How to get the Power of Ready on your side

Enroll in the Aetna insurance plans offered through Schwan’s Shared Services, LLC today

Unexpected stuff happens to all of us. That’s why you need to be ready with insurance options from Aetna Voluntary Plans. This is your opportunity to sign up for benefits. So take a few minutes to find out about your options now!

Please note, these plans provide supplemental benefits and are not a substitute for comprehensive medical insurance.

Open enrollment begins on November 9 and ends on November 21, 2014.

If you were just hired, you have 31 days from the date you become eligible to enroll.

Aetna Vision Plan
Reimburses you for an exam, frames, lenses or contact lenses up to an annual limit.

Aetna Dental Plan
Covers a portion of your bill for common dental procedures.

Aetna Short-Term Disability Plan
Pays a portion of your salary up to a set number of weeks, if you become disabled and are unable to work.

Aetna Term Life Insurance
Pays your beneficiary if you die, to help with funeral or other expenses.

SCHWAN’S SHARED SERVICES, LLC
GROUP NUMBER: 500031

YOUR NAME: ___________________________

FOR MEMBER SERVICES CALL 1-888-772-9682

PAYER NUMBER 57604 0039

Cut out your temporary member identification along the dotted line.
Start your benefits!

How do I enroll?
First, read your enrollment information. To enroll, complete your Enrollment/Change Request form and give it to your employer. If you have questions, please call 1-888-772-9682.

Am I eligible to enroll?
All Schwan employees working less than 30 hours per week are eligible to enroll after completing two months of service. Seasonal employees and Interns are eligible after completing six months of service. If you are an eligible employee, you can also enroll your eligible dependents (except for Short-Term Disability). Your eligible dependents are your lawful spouse and your children from birth until age 26, through any age if handicapped and unable to earn a living, or until they can no longer be legally declared as dependents. Dependent age and status requirements may vary by state.

How do I pay?
Payment is simple. Premium costs will be deducted from your paycheck. If you miss a payment, you can pay directly and keep your coverage active. There is a form in this kit to use when sending in missed premium payments.

When does coverage begin?
Coverage is effective on the first day of the pay period in which a deduction occurs.

First, read your enrollment information.
Call 1-888-772-9682
Between 8 a.m. and 6 p.m., Monday through Friday.

If you choose dental coverage, please use this temporary member ID until you get your plastic member ID card.

www.aetna.com/docfind/custom/avp

INSURED: The person listed on the card has been enrolled in a limited dental plan sponsored by the employer. Available benefits are subject to exclusions and limitations. This card does not guarantee coverage. For verification of coverage, filing a claim or for questions other than the discount programs, contact us at the number printed on the front of this card or mail us at the address below.

EMERGENCY: Call 911 or go to the nearest emergency facility.
For AETNA VISION DISCOUNTS call 1-800-793-8616.
For LASIK call 1-800-422-6600.
For CONTACTS DIRECT call 1-800-391-5367.

Aetna Voluntary Plans
P.O. Box 14079
Lexington, KY 40512

Insurance plans are underwritten by Aetna Life Insurance Company (Aetna). This material is for information only. Providers are independent contractors and are not agents of Aetna. Provider participation may change without notice. Aetna does not provide care or guarantee access to health services. Insurance plans contain exclusions and limitations. Information is believed to be accurate as of the production date; however, it is subject to change. See the limitations and exclusions document included in this kit for the Aetna insurance plans offered by your employer.

Policy forms issued include: GR-9/GR-9N, GR-23, GR-29/GR-29N, GR-96172 and/or GR-96173.
Take good care of your eyesight
For most of us, vision is among the most precious of our senses. Regular eye exams not only detect changes in your vision — they can also help detect medical problems early, including high blood pressure and diabetes.

The Aetna Vision insurance plan can provide you and your loved ones with:
• Benefits to help pay for vision services, from a routine eye exam to eyeglasses or contacts
• Access to discounts through a broad nationwide network of vision care providers
• Discounts on laser eye surgery (LASIK surgery), sunglasses, contact lens solutions and eye care accessories
• Affordable group rates
• Easy payroll deduction

When you enroll in the vision plan, you also receive the Aetna Vision℠ discount program* 
Aetna Vision discount program uses the nationwide EyeMed Select Network of vision care providers to offer you and your loved ones discounted prices on glasses, contact lenses, nonprescription sunglasses, contact lens solutions and other eye care accessories.

*Discount offers provide access to discounted prices and are NOT insured benefits. The member is responsible for the full cost of the discounted services.
Learn more about the discounts offered through this plan

• Locate a local vision provider: www.aetna.com/docfind/custom/avp
• Exams and eyewear: 1-800-793-8616
• Contacts: 1-800-391-5367
• LASIK customer service: 1-800-422-6600

Exclusions and limitations
Reimbursements for vision care services other than eye exams, frames, lenses or contact lenses are not included in this plan. Read your enrollment information for the reimbursement amount of your plan.

Benefit period is 12 consecutive months beginning on the later of your effective date or your most recent eye exam covered under this plan. Coverage is not available if you live and work in New Hampshire. This limited health plan does not meet Massachusetts Minimum Creditable Coverage standards.

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

• Orthoptic vision training (eye exercises to improve vision), subnormal vision aids (tools such as magnifying devices, talking books, etc. used for those with low vision or partial sight), any associated supplemental testing
• Medical and/or surgical treatment of the eyes or supporting structure
• Any eye or vision examination, or any corrective eyewear, required by an employer as a condition of employment

Insurance plans are underwritten by Aetna Life Insurance Company (referred to as “Aetna”) and administered by Aetna or Strategic Resource Company (SRC), an Aetna company.

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Policy forms issued include: GR-23, GR-9/GR-9N, GR-29/GR-29N, GR96172 and/or GR96173.
Protect your smile today and tomorrow

If you had a cavity, would you have the money available to take care of it? Now you can be ready with an Aetna Dental plan.

