-the-counter drugs
- Nutritional supplements
- Smoking cessation aids or drugs
- Growth hormones
- Prophylactic drugs for travel
- Test agents and devices, other than diabetic test agents
- Performance, athletic performance, or lifestyle-enhancement drugs and supplies
- Cosmetics or any drugs used for cosmetic purposes or to promote hair growth, including health and beauty aids
- Replacement for lost or stolen prescriptions

For a complete list of what is not covered by your prescription drug plan, refer to your plan documents after enrollment.

Find out more

Once you are enrolled, log in to Aetna Navigator, our secure member website at **www.aetna.com**. You'll find benefits and claims information, the Preferred Drug List, cost estimates, and more. You can also refer to your Summary of Benefits or call us at the toll-free number on your Aetna member ID card.

Special programs for the special needs of women

Ongoing health management

Work, family, friends. Too much to do, too little time to do it. That's today's woman. Add health needs that change over time, and you'll know why we offer services and information to help you manage your health.

Prevention programs for women

Our preventive programs can help women benefit from:

- Preventive screening reminders for breast and cervical cancer
- Culturally focused initiatives to help reduce health disparities among women of diverse ethnic backgrounds

Women's health online

Go to **http://womenshealth.aetna.com** for information on women's health issues — from heart health, breast cancer and pregnancy to baby care and other topics important to women, as well as:

- An interactive body mass index tool
- A pregnancy guide
- Food pyramid recommendations
- Information on diet and nutrition

For ob/gyn care, no referrals needed

For an annual well-woman exam, unlimited visits for gynecological problems and routine maternity care, women may schedule an appointment with participating obstetrical, gynecological or women's health care professionals without a referral.

Beginning Right® maternity program

Aetna's Beginning Right maternity program offers information and services to expectant mothers, including care coordination by obstetrical nurses experienced in preterm labor education, breastfeeding support and more. We want to make sure expectant mothers have the information needed to make informed decisions about health care while pregnant or planning a pregnancy. Members enrolled in both our medical and dental plans, along with our Beginning Right maternity program, may also receive enhanced dental benefits (additional cleaning or treatment of periodontal (gum) disease, fully covered with no deductible) during pregnancy.

Special maternity care

From the start of pregnancy to birth, our maternity management program offers expectant mothers services and educational materials to help give their newborns a healthy start. Moms-to-be receive:

- Educational materials, available in English or Spanish, that cover:
  - > Prenatal care
  - > Labor and delivery
  - > Newborn and baby care
  - > Breastfeeding
  - > Postpartum depression
- A pregnancy risk survey and nurse care coordination for high-risk pregnancies
- A program to help you stop smoking

Aetna's health care transparency tools

Since 2005, Aetna has empowered members with our suite of member tools that inform you about doctors, hospitals and other medical facilities. You can make more informed health care decisions by using our online transparency tools before visiting a doctor or hospital.*

Our transparency tools allow you to:

- View and compare rates for participating doctors
- Look up costs for medical procedures at facilities in select locations around the country and quickly identify medical specialists who are high performers in their field based on clinical quality and efficiency**
- Use at your convenience since the information is available 24/7 through Aetna Navigator, our secure member website, and DocFind, our online directory of doctors and facilities

Your access as a member to this combination of physician-specific rates, clinical quality and efficiency data, and facility-specific medical procedure costs is a first from a national health carrier and demonstrates our commitment to you.

To access our health care transparency tools, log in to Aetna Navigator. Click on Cost of Care from the home page. There, you can use the easy online instructions to:

- Check rates for doctors and specialists for common treatments and procedures
- Compare hospital costs side by side
- Get personalized cost estimates to find out what you'll pay before you go

Employee Assistance Program (EAP)***

Aetna's Employee Assistance Program is a confidential program that gives employees and members of their household access to useful services and support to help them manage the everyday challenges of work and home. The EAP is available at no charge to members and their family members and includes:

- **Choice** — They'll find a range of resources to help them balance their personal and professional lives.
- **Easy access** — EAP representatives can be reached anytime toll free at **1-866-672-5417** or on the web at **www.aetnaeap.com**.
- **Professional assistance** — Our workplace-trained specialists provide confidential phone support, assessing needs and recommending an appropriate course of action. Employees and their household members receive three phone consultations per member in a calendar year.

Employers can also take advantage of EAP Resources:

- **Management and human resources assistance** — Employers get unlimited phone consultations with workplace-trained clinicians who can provide help in dealing with complex employee issues that may arise.
- **Online tools** — Employers can also get online tools and materials to encourage employees to use the EAP by visiting **www.aetnaeap.com** (enter your company ID and select the "Promotional Materials" link).

*Always consult your doctor about your health care decisions. Members cannot view rates for dentists, vision providers or certain types of health care professionals with these tools.

**Clinical quality and efficiency information is based on Aexcel® designation for specialists in 12 specialty categories. You can learn more about our Aexcel designation in our Understanding Aexcel brochure available under the Learn More section of DocFind. We regularly upgrade our tools to provide the latest cost and clinical quality and efficiency information about Aetna network providers.

***EAP is administered by Aetna Behavioral Health, LLC and Aetna Life Insurance Company.

Aetna Weight Management℠ discount program

Lose weight and feel great! It's easier with the Aetna Weight Management discount program.

You can save on some of today's most popular weight-loss programs and meal plans from eDiets®, Jenny Craig® and Nutrisystem®.

Save on eDiets

You can choose an Online Diet Plan, or a Meal Delivery Plan with food shipped right to your door.

Program options:

- Enroll in an online monthly plan and save 30 percent on membership dues.
- Once you enroll in a monthly plan, you can upgrade to an online annual plan and save 20 percent on the already discounted annual plan price.
- Enroll in the Meal Delivery Plan (5-day or 7-day) and save 15 percent off the cost of food, delivered right to your door.
- When you enroll in an online plan, you can choose from over 20 online diet plans. With the Meal Delivery Plan, delicious, healthy, portion-controlled food is shipped to you each week.
- Save 15 percent on all purchases from the eDiets Online Store. Choose from DVDs, CDs, fitness and exercise equipment, vitamins and supplements, and more. You must enter the Aetna-specific promotion code (available on Aetna Navigator or through Member Services) on the eDiets billing page to receive the discount.

What else you get:

- One-on-one professional support
- Customized menus, recipes and convenient food options
- Phone, chat and e-mail support from registered dieticians
- Diet tools such as eDiets Nutrition Tracker, Food Journal, Dining-Out Guide and more
- 24/7 online member support

Save on Jenny Craig

Save on a sensible weight-loss program that can help you lose the weight and keep it off.

Program options:

- Start with a FREE 30-day Trial Program.*
- Then receive 25 percent off a Jenny Craig Premium Program* available at participating Jenny Craig centres and through Jenny Craig At Home.

What else you get:

- Weekly one-on-one scheduled consultations
- Personalized menus
- Plans to help you get active and stay motivated
- Online support and free Jenny eTools
- 24/7 customer care support, message boards and live chat

Save on Nutrisystem

Control your calories and curb your hunger. You can choose from over 150 menu items that are single serve and easy to make.

Program options:

- Save 12 percent on any 28-day Nutrisystem weight-loss meal plan.**
- PLUS get other offers available from Nutrisystem at the time you enroll.
- Get even bigger discounts with Auto-Delivery.***

What else you get:

- Tasty food delivered right to your door
- Easy-to-follow meal plans
- Unlimited counseling by phone or web with trained weight-loss counselors and dieticians
- FREE online membership

*Food and, if applicable, shipping not included. Offer applies to initial membership fee only and is valid at participating centres in the U.S., Canada and Puerto Rico and through Jenny Craig At Home. Each offer is a separate offer and can be used only once per person. Restrictions apply.

**Applies to these plans: Basic, Silver, Diabetic, Vegetarian or Nutrisystem®Select™. The Aetna discount offer does not apply to any program in which you are already enrolled. To receive the discounted rate, you must wait until your current program ends. If you are enrolled in Auto-Delivery, you must cancel it and then re-enroll to receive the discounted rate.

***Offer good on new 28-day Auto-Delivery programs only. With Auto-Delivery, you receive a 10 percent discount off Nutrisystem's regular 28-day program price and free shipping to continental U.S. only.

Aetna Fitness℠ discount program

There are a million reasons to get fit

To name a few — you'll look and feel better. When you have a healthy weight, you can also lower your risks for heart disease, high blood pressure, diabetes … even depression.

And with the Aetna Fitness discount program, you can save, too. Just for taking good care of yourself.

What you get with the program

You can:

- Save on gym memberships
- Save on treadmills, ellipticals and more
- Try an at-home weight-loss program
- Get health coaching to stop smoking, lower stress and more

Try a gym for free

You can get a free guest pass at most gyms. It's a great way to check out the gym culture, services and equipment before you sign up. To get yours, visit **www.globalfit.com/fitness.**

How to save on a gym membership

You can choose and save at over 10,000 gyms* (and growing) in the GlobalFit® network. So it's easy to find one near work or home.

