2015
Employee Benefits Summary

natural body
spa and shop

Your 2015 - 2016 Employee Benefits Guide

We recognize the important role employee benefits plays as a critical component of your overall compensation. We continue to make every effort to target the best quality benefit plans for our employees and their families. Our program offers a range of plan options to meet the needs of our diverse workforce. We know that your benefits are important to you and your family. This program is designed to assist in providing for the health, well being, and financial security of you and your covered dependents .

Benefits Guide Overview

This Guide, along with your benefit plan summaries, provides a full explanation of the benefits available to you and your family. At this time, you may elect to enroll in the benefit programs offered. Options selected during this enrollment period will remain in place until June 30, 2016 unless you or your dependents experience a qualified life event (See Box below).

Changing Benefits During the Year

The IRS states that eligible employees may only make plan elections during their initial eligibility period or once a year at open enrollment. The benefit choices you make begin on July 1st or the first of the month following 60 days of employment (for new hires) and are binding through June 30, 2016. The following circumstances are the only reasons you may change your benefit elections during the year:

Marriage	Death of a spouse
Divorce	Death of a Dependent
Birth or Adoption	Loss of Dependent Status

Change in Employment Status, Addition of a New Benefits Package, and Open Enrollment for a Spouse

These special circumstances, often referred to as life event changes, allow you to make plan changes at any time during the year when they occur. You must inform Human Resources within 30 days of the event in order to make a qualified change. All other changes will be deferred to open enrollment.

What's New in 2015-16?

New Medical Plans for 2015 - 2016

The medical insurance will remain with Aetna for 2015-2016 and all employees can still choose between a Base plan and a Buy-Up plan. The schedule of benefits for both plans have changed, so please review the benefit summaries closely. The Base plan offered for the 2015-2016 plan year is a Qualified High Deductible Health plan with a Health Savings Account. Employees who enroll in the Base Plan **only** will have the option to open a Health Savings Account (H.S.A) at the bank of their choice. More details on the medical benefits and Health Savings Accounts begin on page 4.

While the plans are changing for the upcoming plan year, the Aetna network that employees utilize will remain the same. Members will continue to have access to the Open Access Managed Choice network—Aetna's broadest network. For employees who are not yet registered on the Aetna Navigator website, follow the steps below to search for a provider in the Open Access Managed Choice network:

STEP 1: Go to www.aetna.com
Click on "Find a Doctor"
STEP 2: Click on the link for "Plan purchased through an employer or organization"
STEP 3: On the next page, select the type of provider and area (city/state or zip) you want to search.
STEP 4: Select the "Managed Choice POS (Open Access)" option under the "Aetna Open Access Plans" list in the drop down menu.

Aetna ID Cards

Because the Natural Body medical plans are changing for the 2015-16 plan year, all enrolled employees will receive new ID cards. Your new Aetna ID card will arrive after July 1st, but if you need to use your benefits prior to receiving your new card, you can use your current (2014-15) Aetna ID card and your provider will be able to call Aetna and verify your new benefits. You should also be able to download a temporary Aetna ID card with new plan information from the Aetna Navigator website by mid to late July.

Benefits Enrollment Changes

All employees currently enrolled in the 2014-15 Base Plan will be mapped to the new 2015-16 Base Plan and all employees currently enrolled in the 2014-15 Buy Up Plan will be mapped to the new 2015-16 Buy Up Plan. Your coverage tier will also remain the same as you elected for the 2014-15 plan year (employee only, employee/spouse, employee/child, or family). In addition, your dental election with BC/BS of GA from the previous year will automatically roll over to the 2015-16 plan year.

If you do not wish to make any changes to your benefits, there is nothing further you need to do. If you would like to move from the Base Plan to the Buy Up Plan (or vice versa), cancel coverage all together, or enroll in benefits for the first time, you will need to fill out an annual enrollment form. If you would like to add or remove a dependent from your benefits, you will need to fill out an annual enrollment form. All annual enrollment forms must be returned to Danielle Ewing no later than Wednesday, July 15th.

UNDERSTANDING YOUR MEDICAL PLAN

Medical Questions? Need to Locate a Provider?
Contact Aetna
1-888-802-3862 or www.aetna.com
Group #: 2038887
Plan Name: Natural Body

MEDICAL BENEFITS

The Natural Body medical benefits are insured through Aetna. Both medical plans offer access to the Aetna Open Access Managed Choice Network. Employees may select either the Base Plan or the Buy Up Plan or waive coverage altogether.

For enrolled members, Register on the Aetna Navigator website at www.aetnanavigator.com and:

-Find in network providers and facilities
-Track claims and account activity
-Review prescription drug costs
-Get answers to coverage questions
-Compare plan options and features
-Find health advice
And much more

UNDERSTANDING YOUR MEDICAL PLAN

Medical Questions? Need to Locate a Provider?
Contact Aetna
1-888-802-3862 or www.aetna.com
Group #: 2038887
Plan Name: Natural Body