The dental insurance plan is affordable and a great way to help you and your loved ones keep your smiles healthy. The plan provides:

• Benefits to help you pay for checkups, cleanings and common dental services
• The flexibility to see any dentist you like
• Access to discounts through Aetna’s broad network of dentists
• Group rates which are typically lower than those you can find on your own
• Easy payroll deduction, so you don’t have to worry about paying a separate bill

How the plan works

Once the annual deductible is met, the plan helps pay for many of the most common dental services up to its stated annual limit. These include:

• Preventive services like checkups and cleanings
• Basic services like fillings and oral surgery
• Major services like crowns, bridges, dentures and root canals

Waiting periods may apply to some services. See your enrollment information for details.
Exclusions and limitations
The dental preferred provider organization (PPO) network is not available in Alabama, Arkansas, Idaho, Hawaii, Louisiana, Mississippi, New Mexico or Puerto Rico. To locate a preferred provider, call toll-free 1-888-772-9682 or visit www.aetna.com/docfind/custom/avp.

Aetna will pay benefits only for expenses incurred while this coverage is in force, and only for the medically necessary treatment of injury or disease. A service or supply is medically necessary if it is determined by Aetna to be appropriate for the diagnosis, care or treatment of the disease or injury involved. The plan requires that a deductible is met before a benefit is paid except for preventive services. A deductible is the amount you must pay for eligible expenses before the plan begins to pay benefits.

This plan does not cover all health care expenses and has exclusions and limitations. Your plan may contain exceptions to this list based on state mandates or the plan design purchased.

The following is a partial list of services and supplies that are generally not covered. However, your plan may contain exceptions to this list based on state mandates or the plan design purchased. The following charges are not covered under the dental plan, and they will not be recognized toward satisfaction of any deductible amount:

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

Did you know there’s a link between dental health and overall health?
Research has shown that diseases of the teeth and gums are risk factors for diabetes, kidney disease, heart disease and even cancer. So going to the dentist twice a year is about more than having a nice smile.

Follow the instructions provided in your enrollment materials.

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This material is for information only. Providers are independent contractors and are not agents of Aetna. Provider participation may change without notice. Aetna does not provide care or guarantee access to dental services. Discount offers provide access to discounted prices and are NOT insured benefits. The member is responsible for the full cost of the discounted services. Dental insurance plans contain exclusions and limitations. Information is believed to be accurate as of the production date; however, it is subject to change.

Policy forms issued include: GR-23, GR-9/GR-9N, GR-29/GR-29N, GR96172 and GR96173.

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57.03.349.1 (5/13)
Income protection if you become disabled

Your job provides the money to pay everyday expenses for you and your loved ones. But what would happen if you couldn’t work because of a disabling illness or injury? Would you be able to pay your bills? Would you be ready?

Now you can be ready with an Aetna Short-Term Disability Plan

The insurance plan provides these valuable benefits:

- **Income protection** if you become disabled and are unable to work
- **Affordable group rates** — See your enrollment information for the cost of the plan offered through your employer
- **Cash benefits** paid directly to you to help you pay for everyday living expenses — from groceries to gas to daycare — whatever you need
- **Weekly benefits** payable for up to six (6) months
- **Easy payroll deduction** so you don’t have to worry about paying a separate bill

Get the Power of READY

and be prepared for life’s little surprises

*Benefit amount is based on the plan offered by your employer. See your enrollment information for details.
How the plan works

You’ll receive a weekly cash benefit if you become disabled and are unable to work. Please refer to your enrollment information for the specific amount of coverage.

Exclusions and limitations

- This plan does not cover all circumstances and has exclusions and limitations. Members should refer to their booklet certificate to determine which circumstances are covered and to what extent. The following is a partial list of circumstances that are generally not covered. However, your plan may contain exceptions to this list based on state mandates or the plan design purchased.
- Coverage for employee only; coverage is not available if you work in California, Hawaii, New Jersey, New York, Rhode Island or Puerto Rico.
- The following is a partial list of services and supplies that are generally not covered. However, your plan may contain exceptions to this list based on state mandates or the plan design purchased:
  - Attempted suicide, while sane or insane, or intentional self-inflicted injury or sickness, unless as the result of a medical condition
  - Commission of or attempt to commit an act which is a felony in the jurisdiction in which the act occurred
  - Substance abuse
  - Occupational injury or sickness

Without disability insurance, nearly 50 percent of workers would face financial trouble within a month and 74 percent within 6 months.¹

Follow the instructions provided in your enrollment materials.


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Policy forms issued include: GR-23, GR-9/GR-9N, GR-29/GR-29N, GR96172 and GR96173.
Protection for those who depend on you

Could your loved ones afford to pay for a funeral? Could they pay everyday living expenses or pay off debts if you die?

Life insurance provides your loved ones with money they can use to help do things like:

• Pay off debts and funeral costs
• Pay the monthly rent or mortgage
• Create a savings fund for education or retirement

Even young, single adults may need life insurance to help family members deal with expenses.

Are you and your family ready?

Now you can be ready with affordable term life insurance that includes these great benefits:

• Flexible options to cover just you or your entire family.
• No health questions.
• Easy payroll deduction.
• Additional benefit pays if your death is the result of an accident. (This applies to you, but not to covered dependents.)
Here's how the plan works:

The beneficiary you choose will receive a lump sum payment upon your death. If you die in an accident, your beneficiary will receive an additional payment, depending on the plan you select.

Exclusions and limitations

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

Term Life exclusions:

• Suicide or attempted suicide (while sane or insane)

Accidental Death Benefit exclusions:

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

Please note that benefits are reduced by 50 percent when you reach age 70.

Protect those who depend on you

Did you know that the average funeral costs more than $10,000?¹

Enroll today

Follow the instructions provided in your enrollment materials.


