floyd county™

2017 Employee Benefit Guide

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EMPLOYEE BENEFITS BEGINNING 8/1/12017

WHAT'S NEW AND WHAT'S CONTINUING!

MEDICAL
Introducing 2 new plan designs and continuing the $2,500 deductible plan. Plans and rates will be reviewed with our Enrollment Counselor.

WELLNESS BENEFITS
New this year! All employees who enroll in one of the 3 medical plans will have access to Wellness Benefits which will include a Health Risk Assessment ($50 gift card incentive); One Journey via Aetna Navigator ($50 gift card incentive); Biometric Screenings and many other great benefits! We will be introducing this benefit in August.

VOLUNTARY DENTAL
Continuing with Blue Cross Shield of Georgia. No plan changes. Slight increase per pay period - $.36 for employee only and $1.12 for family coverage.

VOLUNTARY VISION
Continuing with Aetna. No plan changes. No change to your per pay period deductions!

EMPLOYEE ASSISTANCE PROGRAM- EAP
Our second year offering the EAP benefit at no additional cost to you! Reminder! Up to 6 counseling sessions per issue, per year, no copay, no deductible!

VOLUNTARY SHORT TERM DISABILITY
Colonial Life benefits are tailored to your personal needs depending on how long you can afford to go without a paycheck.

VOLUNTARY ACCIDENT
Colonial Life offers a scheduled amount payable to you if you have an accident. There is a $50.00 additional benefit payable to you when you have your annual exam (health screening).

VOLUNTARY TERM LIFE
New this year! Term Life Insurance you can tailor to your personal needs at 10, 20 and 30 year term options. Spouse and Dependent Term Riders will be available.

ACCIDENTAL DEATH & DISMEMBERMENT VOLUNTARY TERM LIFE
New this year! Complimentary Accidental Death and Dismemberment insurance. You can register for $5,000 AD&D insurance when you meet with our Colonial representatives during Open Enrollment.

**SEE NEXT PAGE TO FIND A PROVIDER IN EACH OF YOUR EMPLOYEE BENEFIT PLANS!!

floyd county™

EMPLOYEE BENEFITS BEGINNING 8/1/12017

WHAT'S NEW AND WHAT'S CONTINUING!

FIND A PROVIDER

Aetna: (Medical) Network-Aetna Health Network Option-Open Access
http://www.aetna.com/dse/search?site_id=dse

Aetna: (Employee Assistance Program – EAP)
Call 888-238-6232
www.resourcesforliving.com
User Name: floyd
Password: eap

Aetna: (Vision) Network – Aetna Vision Preferred
https://www.aetnavision.com/aetna/

Blue Cross Blue Shield: (Dental) Network-Dental Complete
http://www.bcbsga.com/mydental/

aetna®

Floyd County Productions
Effective Date: 08-01-2017
Aetna Health Network Option℠ - Georgia
Qualified High Deductible Health Plan
GA 17 HNOption HSA 5000 100/70 EMB RX14.25

PLAN DESIGN & BENEFITS
PROVIDED BY AETNA HEALTH INC. AND AETNA HEALTH INSURANCE COMPANY - FULL RISK

PLAN FEATURES	IN-NETWORK	OUT-OF-NETWORK
Deductible (per calendar year)	$5,000 Individual $10,000 Family	$10,000 Individual $20,000 Family
Unless otherwise indicated, the deductible must be met prior to benefits being payable. Applicable covered expenses accumulate separately toward the in-network and out-of-network providers Deductible. Member cost sharing for certain services, as indicated in the plan, are excluded from charges to meet the Deductible. Pharmacy expenses apply towards the Deductible. The family Deductible is a cumulative Deductible for all family members. The family Deductible can be met by a combination of family members; however, no single individual within the family will be subject to more than the individual Deductible amount.		
Out-of-Pocket Maximum (per calendar year)	$6,550 Individual $13,100 Family	$20,000 Individual $40,000 Family
All applicable covered expenses accumulate separately toward the in-network and out-of-network Out-of-Pocket-Maximum. In-network expenses include coinsurance/copays and deductibles. Out-of-network expenses include coinsurance and deductible. Penalty amounts do not apply. Pharmacy expenses apply towards the Out-of-Pocket-Maximum. The family Out-of-Pocket Maximum is a cumulative Out-of-Pocket Maximum for all family members. The family Out-of-Pocket Maximum can be met by a combination of family members; however no single individual within the family will be subject to more than the individual Out-of-Pocket Maximum amount.		
Lifetime Maximum	Unlimited except where otherwise indicated.	Unlimited except where otherwise indicated.
Benefit Limitations -- For any service or supply that is subject to a maximum visit, day, or dollar limitation, such services or supplies accumulate toward both the participating provider and non-participating provider benefit limits under this plan.		
Payment for Non-Preferred Care**	Not Applicable	Professional: 105% of Medicare Facility: 140% of Medicare
Primary Care Physician Selection	Optional	Not Applicable
Precertification Requirement Certain non-participating providers/participating provider self referred services require precertification or benefits will be reduced. Refer to your plan documents for a complete list of services that require precertification.		
Referral Requirement	None	None
PREVENTIVE CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Routine Adult Physical Exams/ Immunizations 1 exam every 12 months for members age 22 and older.	Covered 100%; deductible waived	30%; after deductible
Routine Well Child Exams/Immunizations (Age and frequency schedules apply)	Covered 100%; deductible waived	30%; deductible waived
Routine Gynecological Care Exams Includes routine tests and related lab fees without frequency limit.	Covered 100%; deductible waived	Covered 100%; after deductible
Routine Mammograms Recommended: One baseline mammogram for females age 35 - 39; and one annual mammogram for females age 40 and over.	Covered 100%; deductible waived	30%; after deductible

PLAN DESIGN & BENEFITS
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Women's Health	Covered 100%; deductible waived	30%; after deductible
Includes: Screening for gestational diabetes, HPV (Human- Papillomavirus) DNA testing, counseling for sexually transmitted infections, counseling and screening for human immunodeficiency virus, screening and counseling for interpersonal and domestic violence, breastfeeding support, supplies and counseling. Contraceptive methods, sterilization procedures, patient education and counseling. Limitations may apply.		
Routine Digital Rectal Exams / Prostate Specific Antigen Test	Covered 100%; deductible waived	Covered same as routine well adult exam
Recommended for males age 40 and over.		
Colorectal Cancer Screening	Covered 100%; deductible waived	Your cost sharing is based on the type of service and where it is performed
Recommended: For all members age 50 and over. Frequency schedule applies.		
Routine Eye Exams	Covered 100%; deductible waived	Not Covered
1 routine exam per 24 months.		
Routine Hearing Screening	Covered 100%; deductible waived	30%; after deductible
PHYSICIAN SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Primary Care Physician Visits	Covered 100%; after deductible	30%; after deductible
Includes services of an internist, general physician, family practitioner or pediatrician.		
Specialist Office Visits	Covered 100%; after deductible	30%; after deductible
Pre-Natal Maternity	Covered 100%; deductible waived	30%; after deductible
Walk-in Clinics	Covered 100%; after deductible	30%; after deductible
Walk-in Clinics are network, free-standing health care facilities. They are an alternative to a physician's office visit for treatment of unscheduled, non-emergency illnesses and injuries and the administration of certain immunizations. It is not an alternative for emergency room services or the ongoing care provided by a physician. Neither an emergency room, nor the outpatient department of a hospital, shall be considered a Walk-in Clinic.		
Allergy Testing	Your cost sharing is based on the type of service and where it is performed	Your cost sharing is based on the type of service and where it is performed
Allergy Injections	Your cost sharing is based on the type of service and where it is performed. Covered 100% when an office visit charge is not applicable.	Your cost sharing is based on the type of service and where it is performed
DIAGNOSTIC PROCEDURES	**IN-NETWORK**	**OUT-OF-NETWORK**
Diagnostic Laboratory	Covered 100%; after deductible	30%; after deductible
If performed as a part of a physician office visit and billed by the physician, expenses are covered subject to the applicable physician's office visit member cost sharing.		
Diagnostic X-ray	Covered 100%; after deductible	30%; after deductible
If performed as a part of a physician office visit and billed by the physician, expenses are covered subject to the applicable physician's office visit member cost sharing.		

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Diagnostic X-ray for Complex Imaging Services	Covered 100%; after deductible	30%; after deductible
EMERGENCY MEDICAL CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Urgent Care Provider	Covered 100%; after deductible	30%; after deductible
Non-Urgent Use of Urgent Care Provider	Not Covered	Not Covered
Emergency Room	Covered 100%; after deductible	Refer to participating provider benefit.
Non-Emergency Care in an Emergency Room	Not Covered	Not Covered
Emergency Use of Ambulance	Covered 100%; after deductible	Refer to participating provider benefit.
Non-Emergency Use of Ambulance	Not Covered	Not Covered
HOSPITAL CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient Coverage	Covered 100%; after deductible	30% per admission; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Inpatient Maternity Coverage (includes delivery and postpartum care)	Covered 100% for Physician maternity services; after deductible; Covered 100% for Facility services; after deductible	30% for Physician Maternity Services; after deductible; 30% for Facility Services; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Outpatient Hospital	Covered 100%; after deductible	30%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
MENTAL HEALTH SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient	Covered 100%; after deductible	30% per admission; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Outpatient	Covered 100%; after deductible	30% per visit; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
SUBSTANCE ABUSE	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient Detoxification	Covered 100%; after deductible	30% per admission; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Outpatient Detoxification	Covered 100%; after deductible	30% per visit; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Inpatient Rehabilitation	Covered 100%; after deductible	30% per admission; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Residential Treatment Facility	Covered 100%; after deductible	30% per admission; after deductible
Outpatient Rehabilitation	Covered 100%; after deductible	30% per visit; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
OTHER SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Skilled Nursing Facility	Covered 100%; after deductible	30% per admission; after deductible
Limited to 60 days; per calendar year Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Home Health Care	Covered 100%; after deductible	30%; after deductible
Limited to 60 visits; per calendar year Limited to 3 intermittent visits per day by a participating home health care agency; 1 visit equals a period of 4 hrs or less.		
Hospice Care - Inpatient	Covered 100%; after deductible	30% per admission; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Hospice Care - Outpatient	Covered 100%; after deductible	30% per visit; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		

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Outpatient Short-Term Rehabilitation Limited to 20 visits; per calendar year Includes Speech, Physical, and Occupational therapy	Covered 100%; after deductible	30% per visit; after deductible
Spinal Manipulation Therapy Limited to 20 visits; per calendar year	Covered 100%; after deductible	30%; after deductible
Autism Behavioral Therapy Covered same as any other Outpatient Mental Health benefit	Refer to MBH Outpatient Mental Health	Refer to MBH Outpatient Mental Health
Autism Applied Behavior Analysis Covered same as any other Outpatient Mental Health benefit with no age or visit limitations.	Refer to MBH Outpatient Mental Health	Refer to MBH Outpatient Mental Health
Autism Physical Therapy Covered to age 7, unlimited visits.	Covered 100%; after deductible	30%; after deductible
Autism Occupational Therapy Covered to age 7, unlimited visits.	Covered 100%; after deductible	30%; after deductible
Autism Speech Therapy Covered to age 7, unlimited visits.	Covered 100%; after deductible	30%; after deductible
Durable Medical Equipment	Covered 100%; after deductible	30%; after deductible (must precertify if over $1,500)
Diabetic Supplies	Pharmacy cost sharing applies if Pharmacy coverage is included; otherwise PCP office visit cost sharing applies.	Pharmacy cost sharing applies if Pharmacy coverage is included; otherwise PCP office visit cost sharing applies.
Women's Contraceptive drugs and devices not obtainable at a pharmacy	Covered 100%; deductible waived	Covered same as any other medical expense.
Affordable Care Act mandated Women's Contraceptives	Covered 100%; deductible waived	Covered same as any other expense.
Transplants	Covered 100%; after deductible Preferred coverage is provided at an IOE contracted facility only.	30% per admission; after deductible Non-Preferred coverage is provided at a Non-IOE facility.
Bariatric Surgery	Not Covered	Not Covered
FAMILY PLANNING	**IN-NETWORK**	**OUT-OF-NETWORK**
Infertility Treatment Diagnosis and treatment of the underlying medical condition only.	Your cost sharing is based on the type of service and where it is performed	Your cost sharing is based on the type of service and where it is performed
Comprehensive Infertility Services	Not Covered	Not Covered
Advanced Reproductive Technology (ART) In-vitro fertilization (IVF), zygote intrafallopian transfer (ZIFT), gamete intrafallopian transfer (GIFT), cryopreserved embryo transfers, intracytoplasmic sperm injection (ICSI), or ovum microsurgery	Not Covered	Not Covered

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Vasectomy	Your cost sharing is based on the type of service and where it is performed	Your cost sharing is based on the type of service and where it is performed
Tubal Ligation	Covered 100%; deductible waived	Your cost sharing is based on the type of service and where it is performed
PRESCRIPTION DRUG BENEFITS	**IN-NETWORK**	**OUT-OF-NETWORK**
The full cost of the drug is applied to the deductible before any benefits are considered for payment under the pharmacy plan.		
Pharmacy Plan Type	Aetna Value Plus Open Formulary	
Value Drugs Tier 1A		
Retail	$3 copay	Not Covered
Mail Order	$7.50 copay	Not Applicable
Preferred Generic Drugs		
Retail	$10 copay	Not Covered
Mail Order	$25 copay	Not Applicable
Preferred Brand-Name Drugs		
Retail	$30 copay	Not Covered
Mail Order	$75 copay	Not Applicable
Non-Preferred Generic and Brand-Name Drugs		
Retail	$60 copay	Not Covered
Mail Order	$150 copay	Not Applicable
Value Plus Specialty Drugs		
Preferred Specialty	20% Maximum $250	Not Applicable
Non-Preferred Specialty	20% Maximum $500	Not Applicable
Pharmacy Day Supply and Requirements		
Retail	Up to a 30 day supply For a 31-90 day supply you will be responsible for the Mail Order Drug copay.	
Mail Order	Up to a 31-90 day supply from Aetna Rx Home Delivery®.	
Value Plus Specialty	Up to a 30 day supply from Aetna Specialty Pharmacy Network. All prescription fills must be through our preferred specialty pharmacy network.	
Choose Generics with Dispense as Written (DAW) override - The member pays the applicable copay. If the physician requires brand-name, member would pay brand-name copay. If the member requests brand-name when a generic is available, the member pays the applicable copay plus the difference between the generic price and the brand-name price.		
Plan Includes: Diabetic supplies and Contraceptive drugs and devices obtainable from a pharmacy. Oral fertility drugs included. A limited list of over-the-counter medications are covered when filled with a prescription. Oral chemotherapy drugs covered 100% Value Plus Pre-certification included Value Plus Step Therapy included One transition fill allowed within 90 days of member's effective date Affordable Care Act mandated female contraceptives and preventive medications covered 100% in-network.		
GENERAL PROVISIONS		
Dependents Eligibility	Spouse, children from birth to age 26 regardless of student status.	