MEDICAL BENEFITS

Base Plan - Qualified High Deductible Health Plan with H.S.A		
Overview	You may use both In-Network and Out-of-Network providers Use Network providers and receive the In-Network level of benefits. Use Non-Network providers and members are responsible for any difference between the allowed amount and actual charges, as well as any co-payments and/or applicable coinsurance.	
Calendar Year Deductible	**In-Network**	**Out-of-Network**
If you elect individual coverage, benefits are payable after satisfaction of the $3,000 deductible. If you elect other than individual coverage, benefits are payable after satisfaction of the $6,000 deductible.		
Individual	$3,000	$6,000
Family	$6,000	$12,000
Annual Out of Pocket Maximum (Includes Deductible, Coinsurance and Copays)		
Individual	$6,450	$19,000
Family Aggregate	$12,900	$38,000
Member Coinsurance	0%	30%
Lifetime Maximum	Unlimited	
Primary Care Physician Office Visits	Member pays $25 Copay after Deductible	Member pays 30% after Deductible
Specialist Office Visits	Member pays $50 Copay after Deductible	Member pays 30% after Deductible
Preventive Care	Member pays 0%, not subject to Deductible or Copays	Member pays 30% after Deductible
Maternity - Delivery and Post Partum Care	Covered in full after Deductible	Member pays 30% after Deductible
Hospital - Inpatient (includes maternity admission)	Member pays $250 Copay per admission after Deductible	Member pays 30% after Deductible
Outpatient Surgery	Hospital: Member pays $250 Copay after Deductible Freestanding Facility: Member pays $100 Copay after Deductible	Member pays 30% after Deductible
Diagnostic Imaging Services	X-Ray - Covered in full after Deductible Complex (MRI, CT, PET Scans) - Member pays $250 Copay after Deductible	Member pays 30% after Deductible
Urgent Care Facility	Member pays $75 Copay after Deductible	Member pays 30% after Deductible
Emergency Room	Member pays $300 Copay after Deductible (Copay waived if admitted)	Member pays $300 Copay after Deductible (Copay waived if admitted)
Outpatient Therapies *(ex: physical, speech and occupational)* *Maximum Annual Benefit*	Member pays $50 Copay after Deductible 20-visit calendar year maximum	Member pays 30% after Deductible 20-visit calendar year maximum
Chiropractic Care *Maximum Annual Benefit*	Member pays $50 Copay after Deductible 20-visit calendar year maximum	Member pays 30% after Deductible 20-visit calendar year maximum
Mental Health/Behavioral and Alcohol/Drug Abuse Treatment Services	Inpatient: Member pays $250 Copay after Deductible Outpatient Services: Member pays $50 Copay after Deductible	Inpatient: Member pays 30% after Deductible Outpatient: Member pays 30% after Deductible
Prescription Drugs		
Retail Pharmacy (30-day Supply)	Medical Deductible must be met first, then: $3 or $15 Copay for Formulary Generic Drugs $35 Copay for Formulary Brand Drugs $65 Copay for Non-Preferred Brand Drugs	Medical Deductible must be met first, then: $3 Copay or $15 Copay for Formulary Generic Drugs $35 Copay for Formulary Brand Drugs $65 Copay for Non-Preferred Brand Drugs
Mail Service Program (90-day Supply)	Medical Deductible must be met first, then: $7.50 or $37.50 Copay for Formulary Generic Drugs $87.50 Copay for Formulary Brand Drugs $162.50 Copay for Non-Preferred Brand Drugs	Not Covered
Specialty Drugs (30-day Supply)	Medical Deductible must be met first, then: Member pays 30% up to $250 per Preferred Rx Member pays 40% up to $500 per Non-Preferred Rx	Medical Deductible must be met first, then: Member pays 30% up to $250 per Preferred Rx Member pays 40% up to $500 per Non-Preferred Rx
Health Savings Account	Election of the High Deductible Health Plan entitles you to open a Health Savings Account (HSA) at the bank of your choice.	
Employee Contributions *(per pay period)*		
Employee	$93.23	
Employee & Spouse	$321.69	
Employee & Child(ren)	$255.69	
Family	$451.85	

UNDERSTANDING
YOUR MEDICAL PLAN

Medical Questions? Need to Locate a Provider?
Contact Aetna
1-888-802-3862 or www.aetna.com
Group #: 2038887
Plan Name: Natural Body