Three easy steps:

Step 1: Visit **www.globalfit.com/fitness** to find a gym.

Step 2: Pick a gym, and follow the steps to sign up online.

Step 3: Print your confirmation and you're set to go!

You can also call **1-800-298-7800** to sign up.

Keep in mind that this offer is for new gym members only. If you belong to a gym now, or belonged recently, you may not be able to get discounts at that gym.

More reasons to join a gym through GlobalFit

You can:

- Choose from flexible membership options
- Get easy billing through your bank account or major credit card
- Visit a participating gym when you travel**
- Transfer your membership to another participating gym or another person**
- Freeze your membership for up to two months per calendar year**
- Plus — your family members on your health plan can use the program, too!

Save on home exercise equipment, too

Rather get fit in your own home? You can do that, too.

You'll get discounts on:

- Elliptical trainers
- Treadmills
- Resistance bands, mats, yoga accessories
- And more

More support for your healthy lifestyle

Getting fit is just the start to a healthier you.

You can also:

- Try out an at-home weight-loss program
- Get one-on-one health coaching*** to help you quit smoking, lower stress, lose weight and more

*GlobalFit website, www.globalfit.com/fitness, 4/11.
**Not available for month-to-month memberships.
***By WellCall, Inc., through GlobalFit.

Aetna Hearing℠ discount program

The Aetna Hearing discount program helps you and your family save on hearing exams, hearing aids and other hearing services. You can choose between two great offers at no additional premium cost:

- Hearing Care Solutions
- HearPO®

Advantages of Hearing Care Solutions

- Discounted rate of $42 for hearing exams
- Hundreds of hearing aid models to choose from at fixed-rate pricing – savings represent up to 63 percent off standard retail
- 2-year supply of batteries (up to 96 cells) then a discount mail-order program
- In-office service at no charge one year after purchase
- Routine services (cleanings, instrument checks and battery door replacements) at no charge for the life of the instrument

How Hearing Care Solutions works

To schedule an appointment, call Hearing Care Solutions directly at **1-866-344-7756.** Hearing Care Solutions will schedule an appointment for you.

You will also receive an informative welcome packet that includes information on hearing loss, what to expect at your first appointment and complete information on hearing instruments offered.

Hearing Care Solutions offers 2,000 providers in over 1,300 locations. To check the participating locations in your area, go to **www.aetna.com** and search DocFind, our online provider directory. Or, log in to Aetna Navigator, our secure member website, and click on Find a Doctor, Facility or Pharmacy then "hearing."

Advantages of HearPO

- Discounted rate of $48 for hearing exams (40 percent off the national retail cost)
- Savings on many styles from complete-canal to behind-the-ear hearing aids
- Cost break on the newest hearing aid technologies, including programmable and digital instruments from leading manufacturers
- Discounts on hearing aid repairs
- Free follow-up services for one year
- Free batteries (up to 160 cells per hearing aid)

How HearPO works

HearPO includes access to over 1,600 participating locations. To find one near you, call HearPO customer service at **1-888-HEARING (1-888-432-7464)** or visit **http://hearpo.com/hearpoproviderlocations.asp.**

To make an appointment, call HearPO to be sure you access the discounted rates for services and devices.

- HearPO will then send you a validation packet.
- When you receive the validation packet, make an appointment with the selected provider.

Receive the discounts at the point of purchase. Also Call HearPO to learn about their low-price guarantee.

Aetna Vision℠ discount program

See better for less

This program helps you save on what you need to see better, like eye exams, glasses, contacts … even LASIK. You also pay less for vision items that don't need a prescription. So pick up some shades for the summer or stock up on contact lens cleaner. There are plenty more savings where those came from!

Program locations

Choose from thousands of national chains such as:

- Pearle Vision® Centers
- Sears® Optical
- LensCrafters®
- Target® Optical
- JCPenney® Optical

Plus, you can go to many eye doctors in private practice. To find one near you, go to **www.aetna.com** or call **1-800-793-8616.**

What you save*	
Product or Service	**What You Pay**
Eye exams (For plans that cover eye exams)	See your plan documents for details.
Eye exams (For plans that DO NOT cover eye exams)	
Complete eye exam	$42
Standard contact lens fit and follow-up	$40 (plus $42 exam fee)
Specialty contact lens fit and follow-up (for example, toric, bifocal, gas permeable)	$10 off retail (plus $42 exam fee)
Lenses (per pair, uncoated plastic)	
Single vision	$40
Bifocal	$60
Trifocal	$80
Standard progressive (no-line bifocal)	$120
Eyeglass frames	40% off retail price
Lens options, per pair (add to lens price above)	
Standard polycarbonate (includes ultraviolet and scratch-resistant coating)	$40
Scratch-resistant coating	$15
Ultraviolet (UV) coating	$15
Solid or gradient tint	$15
Standard antireflective coating	$45
Glass	20% off retail price
Photochromic glass	20% off retail price
Contact lenses	15% off retail price (5% for disposables)
Contact lens replacement by mail	Call **1-800-391-5367** to order a new pair.
More vision items	20% off retail price
LASIK eye surgery	15% off retail prices (5% off special advertised prices) for U.S. Laser Network services. You must call **1-800-422-6600** to schedule an appointment.

*EyeMed Services and Compensation Schedule, 3/09. Prices are subject to change. Discounts may not be available on certain brand-name vision materials (that is, designer eyeglass frames) in which the manufacturer imposes a no-discount practice.

Relax, recharge and save.
Log in to www.aetna.com to start.

Aetna Natural Products and Services℠ discount program

Save on a natural path to good health

You get the Aetna Natural Products and Services discount program to help. You can save on massage therapy, natural products, online provider consultations and more.

You get the program at no extra cost

It's built right into your Aetna benefits and insurance plan. And it helps you save on services health plans normally don't cover. Once you're an Aetna member, just log in to Aetna Navigator, our secure member website at **www.aetna.com** to start saving.

Save on natural therapy services

Get at least 25 percent off the normal fee for these services though the ChooseHealthy® program:*

- **Massage therapy,** to release tension and improve circulation
- **Acupuncture,** to heal areas of pain or stress with the use of needles
- **Chiropractic care,** to ease neck and back pain by adjusting the spine
- **Dietetic counseling,** for advice from registered dieticians on the foods you should eat

How to start

Find a program provider at **www.aetna.com.** Then take your Aetna ID card to your appointment for savings on the spot.

Save on over 2,400 health and wellness products

You get at least 15 percent off the retail price through the ChooseHealthy program. Free standard shipping, too.

Get discounts on:

- Over-the-counter vitamins
- Herbal and nutritional supplements
- Aromatherapy products
- Homeopathic remedies
- Natural body care products
- Yoga equipment and more

How to start

You can order by phone or the web. Visit Aetna Navigator, our secure member website at **www.aetna.com** for details.

*The ChooseHealthy program is made available through American Specialty Health Networks, Inc. (ASH Networks) and Healthyroads, Inc., subsidiaries of American Specialty Health Incorporated (ASH). ChooseHealthy is a federally registered trademark of ASH and used with permission herein.

Get medical consultations online — and save

You'll get access to a network of medical doctors — the Vital Health Network.

These doctors can help you enhance your body's ability to prevent disease by using its *natural* powers.

You get:

- Advice on natural remedies for joint pain, allergies, headaches and many other conditions
- Secure messaging with a Vital Health Network doctor on the topic you chose
- 30 percent off the retail price of 1 online consultation
- 50 percent off the retail price of 2 or more online consultations

How to start

Log in to Aetna Navigator, our secure member website at **www.aetna.com.** To start your consultation, just choose a condition and answer a few questions.

After you connect with the doctor online, you'll get a customized treatment plan for healthy living. Just visit Aetna Navigator, our secure member website to view your plan.

No paperwork, no waiting

The Aetna Natural Products and Services discount program is easy to use. You can start saving as soon as you're an Aetna member!

More advantages:

- No referrals
- No claim forms to mail in
- No limits on how many times you can save

If your plan covers any of these services, figure out your plan costs before using these discounts. You could pay less that way.

VSP
Vision care for life

Your Vision Benefit Summary

Using your VSP benefit is easy.

- **Find an eyecare provider who's right for you.** With open access to see any eyecare provider, you can see the one who's right for you. Choose a VSP doctor or any other provider. To find a VSP doctor, visit **vsp.com** or call **800.877.7195**.
- **Review your benefit information.** Visit **vsp.com** to review your plan coverage before your appointment.
- **At your appointment, tell them you have VSP.** There's no ID card necessary.

That's it! We'll handle the rest—there are no claim forms to complete when you see a VSP doctor.