**We cover the cost of services based on whether doctors are "in network" or "out of network." We want to help you understand how much we pay 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 "out-of-network" care.

You may choose a provider (doctor or hospital) in our network. You may choose to visit an out-of-network provider. If you choose a doctor who is out of network, your health plan may pay some of that doctor'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 doctor or hospital.
When you choose out-of-network care, we limit the amount it will pay. This limit is called the "recognized" or "allowed" amount.
• For doctors and other professionals the amount is based on what Medicare pays for these services. The government sets the Medicare rate. Exactly how much we "recognize" depends on the plan you or your employer picks.
• For hospitals and other facilities, the amount is based on what Medicare pays for these services. The government sets the Medicare rate. Exactly how much we "recognize" depends on the plan you or your employer picks.
Your doctor sets his or her own rate to charge you. It may be higher -- sometimes much higher -- than what your plan "recognizes." Your doctor may bill you for the dollar amount that we don'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 maximums. To learn more about how we pay out-of-network benefits visit our website.
You can avoid these extra costs by getting your care from Aetna's broad network of health care providers. Go to www.aetna.com and click on "Find a Doctor" on the left side of the page. If you are already a member, sign on to your Navigator member site.
This applies when you choose to get care out of network. When you have no choice (for example: emergency room visit after a car accident, or for other emergency services), we will pay the bill as if you got care in network. You pay cost sharing and deductibles for your in-network level of benefits. Contact us if your provider asks you to pay more. You are not responsible for any outstanding balance billed by your providers for emergency services beyond your cost sharing and deductibles.
This way of paying out-of-network doctors and hospitals applies when you choose to get care out of network. When you have no choice (for example: emergency room visit after a car accident), we will pay the bill as if you got care in network. You pay your plan's copayments, coinsurance and deductibles for your in-network level of benefits. Contact us if your provider asks you to pay more. You are not responsible for any outstanding balance billed by your providers for emergency services beyond your copayments, coinsurance and deductibles.

Exclusions and Limitations

Health benefits and health insurance plans are offered and/or underwritten by Aetna Health Inc. and Aetna Health Insurance Company. Each insurer has sole financial responsibility for its own products.

Investment services are independently offered through JPMorgan Institutional Investors, Inc., a subsidiary of JPMorgan Chase Bank.

This material is for information only. Health benefits and health insurance plans contain exclusions and limitations.

Not all health services are covered. See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by location and are subject to change.

You may be responsible for the health care provider's full charges for any non-covered services, including circumstances where you have exceeded a benefit limit contained in the plan. Providers are independent contractors and are not our agents. Provider participation may change without notice. We do not provide care or guarantee access to health services.

PLAN DESIGN & BENEFITS
PROVIDED BY AETNA HEALTH INC. AND AETNA HEALTH INSURANCE COMPANY - FULL RISK

The following is a list of services and supplies that are generally *not covered*. However, your plan documents may contain exceptions to this list based on state mandates or the plan design or rider(s) purchased by your employer.

• All medical and hospital services not specifically covered in, or which are limited or excluded by your plan documents.
• Cosmetic surgery, including breast reduction.
• Custodial care.
• Dental care and dental x-rays.
• Donor egg retrieval.
• Durable medical equipment.
• Experimental and investigational procedures, except for coverage for medically necessary routine patient care costs for members participating in a cancer clinical trial.
• Hearing aids.
• Home births.
• Immunizations for travel or work except where medically necessary or indicated.
• Implantable drugs and certain injectable drugs including injectable infertility drugs.
• Infertility services, including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI and other related services, unless specifically listed as covered in your plan documents.
• Long-term rehabilitation therapy.
• Non-medically necessary services or supplies.
• Orthotics except diabetic orthotics.
• Outpatient prescription drugs (except for treatment of diabetes), unless covered by a prescription plan rider and over-the-counter medications (except as provided in a hospital) and supplies.
• Radial keratotomy or related procedures.
• Reversal of sterilization.
• Services for the treatment of sexual dysfunction or inadequacies including therapy, supplies or counseling or prescription drugs.
• Special duty nursing.
• Therapy or rehabilitation other than those listed as covered.
• Treatment of behavioral disorders.
• Weight control services including surgical procedures, medical treatments, weight control/loss programs, dietary regimens and supplements, appetite suppressants and other medications; food or food supplements, exercise programs, exercise or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity, including Morbid Obesity, or for the purpose of weight reduction, regardless of the existence of comorbid conditions.

Aetna receives rebates from drug manufacturers that may be taken into account in determining Aetna's Preferred Drug List. Rebates do not reduce the amount a member pays the pharmacy for covered prescriptions. Aetna Rx Home Delivery and Aetna Specialty Pharmacy refer to Aetna Rx Home Delivery, LLC and Aetna Specialty Pharmacy, LLC, respectively. Aetna Rx Home Delivery and Aetna Specialty Pharmacy are licensed pharmacy subsidiaries of Aetna Inc. that operate through mail order. The charges that Aetna negotiates with Aetna Rx Home Delivery and Aetna Specialty Pharmacy may be higher than the cost they pay for the drugs and the cost of the mail order pharmacy services they provide. For these purposes, the pharmacies' cost of purchasing drugs takes into account discounts, credits and other amounts that they may receive from wholesalers, manufacturers, suppliers and distributors.

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

If you require language assistance, please call the Member Services number located on your ID card, and you will be connected with the language line if needed; or you may dial direct at 1-888-982-3862 (140 languages are available. You must ask for an interpreter). TDD 1-800-628-3323 (hearing impaired only).

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Si requiere la asistencia de un representante que hable su idioma, por favor llame al número de Servicios al Miembro que aparece en su tarjeta de identificación y se le comunicará con la línea de idiomas si es necesario; de lo contrario, puede llamar directamente al 1-888-982-3862 (140 idiomas disponibles. Debe pedir un intérprete). TDD-1-800-628-3323 (sólo para las personas con impedimentos auditivos).

Plan features and availability may vary by location and group size.

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

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PROVIDED BY AETNA HEALTH INC. AND AETNA HEALTH INSURANCE COMPANY - FULL RISK

PLAN FEATURES	IN-NETWORK	OUT-OF-NETWORK
Deductible (per calendar year)	$2,500 Individual	$2,500 Individual
	$7,500 Family	$7,500 Family
Unless otherwise indicated, the deductible must be met prior to benefits being payable. Applicable covered expenses accumulate separately toward the in-network and out-of-network providers Deductible. Member cost sharing for certain services, as indicated in the plan, are excluded from charges to meet the Deductible. Pharmacy expenses do not apply towards the Deductible. The family Deductible is a cumulative Deductible for all family members. The family Deductible can be met by a combination of family members; however, no single individual within the family will be subject to more than the individual Deductible amount.		
Out-of-Pocket Maximum (per calendar year)	$6,350 Individual	$9,500 Individual
	$12,700 Family	$19,000 Family
All applicable covered expenses accumulate separately toward the in-network and out-of-network Out-of-Pocket-Maximum. In-network expenses include coinsurance/copays and deductibles. Out-of-network expenses include coinsurance and deductible. Penalty amounts do not apply. Pharmacy expenses apply towards the Out-of-Pocket-Maximum. The family Out-of-Pocket Maximum is a cumulative Out-of-Pocket Maximum for all family members. The family Out-of-Pocket Maximum can be met by a combination of family members; however no single individual within the family will be subject to more than the individual Out-of-Pocket Maximum amount.		
Lifetime Maximum	Unlimited except where otherwise indicated.	Unlimited except where otherwise indicated.
Benefit Limitations -- For any service or supply that is subject to a maximum visit, day, or dollar limitation, such services or supplies accumulate toward both the participating provider and non-participating provider benefit limits under this plan.		
Payment for Non-Preferred Care**	Not Applicable	Professional: 105% of Medicare Facility: 140% of Medicare
Primary Care Physician Selection	Optional	Not Applicable
Precertification Requirement Certain non-participating providers/participating provider self referred services require precertification or benefits will be reduced. Refer to your plan documents for a complete list of services that require precertification.		
Referral Requirement	None	None
PREVENTIVE CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Routine Adult Physical Exams/ Immunizations	Covered 100%; deductible waived	40%; after deductible
1 exam every 12 months for members age 22 and older.		
Routine Well Child Exams/Immunizations (Age and frequency schedules apply)	Covered 100%; deductible waived	40%; deductible waived
Routine Gynecological Care Exams	Covered 100%; deductible waived	Covered 100%; after deductible
Includes routine tests and related lab fees without frequency limit.		
Routine Mammograms	Covered 100%; deductible waived	40%; after deductible
Recommended: One baseline mammogram for females age 35 - 39; and one annual mammogram for females age 40 and over.		

PLAN DESIGN & BENEFITS
PROVIDED BY AETNA HEALTH INC. AND AETNA HEALTH INSURANCE COMPANY - FULL RISK

Women's Health	Covered 100%; deductible waived	40%; after deductible
Includes: Screening for gestational diabetes, HPV (Human- Papillomavirus) DNA testing, counseling for sexually transmitted infections, counseling and screening for human immunodeficiency virus, screening and counseling for interpersonal and domestic violence, breastfeeding support, supplies and counseling. Contraceptive methods, sterilization procedures, patient education and counseling. Limitations may apply.		
Routine Digital Rectal Exams / Prostate Specific Antigen Test Recommended for males age 40 and over.	Covered 100%; deductible waived	Covered same as routine well adult exam
Colorectal Cancer Screening Recommended: For all members age 50 and over. Frequency schedule applies.	Covered 100%; deductible waived	Your cost sharing is based on the type of service and where it is performed
Routine Eye Exams 1 routine exam per 24 months.	$50 copay; deductible waived	40%; after deductible
Routine Hearing Screening	Covered 100%; deductible waived	40%; after deductible
PHYSICIAN SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Office Visits to member's selected Primary Care Physician	Office Hours: $25 copay; After Office Hours/Home: $30 copay; deductible waived	40%; after deductible
Specialist Office Visits	$50 copay; deductible waived	40%; after deductible
Includes services of an internist, general physician, family practitioner or pediatrician if the physician is not the member's selected PCP.		
Pre-Natal Maternity	Covered 100%; deductible waived	40%; after deductible
Walk-in Clinics	$25 copay; deductible waived	40%; after deductible
Walk-in Clinics are network, free-standing health care facilities. They are an alternative to a physician's office visit for treatment of unscheduled, non-emergency illnesses and injuries and the administration of certain immunizations. It is not an alternative for emergency room services or the ongoing care provided by a physician. Neither an emergency room, nor the outpatient department of a hospital, shall be considered a Walk-in Clinic.		
Allergy Testing	Your cost sharing is based on the type of service and where it is performed	Your cost sharing is based on the type of service and where it is performed
Allergy Injections	Your cost sharing is based on the type of service and where it is performed. Covered 100% when an office visit charge is not applicable.	Your cost sharing is based on the type of service and where it is performed
DIAGNOSTIC PROCEDURES	**IN-NETWORK**	**OUT-OF-NETWORK**
Diagnostic Laboratory	Covered 100%; after deductible	40%; after deductible
If performed as a part of a physician office visit and billed by the physician, expenses are covered subject to the applicable physician's office visit member cost sharing.		
Diagnostic X-ray	20%; after deductible	40%; after deductible
If performed as a part of a physician office visit and billed by the physician, expenses are covered subject to the applicable physician's office visit member cost sharing.		