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This material is for information only. Insurance plans contain exclusions and limitations. Information is believed to be accurate as of the production date; however, it is subject to change. For more information about Aetna plans, refer to www.aetna.com.

Policy forms issued in Oklahoma include: GR-23, GR-9/GR-9N, GR-29/GR-29N, GR96172, and GR96173.
Inside this Benefits Summary:
• Vision Care
• Dental
• Short Term Disability (STD)
• Term Life and Accidental Death Insurance

Vision Care
Eye Exams
Reimbursements of up to $100 every 12 months for an exam, frames or lenses.

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

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

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

<table>
<thead>
<tr>
<th>Maximum benefit per coverage year</th>
<th>$500</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductible per coverage year</td>
<td>$50</td>
</tr>
<tr>
<td>Preventive services</td>
<td>You are responsible for paying up to 20%† of the Recognized Charges. These services have no waiting period.</td>
</tr>
<tr>
<td>(includes checkups and cleanings)</td>
<td></td>
</tr>
<tr>
<td>Basic services</td>
<td>You are responsible for paying up to 40%† of the Recognized Charges. You must be covered under the dental plan without interruption for 3 months before the plan begins to pay for these services.</td>
</tr>
<tr>
<td>(includes fillings, oral surgery, and denture, crown and bridge repair)</td>
<td></td>
</tr>
<tr>
<td>Major services</td>
<td>You are responsible for paying up to 50%† of the Recognized Charges. You must be covered under the dental plan without interruption for 12 months before the plan begins to pay for these services.</td>
</tr>
<tr>
<td>(includes Perio and Endodontics, crowns, bridges, and dentures)</td>
<td></td>
</tr>
</tbody>
</table>

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

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

The dental PPO network is not available in Alabama, Arkansas, Idaho, Hawaii, Louisiana, Mississippi, New Mexico, or Puerto Rico. To locate a preferred provider, call toll-free 1-888-772-9682 or visit www.aetna.com/docfind/custom/avp.

Dental Exclusions:

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

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

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

<table>
<thead>
<tr>
<th>Benefit Period</th>
<th>Weekly benefits for up to 6 months while you are disabled.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benefit Amount</td>
<td>50% of base pay received from the employer that sponsors this program (includes reported tips, but not overtime) up to $125 maximum weekly benefit.</td>
</tr>
<tr>
<td>Waiting Period</td>
<td>Benefits begin after 14 days (plan pays immediately if hospitalized).</td>
</tr>
</tbody>
</table>

Coverage for employee only; coverage not available in California, Hawaii, New Jersey, New York, Rhode Island, and Puerto Rico.

**Short Term Disability Exclusions:**

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

- Attempted suicide, while sane or insane, or intentional self-inflicted injury or sickness, unless as the result of a medical condition.
- Commission of or attempt to commit an act which is a felony in the jurisdiction in which the act occurred.
- Substance abuse.
- Occupational injury or sickness.

**Term Life and Accidental Death Insurance**

<table>
<thead>
<tr>
<th>Benefit Type</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee term life benefit</td>
<td>$20,000</td>
</tr>
<tr>
<td>Employee accidental death benefit</td>
<td>$20,000</td>
</tr>
<tr>
<td>Optional dependents coverage</td>
<td>$2,500 in term life for dependents over 6 months of age. $500 for children from birth through 6 months of age.</td>
</tr>
</tbody>
</table>

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

**Term Life and Accidental Death Exclusions:**

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

**Term Life Exclusions:**

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

**Accidental Death Benefit Exclusions:**

- Use of alcohol, intoxicants, or drugs, except as prescribed by a physician.
- Suicide or attempted suicide (while sane or insane).
- An intentionally self-inflicted injury.
- A disease, ptomaine or bacterial infection except for that which results directly from an injury.
- Medical or surgical treatment except for that which results directly from an injury.
- Voluntarily inhalation of poisonous gases.
- Commission of or attempt to commit a criminal act.
What should I do in case of an emergency?
In case of emergency, call 911 or your local emergency hotline, or go directly to an emergency care facility.

What if I don't understand something I've read here, or have more questions?
Please call us. We want you to understand these benefits before you decide to enroll. You may reach one of our Customer Service representatives Monday through Friday, 8 a.m. to 6 p.m., by calling toll free 1-888-772-9682. We’re here to answer questions before and after you enroll.

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Policy forms issued include GR-9/GR-9N, GR-29/GR-29N, GR96172, and GR96173.
Instructions: Read and fill out the Enrollment/Change Request (all pages). Make a copy for yourself. Give the original to your employer.

If you are not changing your existing coverage, you do not need to complete this Enrollment/Change Request.

Information about you Complete all information.

Print your name (first, middle initial, last) Social Security Number Date of birth (MM/DD/YYYY)

Home address Apartment number City State Zip code

Home phone Work phone Email address Sex Male Female Primary language spoken (Idioma principal)

Action you want to take Check the box next to the action you want to take.

I am not currently enrolled and I want to...
- Enroll in the coverage choices selected below.
- Decline this opportunity to participate.

I am currently enrolled and I want to...
- Make changes to my current coverage choices (add, increase, drop, decrease) as selected below.
  (If outside of an open enrollment, see "Making Changes Outside of an Open Enrollment.")
- Update my personal and/or my dependent and/or beneficiary information.
- Drop all of my current coverage choices.

Your payroll deductions will be taken before taxes are taken. (STD and Term Life deductions will be taken after taxes.)

Your coverage choices Check(2) the box for the level of coverage you want.