MEDICAL BENEFITS

Buy Up Plan - Managed Choice Open Access 3000 80		
Overview	You may use both In-Network and Out-of-Network providers Use Network providers and receive the In-Network level of benefits. Use Non-Network providers and members are responsible for any difference between the allowed amount and actual charges, as well as any co-payments and/or applicable coinsurance.	
Annual Deductible	**In-Network**	**Out-of-Network**
Individual	$3,000	$6,000
Family	$6,000	$12,000
Annual Out-of-Pocket Maximum (Includes Deductible and Copays)*		
Individual	$6,000	$18,000
Family	$12,000	$36,000
Member Coinsurance	20%	40%
*All individual Out-of-Pocket Maximum amounts will count towards the family Out-of-Pocket Maximum, but an individual will not have to pay more than the individual Out-of-Pocket Maximum amount. The following do not apply to the out-of-pocket maximum: Non-covered items. Out-of-pocket maximums accumulated separately for in-network and out-of-network services.		
Lifetime Maximum	Unlimited	
Primary Care Physician Office Visits	$30 Copay	Member pays 40% after Deductible
Specialist Office Visits	$60 Copay	Member pays 40% after Deductible
Preventive Care	Member pays 0%, not subject to Deductible or Copays	Member pays 40% after Deductible
Maternity - Delivery and Post Partum Care	Member pays 20% after Deductible	Member pays 40% after Deductible
Hospital - Inpatient (includes maternity admission)	Member pays 20% after Deductible	Member pays 40% after Deductible
Outpatient Surgery	Hospital: Member pays 20% after Deductible Freestanding Facility: Member pays 10% after Deductible	Member pays 40% after Deductible
Diagnostic Imaging Services	X-Ray - Member pays 20% after Deductible Complex (MRI, CT, PET Scans) - Member pays 20% after Deductible	Member pays 40% after Deductible
Urgent Care Facility	$75 Copay	Member pays 40% after Deductible
Emergency Room	$500 Copay (waived if admitted)	$500 Copay (waived if admitted)
Outpatient Therapies *(ex: physical, speech and occupational)* *Maximum Annual Benefit*	Member pays 20% after Deductible 20-visit calendar year maximum	Member pays 40% after Deductible 20-visit calendar year maximum
Chiropractic Care *Maximum Annual Benefit*	Member pays 20% after Deductible 20-visit calendar year maximum	Member pays 40% after Deductible 20-visit calendar year maximum
Mental Health/Behavioral and Alcohol/Drug Abuse Treatment Services	Inpatient: Member pays 20% after Deductible Outpatient Services: $60 Copay	Inpatient: Member pays 40% after Deductible Outpatient: Member pays 40% after Deductible
Prescription Drugs		
Retail Pharmacy *(30 day supply)*	$3 or $15 Copay for Generic drugs $45 Copay for Preferred Brand drugs $75 Copay for Non Preferred drugs	$3 or $15 Copay for Generic drugs $45 Copay for Preferred Brand drugs $75 Copay for Non Preferred drugs
Mail Order Maintenance Drug *(90 day supply)*	$7.50 or $37.50 Copay for Generic drugs $112.50 Copay for Preferred Brand drugs $187.50 Copay for Non Preferred drugs	Not Covered
Specialty Drugs (30-day Supply)	Member pays 30% up to $250 per Preferred Rx Member pays 40% up to $500 per Non-Preferred Rx	Member pays 30% up to $250 per Preferred Rx Member pays 40% up to $500 per Non-Preferred Rx
Employee Contributions *(per pay period)*		
Employee Only	$129.69	
Employee + Spouse	$402.92	
Employee + Child(ren)	$324.00	
Employee + Family	$558.46	

UNDERSTANDING

YOUR H.S.A BENEFIT

If you enroll in the Base Plan—the Qualified High Deductible Health Plan (HDHP)— you are eligible to open and contribute to a Health Savings Account (H.S.A).

An H.S.A is an employee-owned account that allows you to set aside money for your eligible medical expenses (including vision and dental expenses) incurred this year or in future years. Your contributions to the account are tax exempt, so you can save on taxes when you contribute. Unlike a Flexible Spending Account, any unused balance in your H.S.A rolls over from year to year—there is no "use it or lose it" rule.

You must be enrolled in a Qualified High Deductible Health Plan in order to contribute to an H.S.A. In future years, if you decide to dis-enroll from the HDHP plan, you can continue to use any money in your H.S.A for qualified medical expenses, but you are ineligible to contribute any additional funds to the account.

If you withdraw funds from the account for non medical expenses, you will be subject to a penalty. At age 65, however, any unused funds in your H.S.A can be withdrawn without penalty for non-medical purposes. If you withdraw the funds in your H.S.A after age 65, you would be subject to normal income tax on the money in the account, but you would not be limited to using the money for just medical related expenses.

Your H.S.A may be set up at the bank or investment provider of your choice and funds can be deposited however you prefer (one time deposit, monthly deposit, as medical expenses arise throughout the year, etc). Once you have set up your H.S.A, you will receive a debit card for easy access to your funds. You can use this debit card to pay for qualified medical expenses without having to file any paperwork for reimbursement—this card can be used at doctor's offices, pharmacies, hospitals, and other healthcare provider locations. It is recommended to save the receipts for every purchase you make with the card as you may need the receipts to verify expenses should you ever be audited.

There are limits to how much you can contribute to your H.S.A each calendar year. For 2015, the contribution limits are:

		*Age 55+
Individual	$3,350	$4,350
Family	$6,650	$7,350

*If you are over age 55, you can contribute an additional $1,000 to your H.S.A for 2015 as a "catch-up" contribution.

Please use the list on the next page as a guide to help you determine whether a medical expense is qualified or not for an H.S.A distribution.

The following items are qualified medical expenses and may be paid for using your HSA:

- Ambulance
- Annual Physical
- Artificial Limb
- Artificial Teeth
- Nursing Home (for medical care)
- Thermometers
- Abortion
- Acupuncture
- Bandages
- Birth Control Pills
- Blood Pressure Monitor
- Blood Sugar Test Kit
- Blood Tests
- Body Scan
- Body Scan
- Braille Books
- Breast Pump/Supplies
- Breast Reconstruction
- Christian Science (fees to practitioners for care)
- Cold/Hot Pack for medical care
- Condoms
- Contact Lenses and supplies
- Contraceptives
- Crutches
- Dental Treatment
- Dentures and cleaners
- Dermatologist
- Diabetic Supplies
- Diagnostic Devices
- Doctor's Fees not covered by insurance
- Drug Addiction (inpatient treatment)
- Drugs (with prescription)
- Eye Exam
- Eye Surgery (including laser eye surgery)
- Eyeglasses
- Fertility Enhancement
- First Aid Supplies
- Flu Shot
- Guide Dog (incl. maintenance costs - food, vets, etc.…)
- Gynecologist
- Hearing Aids (incl. batteries and repair)
- Homeopathic Care
- Immunizations
- Laboratory Fees
- Lactation Expenses (see breast pump)
- Medical Alert Bracelet
- Operations (non cosmetic)
- Optometrist
- Orthopedist
- Orthotic Inserts
- Osteopath
- Out-of-Network
- Oxygen for medical condition
- Physical Examination
- Pregnancy Test Kit
- Prosthesis
- Psychiatric Care
- Psychoanalysis
- Psychologist
- Splints
- Sterilization
- Surgery (non-cosmetic)
- Therapy.
- Vasectomy
- Vision Surgery
- Wheelchair
- X-Ray