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Diagnostic X-ray for Complex Imaging Services	20%; after deductible	40%; after deductible
EMERGENCY MEDICAL CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Urgent Care Provider	$75 copay; deductible waived	40%; after deductible
Non-Urgent Use of Urgent Care Provider	Not Covered	Not Covered
Emergency Room Copay waived if admitted	$200 copay; deductible waived	Refer to participating provider benefit.
Non-Emergency Care in an Emergency Room	Not Covered	Not Covered
Emergency Use of Ambulance	$200 copay; deductible waived	Refer to participating provider benefit.
Non-Emergency Use of Ambulance	Not Covered	Not Covered
HOSPITAL CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient Coverage	20%; after deductible	40%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Inpatient Maternity Coverage (includes delivery and postpartum care)	$50 for Physician Maternity Services; deductible waived; 20% for Facility Services; after deductible	40% for Physician Maternity Services; after deductible; 40% for Facility Services; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Outpatient Hospital	20%; after deductible	40%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
MENTAL HEALTH SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient	20%; after deductible	40%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Outpatient	$50 copay; deductible waived	40%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
SUBSTANCE ABUSE	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient Detoxification	20%; after deductible	40%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Outpatient Detoxification	$50 copay; deductible waived	40%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Inpatient Rehabilitation	20%; after deductible	40%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Residential Treatment Facility	20%; after deductible	40%; after deductible
Outpatient Rehabilitation	$50 copay; deductible waived	40%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
OTHER SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Skilled Nursing Facility	20%; after deductible	40%; after deductible
Limited to 60 days; per calendar year Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Home Health Care	Covered 100%; after deductible	40%; after deductible
Limited to 60 visits; per calendar year Limited to 3 intermittent visits per day by a participating home health care agency; 1 visit equals a period of 4 hrs or less.		
Hospice Care - Inpatient	Covered 100%; after deductible	40%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Hospice Care - Outpatient	Covered 100%; after deductible	40%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		

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Outpatient Speech Therapy Limited to 20 visits; per calendar year	$50 copay; deductible waived	40%; after deductible
Outpatient Physical and Occupational Therapy Limited to 30 visits; per calendar year	$50 copay; deductible waived	40%; after deductible
Spinal Manipulation Therapy Limited to 20 visits; per calendar year	$50 copay; deductible waived	40%; after deductible
Autism Behavioral Therapy Covered same as any other Outpatient Mental Health benefit	Refer to MBH Outpatient Mental Health	Refer to MBH Outpatient Mental Health
Autism Applied Behavior Analysis Covered same as any other Outpatient Mental Health benefit with no age or visit limitations.	Refer to MBH Outpatient Mental Health	Refer to MBH Outpatient Mental Health
Autism Physical Therapy Covered to age 7, unlimited visits.	$50 copay; deductible waived	40%; after deductible
Autism Occupational Therapy Covered to age 7, unlimited visits.	$50 copay; deductible waived	40%; after deductible
Autism Speech Therapy Covered to age 7, unlimited visits.	$50 copay; deductible waived	40%; after deductible
Durable Medical Equipment	50%; after deductible	50%; after deductible (must precertify if over $1,500)
Diabetic Supplies	Pharmacy cost sharing applies if Pharmacy coverage is included; otherwise PCP office visit cost sharing applies.	Pharmacy cost sharing applies if Pharmacy coverage is included; otherwise PCP office visit cost sharing applies.
Women's Contraceptive drugs and devices not obtainable at a pharmacy	Covered 100%; deductible waived	Covered same as any other medical expense.
Affordable Care Act mandated Women's Contraceptives	Covered 100%; deductible waived	Covered same as any other expense.
Transplants	20%; after deductible Preferred coverage is provided at an IOE contracted facility only.	40% per admission; after deductible Non-Preferred coverage is provided at a Non-IOE facility.
FAMILY PLANNING	**IN-NETWORK**	**OUT-OF-NETWORK**
Infertility Treatment Diagnosis and treatment of the underlying medical condition only.	Your cost sharing is based on the type of service and where it is performed	Your cost sharing is based on the type of service and where it is performed

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Comprehensive Infertility Services	Not Covered	Not Covered
Advanced Reproductive Technology (ART)	Not Covered	Not Covered
Vasectomy	Your cost sharing is based on the type of service and where it is performed	Your cost sharing is based on the type of service and where it is performed
Tubal Ligation	Covered 100%; deductible waived	Your cost sharing is based on the type of service and where it is performed
PRESCRIPTION DRUG BENEFITS	**IN-NETWORK**	**OUT-OF-NETWORK**
Pharmacy Plan Type	Aetna Value Plus Open Formulary	
Value Drugs Tier 1A **Retail**	$3 copay	Not Covered
Mail Order	$6 copay	Not Applicable
Preferred Generic Drugs		
Retail	$15 copay	Not Covered
Mail Order	$30 copay	Not Applicable
Preferred Brand-Name Drugs		
Retail	$35 copay	Not Covered
Mail Order	$70 copay	Not Applicable
Non-Preferred Generic and Brand-Name Drugs		
Retail	$65 copay	Not Covered
Mail Order	$130 copay	Not Applicable
Value Plus Specialty Drugs		
Preferred Specialty	20% Maximum $250	Not Applicable
Non-Preferred Specialty	20% Maximum $500	Not Applicable
Pharmacy Day Supply and Requirements		
Retail	Up to a 30 day supply For a 31-90 day supply you will be responsible for the Mail Order Drug copay.	
Mail Order	Up to a 31-90 day supply from Aetna Rx Home Delivery®.	
Value Plus Specialty	Up to a 30 day supply from Aetna Specialty Pharmacy Network. First prescription fill at any retail or specialty pharmacy. Subsequent fills must be through our preferred specialty pharmacy network.	

Choose Generics - If the member or the physician requests brand-name when generic is available, the member pays the applicable copay plus the difference between the generic price and the brand-name price.

Plan Includes: Diabetic supplies and Contraceptive drugs and devices obtainable from a pharmacy.
A limited list of over-the-counter medications are covered when filled with a prescription.
Oral chemotherapy drugs covered 100%
Value Plus Pre-certification included
Value Plus Step Therapy included
One transition fill allowed within 90 days of member's effective date
Affordable Care Act mandated female contraceptives and preventive medications covered 100% in-network.

GENERAL PROVISIONS	
Dependents Eligibility	Spouse, children from birth to age 26 regardless of student status.

**We cover the cost of services based on whether doctors are "in network" or "out of network." We want to help you understand how much we pay 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 "out-of-network" care.

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You may choose a provider (doctor or hospital) in our network. You may choose to visit an out-of-network provider. If you choose a doctor who is out of network, your health plan may pay some of that doctor'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 doctor or hospital.
When you choose out-of-network care, we limit the amount it will pay. This limit is called the "recognized" or "allowed" amount.
• For doctors and other professionals the amount is based on what Medicare pays for these services. The government sets the Medicare rate. Exactly how much we "recognize" depends on the plan you or your employer picks.
• For hospitals and other facilities, the amount is based on what Medicare pays for these services. The government sets the Medicare rate. Exactly how much we "recognize" depends on the plan you or your employer picks.
Your doctor sets his or her own rate to charge you. It may be higher -- sometimes much higher -- than what your plan "recognizes." Your doctor may bill you for the dollar amount that we don'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 maximums. To learn more about how we pay out-of-network benefits visit our website.
You can avoid these extra costs by getting your care from Aetna's broad network of health care providers. Go to www.aetna.com and click on "Find a Doctor" on the left side of the page. If you are already a member, sign on to your Navigator member site.
This applies when you choose to get care out of network. When you have no choice (for example: emergency room visit after a car accident, or for other emergency services), we will pay the bill as if you got care in network. You pay cost sharing and deductibles for your in-network level of benefits. Contact us if your provider asks you to pay more. You are not responsible for any outstanding balance billed by your providers for emergency services beyond your cost sharing and deductibles.
This way of paying out-of-network doctors and hospitals applies when you choose to get care out of network. When you have no choice (for example: emergency room visit after a car accident), we will pay the bill as if you got care in network. You pay your plan's copayments, coinsurance and deductibles for your in-network level of benefits. Contact us if your provider asks you to pay more. You are not responsible for any outstanding balance billed by your providers for emergency services beyond your copayments, coinsurance and deductibles.

Exclusions and Limitations

Health benefits and health insurance plans are offered and/or underwritten by Aetna Health Inc. and Aetna Health Insurance Company. Each insurer has sole financial responsibility for its own products.

This material is for information only. Health benefits and health insurance plans contain exclusions and limitations. Not all health services are covered. See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by location and are subject to change.

You may be responsible for the health care provider's full charges for any non-covered services, including circumstances where you have exceeded a benefit limit contained in the plan. Providers are independent contractors and are not our agents. Provider participation may change without notice. We do not provide care or guarantee access to health services.
The following is a list of services and supplies that are generally *not covered*. However, your plan documents may contain exceptions to this list based on state mandates or the plan design or rider(s) purchased by your employer.

• All medical and hospital services not specifically covered in, or which are limited or excluded by your plan documents.
• Cosmetic surgery, including breast reduction.
• Custodial care.
• Dental care and dental x-rays.
• Donor egg retrieval.
• Durable medical equipment.

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• Experimental and investigational procedures, except for coverage for medically necessary routine patient care costs for members participating in a cancer clinical trial.
• Hearing aids.
• Home births.
• Immunizations for travel or work except where medically necessary or indicated.
• Implantable drugs and certain injectable drugs including injectable infertility drugs.
• Infertility services, including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI and other related services, unless specifically listed as covered in your plan documents.
• Long-term rehabilitation therapy.
• Non-medically necessary services or supplies.
• Orthotics except diabetic orthotics.
• Outpatient prescription drugs (except for treatment of diabetes), unless covered by a prescription plan rider and over-the-counter medications (except as provided in a hospital) and supplies.
• Radial keratotomy or related procedures.
• Reversal of sterilization.
• Services for the treatment of sexual dysfunction or inadequacies including therapy, supplies or counseling or prescription drugs.
• Special duty nursing.
• Therapy or rehabilitation other than those listed as covered.
• Treatment of behavioral disorders.
• Weight control services including surgical procedures, medical treatments, weight control/loss programs, dietary regimens and supplements, appetite suppressants and other medications; food or food supplements, exercise programs, exercise or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity, including Morbid Obesity, or for the purpose of weight reduction, regardless of the existence of comorbid conditions.

Aetna receives rebates from drug manufacturers that may be taken into account in determining Aetna's Preferred Drug List. Rebates do not reduce the amount a member pays the pharmacy for covered prescriptions. Aetna Rx Home Delivery and Aetna Specialty Pharmacy refer to Aetna Rx Home Delivery, LLC and Aetna Specialty Pharmacy, LLC, respectively. Aetna Rx Home Delivery and Aetna Specialty Pharmacy are licensed pharmacy subsidiaries of Aetna Inc. that operate through mail order. The charges that Aetna negotiates with Aetna Rx Home Delivery and Aetna Specialty Pharmacy may be higher than the cost they pay for the drugs and the cost of the mail order pharmacy services they provide. For these purposes, the pharmacies' cost of purchasing drugs takes into account discounts, credits and other amounts that they may receive from wholesalers, manufacturers, suppliers and distributors.

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

If you require language assistance, please call the Member Services number located on your ID card, and you will be connected with the language line if needed; or you may dial direct at 1-888-982-3862 (140 languages are available. You must ask for an interpreter). TDD 1-800-628-3323 (hearing impaired only).

Si requiere la asistencia de un representante que hable su idioma, por favor llame al número de Servicios al Miembro que aparece en su tarjeta de identificación y se le comunicará con la línea de idiomas si es necesario; de lo contrario, puede llamar directamente al 1-888-982-3862 (140 idiomas disponibles. Debe pedir un intérprete). TDD-1-800-628-3323 (sólo para las personas con impedimentos auditivos).
Plan features and availability may vary by location and group size.
For more information about Aetna plans, refer to **www.aetna.com.** While this material is believed to be accurate as of the production date, it is subject to change.