Coverage type Coverage level Weekly cost Biweekly cost

Vision
- No Vision
- Yourself only .................................................................$ 0.92 .................................$ 1.84
- Yourself plus one .............................................................$ 1.57 .................................$ 3.14
- Yourself and family .......................................................$ 2.22 .................................$ 4.44

Dental
- No Dental
- Yourself only .................................................................$ 5.06 .................................$ 10.12
- Yourself plus one .............................................................$ 10.13 .................................$ 20.26
- Yourself and family .......................................................$ 16.71 .................................$ 33.42

Short Term Disability (STD)
- No Short Term Disability
- Yourself only .................................................................$ 3.49 .................................$ 6.98

Coverage is not available if you work in California, Hawaii, New Jersey, New York, Rhode Island, and Puerto Rico.

Term Life Insurance
- No Term Life
- Yourself only .................................................................$ 1.79 .................................$ 3.58
- Yourself and family .......................................................$ 2.19 .................................$ 4.38

Please name your beneficiary. Beneficiary Relationship Social Security Number

Employer group information This section is to be completed by your employer.

Employee ID Hire date (MM/DD/YYYY) Pay type Total deduction ($) Effective date (MM/DD/YYYY)

Location or site code Authorized signature Title Today's date (MM/DD/YYYY)
### INFORMATION ABOUT YOU
Repeat your name and Social Security number here.

<table>
<thead>
<tr>
<th>Print your name (first, middle initial, last)</th>
<th>Social Security Number</th>
</tr>
</thead>
</table>

### INFORMATION ABOUT YOUR DEPENDENTS
List the dependents for whom you are adding/changing/removing coverage.

If you have more dependents, write down their information on a separate sheet and attach it to this Enrollment/Change Request.

<table>
<thead>
<tr>
<th>Add</th>
<th>Change</th>
<th>Remove</th>
</tr>
</thead>
</table>

#### Print dependent’s name (first, middle initial, last)

<table>
<thead>
<tr>
<th>Social Security Number</th>
</tr>
</thead>
</table>

#### Sex

- Male
- Female

#### Date of birth

#### Enrolled in:

- Vision
- Dental
- Term Life

#### Relationship:

- Spouse
- Child
- Other (Specify): ________________________________

#### Address (if different than yours)

<table>
<thead>
<tr>
<th>City</th>
<th>State</th>
<th>Zip code</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Add</th>
<th>Change</th>
<th>Remove</th>
</tr>
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</table>

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</table>

#### Sex

- Male
- Female

#### Date of birth

#### Enrolled in:

- Vision
- Dental
- Term Life

#### Relationship:

- Spouse
- Child
- Other (Specify): ________________________________

#### Address (if different than yours)

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<thead>
<tr>
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<th>State</th>
<th>Zip code</th>
</tr>
</thead>
</table>

<table>
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<tr>
<th>Add</th>
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#### Print dependent’s name (first, middle initial, last)

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#### Sex

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#### Date of birth

#### Enrolled in:

- Vision
- Dental
- Term Life

#### Relationship:

- Spouse
- Child
- Other (Specify): ________________________________

#### Address (if different than yours)

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<tr>
<th>City</th>
<th>State</th>
<th>Zip code</th>
</tr>
</thead>
</table>

### MAKING CHANGES OUTSIDE OF AN OPEN ENROLLMENT
Please read below to see if you are able to make changes to your coverage.

If your deductions are taken before taxes are taken out of your pay, you can change your coverage during the plan year only if you have a **Qualifying Life Event (QLE)**. QLEs fall under one of these two categories:

**Loss of Other Coverage (LOC):** If you previously declined health coverage because you or your dependents were already covered under another health plan and you or your dependents have lost that other coverage, you may be able to enroll yourself and your dependents. If you had a recent LOC, go to the list on the right and check the box next to your LOC and supply the date of the LOC.

**Family Status Change (FSC):** Whether you are currently enrolled or previously declined coverage, you may be able to add or increase, drop or decrease coverage when you experience certain FSC events. If you had a recent FSC, go to the list on the right and check the box next to your FSC and supply the date of the FSC.

Next, complete the rest of this Enrollment/Change Request. When finished, make a copy and submit it to your employer with your documentation attached. You must submit this Enrollment/Change Request, together with documentation, to your employer within 31 days of the LOC/FSC.

### YOUR AUTHORIZATION
You must sign and date this Enrollment/Change Request for all new enrollments or coverage changes.

I represent that all information supplied in this Enrollment/Change Request is true and complete to the best of my knowledge and/or belief. I have read and agree to the Conditions of Enrollment on the last page of this Enrollment/Change Request.

<table>
<thead>
<tr>
<th>Your signature</th>
<th>Today’s date (MM/DD/YYYY)</th>
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This Enrollment/Change Request is not proof of coverage.

AFBP
12.08.303.1

500031 / SchwansSha
DE - 09/03/2014
On behalf of myself and the dependents listed on this Enrollment/Change Request, I agree to or with the following:

1. I acknowledge that by enrolling in an Aetna plan coverage is underwritten and administered by Aetna Life Insurance Company (Aetna) 151 Farmington Avenue, Hartford, CT 06156.

2. I authorize deductions from my earnings for any contributions required for coverage and I agree to make any necessary payments as required for coverage.

3. **For life and disability coverages:** I understand that the effective date of insurance for myself or for any of my dependents, if applicable, 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. I understand that, in the event I fail to sign this form within 30 days of the effective date of eligibility or that for any reason Aetna does not receive notice of the Enrollment/Change Request within a reasonable time following the date I was eligible to enroll or change my coverage, my and my dependents' eligibility, if applicable, may be affected. 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.