The following items are NOT qualified medical expenses

- Baby Sitting
- Bottled Water
- Controlled Substances
- Cosmetic Surgery
- Cosmetics
- CPR Class
- Dancing Lessons
- Dental Floss
- Diaper Service
- Diet Foods
- Electrolysis Hair Rem.
- Exercise Equip.
- Facial Tissues
- Finance Charge
- Funeral Expenses
- Funeral Expenses
- Health Club Dues
- Household Help
- Illegal Treatments
- Marijuana
- Maternity Clothes
- Medigap Premiums
- Personal Use Items
- Swimming Lessons
- Teeth Whitening
- Veterinary Fees

UNDERSTANDING YOUR VISION PLAN

Vision Questions? Need to Locate a Provider?
Contact Aetna
1-888-802-3862 or www.aetna.com
Group #: 2038887
Plan Name: Natural Body

Aetna Discount Vision Program

All members enrolled in the Aetna medical plan also have access to a vision savings program and can receive discounts on exams, glasses, contacts, and Lasik surgery. Members just need to present their Aetna medical ID card to a participating vision provider at the time of service to receive the discounts.

Choose from thousands of locations

It's easy to find a provider, with thousands of independent locations and national chains. The Aetna vision network includes Pearle Vision Centers, Sears Optical, Target Optical, JCPenney Optical and Lens Crafters. You can find one by visiting DocFind, the Aetna online provider directory. Go to www.aetna.com and follow the standard search prompts to "vision locations". Or, call 1-800-793-8616 for information on provider locations.

PRODUCT OR SERVICE	WHAT YOU'LL PAY
Eye Exams for Plans That Cover Eye Exams	Refer to your health benefits and health insurance plan documents for coverage details
Eye Exams for Plans That Do Not Cover Eye Exams	
▪ Comprehensive eye exam	$42
▪ Standard contact lenses fit & follow up	$40 (plus $42 exam fee)
▪ Specialty contact lenses fit & follow up (e.g. 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 (retail prices)	40% off retail prices
Lens Options per Pair (add to lens price above)	
▪ Standard polycarbonate (includes UV coating 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
▪ Photochromic Glass	20% off retail
Contact Lenses Get a 15% discount (5% on disposables) off retail prices.	
Mail-Order Contact Lens Replacement Program Call 1-800-391-LENS (5367) to order replacement contact lenses. (Mail-order contact pricing is not subject to the discounts received at participating locations.)	
Additional Vision-Related Items Visit any participating location to receive a 20% discount off retail prices.	
LASIK Procedure 15% off standard prices or 5% off promotional prices for LASIK services obtained through the U.S. Laser Network. Members must call before scheduling an appointment.	

Dental Questions? Need to Locate a Provider?
Contact BCBS of Georgia
1-877-330-5973 or www.bcbsga.com
Group #: GA 6033
Plan Name: Natural Body

DENTAL BENEFITS

Blue Cross Blue Shield of Georgia		
Deductible	**In Network**	**Out of Network**
Individual	$50	$50
Family	$150	$150
Calendar Year Maximum	$1,000	$1,000
Deductible Waived for Preventive	No	No
Type of Dental Service		
Preventive Services -*Initial oral exams* -*Periodic oral exams* -*Bitewing X-rays* -*Prophylaxis (cleanings)*	Plan pays 100% after Deductible	Plan pays based on Fee Schedule
Basic Restorative Services -*Fillings* - *All other X-rays*	Plan pays 50% after Deductible	Plan pays based on Fee Schedule
Major Restorative Services -*Crowns* - *Oral Surgery* -*Dentures* - *Simple Extractions* -*Root Canals* -*Periodontics*	Plan pays 50% after Deductible	Plan pays based on Fee Schedule
Orthodontic Services	Not Covered	Not Covered
Benefit Waiting Periods *(for new members)*		
Oral Surgery *All Other Major Services*	6 months 12 months	6 months 12 months
Employee Contributions *(per pay period)*		
Employee Only *Employee + Spouse* *Employee + Child(ren)* *Employee + Family*	$10.02 $20.06 $19.04 $30.08	

2015 Health Plan Notices

*** Women's Health and Cancer Rights Act of 1998**

Your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy – related services, including reconstruction and surgery to achieve symmetry between the breasts, prosthesis, and complications resulting from a mastectomy (including lymphedema).

Please call your plan administrator for more information. These benefits may be subject to annual deductibles, co-insurance provisions or copays that are appropriate and consistent with other benefits under your plan.