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PLAN FEATURES	IN-NETWORK	OUT-OF-NETWORK
Deductible (per calendar year)	$1,500 Individual $3,000 Family	$5,000 Individual $10,000 Family
Unless otherwise indicated, the deductible must be met prior to benefits being payable. Applicable covered expenses accumulate separately toward the in-network and out-of-network providers Deductible. Member cost sharing for certain services, as indicated in the plan, are excluded from charges to meet the Deductible. Pharmacy expenses do not apply towards the Deductible. The family Deductible is a cumulative Deductible for all family members. The family Deductible can be met by a combination of family members; however no single individual within the family will be subject to more than the individual Deductible amount.		
Out-of-Pocket Maximum (per calendar year)	$6,850 Individual $13,700 Family	$10,000 Individual $20,000 Family
All applicable covered expenses accumulate separately toward the in-network and out-of-network Out-of-Pocket-Maximum. In-network expenses include coinsurance/copays and deductibles. Out-of-network expenses include coinsurance and deductible. Penalty amounts do not apply. Pharmacy expenses apply towards the Out-of-Pocket-Maximum. The family Out-of-Pocket Maximum is a cumulative Out-of-Pocket Maximum for all family members. The family Out-of-Pocket Maximum can be met by a combination of family members; however no single individual within the family will be subject to more than the individual Out-of-Pocket Maximum amount.		
Lifetime Maximum	Unlimited except where otherwise indicated.	Unlimited except where otherwise indicated.
Benefit Limitations -- For any service or supply that is subject to a maximum visit, day, or dollar limitation, such services or supplies accumulate toward both the participating provider and non-participating provider benefit limits under this plan.		
Payment for Non-Preferred Care**	Not Applicable	Professional: 105% of Medicare Facility: 140% of Medicare
Primary Care Physician Selection	Optional	Not Applicable
Precertification Requirement Certain non-participating providers/participating provider self referred services require precertification or benefits will be reduced. Refer to your plan documents for a complete list of services that require precertification.		
Referral Requirement	None	None
PREVENTIVE CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Routine Adult Physical Exams/ Immunizations 1 exam every 12 months for members age 22 and older.	Covered 100%; deductible waived	30%; after deductible
Routine Well Child Exams/Immunizations (Age and frequency schedules apply)	Covered 100%; deductible waived	30%; deductible waived
Routine Gynecological Care Exams Includes routine tests and related lab fees without frequency limit.	Covered 100%; deductible waived	Covered 100%; after deductible
Routine Mammograms Recommended: One baseline mammogram for females age 35 - 39; and one annual mammogram for females age 40 and over.	Covered 100%; deductible waived	30%; after deductible

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Women's Health	Covered 100%; deductible waived	30%; after deductible
Includes: Screening for gestational diabetes, HPV (Human- Papillomavirus) DNA testing, counseling for sexually transmitted infections, counseling and screening for human immunodeficiency virus, screening and counseling for interpersonal and domestic violence, breastfeeding support, supplies and counseling. Contraceptive methods, sterilization procedures, patient education and counseling. Limitations may apply.		
Routine Digital Rectal Exams / Prostate Specific Antigen Test Recommended for males age 40 and over.	Covered 100%; deductible waived	Covered same as routine well adult exam
Colorectal Cancer Screening Recommended: For all members age 50 and over. Frequency schedule applies.	Covered 100%; deductible waived	Your cost sharing is based on the type of service and where it is performed
Routine Eye Exams 1 routine exam per24 months.	$50 copay; deductible waived	Not Covered
Routine Hearing Screening	Covered 100%; deductible waived	30%; after deductible
PHYSICIAN SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Primary Care Physician Visits Includes services of an internist, general physician, family practitioner or pediatrician.	$25 office visit copay; deductible waived	30%; after deductible
Specialist Office Visits	$50 copay; deductible waived	30%; after deductible
Pre-Natal Maternity	Covered 100%; deductible waived	30%; after deductible
Walk-in Clinics	$25 copay; deductible waived	30%; after deductible
Walk-in Clinics are network, free-standing health care facilities. They are an alternative to a physician's office visit for treatment of unscheduled, non-emergency illnesses and injuries and the administration of certain immunizations. It is not an alternative for emergency room services or the ongoing care provided by a physician. Neither an emergency room, nor the outpatient department of a hospital, shall be considered a Walk-in Clinic.		
Allergy Testing	Your cost sharing is based on the type of service and where it is performed	Your cost sharing is based on the type of service and where it is performed
Allergy Injections	Your cost sharing is based on the type of service and where it is performed	Your cost sharing is based on the type of service and where it is performed
Audiometric Hearing Exam	Not Covered	Not Covered
DIAGNOSTIC PROCEDURES	**IN-NETWORK**	**OUT-OF-NETWORK**
Diagnostic Laboratory	Covered 100%; after deductible	30%; after deductible
If performed as a part of a physician office visit and billed by the physician, expenses are covered subject to the applicable physician's office visit member cost sharing.		
Diagnostic X-ray	Covered 100%; after deductible	30%; after deductible
If performed as a part of a physician office visit and billed by the physician, expenses are covered subject to the applicable physician's office visit member cost sharing.		
Diagnostic X-ray for Complex Imaging Services	Covered 100%; after deductible	30%; after deductible
EMERGENCY MEDICAL CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Urgent Care Provider	$75 copay; deductible waived	30%; after deductible
Non-Urgent Use of Urgent Care Provider	Not Covered	Not Covered
Emergency Room Copay waived if admitted	$400 copay; deductible waived	Refer to participating provider benefit.

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Non-Emergency Care in an Emergency Room	Not Covered	Not Covered
Emergency Use of Ambulance	Covered 100%; after deductible	Refer to participating provider benefit.
Non-Emergency Use of Ambulance	Not Covered	Not Covered
HOSPITAL CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient Coverage	Covered 100%; after deductible	30% per admission; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Inpatient Maternity Coverage (includes delivery and postpartum care)	$50 for Physician Maternity Services; deductible waived; Covered 100% for Facility services; after deductible	30% for Physician Maternity Services; after deductible; 30% for Facility Services; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Outpatient Hospital	Covered 100%; after deductible	30%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
MENTAL HEALTH SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient	Covered 100%; after deductible	30% per admission; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Outpatient	$50 copay; deductible waived	30% per visit; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
SUBSTANCE ABUSE	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient Detoxification	Covered 100%; after deductible	30% per admission; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Outpatient Detoxification	$50 copay; deductible waived	30% per visit; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Inpatient Rehabilitation	Covered 100%; after deductible	30% per admission; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Residential Treatment Facility	Covered 100%; after deductible	30% per admission; after deductible
Outpatient Rehabilitation	$50 copay; deductible waived	30% per visit; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
OTHER SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Skilled Nursing Facility	Covered 100%; after deductible	30% per admission; after deductible
Limited to 60 days; per calendar year Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Home Health Care	Covered 100%; after deductible	30%; after deductible
Limited to 60 visits; per calendar year Limited to 3 intermittent visits per day by a participating home health care agency; 1 visit equals a period of 4 hrs or less.		
Hospice Care - Inpatient	Covered 100%; after deductible	30% per admission; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Hospice Care - Outpatient	Covered 100%; after deductible	30% per visit; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		

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Outpatient Rehabilitation Therapy Limited to 20 visits; per calendar year Includes speech, physical, occupational therapy	$50 per visit; deductible waived	30% per visit; after deductible
Spinal Manipulation Therapy Limited to 20 visits; per calendar year	$50 copay; deductible waived	30%; after deductible
Autism Behavioral Therapy Covered same as any other Outpatient Mental Health benefit	Refer to MBH Outpatient Mental Health	Refer to MBH Outpatient Mental Health
Autism Applied Behavior Analysis Covered same as any other Outpatient Mental Health benefit	Refer to MBH Outpatient Mental Health	Refer to MBH Outpatient Mental Health
Autism Physical Therapy Covered to age 7, unlimited visits.	$50 copay; deductible waived	30%; after deductible
Autism Occupational Therapy Covered to age 7, unlimited visits.	$50 copay; deductible waived	30%; after deductible
Autism Speech Therapy Covered to age 7, unlimited visits.	$50 copay; deductible waived	30%; after deductible
Durable Medical Equipment	50%; after deductible	50%; after deductible (must precertify if over $1,500)
Diabetic Supplies	Pharmacy cost sharing applies if Pharmacy coverage is included; otherwise PCP office visit cost sharing applies.	30%; after deductible
Contraceptive drugs and devices not obtainable at a pharmacy	Covered 100%; deductible waived	Covered same as any other medical expense.
Generic FDA-approved Women's Contraceptives	Covered 100%; deductible waived	Covered same as any other expense.
Transplants	Covered 100%; after deductible Preferred coverage is provided at an IOE contracted facility only.	30% per admission; after deductible Non-Preferred coverage is provided at a Non-IOE facility.
Bariatric Surgery	Not Covered	Not Covered
FAMILY PLANNING	**IN-NETWORK**	**OUT-OF-NETWORK**
Infertility Treatment Diagnosis and treatment of the underlying medical condition only.	Your cost sharing is based on the type of service and where it is performed	Your cost sharing is based on the type of service and where it is performed
Comprehensive Infertility Services	Not Covered	Not Covered
Advanced Reproductive Technology (ART) In-vitro fertilization (IVF), zygote intrafallopian transfer (ZIFT), gamete intrafallopian transfer (GIFT), cryopreserved embryo transfers, intracytoplasmic sperm injection (ICSI), or ovum microsurgery	Not Covered	Not Covered
Vasectomy	Your cost sharing is based on the type of service and where it is performed	Your cost sharing is based on the type of service and where it is performed
Tubal Ligation	Covered 100%; deductible waived	Your cost sharing is based on the type of service and where it is performed
PRESCRIPTION DRUG BENEFITS	**IN-NETWORK**	**OUT-OF-NETWORK**
Pharmacy Plan Type	Aetna Value Plus Open Formulary	

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Value Drugs Tier 1A		
Retail	$3 copay	Not Covered
Mail Order	$7.5 copay	Not Applicable
Preferred Generic Drugs		
Retail	$15 copay	Not Covered
Mail Order	$37.5 copay	Not Applicable
Preferred Brand-Name Drugs		
Retail	$35 copay	Not Covered
Mail Order	$87.5 copay	Not Applicable
Non-Preferred Generic and Brand-Name Drugs		
Retail	$65 copay	Not Covered
Mail Order	$162.5 copay	Not Applicable
Value Plus Specialty Drugs		
Preferred Specialty	20% Maximum $250	Not Applicable
Non-Preferred Specialty	20% Maximum $500	Not Applicable
Pharmacy Day Supply and Requirements		
Retail	Up to a 30 day supply For a 31-90 day supply you will be responsible for the Mail Order Drug copay.	
Mail Order	Up to a 31-90 day supply from Aetna Rx Home Delivery®.	
Value Plus Specialty	Up to a 30 day supply from Aetna Specialty Pharmacy Network. All prescription fills must be through our preferred Aetna Specialty Pharmacy network.	

Choose Generics with Dispense as Written (DAW) override - The member pays the applicable copay. If the physician requires brand-name, member would pay brand-name copay. If the member requests brand-name when a generic is available, the member pays the applicable copay plus the difference between the generic price and the brand-name price.

Plan Includes: Diabetic supplies and Contraceptive drugs and devices obtainable from a pharmacy.
Oral fertility drugs included.
A limited list of over-the-counter medications are covered when filled with a prescription.
Oral chemotherapy drugs covered 100%
Value Plus Pre-certification included
Value Plus Step Therapy included
One transition fill allowed within 90 days of member's effective date
Formulary Generic FDA-approved Women's Contraceptives and certain over-the-counter preventive medications covered 100% in network.

GENERAL PROVISIONS	
Dependents Eligibility	Spouse, children from birth to age 26 regardless of student status.

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When you choose out-of-network care, we limit the amount it will pay. This limit is called the "recognized" or "allowed" amount.
• For doctors and other professionals the amount is based on what Medicare pays for these services. The government sets the Medicare rate. Exactly how much we "recognize" depends on the plan you or your employer picks.
• For hospitals and other facilities, the amount is based on what Medicare pays for these services. The government sets the Medicare rate. Exactly how much we "recognize" depends on the plan you or your employer picks.
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You can avoid these extra costs by getting your care from Aetna's broad network of health care providers. Go to www.aetna.com and click on "Find a Doctor" on the left side of the page. If you are already a member, sign on to your Navigator member site.
This applies when you choose to get care out of network. When you have no choice (for example: emergency room visit after a car accident, or for other emergency services), we will pay the bill as if you got care in network. You pay cost sharing and deductibles for your in-network level of benefits. Contact us if your provider asks you to pay more. You are not responsible for any outstanding balance billed by your providers for emergency services beyond your cost sharing and deductibles.
This way of paying out-of-network doctors and hospitals applies when you choose to get care out of network. When you have no choice (for example: emergency room visit after a car accident), we will pay the bill as if you got care in network. You pay your plan's copayments, coinsurance and deductibles for your in-network level of benefits. Contact us if your provider asks you to pay more. You are not responsible for any outstanding balance billed by your providers for emergency services beyond your copayments, coinsurance and deductibles.

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This material is for information only. Health benefits and health insurance plans contain exclusions and limitations.

Not all health services are covered. See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by location and are subject to change.

You may be responsible for the health care provider's full charges for any non-covered services, including circumstances where you have exceeded a benefit limit contained in the plan. Providers are independent contractors and are not our agents. Provider participation may change without notice. We do not provide care or guarantee access to health services.

The following is a list of services and supplies that are generally *not covered*. However, your plan documents may contain exceptions to this list based on state mandates or the plan design or rider(s) purchased by your employer.

• All medical and hospital services not specifically covered in, or which are limited or excluded by your plan documents.
• Cosmetic surgery, including breast reduction.
• Custodial care.
• Dental care and dental x-rays.
• Donor egg retrieval.
• Durable medical equipment.
• Experimental and investigational procedures, except for coverage for medically necessary routine patient care costs for members participating in a cancer clinical trial.