4. I understand and agree that this Enrollment/Change Request may be transmitted to Aetna or its agent by my employer or its agent. I authorize any physician, other healthcare professional, hospital or any other healthcare organization ("Providers") to give Aetna or its agent information concerning the medical history, services or treatment provided to anyone listed on this Enrollment/Change Request, including those involving mental health, substance abuse and HIV/AIDS. I further authorize Aetna to use such information and to disclose such information to affiliates, providers, payors, other insurers, third party administrators, vendors, consultants and governmental authorities with jurisdiction when necessary for my care or treatment, payment for services, the operation of my health plan, or to conduct related activities. I have discussed the terms of this authorization with my spouse and competent adult dependents and I have obtained their consent to those terms. I understand that this authorization is provided under state law and that it is not an "authorization" within the meaning of the federal Health Insurance Portability and Accountability Act. This authorization will remain valid for the term of the coverage and so long thereafter as allowed by law. I understand that I am entitled to receive a copy of this authorization upon request and that a photocopy is as valid as the original.

5. 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.

6. I understand and agree that all participating providers and vendors are independent contractors and are neither agents nor employees of Aetna. Aetna Rx Home Delivery, LLC and Aetna Specialty Pharmacy, LLC, wholly owned subsidiaries of Aetna Inc., are participating providers and independent contractors of Aetna, and are neither agents nor employees of Aetna. The availability of any particular provider cannot be guaranteed and provider network composition is subject to change. Notice of the change shall be provided in accordance with applicable state law. Aetna does not provide health or dental care services and, therefore, cannot guarantee any results or outcome. Some benefits are subject to limitations or maximums.

7. **Misrepresentation:**

   Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or 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 is a crime and subjects such person to criminal and civil penalties.

   **Attention Arkansas Residents:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

   **Attention Colorado Residents:** It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

   **Attention Kentucky Residents:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or 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 is a crime and subjects such person to criminal and civil penalties.

   **Attention Maryland Residents:** Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

   **Attention Oregon Residents:** Any person who with intent to injure, defraud or deceive any insurance company or other person submits an enrollment form for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto may have violated state law.

   **Attention Pennsylvania Residents:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or 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 is a crime and subjects such person to criminal and civil penalties.

   **Attention Rhode Island Residents:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

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

   **Attention Vermont Residents:** Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or 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.

   **Attention West Virginia Residents:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
What if I miss a payroll deduction?
Your coverage will not begin until you have your first payroll deduction. Each payroll deduction pays for coverage for one payroll period. If you miss a payroll deduction after your coverage begins, you will not have coverage during the time that payroll deduction would cover, unless you pay the full missed premium directly to Aetna Voluntary.

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

How do I pay my missed premium?
To pay by personal check, cashier’s check, or money order, make payable to Aetna Life Insurance Company and send with a completed copy of the coupon above to: Missed Premiums, P.O. Box 534739, Atlanta, GA 30353. You can get additional payment coupons by calling 1-888-772-9682.

Can I pick which missed premiums I wish to pay?
No. Your missed premium payment will always be applied to the oldest gap in coverage within the last 45 days (from the postmark on your mailed payment). You cannot choose to cover a later gap in coverage if you have an earlier gap within the past 45 days from the date your payment is postmarked. To find out what gaps in coverage you may have, please call toll free 1-888-772-9682, Monday through Friday, 8 a.m. to 6 p.m.

How long do I have to pay a missed premium?
You may pay for a gap in coverage that is up to 45 days old, from the date your payment is postmarked.

Can I pay just a part of a missed premium?
No. You must pay the full premium deduction that was missed in your paycheck, for all coverage you have. We cannot accept partial payments.

If I become ineligible or my employment ends, can I continue coverage with missed premium payments?
No. If your coverage terminates, you may not continue coverage by paying missed premiums.

More questions?
To get help in any language, call toll free 1-888-772-9682
Monday through Friday, 8 a.m. to 6 p.m.

¿Tiene más preguntas?
Si necesita ayuda en cualquier idioma, llame sin cargo al 1-888-772-9682
de lunes a viernes de 8 a.m. a 6 p.m.
Important information about your dental benefits

Dental Preferred Provider Organization (PPO)
Participating Dental Network (PDN)

Dental benefits and dental insurance plans are underwritten and/or administered by Aetna Life Insurance Company. 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 dental services. While this information is believed to be accurate as of the publication date, it is subject to change.
Understanding your plan of benefits

Aetna Dental® PPO plans cover many dental services. However, they do not cover everything. Your “plan documents” list all the details for the plan you choose. This includes what’s covered, what’s not covered and the specific amounts you will pay for services.

Plan document names vary. They may include a Booklet-certificate and/or any riders and updates that are included.

If you can’t find your plan documents, call Member Services to ask for a copy. Use the toll-free number on your Aetna Dental ID card.

Covered services may include dental care provided by general dentists and specialist dentists. However, certain limitations may apply. For example, the dental plan excludes or limits coverage for some services, including, but not limited to, cosmetic and experimental procedures. The information that follows provides general information about Aetna dental PPO/PDN plans.

Members should consult their plan documents for a complete description of what dental services are covered and any applicable exclusions and limitations.

Not all of the information in this booklet applies to your specific plan

State-specific information throughout this booklet does not apply to all plans. To be sure, review your plan documents, ask your benefits administrator or call Aetna Member Services.

Warning: If you or your family members are covered by more than one health care plan, you may not be able to collect benefits from both plans. Each plan may require you to follow its rules or use specific doctors and hospitals, and it may be impossible to comply with both plans at the same time. Before you enroll in this plan, read all of the rules very carefully and compare them with the rules of any other plan that covers you or your family.

Texas

In Texas, the Preferred Provider Organization (PPO) plan is known as the Participating Dental Network (PDN). Please refer to the plan design overview and summary of benefits contained in your pre-enrollment packet for a brief description of the services and benefits covered under your particular plan, as well as those services and benefits that are excluded. After enrollment, you can refer to your plan documents for a more complete description of your covered services and benefits and the exclusions under your plan. For information on whether a specific service is covered or excluded, please contact Member Services at the toll-free number on your Dental ID card.

Help for those who speak another language and for the hearing impaired

Do you need help in another language? Member Services can connect you to a special line where you can talk to someone in your own language. You can also get help with a complaint or appeal.

