XHA
THIS CONFIRMATION STATEMENT IS FOR:

Jennifer Herrera
10924 Telechron Aven
Whittier, CA 90605

Paygroup:
XHA

File Nbr:
000065

Run Date:
05/01/2014

IN THE BUSINESS OF YOUR SUCCESS℠

Employee Service Center
10200 Sunset Drive
Miami, Fl 33173-3033
Toll-free Number
(800) 554-1802
www.adptotalsource.com

Jennifer Herrera
10924 Telechron Aven
Whittier, CA 90605

04/30/2014

BENEFIT CONFIRMATION STATEMENT FOR PLAN YEAR JUNE 1, 2014 THROUGH MAY 31, 2015.

Open Enrollment 2014 - 2015 is coming to a close; please verify that your elections were recorded accurately.

The following page is a Confirmation Statement detailing your elected benefits for the plan year effective **June 1, 2014 through May 31, 2015.** If replacement plans were indicated in the Replacement Plan Table within your Open Enrollment Kit, and you did not submit plan election changes, you have been enrolled in the replacement plan(s) as reflected on this statement. Please be sure to verify that all eligible dependents you elected to enroll for coverage are included and their information such as name, year of birth and the relationship to you is accurate.

Changes to your benefit elections and dependent enrollment are not permitted until the next Open Enrollment period unless such change is related to an event specifically permitted by the Plan, such as a qualified IRS Section 125 change in status or HIPAA special enrollment event. A change in status must be declared within sixty (60) days of the Qualifying Event date.

Examples of Qualifying Events:

- Change in legal marital status, including marriage, death of spouse, divorce or legal separation.
- Change in number of dependents, including birth, adoption or death.
- Change in employment status, including beginning or termination of employment.

Please refer to the Summary Plan Description (SPD) or contact the Employee Service Center for more information, as this list does not include all qualified change in status events.

Information about medical and dental ID cards

Did you know that if you remain enrolled with the same carrier, on June 1st you can generally continue to use your existing ID card? Carriers usually issue ID cards when someone is newly enrolled, or if at renewal certain information that appears on ID cards change, such as copayments, group or member number, carrier customer service number, or a carrier changes the format of the ID cards. In the event that your carrier or plan information is different on June 1st and you have not received a new ID card, here are some steps you can take:

1. Log on to your carrier Web site. If it's your first time logging on to the carrier's Web site, you will need to register.
2. Check your enrollment on the carrier Web site, and look for the ability to print a temporary ID card. Although not every carrier offers this option on their Web site, most of them do. The carrier Web site should also provide you with an option to contact customer service. Customer Service can verify your address, let you know when an ID card was mailed, or place the order for you.
3. If you do not have your carriers' Web site address or customer service number, you can review the carrier's Summary of Benefits and Coverage (SBC) provided in your Open Enrollment materials and on MyTotalSource. The SBC provides your carrier's Website and customer service number in addition to other plan-specific information.
4. If you are unable to locate the carrier's Web site address or customer service number, please contact the ADP TotalSource Employee Service Center at (800) 554-1802 or esc@adp.com.

If you have any questions or the enclosed information is not consistent with the benefit elections you made, please contact the Employee Service Center immediately at (800) 554-1802.

If you do not contact us by May 31, 2014 to report any incorrect information, we will consider you to have approved all the information included in this Confirmation Statement and your benefit elections, as described within the Confirmation Statement, will be considered valid and final. No changes to these benefit elections will be permitted unless a change in status occurs as described above.

To access your insurance certificate of coverage visit My TotalSource or contact the Employee Service Center. Please note that during the start of a new Plan Year, some certificates of coverage may not yet be available.

We look forward to providing you and your family with World Class Service throughout 2014 and beyond.

Sincerely,
ADP TotalSource, Regional Benefits

IN THE BUSINESS OF YOUR SUCCESS℠

Employee Service Center
10200 Sunset Drive
Miami, Fl 33173-3033
Toll-free Number
(800) 554-1802
www.adptotalsource.com

BENEFIT CONFIRMATION STATEMENT FOR PLAN YEAR JUNE 1, 2014 THROUGH MAY 31, 2015

Name of Employee: Jennifer Herrera
Employer: XHA - Multimedia Abacus Corp
Class: A - All Employees

Dependent(s)	D.O.B.	Relationship

Plan Name & Description	Type of Coverage	Current Monthly Rate	Dependents Covered
Aetna HMO AET-HMO 30/100%-S-CA-A	Employee	$ 155.67	
Aetna Dental DMO or PPO/PDN with PPO II AET-FOC Den-California-A	Employee	$ 27.58	
VSP VSP Choice VSP- Choice Vision Plan-A	Employee	Employer Paid	
Aetna Life Insurance Basic $50,000-A		Employer Paid	
Aetna Life Insurance LTD1 60% $5,000/mo-180-A		Employer Paid	
Current Monthly Total Employee Cost:		$ 183.25	

Life Beneficiary	Plan
01 Ornelas,Araceli - Primary Beneficiary	Basic $50,000-A
02 Herrera,Emma - Primary Beneficiary	Basic $50,000-A

* Age Reduction Rule applies. Life Insurance is reduced by 35% at age 65; 50% at age 70; 65% at age 75. The Age Reduction Rule is based on age as of the June 1st that coincides with or follows your birth date.