PLAN DESIGN & BENEFITS
PROVIDED BY AETNA HEALTH INC. AND AETNA HEALTH INSURANCE COMPANY - FULL RISK

• Hearing aids.
• Home births.
• Immunizations for travel or work except where medically necessary or indicated.
• Implantable drugs and certain injectable drugs including injectable infertility drugs.
• Infertility services, including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI and other related services, unless specifically listed as covered in your plan documents.
• Long-term rehabilitation therapy.
• Non-medically necessary services or supplies.
• Orthotics except diabetic orthotics.
• Outpatient prescription drugs (except for treatment of diabetes), unless covered by a prescription plan rider and over-the-counter medications (except as provided in a hospital) and supplies.
• Radial keratotomy or related procedures.
• Reversal of sterilization.
• Services for the treatment of sexual dysfunction or inadequacies including therapy, supplies or counseling or prescription drugs.
• Special duty nursing.
• Therapy or rehabilitation other than those listed as covered.
• Treatment of behavioral disorders.
• Weight control services including surgical procedures, medical treatments, weight control/loss programs, dietary regimens and supplements, appetite suppressants and other medications; food or food supplements, exercise programs, exercise or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity, including Morbid Obesity, or for the purpose of weight reduction, regardless of the existence of comorbid conditions.

Aetna receives rebates from drug manufacturers that may be taken into account in determining Aetna's Preferred Drug List. Rebates do not reduce the amount a member pays the pharmacy for covered prescriptions. Aetna Rx Home Delivery and Aetna Specialty Pharmacy refer to Aetna Rx Home Delivery, LLC and Aetna Specialty Pharmacy, LLC, respectively. Aetna Rx Home Delivery and Aetna Specialty Pharmacy are licensed pharmacy subsidiaries of Aetna Inc. that operate through mail order. The charges that Aetna negotiates with Aetna Rx Home Delivery and Aetna Specialty Pharmacy may be higher than the cost they pay for the drugs and the cost of the mail order pharmacy services they provide. For these purposes, the pharmacies' cost of purchasing drugs takes into account discounts, credits and other amounts that they may receive from wholesalers, manufacturers, suppliers and distributors.

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

If you require language assistance, please call the Member Services number located on your ID card, and you will be connected with the language line if needed; or you may dial direct at 1-888-982-3862 (140 languages are available. You must ask for an interpreter). TDD 1-800-628-3323 (hearing impaired only).

Si requiere la asistencia de un representante que hable su idioma, por favor llame al número de Servicios al Miembro que aparece en su tarjeta de identificación y se le comunicará con la línea de idiomas si es necesario; de lo contrario, puede llamar directamente al 1-888-982-3862 (140 idiomas disponibles. Debe pedir un intérprete). TDD-1-800-628-3323 (sólo para las personas con impedimentos auditivos).

Plan features and availability may vary by location and group size.

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

Your Summary of Benefits
Floyd County Productions
BlueCross BlueShield of Georgia Dental Complete

WELCOME TO YOUR DENTAL PLAN!
This benefit summary outlines how your dental plan works and provides you with a quick reference of your dental plan benefits. For complete coverage details, please refer to your certificate of coverage.

Dental coverage you can count on
Your BlueCross BlueShield of Georgia (BCBS GA) dental plan lets you visit any licensed dentist or specialist you want - with costs that are normally lower when you choose a participating provider.

Savings beyond your dental plan benefits - you get more for your money.
You pay our negotiated rate for covered services from participating dentists even if you exceed your annual benefit maximum.

YOUR DENTAL PLAN AT A GLANCE	Participating Dentist	Nonparticipating Dentist
Annual Benefit Maximum Calendar Year • Per insured person **Annual Maximum Carryover**	**$1,000** **No**	**$1,000** **No**
Orthodontic Lifetime Benefit Maximum • Per eligible insured person	**$1,000**	**$1,000**
Annual Deductible (The Deductible does not apply to Orthodontic Services) • Per insured person Calendar Year • Family maximum	**$50** **3X Individual**	**$50** **3X Individual**
Deductible Waived for Diagnostic/Preventive Services	**Yes**	**Yes**
Nonparticipating Provider Reimbursement Options:	**90th percentile**	

Dental Services	Participating Dentist BCBS GA Pays:	Nonparticipating Dentist BCBS GA Pays:	Waiting Period
Diagnostic and Preventive Services • Periodic oral exam • Teeth cleaning (prophylaxis) • Bitewing X-rays: 1X per 12 months • Intraoral X-rays	100% Coinsurance	100% Coinsurance	No Waiting Period
Basic Services • Amalgam (silver-colored) Filling • Front composite (tooth-colored) Filling • Back composite Filling, Alternated to Amalgam Benefit • Simple Extractions	80% Coinsurance	80% Coinsurance	No Waiting Period
Endodontics • Root Canal	50% Coinsurance	50% Coinsurance	No Waiting Period
Periodontics • Scaling and root planing	50% Coinsurance	50% Coinsurance	No Waiting Period
Oral Surgery • Surgical Extractions	80% Coinsurance	80% Coinsurance	No Waiting Period
Major Services • Crowns	50% Coinsurance	50% Coinsurance	No Waiting Period
Prosthodontics • Dentures • Bridges • Dental implants Not Covered	50% Coinsurance	50% Coinsurance	No Waiting Period
Prosthetic Repairs/Adjustments	80% Coinsurance	80% Coinsurance	No Waiting Period
Orthodontic Services ·Dependent Children Only*	50% Coinsurance	50% Coinsurance	No Waiting Periods

This is not a contract; it is a partial listing of benefits and services. All covered services are subject to the conditions, limitations, exclusions, terms and provisions of your certificate of coverage. In the event of a discrepancy between the information in this summary and the certificate of coverage, the certificate will prevail.

*Child orthodontic coverage begins at age eight and runs through age 18. This means that the child must have been banded between the ages of eight and 19 in order to receive coverage. If children are dependents until age 19, they can continue to receive coverage, but they must have been banded before age 19.

BCBSGA_PCLG_FI-Custom

Emergency dental treatment for the international traveler
As a BlueCross BlueShield of Georgia dental member, you and your eligible, covered dependents automatically have access to the International Emergency Dental Program.** With this program, you may receive emergency dental care from our listing of credentialed dentists while traveling or working nearly anywhere in the world.

** The International Emergency Dental Program is managed by DeCare Dental, an independent company offering dental-management services to BCBS GA.

Promoting healthy mouths for members who are pregnant or living with diabetes
If you are pregnant or living with diabetes, you can sign up to receive one additional dental cleaning or periodontal maintenance procedure per year.

Finding a dentist is easy.
To select a dentist by name or location, do one of the following:
- Go to bcbsga.com/mydental
- Call Customer Service at the toll-free number listed on the back of your ID card.

TO CONTACT US:

Call	Write
Refer to the toll-free number indicated on the back of your plan ID card to speak with a U.S.-based customer service representative during normal business hours. Calling after hours? We may still be able to assist you with our interactive voice-response system.	Refer to the back of your plan ID card for the address.

Limitations & Exclusions

Limitations – Below is a partial listing of dental plan limitations when these services are covered under your plan. Please see your certificate of coverage for a full list.

Diagnostic and Preventive Services

Oral evaluations (exam) Limited to two per Calendar Year

Teeth cleaning (prophylaxis) Limited to two per Calendar Year

Intraoral X-rays, single film Limited to four films per 12-month period

Complete series X-rays (panoramic or full-mouth) Coverage Every 5 Years

Topical fluoride application Limited to once every 12 months for members through age 18

Sealants Limited to first and second molars once every 24 months per tooth for members through age 15; sealants may be covered under Diagnostic and Preventive or Basic Services.

Basic and/or Major Services***

Fillings Limited to once per surface per tooth in any 24 months

Space Maintainers Limited to extracted primary posterior teeth once per lifetime per tooth for members through age 16; Space Maintainers may be covered under Diagnostic and Preventive or Basic Services.

Crowns Limited to once per tooth in a seven-year period

Fixed or removable prosthodontics – dentures, partials, bridges

Covered once in any seven-year period; benefits are provided for the replacement of an existing bridge, denture or partial for members age 16 or older if the appliance is seven years old or older and cannot be made serviceable.

Root canal therapy Limited to once per lifetime per tooth; coverage is for permanent teeth only.

Periodontal surgery Limited to one complex service per single tooth or quadrant in any 36 months, and only if the pocket depth of the tooth is five millimeters or greater

Periodontal scaling and root planing Limited to once per quadrant in 36 months when the tooth pocket has a depth of four millimeters or greater

Brush Biopsy Standard - Covered

***Waiting periods** for endodontic, periodontic and oral surgery services may differ from other Basic Services or Major Services under the same dental plan.

There is a waiting period of up to 24 months for replacement of congenitally missing teeth or teeth extracted prior to coverage under this plan.

ADDITIONAL LIMITATION FOR ORTHODONTIC SERVICES

Orthodontia Limited to one course of treatment per member per lifetime

Exclusions – Below is a partial listing of noncovered services under your dental plan. Please see your certificate of coverage for a full list.

Services provided before or after the term of this coverage

Services received before your effective date or after your coverage ends, unless otherwise specified in the dental plan certificate

Orthodontics (unless included as part of your dental plan benefits) Orthodontic braces, appliances and all related services

Cosmetic dentistry Services provided by dentists solely for the purpose of improving the appearance of the tooth when tooth structure and function are satisfactory and no pathologic conditions (cavities) exist

Drugs and medications Intravenous conscious sedation, IV sedation and general anesthesia when performed with nonsurgical dental care

Analgesia, analgesic agents, anxiolysis nitrous oxide, therapeutic drug injections, medicines or drugs for nonsurgical or surgical dental care except that intravenous conscious sedation is eligible as a separate benefit when performed in conjunction with complex surgical services.

Extractions - Surgical removal of third molars (wisdom teeth) that do not exhibit symptoms or impact the oral health of the member

The participating dental providers mentioned in this communication are independently contracted providers who exercise independent professional judgment. They are not agents or employees of BlueCross BlueShield of Georgia.

Choice of dentists
While your dental plan lets you choose any dentist, you may end up paying more for a service if you visit a nonparticipating dentist.

Here's why:

Participating dentists have agreed to payment rates for various services and cannot charge you more. On the other hand, nonparticipating dentists don't have a contract with us and are able to bill you for the difference between the total amount we allow to be paid for a service – called the "maximum allowed amount" – and the amount they usually charge for a service. When they bill you for this difference, it's called "balance billing."

How BlueCross BlueShield of Georgia dental decides on maximum allowed amounts
For services from a nonparticipating dentist, the maximum allowed amount is determined in one of the following ways:

- Nonparticipating dental fee schedule/rate developed by BCBS GA, which may be updated based on such things as reimbursement accepted by dentists contracted with our dental plans, or other industry cost and usage data
- Information provided by a third-party vendor that shows comparable costs for dental services
- Participating dentist fee schedule

Here's an example of higher costs for nonparticipating dental services

This is an example only. Your experience may be different, depending on your insurance plan, the services you receive and the dentist who provides the services.

Ted gets a crown from a nonparticipating dentist, who charges $1,200 for the service and bills BCBS GA for that amount.
The maximum allowed amount for this dental service is $800. That means there will be a $400 difference, which the dentist can "balance bill" Ted.

Since Ted will also need to pay $400 coinsurance, the total he'll pay the nonparticipating dentist is $800.
Here's the math:

- Dentist's charge: $1,200
- BCBS GA's maximum allowed amount: $800
- BCBS GA pays 50%: $400
- Ted pays 50% (coinsurance): $400
- Balance Ted owes the provider: $1,200 - $800 = $400
- Ted's total cost: $400 coinsurance + $400 provider balance = $800

In the example, if Ted had gone to a participating dentist, his cost would be only $400 for the coinsurance because he would not have been "balance billed" the $400 difference.