Personalized Care

A VSP doctor provides personalized care that focuses on keeping you and your eyes healthy year after year. Plus, when you see a VSP doctor, you'll get the most out of your benefit, have lower out-of-pocket costs, and your satisfaction is guaranteed.

Choice in Eyewear

From classic styles to the latest designer frames, you'll find hundreds of options for you and your family. You'll have access to great brands, like bebe®, Calvin Klein, Disney, FENDI, Nike, and Tommy Bahama®.

Plan Information

VSP Doctor Network: VSP Signature

Benefit	Description	Copay
Your Coverage with a VSP Doctor		
WellVision Exam	• Focuses on your eyes and overall wellness • Every 12 months	$10
Prescription Glasses		$25
Frame	• $130 allowance for a wide selection of frames • 20% off amount over your allowance • Every 24 months	Included in Prescription Glasses
Lenses	• Single vision, lined bifocal, and lined trifocal lenses • Polycarbonate lenses for dependent children • Every 24 months	Included in Prescription Glasses
Lens Options	• Standard progressive lenses • Premium progressive lenses • Custom progressive lenses • Average 35-40% off other lens options	$50 $80 - $90 $120 - $160
Contacts (instead of glasses)	• $130 allowance for contacts and contact lens exam (fitting and evaluation) • 15% off contact lens exam (fitting and evaluation) • Every 24 months	$0
Extra Savings and Discounts	**Glasses and Sunglasses** • 30% off additional glasses and sunglasses, including lens options, from the same VSP doctor on the same day as your WellVision Exam. Or get 20% off from any VSP doctor within 12 months of your last WellVision Exam. **Retinal Screening** • Guaranteed pricing on retinal screening as an enhancement to your WellVision Exam. **Laser Vision Correction** • Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities • After surgery, use your frame allowance (if eligible) for sunglasses from any VSP doctor	

Your Coverage with Other Providers

Visit vsp.com for details, if you plan to see a provider other than a VSP doctor.

Exam..... up to $50	Lined Trifocal Lenses.... up to $100
Frame..... up to $70	Progressive Lenses..... up to $75
Single Vision Lenses..... up to $50	Contacts..... up to $105
Lined Bifocal Lenses..... up to $75	

VSP guarantees coverage from VSP doctors only. Coverage information is subject to change. In the event of a conflict between this information and your organization's contract with VSP, the terms of the contract will prevail.

Visit **vsp.com** or call **800.877.7195** for more details on your vision coverage and exclusive savings and promotions for VSP members.

Using VSP – Exceptional Member Service

Our Promise to You and Our Members

At VSP, we strive to deliver the kind of personalized care and exceptional service we'd expect for ourselves. That's why we've instituted a promise to our members that guarantees their satisfaction. We know that satisfied members lead to satisfied clients. And by providing you with the knowledge that we are taking good care of your members, you can focus your valuable resources elsewhere.

Our promise is this: If at any time VSP members are not completely satisfied with their eyecare services or their eyewear, they can just let us know, and we'll make it right.

Did You Know?

- 93% of VSP patients visit VSP's doctors
- 84% of VSP doctors offer morning, evening and/or weekend hours.

Using the VSP Benefit, Easy as 1, 2, 3

VSP members just:

1. Consult benefit information for coverage details.
2. Find a VSP doctor online or by phone 24 hours a day.
3. Make an appointment with a VSP doctor, identifying himself/herself as a VSP member.

It's that simple! The VSP doctor will take care of the rest.

In addition, although most VSP members receive services from VSP doctors, members may choose to see an out-of-network provider. However, when members visit a VSP network doctor, benefits are greater, and they are covered by VSP's Member Promise, guaranteeing their satisfaction.

Dental Benefits

Savings, flexibility and service. For healthier smiles.

MetLife

For the savings you need, the flexibility you want and service you can trust.

To help you enroll, the following pages outline your company's dental plan and address any questions you may have.

Coverage Type	**In-Network[1]** % of PDP Fee[2]	**Out-of-Network[1]** % of R&C Fee[4]
Type A - Preventive	100%	100%
Type B - Basic Restorative	80%	80%
Type C - Major Restorative	50%	50%
Deductible	**In-Network[3a]**	**Out-of-Network[3b]**
Individual	$50	$50
Family	$150	$150
Annual Maximum Benefits	**In-Network**	**Out-of-Network**
Per Person	$2000	$2000

1. "In-Network Benefits" means benefits under this plan for covered dental services that are provided by a MetLife PDP Dentist. "Out-of-Network Benefits" means benefits under this plan for covered dental services that are not provided by a MetLife PDP Dentist.

2. PDP Fee refers to the fees that MetLife PDP dentists have agreed to accept as payment in full.

3a. Applies to Type B & C services only 3b. Applies to Type B & C services only

4. Out-of-network benefits are payable for services rendered by a dentist who is not a participating provider. The Reasonable and Customary charge is based on the lowest of:
   • The dentist's actual charge (the 'Actual Charge'),
   • The dentist's usual charge for the same or similar services (the 'Usual Charge') or
   • The usual charge of most dentists in the same geographic area for the same or similar services as determined by MetLife (the 'Customary Charge'). For your plan, the Customary Charge is based on the 90th Percentile. Services must be necessary in terms of generally accepted dental standards.

Selected Covered Services and Frequency Limitations

Type A - Preventive	How Many / How Often
• Prophylaxis - Cleanings	1 in 6 months.
• Oral Examinations	1 in 6 months.
• Topical Fluoride Applications	1 in 12 months for children up to 14th birthday.
• Full Mouth X-Rays	1 in 60 months.
• Bitewing X-Rays (Adult/Child)	Adult 1 in 12 months / Child 1 in 12 months up to 14th birthday.
• Space Maintainers	Children up to 14th birthday. Limited to 1 per lifetime per area.
• Sealants	1 in Lifetime (per permanent 1st & 2nd non-restored molar) children up to 14th birthday.
Type B - Basic Restorative	**How Many / How Often**
• Endodontics - Root Canal	1 in 24 months.
• General Anesthesia	For oral surgery, extractions or other covered services.
• Oral Surgery (Simple Extractions)	
• Oral Surgery (Surgical Extractions)	
• Other Oral Surgery	
• Periodontal Surgery	1 in 36 months.
• Periodontal Scaling & Root Planing	1 in 24 months.
• Periodontal Maintenance	2 in 1 year, includes 2 cleanings.
• Amalgam & Composite Fillings	1 in 24 months.
• Emergency Palliative Treatment	
Type C - Major Restorative	**How Many / How Often**
• Repairs	1 in 24 months.
• Implants	Services: 1 in 60 months Repairs: 1 in 60 months.
• Bridges	1 in 10 years.
• Dentures	1 in 10 years.
• Crowns/Inlays/Onlays	1 in 10 years.
• Consultations	2 in 12 months.
• Prefabricated Stainless Steel & Resin Crowns	1 in 10 Years.

The service categories and plan limitations shown above represent an overview of your Plan Benefits. This document presents the majority of services within each category, but is not a complete description of the Plan.

* **Alternate Benefits:** Your dental plan provides that if there are two or more professionally acceptable dental treatment alternatives for a dental condition, your plan bases reimbursement, and the associated procedure charge, on the least costly treatment alternative. If you receive a more costly treatment alternative, your dentist may charge you or your dependent for the difference between the cost of the service that was performed and the least costly treatment alternative.

The service categories and plan limitations shown above represent an overview of your Plan of Benefits. This document presents many services within each category, but is not a complete description of the Plan. Please see your Plan description for complete details. In the event of a conflict with this summary, the terms of the certificate will govern.

Like most group dental insurance policies, MetLife group policies contain certain exclusions, limitations and waiting periods and terms for keeping them in force. Please contact MetLife for details.

Exclusions

We will not pay Dental Insurance benefits for charges incurred for:

1. Services which are not Dentally Necessary, those which do not meet generally accepted standards of care for treating the particular dental condition, or which We deem experimental in nature;
2. Services for which You would not be required to pay in the absence of Dental Insurance;
3. Services or supplies received by You or Your Dependent before the Dental Insurance starts for that person;
4. Services which are primarily cosmetic (For residents of Texas, see notice page section in your certificate).
5. Services which are neither performed nor prescribed by a Dentist except for those services of a licensed dental hygienist which are supervised and billed by a Dentist and which are for:
   - scaling and polishing of teeth; or
   - fluoride treatments.

   For NY Sitused Groups, this exclusion does not apply.
6. Services or appliances which restore or alter occlusion or vertical dimension.
7. Restoration of tooth structure damaged by attrition, abrasion or erosion.
8. Restorations or appliances used for the purpose of periodontal splinting.
9. Counseling or instruction about oral hygiene, plaque control, nutrition and tobacco.
10. Personal supplies or devices including, but not limited to: water piks, toothbrushes, or dental floss.
11. Decoration, personalization or inscription of any tooth, device, appliance, crown or other dental work.
12. Missed appointments.
13. Services
    - covered under any workers' compensation or occupational disease law;
    - covered under any employer liability law
    - for which the employer of the person receiving such services is not required to pay; or
    - received at a facility maintained by the Employer, labor union, mutual benefit association, or VA hospital.