Language hotline – 1-888-982-3862 (140 languages are available, ask for an interpreter.)

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

Ayuda para las personas que hablan otro idioma y para personas con impedimentos auditivos

¿Necesita ayuda en otro idioma? Los representantes de Servicios al Miembro le pueden conectar a una línea especial donde puede hablar con alguien en su propio idioma. También puede obtener asistencia de un intérprete para presentar una queja o apelación.

Línea directa – 1-888-982-3862 (Tenemos 140 idiomas disponibles. Debe pedir un intérprete.)

TDD 1-800-628-3323 (solo para personas con impedimentos auditivos)
**Getting help**

**Contact Member Services with questions**

Call the toll-free number on your Dental ID card. Or, call 1-800-US-Aetna (1-800-872-3862) Monday through Friday, 7 a.m. to 7 p.m. ET. You can also send Member Services an e-mail. Just go to your secure Aetna Navigator® member website at www.aetna.com. Click on “Contact Us” after you log in.

Member Services can help you:

- Understand how your plan works or what you will pay.
- Get information about how to file a claim.
- File a complaint or appeal.
- Get copies of your plan documents.
- Find specific dental health information.

**Your state may have different contact information:**

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

**Maryland**  
For quality of care issues and life and health care insurance complaints, you may contact:

- Aetna Dental Grievance and Appeals Unit  
P.O. Box 14080  
Lexington, KY 40512-4080  
Toll-free phone: 1-877-238-6200  
Maryland Insurance Administration of Life and Health Insurance Complaints  
200 Saint Paul Place, Suite 2700  
Baltimore, MD 21202  
Toll-free phone: 1-800-492-6116  
Local phone: 410-468-2244  
Fax: 410-468-2243

For help resolving a billing or payment dispute with the dental plan or your dental care provider you may contact:

- Aetna Dental Grievance and Appeals Unit  
P.O. Box 14080  
Lexington, KY 40512-4080  
Telephone: 1-877-238-6200

- Health Education and Advocacy Unit  
Consumer Protection Division  
Office of the Attorney General  
16th Floor 200 Saint Paul Place  
Baltimore, MD 21202  
Telephone: 410-528-1840  
Fax: 410-576-7040

Nothing herein shall be construed to require the plan to pay counsel fees or any other fees or costs incurred by a member in pursuing a complaint or appeal.

**Virginia contact information**

If you need to contact someone about this insurance for any reason, please contact your agent. If no agent was involved in the sale of this insurance, or if you have questions, you may contact the insurance company issuing this insurance at the following address and telephone number:

- Aetna Life Insurance Company  
P.O. Box 14080  
Lexington, KY 40512-4597  
Toll-free phone: 1-877-238-6200

If you have been unable to contact or obtain satisfaction from the company or the agent, you may also contact:

- **The Virginia State Corporation Commission**  
**Bureau of Insurance**  
P.O. Box 1157  
Richmond, Virginia 23218-1157  
Call: 804-371-9741 or 1-800-552-7945 (VA Only)

- **The Office of the Managed Care Ombudsman**  
Office of the Managed Care Ombudsman, Bureau of Insurance  
P.O. Box 1157  
Richmond, Virginia 23218  
Toll-free phone: 1-877-310-6560, select option 1  
Fax: 804-371-9944  
Email: ombudsman@scc.virginia.gov

- **Virginia Department of Health**  
Complaint Intake  
Office of Licensure and Certification  
9960 Mayland Drive, Suite 401  
Henrico, VA 23233-1463  
Toll Free: 1-800-955-1819  
Metro Richmond area: 804-367-2106  
Fax: 804-527-4503  
Email: OLC-Complaints@vdh.virginia.gov

Written correspondence is preferable so that a record of your inquiry is maintained. When contacting your agent, company or the Bureau of Insurance, have your policy number available.

Aetna Life Insurance Company is regulated as a Managed Care Health Insurance Plan (MCHIP) and as such, is subject to regulation by both the Virginia State Corporation Commission Bureau of Insurance and the Virginia Department of Health.

**Search our network for dental care providers**

You can choose to visit a dentist that participates in the Aetna Dental PPO/PDN network. Or you may visit any licensed dental care provider. The choice is yours.

Here’s how you can find out if your dentist is in our network:

- Log in to www.aetna.com. Follow the path to find a doctor, and enter your dentist’s name in the search field.
- Call us at the toll-free number on your Aetna Dental ID card. If you don’t have your card, you can call us at 1-877-238-6200.
Georgia
Members can call **1-877-238-6200** (toll free) to confirm whether a dental provider is in the network and/or accepting new patients. A summary of any agreement or contract between Aetna and any dental care provider will be made available upon request by calling the Member Services telephone number on your ID card. The summary will not include financial agreements as to actual rates, reimbursements, charges or fees negotiated by Aetna and the provider. The summary will include a category or type of compensation paid by Aetna to each class of provider under contract with Aetna.

Illinois
While every primary care dentist listed in the Dental Directory contracts with Aetna to provide primary care services, not every provider listed will be accepting new patients. Although we have identified those providers who were not accepting patients as known to us at the time the Dental Directory was created, the status of the dental practice may have changed. For the most current information about the status change of any dental practice, please contact either the selected dentist or Member Services at the number on your ID card. You can get more information about the network, participating providers or our grievance procedures through the DocFind® directory at [www.aetna.com](http://www.aetna.com) or by calling **1-877-238-6200**.

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

**Customary Waiting Times**
Emergency/Immediately Urgently Care – within 24 hours
Routine Care – Within 5 weeks
Routine Hygiene Visit – Within 8 weeks

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

**Transition of Care When a Provider Leaves the Network**
Our contracts are designed to provide transition of care for covered persons should the treating dental care provider contract terminate.