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visit www.aetnavision.com

Summary of Benefits for Floyd County Productions

Effective Date: 08-01-2017
Plan 17 External Plan ID 9919705117
Line Value 605
12 12 24

	In Network	Out of Network*
Exam	**Aetna Vision Network**	
Use your Exam coverage once every rolling 12 months		
Routine/Comprehensive Eye Exam	**$10 Copay**	$25 Reimbursement
Standard Contact Lens Fit/Follow-Up	**Member pays discounted fee of $40**	Not Covered
Premium Contact Lens Fit/Follow-Up	**Member pays 90% of retail**	Not Covered
Eyeglass Lenses / Lens options		
Use your Lens coverage once every rolling 12 months to purchase either 1 pair of eyeglass lenses OR 1 order of contact lenses		
Standard Plastic Single Vision Lenses	**$10 Copay**	$20 Reimbursement
Standard Plastic Bifocal Vision Lenses	**$10 Copay**	$40 Reimbursement
Standard Plastic Trifocal Vision Lenses	**$10 Copay**	$65 Reimbursement
Standard Plastic Lenticular Vision Lenses	**$10 Copay**	$65 Reimbursement
Standard Progressive Vision Lenses	**$75 Copay**	$40 Reimbursement
Premium Progressive Vision Lenses[1]	**20% Discount off retail minus $120 plan allowance plus $75 copay = member out-of-pocket**	$40 Reimbursement
UV Treatment	**Member pays discounted fee of $15**	Not Covered
Tint (Solid And Gradient)	**Member pays discounted fee of $15**	Not Covered
Standard Plastic Scratch Coating	**Member pays discounted fee of $15**	Not Covered
Standard Polycarbonate Lenses - Adult	**Member pays discounted fee of $40**	Not Covered
Standard Polycarbonate Lenses - Children To Age 19	**Member pays discounted fee of $40**	Not Covered
Standard Anti-Reflective Coating	**Member pays discounted fee of $45**	Not Covered
Polarized And Other Lens Add Ons	**Member pays 80% of retail**	Not Covered
Contact Lenses		
Use your Lens coverage once every rolling 12 months to purchase either 1 pair of eyeglass lenses OR 1 order of contact lenses		
Conventional Contact Lenses	**$115 Allowance** Additional 15% off balance over allowance**	$80 Reimbursement
Disposable Contact Lenses	**$115 Allowance**	$80 Reimbursement
Medically Necessary Contact Lenses	**$0 Copay**	$200 Reimbursement
Frames		
Use your frame coverage once every rolling 24 months		
Any Frame available, including frames for prescription sunglasses	**$130 Allowance** Additional 20% off balance over allowance**	$65 Reimbursement
Discounts	**In Network**	**Out of Network**
Discounts cannot be combined with any other discounts or promotional offers and may not be available on all brands.		
Additional pairs of eyeglasses or prescription sunglasses. Discount applies to purchases made after the plan allowances have been exhausted.	**Up to a 40% Discount**	No Discount
Non-covered items such as cleaning cloths and contact lens solution[2]	**20% Discount**	No Discount
Lasik Laser vision correction or PRK from U.S. Laser Network[3] only. Call 1-800-422-6600	**15% discount off retail or 5% discount off the promotional price**	No Discount
Retinal Imaging[4]	**Member pays a discounted fee up to $39**	No Discount
Replacement contact lenses	**Receive significant savings on replacement contacts by ordering online. Visit ContactsDirect.com for details**	No Discount

Partial list of Exclusions and Limitations

Exclusions and limitations for vision include: any charges in excess of the benefits, dollar or supply limits listed above; special vision procedures, such as orthoptics, vision therapy or vision training; vision services or supplies that do not meet professionally accepted standards; plano (non-prescription) lenses; non-prescription sunglasses; two pair of glasses in lieu of bifocals; medical and/or surgical treatment of the eyes; cosmetic services; lost or broken lenses, frames, glasses or contact lenses. Other exclusions and limitations may also apply.

*You can choose to receive care outside the network. Simply pay for the services up front and then submit a claim form to receive an amount up to the out of network reimbursement amounts listed above. Reimbursement will not exceed the providers actual charge. Claim forms can be found at www.aetnavision.com or by calling customer service Mon-Sun @ 877-9-SEE-AETNA. Submit completed claim form with receipts to Aetna, PO Box 8504 Mason, OH 45040-7111.
Enrolled members can access our secure member website once their plan becomes effective. Enrolled subscribers will receive a welcome packet with ID card mailed to their home within 15 business days after enrollment is processed.
**Allowances are one-time use benefits. No remaining balances may be used. The plan does not provide a declining balance benefit.
[1]Premium progressives and premium anti-reflective Brand designations are subject to annual review and change based on market conditions. Ask your eye care provider for more information.
[2]Non covered discounts may not be available in all states.
[3]Lasik or PRK from the US Laser Network, owned and operated by LCA Vision.
[4]Retinal Imaging available at participating locations. Contact your eyecare provider to verify if available.
Vision insurance plans are underwritten by Aetna Life Insurance Company (Aetna). Certain claims administration services are provided by First American Administrators, Inc. and certain network administration services are provided through EyeMed Vision Care ("EyeMed"), LLC.
Providers participating in the Aetna Vision network are contracted through EyeMed Vision Care, LLC. EyeMed and Aetna are independent contractors and not employees or agents of each other. Participating vision providers are credentialed by and subject to the credentialing requirements of EyeMed. Aetna does not provide medical/vision care or treatment and is not responsible for outcomes. Aetna does not guarantee access to vision care services or access to specific vision care providers and provider network composition is subject to change without notice.

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Financial well-being
Intelligent solutions

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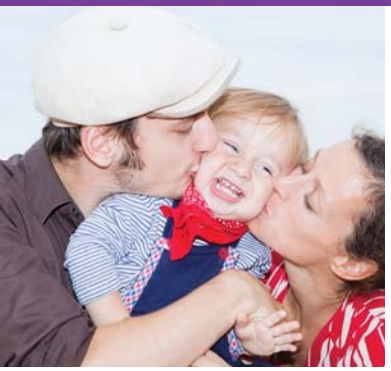


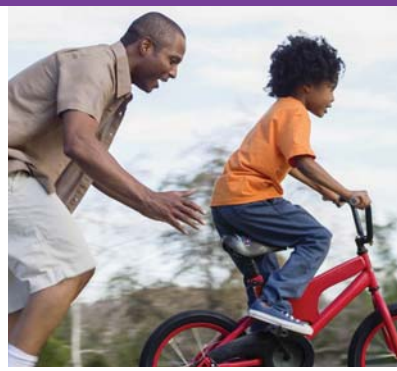

Aetna Resources For Living℠

Employee Assistance Program (EAP)

To access services:
1-888-238-6232
www.resourcesforliving.com
Username: floyd
Password: eap

Floyd County Productions

Aetna Resources For Living is an employer sponsored program, available at no cost to you and all members of your household. That includes dependent children up to age 26, whether or not they live at home. Services are confidential and available 24 hours a day, 7 days a week.

Counseling and Relationship Support

- You can call our dedicated staff, 24 hours a day; you can also talk to licensed behavioral health professionals for emotional support
- Up to 6 counseling sessions per issue per year with licensed network professionals at no cost to you; you don't have to worry about copays or deductibles
- Counseling sessions are available face to face, by phone or televideo
- Support, consultation and resources for a range of issues such as: helping you balance work and home life, family relationship issues, depression, conflict management, alcohol/substance abuse, stress management and more

Web-based Resources

- A customized website which offers a full range of tools and resources on behavioral health and worklife balance topics. Most sections of the website are available in Spanish. Website links include:

  - Articles and self-assessments
  - Access to worklife service providers
  - Stress Resource Center
  - Live webinars and on-demand library
  - Mobile app
  - myStrength – a "health club" for your mind

- Discount Center with discounts on brand-name products and services, including computers and electronics, theme parks, movie tickets, local attractions, travel, gifts, apparel, flowers, jewelry, fitness centers and more

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Worklife Balance Services

- Consultation, information, and assistance with locating resources such as:
  - Child care, parenting and adoption
  - Summer programs for kids
  - School and financial aid research
  - Care for older adults
  - Caregiver support
  - Special needs
  - Pet care
  - Home repair and improvement
  - Household services
- Care kits related to prenatal, child care or adult care

Legal Services

- ½ hour free consultation with a participating attorney for each new legal topic (each plan year) related to:
  - General, family, criminal law
  - Elder law and estate planning
  - Divorce
  - Wills and other document preparation
  - Real estate transactions
  - Mediation services
- A discount of 25% off of the fees for services beyond the initial consultation (excluding flat legal fees, contingency fees and plan mediator services)
- Services must be related to the employee/ eligible household members; employment law is excluded

Financial Services

- ½ hour free telephonic consultation for each new financial topic (each plan year) related to:
  - Budgeting
  - Retirement or other financial planning
  - Mortgages and refinancing
  - Credit and debt issues
  - College funding
  - Tax and IRS questions and preparation
- A discount of 25% off tax preparation services
- Services must be for financial matters related to the employee and eligible household members

Other Services

- Identity theft services – One hour fraud resolution phone consultation or coaching about ID theft prevention and credit restoration. Services include a free emergency kit for victims.

Short-Term Disability Insurance

Colonial Life®
Making benefits count.

How long could you afford to go without a paycheck?

Help protect your paycheck with Colonial Life's short-term disability insurance.

You use your paycheck mainly to pay for your home, your car, groceries, medical bills and utilities. What if you couldn't go to work due to an accident or sickness?

Monthly Expenses: $_____ $_____ $_____

$_____ $_____ $_____

Total $_____

My Coverage Worksheet (For use with your Colonial Life Benefits Counselor)

How much coverage do I need?

On-Job Accident and On-Job Sickness $_____ Off-Job Accident and Off-Job Sickness $_____

How long will I receive benefits?

Total Disability: _____ months

Partial Disability: 3 months*

*Partial Disability is 50% of the Total Disability Amount

When will my benefits start?

After an Accident: _____ days

After a Sickness: _____ days

How much will it cost?

Your cost will vary based on the level of coverage you select.

What additional features are included?

- Waiver of Premium
- Worldwide Coverage

Disability 1000-GA

Here are some frequently asked questions about Colonial Life's disability insurance:

Will my disability income payment be reduced if I have other insurance?

You're paid regardless of any other insurance you may have with other insurance companies. Benefits are paid directly to you (unless you specify otherwise).

When am I considered totally disabled?

Totally disabled means you are:

- Unable to perform the material and substantial duties of your job;
- Not working at any job; and
- Under the regular and appropriate care of a doctor.

What if I want to return to work part-time after I am totally disabled?

You may be able to return to work part-time and still receive benefits. We call this "Partial Disability." This means you may be eligible for coverage if:

- You are unable to perform the material and substantial duties of your job 20 hours or more per week,
- You are able to work at your job or any other job for less than 20 hours per week,
- Your employer will allow you to work for less than 20 hours per week, and
- You are under the regular and appropriate care of a doctor.

The total disability benefit must have been paid for at least one full month immediately prior to your being partially disabled.

What if I change employers?

If you change jobs or leave your employer, you can take your coverage with you at no additional cost. Your coverage is guaranteed renewable to age 70 as long as you continue to pay your premiums when they are due.

What is a pre-existing condition?

A pre-existing condition is when you have a sickness or physical condition for which you were treated, received medical advice, or had taken medication within 12 months before the effective date of your policy.

If you become disabled because of a pre-existing condition, Colonial Life will not pay for any disability period if it begins during the first 12 months the policy is in force.

Can my premium change?

You may choose the amount of coverage to meet your needs (subject to your income). You can elect more or less coverage which will change your premium. Colonial Life can change your premium only if we change it on all policies of this kind in the state where your policy was issued.

What is a covered accident or a covered sickness?

A covered accident is an accident. A covered sickness means an illness, infection, disease or any other abnormal physical condition, not caused by an injury.

A covered accident or covered sickness:

- Occurs after the effective date of the policy;
- Is of a type listed on the Policy Schedule;
- Occurs while the policy is in force; and
- Is not excluded by name or specific description in the policy.

How do I file a claim?

Visit coloniallife.com or call our Policyholder Service Center at 1.800.325.4368 for additional information.

EXCLUSIONS

We will not pay benefits for losses that are caused by or are the result of: alcoholism or drug addiction; felonies or illegal occupation; flying; giving birth within the first nine months after the effective date of the policy; hazardous avocations; having a pre-existing condition as described and limited by the policy; psychiatric or psychological conditions; racing; semi-professional or professional sports; suicide or self-inflicted injuries; war or armed conflict.

For cost and complete details, see your Colonial Life benefits counselor. Applicable to policy form DIS1000-GA. This is not an insurance contract and only the actual policy provisions will control.

Disability 1000-GA

Colonial Life
1200 Colonial Life Boulevard
Columbia, South Carolina 29210
coloniallife.com

Group Accident Insurance

Colonial Life®
Making benefits count.

You can't predict when or where an accident will strike. But you can make sure you have a safety net of financial protection to help if an accidental injury occurs.

Accidents can happen anytime, anywhere—at home or at work, on the playground or on the road. Some of the most common injuries include:

- Broken bones
- Burns
- Concussions
- Lacerations
- Back or knee injuries
- Accidental injuries that send you to the Emergency Room, Urgent Care or a doctor's office.

Colonial Life's Group Accident Insurance helps you fill some of the gaps caused by increasing deductibles, co-payments and out-of-pocket costs related to an accidental injury. With this coverage you may not need to use your savings or secure a loan to help pay those unexpected out-of-pocket expenses associated with a covered accident.

Here's how it works...

Imagine while cleaning the gutters, you fall from the ladder and break your leg.

These are out-of-pocket expenses you may encounter:

$100	Emergency room copay
$250	Deductible (copays do not count toward deductible)
$35	Specialist visit copay – orthopedic physician
$350	Specialist visit copay – occupational/physical therapy for 10 days
$735	**Out-of-pocket expenses**

And here is a sample of benefits you may be eligible for with Colonial Life's Group Accident Insurance:

$125	Accident Emergency Treatment
$150	Accident Follow-up Doctor Visit ($50 per visit, up to 3 per accident)
$100	Appliance (crutches)
$1,125	Fracture (broken leg)
$250	Occupational/Physical Therapy ($25/day for 10 days)
$30	X-Ray (for diagnosis of broken leg)

$1,780 of benefits paid to you in addition to other coverage you may have with other insurance companies.