    For North Carolina and Virginia Sitused Groups, this exclusion does not apply.
14. Services paid under any worker's compensation, occupational disease or employer liability law as follows:
    - for persons who are covered in North Carolina for the treatment of an Occupational Injury or Sickness which are paid under the North Carolina Workers' Compensation Act only to the extent such services are the liability of the employee, employer or workers' compensation insurance carrier according to a final adjudication under the North Carolina Workers' Compensation Act or an order of the North Carolina Industrial Commission approving a settlement agreement under the North Carolina Workers' compensation Act;
    - or for persons who are not covered in North Carolina, services paid or payable under any workers compensation or occupational disease law.

    This exclusion only applies for North Carolina Sitused Groups.
15. Services:
    - for which the employer of the person receiving such services is not required to pay; or
    - received at a facility maintained by the Employer, labor union, mutual benefit association, or VA hospital.

    This exclusion only applies for North Carolina Sitused Groups.
16. Services covered under any workers' compensation, occupational disease or employer liability law for which the employee/or Dependent received benefits under that law.

    This exclusion only applies for Virginia Sitused Groups.
17. Services:
    - for which the employer of the person receiving such services is not required to pay; or
    - received at a facility maintained by the policyholder, labor union, mutual benefit association, or VA hospital.

    This exclusion only applies for Virginia Sitused Groups.
18. Services covered under other coverage provided by the Employer.
19. Temporary or provisional restorations.
20. Temporary or provisional appliances.
21. Prescription drugs.
22. Services for which the submitted documentation indicates a poor prognosis.
23. The following when charged by the Dentist on a separate basis:
    - claim form completion;
    - infection control such as gloves, masks, and sterilization of supplies; or
    - local anesthesia, non-intravenous conscious sedation or analgesia such as nitrous oxide.
24. Dental services arising out of accidental injury to the teeth and supporting structures, except for injuries to the teeth due to chewing or biting of food.

    For NY Sitused Groups, this exclusion does not apply.
25. Caries susceptibility tests.
26. Initial installation of a fixed and permanent Denture to replace one or more natural teeth which were missing before such person was insured for Dental Insurance, except for congenitally missing natural teeth.
27. Other fixed Denture prosthetic services not described elsewhere in this certificate.
28. Precision attachments, except when the precision attachment is related to implant prosthetics.
29. Initial installation or replacement of a full or removable Denture to replace one or more natural teeth which were missing before such person was insured for Dental Insurance, except for congenitally missing natural teeth.
30. Addition of teeth to a partial removable Denture to replace one or more natural teeth which were missing before such person was insured for Dental Insurance, except for congenitally missing natural teeth.
31. Adjustment of a Denture made within 6 months after installation by the same Dentist who installed it.
32. Implants to replace one or more natural teeth which were missing before such person was insured for Dental Insurance, except for congenitally missing natural teeth.
33. Implants supported prosthetics to replace one or more natural teeth which were missing before such person was insured for Dental Insurance, except for congenitally missing natural teeth.
34. Duplicate prosthetic devices or appliances.
35. Replacement of a lost or stolen appliance, Cast Restoration, or Denture.
36. Intra and extraoral photographic images.
37. Services or supplies furnished as a result of a referral prohibited by Section 1-302 of the Maryland Health Occupations Article.
    A prohibited referral is one in which a Health Care Practitioner refers You to a Health Care Entity in which the Health Care Practitioner or Health Care Practitioner's immediate family or both own a Beneficial Interest or have a Compensation Agreement. For the purposes of this exclusion, the terms "Referral", "Health Care Practitioner" , "Health Care Entity", "Beneficial Interest" and Compensation Agreement have the same meaning as provided in Section 1-301 of the Maryland Health Occupations Article.

    This exclusion only applies for Maryland Sitused Groups
38. Fixed and removable appliances for correction of harmful habits.[1]
39. Appliances or treatment for bruxism (grinding teeth), including but not limited to occlusal guards and night guards.[1]
40. Diagnosis and treatment of temporomandibular joint (TMJ) disorders. This exclusion does not apply to residents of Minnesota.[1]
41. Orthodontic services or appliances.[1]
42. Repair or replacement of an orthodontic device.[1]

1 Some of these exclusions may not apply. Please see your plan design and certificate for details.

Like most group dental insurance policies, MetLife group insurance policies contain certain exclusions, waiting periods, reductions and terms for keeping them in force. Please contact MetLife for details.

Common Questions… Important Answers

Who is a participating Preferred Dentist Program (PDP) dentist? A participating dentist is a general dentist or specialist who has agreed to accept MetLife's negotiated fees as payment in-full for services provided to plan participants. PDP fees typically range from 15-45%* below the average fees charged in a dentist's community for the same or substantially similar services.

*Based on internal analysis by MetLife

How do I find a participating PDP dentist? There are more than 135,000 participating PDP dentist locations nationwide, including over 30,000 specialist locations. You can receive a list of these participating PDP dentists online at www.metlife.com/mybenefits or call 1-800-942-0854 to have a list faxed or mailed to you.

What services are covered by my plan? All services defined under your group dental benefits plan are covered. Please review the enclosed plan benefits to learn more.

Does the Preferred Dentist Program (PDP) offer any negotiated fees on non-covered services? MetLife's negotiated fees with PDP (in-network) dentists may extend to services not covered under your plan and services received after your plan maximum has been met, where permitted by applicable state law. If you receive services from a PDP dentist that are not covered under your plan or where the maximum has been met, in those states where permitted by law, you may only be responsible for the PDP (in-network) fee.

May I choose a non-participating dentist? Yes. You are always free to select the dentist of your choice. However, if you choose a dentist who does not participate in the MetLife PDP, your out-of-pocket expenses may be more, since you will be responsible to pay for any difference between the dentist's fee and your plan's payment for the approved service. If you receive services from a participating PDP dentist, you are only responsible for the difference between the PDP in-network fee for the service provided and your plan's payment for the approved service. Please note: any plan deductibles must be met before benefits are paid.

Can my dentist apply for PDP participation? Yes. If your current dentist does not participate in the PDP and you'd like to encourage him or her to apply, tell your dentist to visit www.metdental.com, or call 1-877-MET-DDS9 for an application. The website and phone number are designed for use by dental professionals only.

How are claims processed? Dentists may submit your claims for you which means you have little or no paperwork. You can track your claims online and even receive e-mail alerts when a claim has been processed. If you need a claim form, visit www.metlife.com/mybenefits or request one by calling 1-800-942-0854.

Can I find out what my out-of-pocket expenses will be before receiving a service? Yes. MetLife recommends that you request a pre-treatment estimate for services in excess of $300. Simply have your dentist submit a request online at www.metdental.com or call 1-877-MET-DDS9. You and your dentist will receive a benefit estimate for most procedures while you're still in the office. Actual payments may vary depending upon plan maximums, deductibles, frequency limits and other conditions at time of payment.

How can I learn about what dentists in my area charge for different procedures? With the Dental Procedure Fee Tool provided by go2dental.com, you can learn more about approximate fees for services such as exams, cleanings, fillings, crowns and more. Simply visit www.metlife.com/mybenefits and use the Dental Procedure Fee Tool to help you estimate the in-network (PDP fees) and out-of-network fee* for dental services in your area.

*Out-of-network fee information is provided by go2dental.com, Inc., an industry source independent of MetLife. This site does not provide the benefit payment information used by MetLife when processing your claims. Prior to receiving services, we recommend that you obtain pre-treatment estimates through your dentist.

Can MetLife help me find a dentist outside of the U.S. if I am traveling? Yes. Through international dental travel assistance services* you can obtain a referral to a local dentist by calling +1-312-356-5970 (collect) when outside the U.S. to receive immediate care until you can see your dentist. Coverage will be considered under your out-of-network benefits.** Please remember to hold on to all receipts to submit a dental claim.

*International Dental Travel Assistance services are administered by AXA Assistance USA, Inc. AXA Assistance is not affiliated with MetLife, and the services they provide are separate and apart form the benefits provided by MetLife.

**Refer to your dental benefits plan summary for your out-of-network dental coverage.

How does MetLife coordinate benefits with other insurance plans? Coordination of benefits provision in dental benefits plans are a set of rules that are followed when a patient is covered by more than one dental benefits plan. These rules determine the order in which the plans will pay benefits. If the MetLife dental benefit plan is primary, MetLife will pay the full amount of benefits that would normally be available under the plan. If the MetLife dental benefit plan is secondary, most coordination of benefits provisions require MetLife to determine benefits after benefits have been determined under the primary plan. The amount of benefits payable by MetLife may be reduced due to the benefits paid under the primary plan.