1. Participating dental care providers are contractually obligated for continued treatment of certain members after termination for any reason as outlined below:

   “Provider shall remain obligated at company’s sole discretion to provide covered services to: (a) any member receiving active treatment from provider at the time of termination until the course of treatment is completed to company’s satisfaction or the orderly transition of such member’s care to another provider by the applicable affiliate of company; and (b) any member, upon request of such member or the applicable payor, until the anniversary date of such member’s respective plan or for one (1) calendar year, whichever is less. The terms of this agreement shall apply to such services.”

2. In cases of provider termination, in order to allow for the transition of members with minimal disruption to participating providers, Aetna may permit a member who has met certain requirements to continue an “Active Course of Treatment” for covered benefits with a non-participating provider for a transitional period of time without penalty subject to any out-of-pocket expenses outlined in the member’s plan design.
Costs and rules for using your plan

What you pay

You will share in the cost of your dental care. These are called “out-of-pocket” costs. Your plan documents show the amounts that apply to your specific plan. Those costs may include:

- **Copay** — A set amount (for example, $15) you pay for a covered dental care service. You usually pay this when you receive the service. The amount can vary by the type of service. For example, the copay for your primary dentist’s office visit may be different than a specialist’s office visit.

- **Coinsurance** — Your share of the costs for a covered service. This is usually a percentage (for example, 20%) of the allowed amount for the service.

- **Deductible** — This is the amount you owe for dental care services before your dental plan begins to pay.

Your costs when you go outside the network

You may choose a dentist in our network. You may choose to visit an out-of-network dentist. We cover the cost of care based on if the dentist is “in network” or “out of network.” We want to help you understand how much Aetna pays for your out-of-network care. At the same time, we want to make it clear how much more you will need to pay for this care.

If you choose a dentist who is out of network, your Aetna dental plan may pay some of that dentist’s bill. Most of the time, you will pay a lot more money out of your own pocket if you choose to use an out-of-network dentist.

“In network” means we have a contract with that dentist. He agrees to how much he will charge you for covered services. That amount is often less than what he would charge if he was not in our network. Most of the time it costs you less to use dentists in our network. Many plans pay a higher percentage of the bill if you stay in network. The dentist agrees he won’t bill you for any amount over his contract rate. All you have to pay is your coinsurance or copayments, along with any deductible.

“Out of network” means that we do not have a contract for discounted rates with that dentist. We don’t know exactly what an out-of-network dentist will charge you. If you choose a dentist who is out of network, your Aetna dental plan may pay some of that dentist’s bill. Most of the time, you will pay a lot more money out of your own pocket if you choose to use an out-of-network dentist. Your out-of-network dentist sets the rate to charge you. It may be higher — sometimes much higher — than what your Aetna plan “recognizes” or “allows.” Your dentist may bill you for the dollar amount that Aetna doesn’t “recognize.”

You must also pay any copayments, coinsurance and deductibles under your plan. No dollar amount above the “recognized charge” counts toward your deductible or out-of-pocket limits. This means that you are fully responsible for paying everything above the amount that Aetna allows for a service or procedure.

North Carolina members can request approval for in-network level of benefits when specialty care for covered services is not available within the network. Call Member Services if you cannot find a dental specialist in the network for your needs. Member Services will find a participating specialty provider for you, or authorize you to receive specialty services from a specialty dentist outside the network. Your out-of-pocket costs will be the same as if you received services in the network.

*Specialty providers include endodontists, periodontists, pedodontists, oral surgeons and orthodontists.

How we pay dentists who are not in our network

**PPO/PDN:** When you choose to see an out-of-network dentist, Aetna pays for your health care using “prevailing or reasonable” charge that we get from an industry database; a rate based on what Medicare would pay for that service; or a local market fee set by Aetna. Your plan will state which method is used. This way of paying out-of-network dentists applies when you choose to get care out of network.

**PPO MAX/PDN MAX plans:** We use a fee schedule to pay both in-network and out-of-network dentists. In-network dentists have agreed to accept this fee. When you choose to see an out-of-network dentist, your coinsurance share of the bill is calculated based on the fee schedule (allowed amount) instead of the dentist’s actual charge. Dentists will charge you the difference between what the plan allows and the actual charge for the service. You would owe this in addition to your normal share of the costs.

Going in network just makes sense.

- We have negotiated discounted rates for you.
- In-network dentists won’t bill you for costs above our rates for covered services.
- You are in great hands with access to quality care from our national network.

To learn more about how we pay out-of-network benefits visit [www.aetna.com](http://www.aetna.com). Type “how Aetna pays” in the search box.

Emergency and urgent care

If you need emergency dental care, you are covered 24 hours a day, 7 days a week, anywhere in the world. When emergency services are provided by a participating PPO/PDN dentist, your copayment/coinsurance amount will be based on a negotiated fee schedule.

Refer to your plan documents. Subject to state requirements. Out-of-area emergency dental care may be reviewed by our dental consultants to verify appropriateness of treatment.
You can avoid unexpected bills with a simple call to Member Services. Call the toll-free number on your dental ID card to find out what’s covered before you receive the care.

Knowing what is covered
We have developed a dental clinical review program to help us determine what dental services are covered under the dental plan and the extent of that coverage. Some services may be subject to a review after you received the care. Only dental consultants who are licensed dentists make clinical determinations. We will notify you and your dentist if we deny coverage for any reason. The reason is stated on our notification. For more information about Clinical Reviews or any other topic, please call the number on your Dental ID card.

What to do if you disagree with us
Complaints, appeals and external review
Please tell us if you are not satisfied with a response you received from us or with how we do business.

The complaint and appeal processes can be different depending on your plan and where you live. Some states have laws that include their own appeal processes. So it’s best to check your plan documents or talk to someone in Member Services to see how it works for you.

Call Member Services to file a verbal complaint or to ask for the address to mail a written complaint. The phone number is on your Aetna Dental ID card. You can also send us an e-mail through our secure member website, www.aetna.com.