The claims example above is based on a covered person aged 41 who receives a complete fracture of the leg and requires non-surgical repair. The policy has exclusions and limitations. Costs of treatment and benefit amounts may vary.

Group Accident Plan 2 – GA

Benefits listed are for each covered person per covered accident unless otherwise specified.

Initial Care

- Accident Emergency Treatment $125
- Ambulance $200
- Air Ambulance $1,500
- X-Ray Benefit $30

Common Accidental Injuries

Dislocation (Separated Joint)	Non-Surgical	Surgical
Hip	$3,000	$6,000
Knee	$1,500	$3,000
Ankle – Bone or Bones of the Foot	$1,200	$2,400
Collarbone (sternoclavicular)	$750	$1,500
Lower Jaw, Shoulder, Elbow, Wrist	$450	$900
Bone or Bones of the Hand	$450	$900
Collarbone (acromioclavicular and separation)	$150	$300
One Toe or Finger	$150	$300

Fracture (Broken Bone)	Non-Surgical	Surgical
Depressed Skull	$3,750	$7,500
Non-Depressed Skull	$1,500	$3,000
Hip, Thigh	$2,250	$4,500
Body of Vertebrae, Pelvis, Leg	$1,125	$2,250
Bones of Face or Nose	$525	$1,050
Upper Jaw, Maxilla	$525	$1,050
Upper Arm between Elbow and Shoulder	$525	$1,050
Lower Jaw, Mandible; Kneecap, Ankle, Foot	$450	$900
Shoulder Blade, Collarbone, Vertebral Process	$450	$900
Forearm, Wrist, Hand	$450	$900
Rib	$375	$750
Coccyx	$300	$600
Finger, Toe	$150	$300

Your Colonial Life certificate also provides benefits for the following injuries received as a result of a covered accident.

- Burn (based on size and degree) ..... $1,000 to $12,000
- Burn - Skin Graft for 2nd or 3rd degree burns ..... 50% of Burn benefit
- Coma $10,000
- Concussion $150
- Emergency Dental Work ..... $100 Extraction, $300 Crown, Implant, or Denture
- Lacerations (based on size) ..... $25 to $600

Requires Surgery

- Eye Injury $300
- Ruptured Disc $500
- Tendon/Ligament/Rotator Cuff ..... $500 - one, $750 - two or more
- Torn Knee Cartilage $500

Surgical Care

- Blood/Plasma/Platelets $300
- Surgery (arthroscopic or exploratory) $150
- Surgery (cranial, open abdominal or thoracic) $1,500
- Surgery (hernia) $200

Benefits listed are for each covered person per covered accident unless otherwise specified.

Transportation/Lodging Assistance

If injured, the covered person must travel more than 50 miles from residence to receive special treatment and confinement in a hospital.

- Lodging (family member or companion) ..... $150 per night up to 30 days for a hotel/motel lodging costs
- Transportation ..... $500 per round trip up to 3 round trips

Accident Hospital Care

- Hospital Admission[1] ..... $1,000 per accident
- Hospital ICU Admission[1] ..... $1,500 per accident

[1] *We will not pay the hospital admission benefit and the hospital intensive care unit (ICU) admission benefit for the same covered accident simultaneously.*

- Hospital Confinement[2] ..... $200 per day up to 365 days per accident
- Hospital ICU Confinement[2] ..... $400 per day up to 15 days per accident

[2] *We will not pay the hospital confinement benefit and the hospital ICU confinement benefit simultaneously.*

Accident Follow-Up Care

- Accident Follow-Up Doctor Visit ..... $50 (up to 3 visits per accident)
- Appliances ..... $100 (such as wheelchair, crutches)
- Medical Imaging Study ..... $150 per accident (limit 1 per covered accident and 1 per calendar year)
- Occupational or Physical Therapy ..... $25 per day up to 10 days
- Pain Management (Epidural Anesthesia) ..... $100 (limit 1 per covered accident)
- Prosthetic Devices/Artificial Limb ..... $500 - one, $1,000 - two or more
- Rehabilitation Unit Confinement [3] ..... $100 per day up to 15 days per covered accident, and 30 days per calendar year

[3] *We will not pay the hospital confinement benefit and the rehabilitation unit confinement benefit simultaneously.*

Accidental Dismemberment

- Loss of Finger/Toe ..... $750 – one, $1,500 – two or more
- Loss or Loss of Use of Hand/Foot/Sight of Eye ..... $7,500 – one, $15,000 – two or more

Extended Accidental Dismemberment

For severe injuries that result in the total and irrecoverable:

- Loss of one hand and one foot
- Loss of both hands or both feet
- Loss or loss of use of one arm and one leg
- Loss or loss of use of both arms or both legs
- Loss of the sight of both eyes
- Loss of the hearing of both ears
- Loss of the ability to speak

Named Insured ..... $50,000 Spouse ..... $50,000 Child(ren) $25,000

365-day elimination period. Payable once per lifetime for each covered person.

Accidental Death

	Accidental Death	Common Carrier
• Named Insured	$25,000	$100,000
• Spouse	$25,000	$100,000
• Child(ren)	$5,000	$20,000

Will I have to answer health questions to receive coverage?

Coverage is Guaranteed Issue. No health questions will be asked.

What additional features are included?

- Worldwide coverage
- Portable
- Compliant with Health Savings Account (HSA) guidelines

How do I know how much a benefit pays?

Benefit amounts are preset and not based on the medical expenses you are charged. You get a lump sum payment that is specific to the injury or treatment required.

Will my accident claim payment be reduced if I have other insurance?

You're paid regardless of any other insurance you may have with other insurance companies, and the benefits are paid directly to you (unless you specify otherwise).

How do I file a claim?

Visit coloniallife.com or call our Customer Service Department at 1.800.325.4368 for additional information.

My Coverage Worksheet **(For use with your Colonial Life benefits counselor)**

Who will be covered? (check one)

○ Employee Only ○ Employee & Spouse

○ One-Parent Family ○ Two-Parent Family

When are covered accident benefits available? (check one)

○ On and Off-Job Benefits ○ Off-Job Only Benefits

EXCLUSIONS AND LIMITATIONS

We will not pay any benefits for losses that are caused by, contributed to by or occur as a result of: felonies or illegal occupations; hazardous avocations; racing; semi-professional or professional sports; sickness; suicide or injuries which any covered person intentionally does to himself; war or armed conflict; in addition to the exclusions listed above, we also will not pay the Extended Accidental Dismemberment benefit for injuries that are caused by or are the result of: birth or intoxicants and narcotics. The covered person must incur a charge and the certificate must be in force for benefits to be payable.

For cost and complete details, see your Colonial Life benefits counselor. Applicable to policy number GACC1.0-P and certificate number GACC1.0-C (including state abbreviations where used, for example: GACC1.0-C-TX). This is not an insurance contract and only the actual policy provisions will control.

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1200 Colonial Life Boulevard
Columbia, South Carolina 29210
coloniallife.com

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Making benefits count.

Health Screening Benefit - $50

This benefit helps you pay for part of the expense of preventive medical tests you may normally have each year. The benefit allows a maximum of 1 health screening test per covered person per calendar year.

Tests that qualify:

Blood test for triglycerides	Flexible sigmoidoscopy
Bone marrow testing	Hemoccult stool analysis
Breast ultrasound	Mammography
CA 15-3 (blood test for breast cancer)	Pap smear
CA 125 (blood test for ovarian cancer)	PSA (blood test for prostate cancer)
Carotid Doppler	Serum cholesterol test to determine level of HDL and LDL
CEA (blood test for colon cancer)	Serum protein electrophoresis (blood test for myeloma)
Chest x-ray	Skin cancer biopsy
Colonoscopy	Stress test on a bicycle or treadmill
Echocardiogram (ECHO)	Thermography
Electrocardiogram (EKG, ECG)	ThinPrep pap test
Fasting blood glucose test	Virtual colonoscopy

The covered person must incur a charge and the certificate must be in force for benefits to be payable. A 30-day waiting period must be met. For cost and complete details, see your Colonial Life benefits counselor. Applicable to policy number GACC1.0-P and certificate number GACC1.0-C (including state abbreviations where used, for example: GACC1.0-C-TX). Coverage may vary by state and may not be available in all states. This is not an insurance contract and only the actual policy provisions will control.

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Colonial Life
The benefits of good hard work.®

Term Life Insurance

Help protect the people who depend on you

If something happened to you, the last thing your family should have to worry about is financial burdens. Funeral expenses, medical bills and taxes could be just the beginning. How would they cover ongoing living expenses, such as a mortgage, utilities and health care?

Plan for the future with term life insurance from Colonial Life & Accident Insurance Company.

The advantages of term life insurance

- Level death benefit.
- Lower cost option compared with cash value insurance.
- Coverage for specified periods of time, which can be during high-need years.
- Benefit for the beneficiary that is typically free from income tax.

Benefits and features

- Guaranteed premiums do not increase during the term.
- Coverage is guaranteed renewable to age 95 as long as premiums are paid when due.
- You can convert it to cash value insurance.
- Portability allows you to take it with you if you change jobs or retire.
- An Accelerated Death Benefit is included.

Your cost will vary based on the level of coverage you select.

Talk with your Colonial Life benefits counselor for information about what level of coverage would work best for you.

Benefits worksheet

For use with your Colonial Life benefits counselor

HOW MUCH COVERAGE DO YOU NEED?

☐ **YOU** $ _____
FACE AMOUNT

Select the term period
☐ 10-year term
☐ 20-year term
☐ 30-year term

☐ **SPOUSE** $ _____
FACE AMOUNT

Select the term period
☐ 10-year term
☐ 20-year term
☐ 30-year term

Select any optional riders:

☐ Spouse Term Life Rider
$ _____ face amount
for _____-year term period

☐ Children's Term Life Rider
$ _____ face amount

☐ Waiver of Premium Benefit Rider

☐ Accidental Death Benefit Rider

To learn more, talk with your Colonial Life benefits counselor.

ColonialLife.com

Cash value policy conversion

You can convert your policy to a Colonial Life cash value life insurance policy any time through age 75 (unless you have used the Accelerated Death Benefit or Waiver of Premium Benefit Rider) with no evidence of insurability. Premiums will be based on your age at the time you convert your policy.

Accelerated Death Benefit

If you are diagnosed with a terminal illness, you can request up to 75% of the policy's death benefit, not to exceed $150,000. We deduct a fee only if you use the benefit, and your death benefit will then be reduced by the amount you receive. In addition, there may be tax consequences for receiving the accelerated benefit; ask your tax advisor for advice. Please refer to your policy for details.

Spouse coverage options

Two options are available for spouse coverage at an additional cost:

1. **Spouse Term Life Policy:** Offers guaranteed premiums and level death benefits equivalent to those available to you – whether or not you buy a policy for yourself.
2. **Spouse Term Life Rider:** Add a term rider for your spouse to your policy, up to a maximum death benefit of $50,000; 10-year and 20-year are available (20-year rider only available with a 20- or 30-year term policy).

Dependent coverage

You may add a Children's Term Life Rider to cover all of your eligible dependent children with up to $10,000 in coverage each for one premium. The Children's Term Life Rider may be added to either the primary or spouse policy, not both.

Waiver of Premium Benefit Rider

This rider waives all premiums (for the policy and any riders) if you become totally and permanently disabled before the age of 65. To be considered permanent, your total disability must continue with no interruptions for at least six consecutive months. Premiums waived by this rider do not have to be repaid. This rider is available for the spouse policy as well, subject to home office approval.

Accidental Death Benefit Rider

This rider provides an additional benefit to the beneficiary if the insured dies as a result of an accident before age 70. The benefit doubles if the injury resulting in death occurs while insured is a fare-paying passenger on a public conveyance, such as a commercial aircraft or taxicab. An additional seatbelt benefit is also payable.

EXCLUSIONS AND LIMITATIONS

If the insured commits suicide within two years (one year in CO and ND) from the coverage effective date, whether he is sane or insane (not applicable in AZ), we will not pay the death benefit. We will terminate this policy and return the premiums paid, without interest. In MO, should death occur as a result of suicide, our company is responsible only for the return of premiums paid when application is made with intent to commit suicide.

You will receive a policy summary or illustration (whichever is applicable to your state) when your policy is issued if this policy has exclusions, limitations or reductions of benefits. For costs and complete details, call or write your Colonial Life benefits counselor or the company. This brochure is applicable to policy forms TERM1000, R-TERM1000-ADB, R-TERM1000-CTR, R-TERM1000-STR, R-TERM1000-WAIVER and applicable state variations.

See your Colonial Life benefits counselor for additional information specific for your state. This coverage contains limitations and exclusions that may affect benefits payable. Product may vary by state.

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Expand your benefits – not your budget

Colonial Life
The benefits of good hard work.®

Add AD&D coverage to your benefits package

Your budget may be growing tighter, but your employees still need a benefits package that can help provide financial protection in the event of an accident. We can help you satisfy both needs with one year of complimentary accidental death and dismemberment (AD&D) insurance.