Do I need an ID card? No, you do not need to present an ID card to confirm that you're eligible. You should notify your dentist that you participate in MetLife's PDP. Your dentist can easily verify information about your coverage through a toll-free automated Computer Voice Response system.

Do my dependents have to visit the same dentist that I select? No, you and your dependents each have the freedom to choose any dentist.

If I do not enroll during my initial enrollment period can I still purchase Dental Insurance at a later date? Yes, employees who do not elect coverage during their 31-day application period may still elect coverage later. Dental coverage would be subject to the following waiting periods.

- No waiting period on Preventive Services
- 24 months on Major Services
- 6 months on Basic Restorative (Fillings)
- 24 months on Orthodontia Services (if applicable)
- 12 months on all other Basic Services

218 Main St. #513
Kirkland, WA 98033

www.tbsmga.com

Phone# 425.897.7150
Fax# 877.653.2118

Cascade Employers Health Insurance Trust

Employee Group Life/ AD&D Ultra Benefits

$20,000 of employee life and $20,000 of employee AD&D are required for all those enrolling in a medical plan.

Accelerated Death Benefit

Up to 75% of the Life Amount for terminal illness.

Age Reduction Schedule

Original Life Amount reduces to:
65% at age 65
40% at age 70
25% at age 75

www.dearbornnational.com

Dearborn National™
Strength. Independence. Solutions.

VOLUNTARY GROUP TERM LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT

A simple, economical way to plan for your and your family's future. The voluntary coverage is payroll deducted and sponsored by your employer at a conveniently cost effective rate.

Most families depend upon each paycheck to pay expenses and plan for the future. In the unexpected event of death, life insurance provides immediate financial assistance for you and your family when it is most needed.

VOLUNTARY GROUP TERM LIFE BENEFIT OPTIONS...

- $10,000 to a maximum of $500,000, in increments of $10,000.
- If you and/or your spouse elect at least $10,000 of Voluntary Group Term Life coverage and the minimum group employee participation requirements are met during the initial enrollment period, you will be eligible for $10,000 of additional coverage without evidence of insurability, up to the group's guarantee issue level during the next open enrollment.
- Voluntary group term life benefits do not reduce.
- A one-year suicide exclusion applies to Voluntary Group Term Life coverage.

YOU ARE ELIGIBLE IF...

- You are currently employed, work full-time (at least 20 hours per week unless otherwise mandated by your employer) and have satisfied your group's waiting period.

You must be covered under your employer's group life plan to enroll for Voluntary Group Term Life in VT and SD. The spouse benefit is limited to 50% of the employee benefit in FL, and NE. In addition, coverage may not exceed the employee benefit in AZ, CA, HI, IL, MD, NJ, VA, VT and WA. In TX, the spouse benefit may not exceed the amount for which the employee is eligible.

LIFE INSURANCE CAN BE PURCHASED FOR YOUR CHILDREN...

at an inexpensive cost. You have the option of choosing from two plans:

- $5,000
- $10,000

Each plan will cover your children from live birth to 6 months for $100 of term life insurance. Children of the age 6 months to 19 years (23 years if full-time student) who depend on you for support are covered for the full amount elected.

If you elect this coverage, your unmarried dependent children (who are not in the active military service) will be insured without medical underwriting.

A person cannot be insured as an employee and as a dependent under this benefit. If both the husband and wife are covered as insureds under a policy, only one may enroll for coverage on dependent children.

YOUR PERSONAL MONTHLY PREMIUMS...

are based upon your age and the industry in which you are employed. Your monthly premiums will depend on the amount of insurance selected. Premiums will increase in accordance with the applicable rate table, as your age and/or your spouse's age increases—refer to your group's rate grid.

YOU MUST DESIGNATE A BENEFICIARY...

on your enrollment application and may change your beneficiary at any time.

Should you elect for spousal or dependent children coverage you, the employee, will automatically be the beneficiary of the policy proceeds on your spouse and dependent child(ren).

ADDITIONAL VOLUNTARY GROUP TERM LIFE FEATURES...

- Portability
- Waiver of Premium*
- Conversion
- Accelerated Death Benefit*

ACCELERATED DEATH BENEFIT DISCLOSURE:

If you have a Voluntary Term Life Insurance benefit of at least $20,000, you are eligible for an Accelerated Death Benefit (ADB). The ADB is equal to 50% of your Voluntary Term Life Insurance amount and may not exceed $150,000. We will pay an accelerated benefit if we receive due written proof that you are terminally ill with less than 12 months to live. Payment of an accelerated benefit will reduce the death benefit otherwise payable to your designated beneficiary.

*Employee only

Following the payment of an accelerated death benefit, your life insurance premium will be calculated on the amount of life insurance remaining in force after deducting the amount of the accelerated benefit

The Accelerated Death Benefit offered under the Policy is intended to qualify for favorable tax treatment under the Internal Revenue Code of 1986. If the Accelerated Death Benefit qualifies for such favorable tax treatment, the benefits will be excluded from the insured Employee's income and not subject to federal taxation. Tax laws relating to Accelerated Death Benefits are complex. The insured Employee is advised to consult with a qualified tax advisor about circumstances under which he or she could receive the Accelerated Death Benefits excludable from income under federal law.

Receipt of the Accelerated Death Benefit payment may affect the insured Employee, his or her spouse, or his or her family's eligibility for public assistance such as medical assistance (Medicaid), Aid to Families with Dependent Children (AFDC), Supplementary Social Security Income (SSI), and drug assistance programs. The insured Employee is advised to consult with a qualified tax advisor and with social service agencies concerning how receipt of such payment will affect the insured Employee, his or her spouse, or his or her family's eligibility for public assistance.

VOLUNTARY GROUP ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D)

You have the option of purchasing Voluntary AD&D coverage. However, Voluntary AD&D may not be purchased separately. You must apply for Voluntary Group Life insurance if you wish to select Voluntary AD&D coverage.

Satisfactory Evidence of Insurability may be required for Voluntary Group Life insurance. If your application for life insurance is declined, no AD&D coverage will be issued.

Individual Plan - allows you to choose a benefit amount up to $500,000, in increments of $10,000.

Family Plan - allows you to insure your spouse and/or dependent children. The spouse benefit is equal to 50% of your benefit, and each child is covered for 10% of your benefit amount.

- Voluntary Group AD&D pays a benefit in the event of death or dismemberment within 365 days of the date of a covered accident. The benefit will be paid as follows:

For	Amount Payable
Loss of life	Full benefit
Loss of two or more members	Full benefit
Quadriplegia	Full benefit
Paraplegia	One half of benefit
Loss of one member	One half of benefit
Hemiplegia	One half of benefit
Loss of thumb and index finger on same hand	One quarter benefit
Uniplegia	One quarter benefit

**This information is only a product highlight. Life benefits may be subject to medical underwriting. Coverage for a medically underwritten benefit is not effective until the date the insurer has approved the employee's application. The policy has exclusions, limitations, and reduction of benefits and/or terms under which the policy may be continued or discontinued. The policy may be cancelled by the insurer at any time. The insurer reserves the right to change premium rates, but not more than once in a 12-month period.*

"Member" means hand, foot, sight, speech or hearing. Loss will be completely defined in your certificate of insurance.

- Benefit amounts for insured persons over the age of 69 will be equal to the following schedule:

Age	Principal Sum Equal to	Age	Principal Sum Equal to
70-74	65% of benefit	80-84	30% of benefit
75-79	45% of benefit	85+	15% of benefit

VOLUNTARY GROUP AD&D ADDITIONAL FEATURES:

- Seat Belt Benefit
- Air Bag Benefit
- Education Benefit
- Repatriation Benefit
- Common Disaster Benefit

VOLUNTARY GROUP AD&D LIMITATIONS

We will not pay any benefit for any Loss that, directly or indirectly, results in any way from or is contributed to by:

- Any disease or infirmity of mind or body and any medical or surgical treatment thereof.
- Any infection, except a pus-forming infection of an accidental cut or wound.
- Suicide or attempted suicide, while sane or insane.
- Any intentionally self-inflicted Accident.
- War, declared or undeclared, whether or not the insured person is a member of any armed forces.
- Travel or flight in an aircraft while a member of the crew, or while engaged in the operation of the aircraft, or giving or receiving training or instruction in such aircraft.
- Commission of, participation in, or attempt to commit an assault or felony.
- Being under the influence of any narcotic, hallucinogen, barbiturate, amphetamine, gas or fumes, poison or any other controlled substance as defined in Title II of the Comprehensive Drug Abuse.
- Intoxication as defined by the laws of the jurisdiction in which the Accident occurred or .08% blood alcohol content if the jurisdiction in which the Accident occurred does not define intoxication. Conviction is not necessary for a determination of being intoxicated.
- Active participation in a Riot.