*** The Genetic Information Nondiscrimination Act (GINA)**

The Genetic Information Nondiscrimination Act of 2008, also referred to as GINA, is a new federal law that protects Americans from being treated unfairly because of differences in their DNA that may affect their health. The new law prevents discrimination from health insurers and employers. The President signed the act into federal law on May 21, 2008. The parts of the law relating to health insurers will take effect by May 2009, and those relating to employers will take effect by November 2009.

Who needs protection from genetic discrimination?

Everyone should care about the potential for genetic discrimination. Every person has dozens of DNA differences that could increase or decrease his or her chance of getting a disease such as diabetes, heart disease, cancer or Alzheimer's. It's important to remember that these DNA differences don't always mean someone will develop a disease, just that the risk to get the disease may be greater.

More and more tests are being developed to find DNA differences that affect our health. These tests (called genetic tests) will become a routine part of health care in the future. Health care providers will use information about each person's DNA to develop more individualized ways of detecting, treating and preventing disease. But unless this DNA information is protected, it could be used to discriminate against people.

Why was the law needed?

The law was needed to help ease concerns about discrimination that might keep some people from getting genetic tests that could benefit their health. The law also enables people to take part in research studies without fear that their DNA information might be used against them in health insurance or the workplace.

Important Notice from Natural Body About
Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Natural Body and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

Natural Body has determined that the prescription drug coverage offered by Aetna is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th through December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Natural Body coverage may be affected.

If you do decide to join a Medicare drug plan and drop your current Natural Body coverage, be aware that you and your dependents may not be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Natural Body and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage…

Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Natural Body changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date:	July 1, 2015
Name of Entity/Sender:	Natural Body
Contact--Position/Office:	Danielle Ewing
Address:	1123 Zonolite Road, Suite 18, Atlanta, GA 30306
Phone Number:	678-904-5697

Georgia Consumer Choice

What is Consumer Choice?

Georgia law requires insurers to offer a "Consumer Choice" option to members enrolling in an insured HMO, POS or PPO plan. This Consumer Choice option allows members to receive services from a non-network provider (physician, hospital or other provider) while still being covered at an in-network level.

Although members may "nominate" any non-network provider, the nominated doctor or hospital must first agree to the following in order for the member's services to be covered at the in-network rate:

1. Accept the insurer's reimbursement as payment in full (in addition to the member's usual copayments, deductibles and/or coinsurance)
2. Comply with the insurer's utilization management programs

Is there a charge to elect the Consumer Choice Option?

Yes. The law allows insurers to increase the monthly premium rate for members who elect this offering. The amount of the monthly premium increase is 17.5% for Consumer Choice Option HMO and POS benefit plans, and 10% for Consumer Choice Option PPO plans.

How do I choose the Consumer Choice Option?

Selecting the Consumer Choice Option is just like selecting any other benefit option. You must do so either at open enrollment, if you are a new hire, or when your employer's eligibility rules allow you to do so. To select the Consumer Choice Option:

Newly applying members must complete the insurer's Member Enrollment Application and select the Consumer Choice Option plan desired. (Members must still select a network Primary Care Physician for each person enrolled if a HMO or POS Consumer Choice Option is selected.)

Currently enrolled members must complete a Member Change Form and select the Consumer Choice Option plan desired.

How is the Consumer Choice Option different from a PPO or POS plan?

A PPO or POS plan allows members access to out-of-network providers at an out-of-network benefit level. When a member utilizes the services of an out-of-network provider, the member usually pays more in the form of increased copayments, deductibles and/or coinsurance.

Under the Consumer Choice Option, members may utilize the services of an out-of-network provider at in-network benefit levels only when that provider has:

1. Been nominated by the member:
2. Signed a form accepting the insurer's conditions; and
3. Been approved by the insurer.

After a provider has been approved, the member's benefits are paid as though the provider were part of the insurer's network.

Once I elect the Consumer Choice Option, can I go to any doctor and get benefits paid at in-network levels?|

No. First, you must complete a Provider Nomination Form and receive notification from the insurer that the nomination has been accepted before out-of-network providers can be reimbursed at in-network benefit levels. For any nomination to be approved, the provider must sign the nomination form agreeing to the insurer's terms and conditions before that provider's services will be covered at in-network levels. The provider has absolute discretion regarding whether he or she wishes to participate in the Consumer Choice Option.

How do I nominate my physician?

Call the insurer's customer service department to request a Consumer Choice Physician Nomination Form. Members must complete the provider nomination form, which is a two-step process:

1. The provider must sign the nomination form and request details about the insurer's reimbursement rates for the services he or she intends to provide.
2. The provider must sign the form again to indicate his or her acceptance of the rates and other terms and conditions, once he or she has reviewed them.

After you have completed these steps, please return the completed nomination form to the insurer for approval.

How long will it take to get approval of a nominated provider?
Once the insurer has received a completed nomination form – completed and signed by both the provider and the member – they will respond by mail or fax within three business days.

What if I select the Consumer Choice Option and then decide I want to return to a non-Consumer Choice Option plan?

Under most employers' rules, you may make a plan election only once during each year. If your employer's rules allow you to switch plans other than during your open enrollment period, you may move from the Consumer Choice Option plan you elected back to the non-Consumer Choice version of that plan within 31 days of enrolling. Please check with your employer for details. Your employer must submit any such requests in writing to the insurer.