AD&D insurance at no cost to you

Employees can register for $5,000 of complimentary AD&D insurance* offered through Chubb Group of Insurance simply by participating in a 1-to-1 benefits counseling session with a Colonial Life benefits representative. And if they choose to register, we'll provide their AD&D certificate and ID card at that time – no purchase necessary.

The AD&D policy can pay a benefit if a covered accident results in loss of life, limb, sight, speech or hearing. Insured individuals are covered 24 hours a day, 365 days a year, anywhere in the world.

The added value of benefits education

By attending a 1-to-1 benefits counseling session to register for their AD&D coverage, your employees can learn more about their entire benefits package. Our benefit representatives are able to review your core benefits and help your employees determine which coverage works best for their personal situations.

Give your employees important financial protection while protecting your budget.

Call your Colonial Life benefits representative today to learn more.

*Accidental Death and Dismemberment insurance coverage provided by Federal Insurance Company, a member insurer of the Chubb Group of Insurance. This coverage may not be available in all states. Complimentary AD&D coverage will be effective for 12 months from the employees' date of enrollment. Subject to availability, employees may choose to continue coverage by meeting with their Colonial Life benefits representative at the following year's enrollment.

ColonialLife.com

Help your employees achieve financial success

KOFE
Knowledge of Financial Education
A product of CONSOLIDATED CREDIT™ When debt is the problem, we are the solution.

KOFE can answer questions about:

- Personal finance
- Budgets
- Savings
- Debt
- Payment options
- Credit and credit reports

Colonial Life®
The benefits of good hard work.®

No matter how well you take care of your employees, many of them face considerable financial stress, and they can bring these problems to work.

In fact, 44% of full-time employees say they worry about their personal finances during work hours, and 46% of these employees say they spend two to three hours per week dealing with personal finances at work.[1]

These distractions can impact your employees' productivity – and your bottom line. **Fortunately, we can help.**

Our service solution

Colonial Life has partnered with Knowledge of Financial Education, or KOFE, a corporate financial wellness program created by Consolidated Credit. Consolidated Credit is one of the largest non-profit credit counseling agencies with more than 20 years of expertise.

While some companies only provide financial education and others only offer counseling, your employees will have both. And it's available at no direct cost to you. Your employees can have access to these services simply by attending a 1-to-1 benefits counseling session with a Colonial Life benefits counselor. They'll have a variety of resources to help improve their financial situations:

- **Financial coaching** – Unlimited access to highly trained senior certified credit counselors by calling 866-932-4185
- **Online tools** – Access to 100+ videos, books, budgeting tools and more, all easily accessible at ColonialLife.com/KOFE
- **Webinars** – Educational sessions throughout the year on a variety of topics

Give your employees support to succeed

By offering KOFE's services, you can let your employees know that you care about their financial difficulties. With this support, you can keep employees focused, boost employee morale and help reduce absenteeism.

To learn more, talk with your Colonial Life representative or visit ColonialLife.com/KOFE.

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1 Harris Interactive and Purchasing Power, *Financial Wellness: Addressing the "9 to 5" Impact of 24/7 Financial Stress*, June 20-24, 2013

Terms and availability of service are subject to change.

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Provide health and wellness discounts with WellCard

Colonial Life
The benefits of good hard work.®

WellCard can help employees and their families with out-of-pocket costs that health insurance doesn't cover. To receive discounts, your employees simply present the card at a participating pharmacy or health care provider.

How does it work?

If the employee's benefits are limited to a certain number of visits or products, WellCard discounts can help with out-of-pocket costs if the employee exceeds the limit.

Other discount programs often require a monthly fee for each member to access services that may or may not be used. WellCard offers discounts at the point of service when the employee chooses to make a purchase, so employees aren't paying for services they aren't using. WellCard is available to you and your employees at no direct cost to you.

WellCard can benefit your business and your employees whether you offer a health care plan, offer a high-deductible plan or are unable to offer health insurance.

Additional WellCard features include:

- **24/7 telemedicine**
  Accessing CallMD, a 24/7 telemedicine service, could help prevent employees from having to leave the worksite for doctor's office visits. It could also help them with out-of-pocket costs, such as travel expenses and multiple co-pays. Unlimited telephone consultations are available to the employees 24/7 for a $35 per consult fee when they mention they have WellCard.

- **Medical bill advocate**
  At no charge, experienced auditors review medical bills for accuracy and help employees organize and understand medical expenses. They also negotiate any claim that has a patient balance exceeding $500, with the negotiation fee reduced to 30% of total savings with WellCard membership.

- **Cash rewards and entertainment benefits**
  With WellCard Savings Rewards, cardholders can get help paying for their health care expenses through cash rewards from everyday purchases made through a network of merchants. Cardholders can also save money on entertainment benefits, with discounts on Disney™ and Universal Studios™ theme parks, Las Vegas and New York Broadway shows, movie tickets, hotels and rental cars.

The WellCard program offers health and wellness products and services from brand-name vendors nationwide:

Pharmacy (retail and mail order)
Vision care and LASIK
Hearing
Dental
Medical network
MRI and imaging
Lab savings
24/7 doctor telephone consult
Medical bill help
Diabetes care and supplies
Vitamins
Daily living products
Cash rewards and entertainment benefits

Contact your Colonial Life benefits counselor today to learn how WellCard can enhance your benefits package.

This discount program is powered by AccessOne Consumer Health, Inc.
84 Villa Rd, Greenville, S.C. 29615 accessonedmpo.com

This is not a Part D Medicare prescription drug program. This is not insurance and is not intended to replace insurance. Discounts are only available at participating pharmacies and providers. Payment must be made at the time of service to receive discounts from participating providers. Void where prohibited by law.

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

Did you know that 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.

- **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.

- **Newborn's Act Disclosure**

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay with connection to childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother and her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours)

- **HIPAA Notice of Privacy Practices**

This rule required health plans to send participants an initial notice of privacy practices and then reminders must be given once every three years. This memo is a reminder that if you would like to see or obtain another copy of the health plan's HIPAA Privacy Notice, please contact Human Resources

- **Michelle's Law**

NOTICE OF EXTENDED COVERAGE TO PARTICIPANTS COVERED UNDER A GROUP HEALTH PLAN

Federal legislation known as "Michelle's Law" generally extends eligibility for group health benefit plan coverage to a dependent child who is enrolled in an institution of higher education at the beginning of a medically necessary leave of absence if the leave normally would cause the dependent child to lose eligibility for coverage under the plan due to loss of student status. The extension of eligibility protects eligibility of a sick or injured dependent child for up to one year.
The Plan currently permits an employee to continue a child's coverage if that child is enrolled at an accredited institution of learning on a full-time basis, with full-time defined by the accredited institution's registration and/or attendance policies. Michelle's Law requires the Plan to allow extended eligibility in some cases for a dependent child who would lose eligibility for Plan coverage due to loss of full-time student status.
There are two definitions that are important for purposes of determining whether the Michelle's Law extension of eligibility applies to a particular child:

- *Dependent child* means a child of a plan participant who is eligible under the terms of a group health benefit plan based on his or her student status and who was enrolled at a post-secondary educational institution immediately before the first day of a medically necessary leave of absence.
- *Medically necessary leave of absence* means a leave of absence or any other change in enrollment:
    - of a dependent child from a post-secondary educational institution that begins while the child is suffering from a serious illness or injury
    - which is medically necessary
    - and which causes the dependent child to lose student status under the terms of the Plan

For the Michelle's Law extension of eligibility to apply, a dependent child's treating physician must provide written certification of medical necessity (i.e., certification that the dependent child suffers from a serious illness or injury that necessitates the leave of absence or other enrollment change that would otherwise cause loss of eligibility).
If a dependent child qualifies for the Michelle's Law extension of eligibility, the Plan will treat the dependent child as eligible for coverage until the earlier of:

- One year after the first day of the leave of absence
- The date that Plan coverage would otherwise terminate (for reasons other than failure to be a full-time student)

A dependent child on a medically necessary leave of absence is entitled to receive the same Plan benefits as other dependent children covered under the Plan. Further, any change to Plan coverage that occurs during the Michelle's Law extension of eligibility will apply to the dependent child to the same extent as it applies to other dependent children covered under the Plan.

- **Patient Protection Model Disclosure**

Medical plans generally allow the designation of a primary care provider. You have the right to designate any primary care provider who participates in the network and who is available to accept new members. For children, a pediatrician can be selected as the primary care provider.

Premium Assistance Under Medicaid & 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 July 31, 2016. Contact your State for more information on eligibility –

ALABAMA – Medicaid	FLORIDA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
ALASKA – Medicaid	**GEORGIA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: http://dch.georgia.gov/medicaid - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
ARKANSAS – Medicaid	**INDIANA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.hip.in.gov Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864
COLORADO – Medicaid	**IOWA – Medicaid**
Medicaid Website: http://www.colorado.gov/hcpf Medicaid Customer Contact Center: 1-800-221-3943	Website: http://www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562

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

KANSAS – Medicaid	NEW HAMPSHIRE – Medicaid
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218
KENTUCKY – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	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
LOUISIANA – Medicaid	**NEW YORK – Medicaid**
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831
MAINE – Medicaid	**NORTH CAROLINA – Medicaid**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: http://www.ncdhhs.gov/dma Phone: 919-855-4100
MASSACHUSETTS – Medicaid and CHIP	**NORTH DAKOTA – Medicaid**
Website: http://www.mass.gov/MassHealth Phone: 1-800-462-1120	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MINNESOTA – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: http://mn.gov/dhs/ma/ Phone: 1-800-657-3739	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MISSOURI – Medicaid	**OREGON – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
MONTANA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://www.dhs.pa.gov/hipp Phone: 1-800-692-7462
NEBRASKA – Medicaid	**RHODE ISLAND – Medicaid**
Website: http://dhhs.ne.gov/Children_Family_Services/AccessNebraska/Pages/accessnebraska_index.aspx Phone: 1-855-632-7633	Website: http://www.eohhs.ri.gov/ Phone: 401-462-5300
NEVADA – Medicaid	**SOUTH CAROLINA – Medicaid**
Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900	Website: http://www.scdhhs.gov Phone: 1-888-549-0820

SOUTH DAKOTA - Medicaid	WASHINGTON – Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://www.dhhr.wv.gov/bms/Medicaid%20Expansion/Pages/default.aspx 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: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
VERMONT– Medicaid	**WYOMING – Medicaid**
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531
VIRGINIA – Medicaid and CHIP	
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	

To see if any other states have added a premium assistance program since July 31, 2016, 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

Important Notice from Floyd County Productions 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 Floyd County Productions 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.

Floyd County Productions has determined that the prescription drug coverage offered by the Group Medical Plan 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.

Important Notice from Floyd County Productions About Your Prescription Drug Coverage and Medicare

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 Floyd County Productions coverage will be affected.

If you do decide to join a Medicare drug plan and drop your current Floyd County Productions 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 Floyd County Productions 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 Floyd County Productions 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.

Important Notice from Floyd County Productions About Your Prescription Drug Coverage and Medicare

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:	August 1, 2017
Name of Entity/Sender:	Floyd County Productions
Contact--Position/Office:	Jamie Moss, HR Director
Address:	231 18th St NW, Suite 8150, Atlanta, GA 30363
Phone Number:	(404) 445-8300

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 1-31-2017)

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact Jamie Moss, HR Director.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

Part B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name	4. Employer Identification Number (EIN)
FLOYD COUNTY PRODUCTIONS	94-3448940
5. Employer address	6. Employer phone number
231 18th St NW Suite 8150	404-445-8300

7. City	8. State	9. ZIP code
Atlanta	GA	30363

10. Who can we contact about employee health coverage at this job?	
Jamie Moss HR Director	
11. Phone number (if different from above)	12. Email address
	jamie@floydcounty.tv

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:
  - [x] All employees. Eligible employees are: All full-time active employees who work 40 hours per week.
  - [ ] Some employees. Eligible employees are:
- With respect to dependents:
  - [x] We do offer coverage. Eligible dependents are: Legal spouses, documented domestic partners, children up to age 26 to include: natural born children, step children, legally adopted children, grandchildren if employee has court ordered power of attorney. Handicapped children are also eligible beyond age 26.
  - [ ] We do not offer coverage.

[x] If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. Here's the employer information you'll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.

Marketplace Notices

The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers, but will help ensure employees understand their coverage choices.

13. **Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?**

☐ **Yes** (Continue)
13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage?_____ (mm/dd/yyyy) (Continue)
☐ **No** (STOP and return this form to employee)

14. Does the employer offer a health plan that meets the minimum value standard*?
☐ Yes (Go to question 15) ☐ No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* **offered only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.
a. How much would the employee have to pay in premiums for this plan? $
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year?
☐ Employer won't offer health coverage
☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)
a. How much would the employee have to pay in premiums for this plan? $
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

• An employer–sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

NOTES

floyd county™

CBIZ Benefits & Insurance Services

Disclaimer: This benefit summary highlights key features of Floyd County's benefits program and does not include all plan rules and details. The terms of your benefit plans are governed by legal documents, including insurance contracts. Should there be any inconsistencies between this summary and the legal plan documents, the plan documents are the final authority. Floyd County reserves the right to change or discontinue its benefit plans at any time without prior advance notice.