HOW TO ENROLL

Simply complete the provided enrollment form(s) and indicate the amount of Voluntary Group Term Life/ AD&D coverage you would like for you and your family. Depending on the amount of Voluntary Group Term Life coverage, you and/or your spouse may be required to complete a health questionnaire – coverage will only become effective if the company approves your application.

Once completed, return the provided enrollment form(s) promptly to your employer for processing.

Dearborn National™

A08-0106-0608

Z6140 (10/09) DN

VOLUNTARY GROUP LIFE AND AD&D PREMIUM RATE GRID

Dearborn National™

Eligibility

You are eligible to enroll if you work the minimum number of hours per week required by your employer, and have satisfied any waiting period.

You must also be covered under the group life insurance plan sponsored by your employer in Vermont, South Dakota.

Voluntary Group Life

Employee & Spouse Benefit - $10,000 to $500,000 in $10,000 increments

The amount of spouse life insurance is limited to 50% of the employee benefit in Florida, Indiana, Kentucky and Wyoming. The spouse benefit may not exceed the employee benefit amount in Arizona, California, Hawaii, Illinois, Maryland, New Jersey, Vermont, Virginia and Washington.

Child Coverage

Ages 15 days to 6 months: $100
Ages 6 months to 19 years (23 years if full time student): $5,000 or $10,000

Voluntary Group AD&D

The Individual Plan covers you in the event of accidental death or dismemberment. Benefits from $10,000 to $500,000 in $10,000 increments.

The Family Plan insures you, your spouse and/or any dependent children. The spouse benefit is equal to 50% of your benefit and the child benefit is 10% of your benefit.

VOLUNTARY GROUP LIFE
NON-TOBACCO USER

MONTHLY RATES PER $1,000

AGE	RATES
Under 30	$0.10
30 - 34	0.10
35 - 39	0.14
40 - 44	0.24
45 - 49	0.35
50 - 54	0.58
55 - 59	1.01
60 - 64	1.58
65 - 69	2.49
70 - 74	3.98
75 and Over	7.06

VOLUNTARY GROUP AD&D

MONTHLY RATES PER $1,000

INDIVIDUAL PLAN	$0.05
FAMILY PLAN	$0.08

DEPENDENT LIFE

MONTHLY RATE PER FAMILY

$5,000 - $1.00

$10,000 - $2.00

IF YOU HAVE USED TOBACCO PRODUCTS IN THE LAST TWO YEARS, THE TOBACCO USER RATES WILL APPLY.

Non-Tobacco User Voluntary Group Life

Bi-Weekly Premium Cost (based on 26 payroll deductions per year)

Age	< 30	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75+
$10,000	$0.46	$0.46	$0.65	$1.11	$1.62	$2.68	$4.66	$7.29	$11.49	$18.37	$32.58
$20,000	0.92	0.92	1.29	2.22	3.23	5.35	9.32	14.58	22.98	36.74	65.17
$30,000	1.38	1.38	1.94	3.32	4.85	8.03	13.98	21.88	34.48	55.11	97.75
$40,000	1.85	1.85	2.58	4.43	6.46	10.71	18.65	29.17	45.97	73.48	130.34
$50,000	2.31	2.31	3.23	5.54	8.08	13.38	23.31	36.46	57.46	91.85	162.92
$60,000	2.77	2.77	3.88	6.65	9.69	16.06	27.97	43.75	68.95	110.22	195.51
$70,000	3.23	3.23	4.52	7.75	11.31	18.74	32.63	51.05	80.45	128.58	228.09
$80,000	3.69	3.69	5.17	8.86	12.92	21.42	37.29	58.34	91.94	146.95	260.68
$90,000	4.15	4.15	5.82	9.97	14.54	24.09	41.95	65.63	103.43	165.32	293.26
$100,000	4.62	4.62	6.46	11.08	16.15	26.77	46.62	72.92	114.92	183.69	325.85
$110,000	5.08	5.08	7.11	12.18	17.77	29.45	51.28	80.22	126.42	202.06	358.43
$120,000	5.54	5.54	7.75	13.29	19.38	32.12	55.94	87.51	137.91	220.43	391.02
$130,000	6.00	6.00	8.40	14.40	21.00	34.80	60.60	94.80	149.40	238.80	423.60
$140,000	6.46	6.46	9.05	15.51	22.62	37.48	65.26	102.09	160.89	257.17	456.18
$150,000	6.92	6.92	9.69	16.62	24.23	40.15	69.92	109.38	172.38	275.54	488.77

Additional benefit amounts are available in $10,000 increments to a maximum of $500,000.

Policy Provisions may vary by state. Refer to a certificate or enrollment brochure for details about coverage features and limitations (Policy number FDL1-504-707)

LIFE Industry Code: I-3

Quote id: 93814

Quote Date: 08/10/2010

VOLUNTARY GROUP LIFE AND AD&D PREMIUM RATE GRID

Dearborn National™

Eligibility

You are eligible to enroll if you work the minimum number of hours per week required by your employer, and have satisfied any waiting period.

You must also be covered under the group life insurance plan sponsored by your employer in Vermont, South Dakota.

Voluntary Group Life

Employee & Spouse Benefit - $10,000 to $500,000 in $10,000 increments

The amount of spouse life insurance is limited to 50% of the employee benefit in Florida, Indiana, Kentucky and Wyoming. The spouse benefit may not exceed the employee benefit amount in Arizona, California, Hawaii, Illinois, Maryland, New Jersey, Vermont, Virginia and Washington.

Child Coverage

Ages 15 days to 6 months: $100
Ages 6 months to 19 years (23 years if full time student): $5,000 or $10,000

Voluntary Group AD&D

The Individual Plan covers you in the event of accidental death or dismemberment. Benefits from $10,000 to $500,000 in $10,000 increments.

The Family Plan insures you, your spouse and/or any dependent children. The spouse benefit is equal to 50% of your benefit and the child benefit is 10% of your benefit.

VOLUNTARY GROUP LIFE
TOBACCO USER

MONTHLY RATES PER $1,000

AGE	RATES
Under 30	$0.18
30 - 34	0.19
35 - 39	0.26
40 - 44	0.41
45 - 49	0.76
50 - 54	1.24
55 - 59	2.24
60 - 64	2.73
65 - 69	4.40
70 - 74	6.99
75 and Over	11.76

VOLUNTARY GROUP AD&D
MONTHLY RATES PER $1,000

INDIVIDUAL PLAN	$0.05
FAMILY PLAN	$0.08

DEPENDENT LIFE
MONTHLY RATE PER FAMILY

$5,000 - $1.00
$10,000 - $2.00

IF YOU HAVE USED TOBACCO PRODUCTS IN THE LAST TWO YEARS, THE TOBACCO USER RATES WILL APPLY.

Tobacco User Voluntary Group Life

Bi-Weekly Premium Cost (based on 26 payroll deductions per year)

Age	< 30	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75+
$10,000	$0.83	$0.88	$1.20	$1.89	$3.51	$5.72	$10.34	$12.60	$20.31	$32.26	$54.28
$20,000	1.66	1.75	2.40	3.78	7.02	11.45	20.68	25.20	40.62	64.52	108.55
$30,000	2.49	2.63	3.60	5.68	10.52	17.17	31.02	37.80	60.92	96.78	162.83
$40,000	3.32	3.51	4.80	7.57	14.03	22.89	41.35	50.40	81.23	129.05	217.11
$50,000	4.15	4.38	6.00	9.46	17.54	28.62	51.69	63.00	101.54	161.31	271.38
$60,000	4.98	5.26	7.20	11.35	21.05	34.34	62.03	75.60	121.85	193.57	325.66
$70,000	5.82	6.14	8.40	13.25	24.55	40.06	72.37	88.20	142.15	225.83	379.94
$80,000	6.65	7.02	9.60	15.14	28.06	45.78	82.71	100.80	162.46	258.09	434.22
$90,000	7.48	7.89	10.80	17.03	31.57	51.51	93.05	113.40	182.77	290.35	488.49
$100,000	8.31	8.77	12.00	18.92	35.08	57.23	103.38	126.00	203.08	322.62	542.77
$110,000	9.14	9.65	13.20	20.82	38.58	62.95	113.72	138.60	223.38	354.88	597.05
$120,000	9.97	10.52	14.40	22.71	42.09	68.68	124.06	151.20	243.69	387.14	651.32
$130,000	10.80	11.40	15.60	24.60	45.60	74.40	134.40	163.80	264.00	419.40	705.60
$140,000	11.63	12.28	16.80	26.49	49.11	80.12	144.74	176.40	284.31	451.66	759.88
$150,000	12.46	13.15	18.00	28.38	52.62	85.85	155.08	189.00	304.62	483.92	814.15

Additional benefit amounts are available in $10,000 increments to a maximum of $500,000.
Policy Provisions may vary by state. Refer to a certificate or enrollment brochure for details about coverage features and limitations (Policy number FDL1-504-707)

Washington Cascade Employer Health Insurance Trust
Employee Enrollment/Change Form

TO COMPLY WITH WASHINGTON LAW, WHEREVER THE TERM "SPOUSE" APPEARS IT WILL BE CONSTRUED TO INCLUDE DOMESTIC PARTNER.