What if my doctor doesn't want to accept reimbursement terms or comply with utilization management guidelines required by the insurer?
The law does not obligate a provider to accept the terms and conditions or reimbursement rates. If a provider elects not to sign the Consumer Choice Option Provider Nomination Form, he or she is under no obligation to do so.

If you are seeking services from a specific provider, check with that provider BEFORE completing the Consumer Choice Option application and making a final plan election. Once you have selected a Consumer Choice Option plan, you cannot switch plans until the following open enrollment, except within 31-day grace period described above.

Once a doctor has agreed to your terms, can I receive services from that doctor or hospital for the remainder of the time I'm enrolled in the health plan?
Once the provider has signed the form agreeing to the reimbursement and other terms and conditions, you may utilize the services of the provider until your plan's anniversary the following year. You will need to repeat the nomination/approval process each year for the out-of-network provider's services to be covered at in-network benefit levels.

Will prescriptions written by a non-network doctor be covered?
If you nominate a provider and that provider is ultimately approved under the Consumer Choice Option, he or she may write prescriptions that will be covered at in-network benefit levels. Remember, if your plan restricts you to having prescriptions filled at network pharmacies, you must either use only network pharmacies or have a completed and approved Provider Nomination Form for any non-network pharmacy. (Note: This requirement does not apply to PPO plans.)

If my doctor admits me to a non-network hospital, will the hospital charges be covered?
Any services must be provided by either a network hospital or a hospital for which a Provider Nomination Form has been completed and approved. This form must also be completed and approved for any other providers rendering services – for example, radiology, anesthesia services, physical therapy or lab work. To be eligible for in-network benefit levels, all services must be provided by either in-network providers or providers approved under the Consumer Choice Option.

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2015. Contact your State for more information on eligibility –

ALABAMA – Medicaid	GEORGIA – Medicaid
Website: www.myalhipp.com Phone: 1-855-692-5447	Website: http://dch.georgia.gov/ - Click on Programs, then Medicaid, then Health Insurance Premium Payment (HIPP) Phone: 1-800-869-1150
ALASKA – Medicaid	**INDIANA – Medicaid**
Website: http://health.hss.state.ak.us/dpa/programs/medicaid/ Phone (Outside of Anchorage): 1-888-318-8890 Phone (Anchorage): 907-269-6529	Website: http://www.in.gov/fssa Phone: 1-800-889-9949
COLORADO – Medicaid	**IOWA – Medicaid**
Medicaid Website: http://www.colorado.gov/hcpf Medicaid Customer Contact Center: 1-800-221-3943	Website: www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562
FLORIDA – Medicaid	**KANSAS – Medicaid**
Website: https://www.flmedicaidtplrecovery.com/ Phone: 1-877-357-3268	Website: http://www.kdheks.gov/hcf/ Phone: 1-800-792-4884

KENTUCKY – Medicaid	NEW HAMPSHIRE – Medicaid
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218
LOUISIANA – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: http://www.lahipp.dhh.louisiana.gov Phone: 1-888-695-2447	Medicaid Website: http://www.state.nj.us/humanservices/ dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
MAINE – Medicaid	**NEW YORK – Medicaid**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-977-6740 TTY 1-800-977-6741	Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831
MASSACHUSETTS – Medicaid and CHIP	**NORTH CAROLINA – Medicaid**
Website: http://www.mass.gov/MassHealth Phone: 1-800-462-1120	Website: http://www.ncdhhs.gov/dma Phone: 919-855-4100
MINNESOTA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: http://www.dhs.state.mn.us/id_006254 Click on Health Care, then Medical Assistance Phone: 1-800-657-3739	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-800-755-2604
MISSOURI – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MONTANA – Medicaid	**OREGON – Medicaid**
Website: http://medicaid.mt.gov/member Phone: 1-800-694-3084	Website: http://www.oregonhealthykids.gov http://www.hijossaludablesoregon.gov Phone: 1-800-699-9075
NEBRASKA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633	Website: http://www.dpw.state.pa.us/hipp Phone: 1-800-692-7462
NEVADA – Medicaid	**RHODE ISLAND – Medicaid**
Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900	Website: www.ohhs.ri.gov Phone: 401-462-5300

SOUTH CAROLINA – Medicaid	VIRGINIA – Medicaid and CHIP
Website: http://www.scdhhs.gov Phone: 1-888-549-0820	Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282
SOUTH DAKOTA - Medicaid	**WASHINGTON – Medicaid**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.hca.wa.gov/medicaid/premiumpymt/pages/ index.aspx Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: https://www.gethipptexas.com/ Phone: 1-800-440-0493	Website: www.dhhr.wv.gov/bms/ Phone: 1-877-598-5820, HMS Third Party Liability
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Website: Medicaid: http://health.utah.gov/medicaid CHIP: http://health.utah.gov/chip Phone: 1-866-435-7414	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
VERMONT– Medicaid	**WYOMING – Medicaid**
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: http://health.wyo.gov/healthcarefin/equalitycare Phone: 307-777-7531

To see if any other states have added a premium assistance program since January 31, 2015, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

OMB Control Number 1210-0137 (expires 10/31/2016)

NOTICE OF SPECIAL ENROLLMENT RIGHTS

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends and you fulfill other special enrollment requirements. (These requirements are set out in your Certificate of Coverage)

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

There is an additional enrollment period if an employee or dependent loses eligibility for Children's Health Insurance Program (CHIP), Medicaid or becomes eligible for CHIP for Medicaid premium assistance. The special enrollment allows children or their parents to have 60 days, rather than 30, to request enrollment.