If you’re not satisfied after talking to a Member Services representative, you can ask us to send your issue to the appropriate department.

If you don’t agree with a denied claim, you can file an appeal. To file an appeal, write to us at the appropriate address as follows:

• **Northeast Territory** – includes Mid-Atlantic and Northeastern states (CT, DE, DC, IL, IN, KY, ME, MD, MA, MI, NH, NJ, NY, OH, PA, RI, VA, VT, WV, WI)
  - Aetna Dental Grievance and Appeals Unit
    P.O. Box 14080
    Lexington, KY 40512-4080

• **South Territory** – (AL, AR, FL, GA, LA, MS, NC, OK, SC, TN, TX)
  - Aetna Dental Grievance and Appeals Unit
    P.O. Box 14597
    Lexington, KY 40512-4597

• **West Territory** – (AK, AZ, CA, CO, HI, IA, ID, KS, MN, MO, MT, ND, NE, NV, NM, OR, SD, UT, WA, WY)
  - Aetna Dental Grievance and Appeals Unit
    P.O. Box 10462
    Van Nuys, CA 91410

Link to your state insurance department website
Visit the National Association of Insurance Commissioners (NAIC) at www.naic.org.

Kentucky appeals process
1. As a member of Aetna, you have the right to file an appeal about service(s) you have received from your dental care provider or Aetna, when you are not satisfied with the outcome of the initial determination and the request is regarding a change in the decision for:
   - Certification of health care services
   - Claim payment
   - Plan interpretation
   - Benefit determination
   - Eligibility

2. You or your authorized representative may file an appeal within 180 days of an initial determination. You may contact Member Services at the number listed on your identification card.

3. A Customer Resolution Consultant will acknowledge the appeal within five (5) business days of receipt. A Customer Resolution Consultant may call you or your dental care provider for dental records and/or other pertinent information.

4. Our goal is to complete the appeal process within 30 days of receipt of your appeal. An appeal file is reviewed by an individual who was neither involved in any prior coverage determinations related to the appeal nor a subordinate of the person who rendered a prior coverage determination. A dentist or other appropriate clinical peer will review clinical appeals. A letter of resolution will be sent to you upon completion of the appeal. It is important to note that it is a covered member’s right to submit new clinical information at any time during the appeal of an adverse determination or coverage denial to an insurer or provider.

5. If the appeal is for a decision not to certify urgent or ongoing services, it should be requested as an expedited appeal. An example of an expedited appeal is a case where a delay in making a decision might seriously jeopardize the life or health of the member or jeopardizes the member’s ability to regain maximum function. An expedited appeal will be resolved within 72 hours. If you do not agree with the final determination on review, you have the right to bring a civil action under Section 502(a) of ERISA, if applicable.

6. If you are dissatisfied with the outcome of a clinical appeal and the amount of the treatment or service would cost the covered individual at least $100.00 if they had no insurance, you may request a review by an external review organization (ERO). The request must be made within 60 days of the final internal review. A request form will be included in your Final determination letter. It can also be obtained by calling Member Services. A decision will be rendered by the ERO within 21 calendar days of your request. An expedited process is available to address clinical urgency. If you disagree with the decision regarding your right to an external review, you may file a complaint with the Kentucky Department of Insurance.
7. As a member, you may, at any time, contact your local state agency that regulates health care service plans for complaint and appeal issues, which Aetna has not resolved or has not resolved to your satisfaction. Requests may be submitted to:

Kentucky Department of Insurance
P.O. Box 517
Frankfort, KY 40602-0517

8. You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your plan administrator, your local U.S. Department of Labor Office and your state insurance regulatory agency.

We protect your privacy

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

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

Summary of the Aetna Privacy Policy

When necessary for your care or treatment, the operation of our health plans, or other related activities, we use personal information within our company, share it with our affiliates, and may disclose it to:

• Your doctors, dentists, pharmacies, hospitals and other caregivers
• Other insurers
• Vendors
• Government departments
• Third party administrators

These parties are required to keep your information private as required by law.

Some of the ways in which we may use your information include:

• Paying claims
• Making decisions about what the plan covers
• Coordination of payments with other insurers
• Quality assessment
• Activities to improve our plans
• Audits

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

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

If you’d like a copy of our privacy policy, call the toll-free number on your ID card or visit us at www.aetna.com.

Member Rights

We publish a list of rights and responsibilities on our website. Visit www.aetna.com/individuals-families-healthinsurance/member-guidelines/member-rights.html to view the list. You can also call Member Services at the number on your ID card to ask for a printed copy.

Hawaii

Informed Consent:

Members have the right to be fully informed when making any decision about any treatment, benefit or nontreatment. Your dental provider will:

• Discuss all treatment options, including the option of no treatment at all
• Ensure that persons with disabilities have an effective means of communication with the provider and other members of the managed care plan
• Discuss all risks, benefits and consequences to treatment and nontreatment

Kansas

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

• A complete description of the dental care services, items and other benefits to which the insured is entitled in the particular dental plan that is covering or being offered to such person
• A description of any limitations, exceptions or exclusions to coverage in the dental benefit plan, including prior authorization policies or other provisions that restrict access to covered services or items by the insured
• A listing of the plan’s participating dental care providers, their business addresses and telephone numbers, their availability, and any limitation on an insured’s choice of provider
• Notification in advance of any changes in the dental benefit plan that either reduces the coverage or benefits or increases the cost, to such person
• A description of the grievance and appeal procedures available under the dental benefit plan and an insured’s rights regarding termination, disenrollment, nonrenewal or cancellation of coverage

Washington State

The following materials are available: any documents referred to in the enrollment agreement; any applicable preauthorization procedures; dentist compensation arrangements and descriptions of and justification for provider compensation programs; circumstances under which the plan may retrospectively deny coverage previously authorized.