Life, Accidental Death & Dismemberment, and Aetna PPO and Traditional plans are underwritten by Aetna Life Insurance Company. Dental Plans are provided by Aetna Life Insurance Company.

Member Aetna ID Number (if available)

Employer Name

INSTRUCTIONS: You, the employee, must complete this enrollment form in full or it will be returned to you resulting in a delay in processing. You are solely responsible for its accuracy and completeness. **If waiving coverage, please complete Sections B and F.**

Effective Date _____

Date of Hire _____

☐ New Hire
☐ Rehire/Reinstatement
☐ New Group Enrollment
☐ Late Enrollment
☐ Other _____

☐ Change of Coverage
☐ Add Spouse/Dependent Child
☐ Name Change
☐ Other _____

☐ Employee Termination
☐ Remove Spouse/Dependent Child
☐ Cancel Coverage

COBRA/State Continuation for:
☐ Employee ☐ Dependent
Length of Continuation:
☐ 18 ☐ 36 ☐ Other _____
Original Qualifying Event Date _____
Reason _____

A. Coverage Selection – *Please print clearly, using black ink. (Shaded sections for Employer/Aetna Use Only)*

Control/Group No.	Suffix	Account	Plan No.	Class Code	Control/Group No.	Suffix	Account	Plan No.	Control/Group No.	Suffix	Account	Plan No.

1. Medical - Check one.

☐ PPO Value 1000 80/50

☐ PPO Saver 2500 70/50

☐ PPO HSA HDHP 1500 80/50

3. Life

☐ Basic Life/AD&D Ultra®

Beneficiary Designation - **Full Name** (First, Middle, Last)

Beneficiary Social Security Number

Relationship to Employee

B. Employee Information - *Must be completed by the employee.*

Social Security Number	Last Name, First Name, M.I.	Job Title	Home Telephone	Primary Language Spoken (Optional)

Home Address	Apt. No.	City, State	ZIP Code

Work Address	City, State	ZIP Code	Work Telephone

Salary	No. of Hours Worked Per Week	Check One	No. of Dependents Including Spouse
$ ☐ Hourly ☐ Weekly ☐ Monthly		☐ Full-Time ☐ Part-Time	

C. Individuals Covered - *List individuals for whom you are enrolling or adding/changing/removing coverage. Insert additional sheets if necessary.*

NOTE FOR MEDICAL AND DENTAL COVERAGE: While the Federal Patient Protection and Affordable Care Act mandates coverage of dependent children up to age 26, your plan may allow coverage beyond age 26. Some exceptions apply. Please refer to your plan documents or contact your benefits administrator.

(A)dd (C)hange (R)emove	Name (Last, First, M.I.)	Sex M/F	Social Security Number	Birthdate (MM/DD/YYYY)	Height (ft, in)	Weight (lbs)	Status	Coverage Election	Primary Office ID Number (if applicable)	Current Patient
	Employee 1.			/ /			☐ Single ☐ Divorced ☐ Married ☐ Widowed ☐ Legally Separated	☐ Medical ☐ Dental ☐ Life		Yes ☐
	Spouse/Domestic Partner 2.			/ /			☐ Different Last Name	☐ Medical ☐ Dental ☐ Life		☐
	Child 3.			/ /			☐ Different Last Name ☐ Lives at another address ☐ Disabled	☐ Medical ☐ Dental ☐ Life		☐
	Child 4.			/ /			☐ Different Last Name ☐ Lives at another address ☐ Disabled	☐ Medical ☐ Dental ☐ Life		☐

D. Dependent Information

List any dependent in Section C living at another address.	Name:	Reason:	Address:
If any dependent's last name differs from yours, explain.	Name:	Reason:	

E. Race/Ethnicity – Optional (This information is designed for the purpose of data collection and will not be used for determining eligibility, rating or claim payment.)

Employee 1.	☐ White – 01 ☐ African American or Black – 02 ☐ Hispanic or Latino – 03 ☐ Asian – 04 ☐ Other – 05 _____	**Child 3.**	☐ White – 01 ☐ African American or Black – 02 ☐ Hispanic or Latino – 03 ☐ Asian – 04 ☐ Other – 05 _____
Spouse 2.	☐ White – 01 ☐ African American or Black – 02 ☐ Hispanic or Latino – 03 ☐ Asian – 04 ☐ Other – 05 _____	**Child 4.**	☐ White – 01 ☐ African American or Black – 02 ☐ Hispanic or Latino – 03 ☐ Asian – 04 ☐ Other – 05 _____

F. Declination/Waiver of Coverage - *To be completed ONLY if medical and/or dental coverage is declined or refused by an eligible employee and/or their eligible family members.*

1. Medical Coverage Declined for:
☐ Myself ☐ Spouse ☐ Dependents

2. Dental Coverage Declined for:
☐ Myself ☐ Spouse ☐ Dependents

Reason for Declining Coverage *(If applicable, please attach front/back of your health coverage ID card.)*:
☐ Covered by spouse's group coverage - Carrier Name and ID _____
☐ Enrolled in other Insurance Carrier Plans - Carrier Name and ID _____
☐ Spouse covered by medical coverage ☐ Spouse covered by employer's group dental coverage
☐ Spouse covered by employer's group coverage
☐ Medicare ☐ Covered by TRICARE or CHAMPVA ☐ Medicaid ☐ Indian Health Services ☐ Other _____

I acknowledge I have been given the right to apply for this coverage, however, I am electing not to enroll for the reason checked above. By declining this group coverage I acknowledge that myself and/or my dependents may have to wait until the plan's next anniversary date to be enrolled for group coverage. Pre-existing conditions may not be covered for three (3) months. **NOTE**: If your Plan contains a pre-existing conditions provision, the pre-existing conditions exclusion and limitation will not apply to a person under 19 years of age.

Please sign here ONLY if you are declining coverage for yourself and/or dependent(s).	***Date (Month/Day/Year)***
X Employee Signature	

G. Other Insurance

Does anyone age 19 and over enrolling on this enrollment form have current or prior medical and/or dental coverage? ☐ Yes ☐ No

Proof of coverage should accompany this enrollment form for pre-existing condition credit and if an employee is waiving coverage. Acceptable forms of proof are:
1. Certificate of Creditable Coverage from prior carrier, or
2. Copy of ID card or most recent payroll stub showing medical coverage deduction, or
3. Copy of most recent medical premium bill from prior carrier.

Failure to provide Proof of Prior Coverage may subject you or a family member (age 19 and over) to the full pre-existing conditions limitation with no credit for prior coverage. You may request a Certificate of Creditable Coverage from your prior carrier. NOTE: If your Plan contains a pre-existing conditions provision, the pre-existing conditions exclusion and limitation will not apply to a person under 19 years of age.

Name of Covered Individual	Carrier Name	Group Number	Start Date	Termination Date	Health	Dental
					☐ Yes ☐ No	☐ Yes ☐ No
					☐ Yes ☐ No	☐ Yes ☐ No

H. Medicare Information

Name of Person	Medicare Part A	Medicare Part B	Medicare Part D	Over Age 65	Disability	End-Stage Renal Disease Eff Date
	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	

Conditions of Enrollment

On behalf of myself and the dependents listed on the reverse side, I agree to or with the following:

1. I acknowledge that by enrolling in the following plans, coverage is provided by Aetna Life Insurance Company (referred to as "Aetna"): Aetna PPO plans, Life, Accidental Death & Dismemberment, dental and all other coverages.
2. I understand and agree that my employer's enrollment form will determine coverage and that there is no coverage unless and until both the eligible employee enrollment form and employer applications have been accepted and approved by Aetna. Even if this enrollment form is approved, any misstatements or omissions may result in future claims being denied and the policy or my coverage under the policy being rescinded or reevaluated, as of the effective date, for eligibility and rating purposes. ***For life coverages:*** I understand that the effective date of insurance for myself or for any of my dependents is subject to my being actively at work on that date and that the effective date of insurance for any of my dependents is also subject to the dependent health condition requirements of the benefit plan. Further, I understand that any insurance subject to evidence of good health or medical information will not become effective until Aetna gives its written consent. For Dependent Life, dependents are eligible from 14 days of age up to their 19th birthday or up to their 23rd birthday, if a full-time student.
3. Authorizations signed for the purpose of collecting information in connection with this enrollment form for an insurance policy, a policy reinstatement or a request for a change in policy benefits shall remain valid for thirty (30) months from the date signed. Authorizations signed for the purpose of collecting information in connection with a claim for benefits shall remain valid for the term of this coverage or for so long as allowed by law. The information, as well as other personal or privileged information, subsequently collected by the insurance institution or insurance producer may, in certain circumstances, be disclosed to third parties without authorization. A right of access and correction exists with respect to all personal information collected. Further disclosures required by **Washington** law will be furnished to the policyholder upon request. Personal information may be collected from persons other than the individual or individuals proposed for coverage.
4. The plan documents will determine the rights and responsibilities of member(s) and will govern in the event they conflict with any benefits comparison, summary or other description of the plan.
5. I understand and agree that providers and vendors are independent contractors in private practice and are neither employees nor agents of Aetna or its affiliates. The availability of any particular provider cannot be guaranteed, and provider network composition is subject to change.
6. I understand and agree that, with certain exceptions described in the plan documents, DMO plans only provide coverage for referred benefits, and that, in order to be covered, services must be performed either by a participating primary care physician, primary care dentist, or by the participating specialist, hospital, pharmacy, dentist, or other provider as authorized by a referral from a participating primary care physician.
7. I understand and agree that, as described in the plan documents, any pre-existing conditions for my spouse, dependents or myself may not be covered for 3 months. NOTE: If your Plan contains a pre-existing conditions provision, the pre-existing conditions exclusion and limitation will not apply to a person under 19 years of age.

I represent that all information supplied in this form is true and complete. I have read and agree to the Conditions of Enrollment on this **Cascade Employer Health Insurance Trust Employee** Enrollment/Change Form. I understand that, in the event I fail to sign this form within 31 days after the above transaction request or for any reason Aetna does not receive notice of the above transaction request within a reasonable time following the event, my and my dependents' eligibility may be affected. I am employed by the employer shown on Page 1 at the regular place of business.

It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

Employee Signature	***Employee E-mail Address (optional)***	***Date (Month/Day/Year)***
X		

ALLIED STEEL FABRICATORS, INC.
HSA Payroll Deduction Form

PAYROLL DEDUCTION AUTHORIZATION

NAME _____

I authorize Allied Steel Fabricators to deduct the following monthly HSA Contributions from my paycheck via Section 125 Pre-Tax:

☐ Single Employee Coverage: _____ per month
(**Total Employee Portion can be no more than $215.00)**
Allied Steel will contribute $43.34 per month ($520.00 per year) into your HSA account. Maximum total contribution is $3,100/year ($258.34/month). If you are over age 55 you may be eligible to contribute an extra and $1,000.

☐ Family Coverage: _____ per month
(**Total Employee Portion can be no more than $477.50).**
Allied Steel will contribute $43.34 per month ($520.00 per year) into your HSA account. Maximum total contribution, including employer contribution, is $6,250 per year ($520.84 per month). If you are over age 55 you may be eligible to contribute an extra and $1,000.

Dated:_____ _____
Signature of participant

The above summary is an overview only and is not a guarantee of benefits. For complete description of benefits and limitations see your benefit book.

Cascade Employer Health Insurance Trust

Deductible Credit Form

Amounts applied toward your calendar year deductible on your previous group health plan will be credited to your calendar year deductible on your new CEHIT plan if

- You are a member of a **NEW** group plan that has transferred its coverage from another insurance carrier with no break in coverage.
- A copy of an **Explanation of Benefits** or a statement from your prior insurance carrier is attached.
- You provide this form within 90 days of transfer to the CEHIT plan

Please fax this form with the attachments to 1-866-474-4040
With the subject line: **Deductible Credit SFRE**

Employee Name: _____

Employee Aetna ID #: _____

Employee SS#: _____

Group Name: _____

		Date of Birth	*Medical Deductible Met*
Employee:	_____	_____/_____/_____	$_____
Dependant:	_____	_____/_____/_____	$_____
Dependant:	_____	_____/_____/_____	$_____
Dependant:	_____	_____/_____/_____	$_____
Dependant:	_____	_____/_____/_____	$_____
Dependant:	_____	_____/_____/_____	$_____

The information provided here is true to the best of my knowledge.

Employee Signature

_____ Date _____

MetLife®
Metropolitan Life Insurance Company, New York, NY
Small Market Administration
P.O. Box 14593, Lexington, KY 40512-4593
Fax: 1-888-505-7446

ENROLLMENT FORM FOR GROUP INSURANCE

SECTION TO BE COMPLETED BY EMPLOYEE (PLEASE PRINT)

Name of Employee Last First Middle	Social Security #	Date of Birth (Mo./Day/Yr.)	☐ Male ☐ Female
Employee's Address Street City State Zip Code		Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced	
Employee's E-mail Address	Phone No. (include area code)		
Name of Employer	Group Customer #	Division / Class / Dept Code	
Employer's Street Address	City / State	Zip Code	Employee's Work Location
Date of Hire (Mo./Day/Yr.)	☐ Full-Time ☐ Part-Time	Employee's Occupation	Coverage Effective Date (Mo./Day/Yr.)
Work Status: ☐ New Hire ☐ Active ☐ Retired ☐ Disabled ☐ Rehire ☐ On Layoff/Leave of Absence		Hours Worked Per Week	☐ Hourly Paid ☐ Annual ☐ Monthly
☐ Original COBRA Effective Date (Mo./Day/Yr.)		Salary $	

Reason for Enrollment: ☐ New Coverage ☐ New Hire/First Time Eligible ☐ Change in Enrollment
☐ Family Status Change (not applicable to new enrollments) Date (Mo./Day/Yr.) _____

COVERAGE REQUEST DATA:

I have received and read a copy of my employer's current announcement of the group plan. I want to be covered under the group plan for the benefits for which I am or may become eligible, requested below.

I request the following coverage:

Employee Coverage

☐ Dental

Dependent Spouse Coverage (**Note**: Dependent coverage is provided under the same plan the employee has chosen.)

☐ Dental/Dental Dual Option/Voluntary Dental

Dependent Child Coverage (**Note**: Dependent coverage is provided under the same plan the employee has chosen.)

☐ Dental/Dental Dual Option/Voluntary Dental

☐ **I wish to DECLINE any coverage not checked above for which I may be eligible.** For Dental and/or Dependent Dental Coverage, a waiting period may be required before I and/or a dependent can be enrolled. Reason for declining employee and/or dependent coverage (i.e. benefits elsewhere, cost, other): _____

If applying for Dependent coverage (Spouse or Child), complete the following:

Number of dependents (including spouse) ____

Name of Spouse (Last, First, MI)	Date of Birth	Sex	
		☐ M ☐ F	
Name(s) of Child(ren) (Last, First, MI)	**Date of Birth**	**Sex**	**Is child a full-time student?**
		☐ M ☐ F	☐ Yes
		☐ M ☐ F	☐ Yes
		☐ M ☐ F	☐ Yes
		☐ M ☐ F	☐ Yes

Please Retain A Copy Of The Fully-Completed Form For Your Records And Return The Original To Your Employer

(Continued on Following Page)

DECLARATION SECTION

Each person signing below **declares** that all the information given in this enrollment form is true and complete to the best of his/her knowledge and belief.

The employee **declares** that he or she is actively at work on the date of this enrollment form.

For Changes Requested After Initial Enrollment Period Expires

I **understand** that if dental coverage is not elected, a waiting period may be required before I can enroll for such coverage after the initial enrollment period has expired.

For Payroll Deduction Authorization By the Employee

I **authorize** my employer to deduct the required contributions from my pay for the coverage requested in this enrollment form. This authorization applies to such coverage until I rescind it in writing.

Fraud Warning:

If you reside in or are applying for insurance under a policy issued in one of the following states, please read the applicable warning.

New York [only applies to Accident and Health Benefits (AD&D/Disability/Dental)]: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Florida: Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Massachusetts: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, and may subject such person to criminal and civil penalties.

New Jersey: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Oklahoma: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Kansas, Oregon, and Vermont: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto may be guilty of insurance fraud, and may be subject to criminal and civil penalties.

Puerto Rico: Any person who, knowingly and with the intent to defraud, presents false information in an insurance request form, or who presents, helps or has presented, a fraudulent claim for the payment of a loss or other benefit, or presents more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine no less than five thousand (5,000) dollars nor more than ten thousand (10,000), or imprisonment for a fixed term of three (3) years, or both penalties. If aggravated circumstances prevail, the fixed established imprisonment may be increased to a maximum of five (5) years; if attenuating circumstances prevail, it may be reduced to a minimum of two (2) years.

Virginia and Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

All other states:

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which may be a crime and may subject such person to criminal and civil penalties.

Signature(s): The employee must sign in all cases. The person signing below acknowledges that they have read and understand the statements and declarations made in this enrollment form.

Employee Signature	Print Name	Date Signed (Mo./Day/Yr.)