Also, your health plan may not establish rules for eligibility (including continued eligibility) of an individual to enroll under the terms of the plan based on a health status-related factor.

Complete If You Are Declining Coverage For Yourself Or Any Dependent:

If you are declining coverage for yourself or for any of your eligible dependents, you must complete the following information if you want to preserve your rights of Special Enrollment as explained above. If you decline coverage for yourself, the reason is:

☐ **I have other coverage** ☐ **Another reason**

If you decline coverage for one or more eligible dependents, please give the dependent's name below and indicate the reason coverage is declined.

Name ______________________ ☐ Dependent has other coverage ☐ Another reason

Name ______________________ ☐ Dependent has other coverage ☐ Another reason

Name ______________________ ☐ Dependent has other coverage ☐ Another reason

Name ______________________ ☐ Dependent has other coverage ☐ Another reason

________________________________ ________________________________

Employee Name – Please Print **Employee Social Security Number**

________________________________ ________/_________/________

Employee Signature **Date**

Notice of Privacy Practices

Para recibir esta notificación en español por favor llamar al número gratuito de Member Services (Servicios a Miembros) que figura en su tarjeta de identificación.

This Notice of Privacy Practices applies to Aetna's insured health benefit plans. It does not apply to any plans that are self-funded by an employer. If you receive benefits through a group health insurance plan, your employer will be able to tell you if your plan is insured or self-funded. If your plan is self-funded, you may want to ask for a copy of your employer's privacy notice.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

Please review it carefully.

Aetna[1] considers personal information to be confidential. We protect the privacy of that information in accordance with federal and state privacy laws, as well as our own company privacy policies.

This notice describes how we may use and disclose information about you in administering your benefits, and it explains your legal rights regarding the information.

When we use the term "personal information," we mean information that identifies you as an individual, such as your name and Social Security Number, as well as financial, health and other information about you that is nonpublic, and that we obtain so we can provide you with insurance coverage. By "health information," we mean information that identifies you and relates to your medical history (i.e., the health care you receive or the amounts paid for that care).

This notice became effective on April 26, 2013.

How Aetna Uses and Discloses Personal Information

In order to provide you with insurance coverage, we need personal information about you, and we obtain that information from many different sources – particularly you, your employer or benefits plan sponsor if applicable, other insurers, HMOs or third-party administrators (TPAs), and health care providers. In administering your health benefits, we may use and disclose personal information about you in various ways, including:

[1] For purposes of this notice, "Aetna" and the pronouns "we," "us" and "our" refer to all of the HMO and licensed insurer subsidiaries of Aetna Inc., including the entities listed on the last page of this notice. These entities have been designated as a single affiliated covered entity for federal privacy purposes.

Health Care Operations: We may use and disclose personal information during the course of running our health business – that is, during operational activities such as quality assessment and improvement; licensing; accreditation by independent organizations; performance measurement and outcomes assessment; health services research; and preventive health, disease management, case management and care coordination. For example, we may use the information to provide disease management programs for members with specific conditions, such as diabetes, asthma or heart failure. Other operational activities requiring use and disclosure include administration of reinsurance and stop loss; underwriting and rating; detection and investigation of fraud; administration of pharmaceutical programs and payments; transfer of policies or contracts from and to other health plans; facilitation of a sale, transfer, merger or consolidation of all or part of Aetna with another entity (including due diligence related to such activity); and other general administrative activities, including data and information systems management, and customer service.

Payment: To help pay for your covered services, we may use and disclose personal information in a number of ways – in conducting utilization and medical necessity reviews; coordinating care; determining eligibility; determining formulary compliance; collecting premiums; calculating cost-sharing amounts; and responding to complaints, appeals and requests for external review. For example, we may use your medical history and other health information about you to decide whether a particular treatment is medically necessary and what the payment should be – and during the process, we may disclose information to your provider. We also mail Explanation of Benefits forms and other information to the address we have on record for the subscriber (i.e., the primary insured). In addition, we make claims information contained on our Aetna Navigator™ health site and telephonic claims status sites available to the subscriber and all covered dependents. We also use personal information to obtain payment for any mail order pharmacy services provided to you.

Treatment: We may disclose information to doctors, dentists, pharmacies, hospitals and other health care providers who take care of you. For example, doctors may request medical information from us to supplement their own records. We also may use personal information in providing mail order pharmacy services and by sending certain information to doctors for patient safety or other treatment-related reasons.

Disclosures to Other Covered Entities: We may disclose personal information to other covered entities, or business associates of those entities for treatment, payment and certain health care operations purposes. For example, if you receive benefits through a group health insurance plan, we may disclose personal information to other health plans maintained by your employer if it has been arranged for us to do so in order to have certain expenses reimbursed.

Additional Reasons for Disclosure

We may use or disclose personal information about you in providing you with treatment alternatives, treatment reminders, or other health-related benefits and services. We also may disclose such information in support of:

- **Plan Administration** – to your employer (for group health insurance plans), when we have been informed that appropriate language has been included in your plan documents, or when summary data is disclosed to assist in bidding or amending a group health plan.
- **Research** – to researchers, provided measures are taken to protect your privacy.
- **Business Partners** – to persons who provide services to us and assure us they will protect the information.
- **Industry Regulation** – to state insurance departments, boards of pharmacy, U.S. Food and Drug Administration, U.S. Department of Labor and other government agencies that regulate us.
- **Law Enforcement** – to federal, state and local law enforcement officials.
- **Legal Proceedings** – in response to a court order or other lawful process.
- **Public Welfare** – to address matters of public interest as required or permitted by law (e.g., child abuse and neglect, threats to public health and safety, and national security).

Disclosure to Others Involved in Your Health Care

We may disclose health information about you to a relative, a friend, the subscriber of your health benefits plan or any other person you identify, provided the information is directly relevant to that person's involvement with your health care or payment for that care. For example, if a family member or a caregiver calls us with prior knowledge of a claim, we may confirm whether or not the claim has been received and paid. You have the right to stop or limit this kind of disclosure by calling the toll-free Member Services number on your ID card.

If you are a minor, you also may have the right to block parental access to your health information in certain circumstances, if permitted by state law. You can contact us using the toll-free Member Services number on your ID card – or have your provider contact us.

Uses and Disclosures Requiring Your Written Authorization

In all situations other than those described above, we will ask for your written authorization before using or disclosing personal information about you. For example, we will get your authorization:

- for marketing purposes that are unrelated to your benefit plan(s),
- before disclosing any psychotherapy notes,
- related to the sale of your health information, and
- for other reasons as required by law.

If you have given us an authorization, you may revoke it at any time, if we have not already acted on it. If you have questions regarding authorizations, please call the toll-free Member Services number on your ID card.

Your Legal Rights

The federal privacy regulations give you several rights regarding your health information:

- You have the right to ask us to communicate with you in a certain way or at a certain location. For example, if you are covered as an adult dependent, you might want us to send health information to a different address from that of your subscriber. We will accommodate reasonable requests.
- You have the right to ask us to restrict the way we use or disclose health information about you in connection with health care operations, payment and treatment. We will consider, but may not agree to, such requests. You also have the right to ask us to restrict disclosures to persons involved in your health care.
- You have the right to ask us to obtain a copy of health information that is contained in a "designated record set" – medical records and other records maintained and used in making enrollment, payment, claims adjudication, medical management and other decisions. We may ask you to make your request in writing, may charge a reasonable fee for producing and mailing the copies and, in certain cases, may deny the request.
- You have the right to ask us to amend health information that is in a "designated record set." Your request must be in writing and must include the reason for the request. If we deny the request, you may file a written statement of disagreement.
- You have the right to ask us to provide a list of certain disclosures we have made about you, such as disclosures of health information to government agencies that license us. Your request must be in writing. If you request such an accounting more than once in a 12-month period, we may charge a reasonable fee.
- You have the right to be notified following a breach involving your health information.

- You have the right to know the reasons for an unfavorable underwriting decision. Previous unfavorable underwriting decisions may not be used as the basis for future underwriting decisions unless we make an independent evaluation of the basic facts. Your genetic information cannot be used for underwriting purposes.
- You have the right with very limited exceptions, not to be subjected to pretext interviews.[1]

You may make any of the requests described above (if applicable), may request a paper copy of this notice, or ask questions regarding this notice by calling the toll-free Member Services number on your ID card.

You also have the right to file a complaint if you think your privacy rights have been violated. To do so, please send your inquiry to the following address:

HIPAA Member Rights Team
Aetna Inc.
151 Farmington Avenue RT65
Hartford, CT 06156

You also may write to the Secretary of the U.S. Department of Health and Human Services. You will not be penalized for filing a complaint.

Aetna's Legal Obligations

The federal privacy regulations require us to keep personal information about you private, to give you notice of our legal duties and privacy practices, and to follow the terms of the notice currently in effect.

Safeguarding Your Information

We guard your information with administrative, technical, and physical safeguards to protect it against unauthorized access and against threats and hazards to its security and integrity. We comply with all applicable state and federal law pertaining to the security and confidentiality of personal information.

This Notice is Subject to Change

We may change the terms of this notice and our privacy policies at any time. If we do, the new terms and policies will be effective for all of the information that we already have about you, as well as any information that we may receive or hold in the future.

Please note that we do not destroy personal information about you when you terminate your coverage with us. It may be necessary to use and disclose this information for the purposes described above even after your coverage terminates, although policies and procedures will remain in place to protect against inappropriate use or disclosure.

Coverage may be underwritten or administered by one or more of the following companies: Aetna Health Inc.; Aetna Health of California Inc.; Aetna Dental of California Inc.; Aetna Health of the Carolinas Inc.; Aetna Health of Illinois Inc.; Aetna Dental Inc.; Aetna Health of Washington Inc.; Aetna Life Insurance Company; Aetna Insurance Company of Connecticut; Aetna Health Insurance Company of Connecticut; and Aetna Health Insurance Company of New York. Mail order pharmacy services may be provided by Aetna R_x Home Delivery, LLC.

[1] Aetna does not participate in pretext interviews.

Disclaimer: This Benefit Guide provides only the briefest of summaries of the benefits available under Natural Body. In the event of any discrepancy between this summary and any Plan Document, the Plan Document will prevail. Natural Body retains the right to modify or eliminate these or any benefits at any time and for any reason.