IMPORTANT MESSAGES:

- Verify that the benefit elections and dependents listed for enrollment above for the new Plan year are accurate. Changes to your benefit elections and dependent enrollments are not permitted until the next Open Enrollment period unless such change is related to an event specifically permitted by the Plan, such as a qualified IRS Section 125 change in status or HIPAA special enrollment event.

-If you have changed providers or plans during this Open Enrollment, you may need to contact your new provider for instructions on the best method of transferring deductible credits, out-of-pocket maximums and any other annual maximums to your new plan for the remainder of the calendar year.

- If you have any questions or if the Benefit information indicated above is not consistent with your benefit elections, contact the Employee Service Center immediately at (800) 554-1802. If you do not contact the Employee Service Center by May 31, 2014 the Benefit information above will become final and no changes will be permitted unless a change in status occurs.

Don't Miss Out On Added My TotalSource® Benefits – Register With Netsecure Today!

In addition to the comprehensive benefits available to you through ADP TotalSource® TotalBenefits, you also have access to some great online tools and services on My TotalSource®.

Once you register with the Netsecure login (instructions below), say goodbye to the paycheck paper chase and get immediate access to current and archived pay statements and W-2s.

Direct Deposit: Tired of trekking to the bank to deposit your paycheck? Worried when the weather's bad and your paper paycheck is late? Direct Deposit is the ideal solution! If you have a bank account, this solution provides the most efficient method and is guaranteed! You can enroll online on My TotalSource at anytime that is convenient for you.

Pay Statements and Annual Statements: View, download and print your current and archived pay statements and W-2s – up to 3 years worth. Go paperless and do your part to help the planet. If you want – view online and only print out statements as needed. No more filing, no more stacks of paper, no more hassle if you misplace a pay statement or W-2!

TotalPay® Card: Get your payroll payment in the form of a reloadable debit card – no bank account or credit check necessary! (Note this requires your company to elect this product. Check with your manager for availability.)

In order to access these tools, you need to sign up for the Netsecure login to My TotalSource.

The first step is to register with Netsecure – it's easy!

1. Sign in using your My TotalSource Classic login, on the left side of the login page.
2. The system will display your company's Registration Pass Code. **Write this number down – you will need it before you click "Register Now!"**
3. Follow the on-screen prompts to complete registration.
4. If you forget your new password after you complete the Netsecure registration, don't worry – simply click on the "Forgot my password" link on the login page.

Note: If you have forgotten your Classic login, ask your payroll administrator for your company's Registration Pass Code, or call the Employee Service Center at (800) 554-1802 and then choose the "Register Now" link on the right side of the login page.

Still Have Questions?

If you need any help logging on or need assistance in enrolling in direct deposit, please contact the ADP TotalSource Employee Service Center at (800) 554-1802 or esc@adp.com.

ADP TotalSource
Bottom Line. Your team just got better.®

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ADP TOTALSOURCE®

Health Advocate™

An additional benefit when choosing an Aetna® medical plan

Aetna® is pleased to announce that Health Advocate™, Inc., the nation's leader in health advocacy, will be included as a standard feature if you enroll in an Aetna medical plan offered through ADP TotalSource®. This independent and objective service will provide you with a team of Personal Health Advocates (PHAs), typically registered nurses supported by medical directors and benefit specialists. PHAs help you navigate the health care system with time and money-saving solutions. Health Advocate takes a non-adversarial approach to finding the right answers. Its services help with clinical and administrative issues involving medical, hospital, pharmacy and other health care needs while complying with HIPAA privacy and confidentiality requirements. Health Advocate's services are available to you and your spouse, dependent children, parents and parents-in-law.

Here is a summary of the benefits you'll receive through Health Advocate, if you enroll in an Aetna medical plan. Health Advocate can:

- Find the right doctors, dentists, hospitals and other health care providers anywhere in the country
- Expedite appointments with providers, including hard-to-reach specialists, and arrange for specialized treatments and tests
- Help resolve insurance claims issues, negotiate billing/payment arrangements and uncover billing errors that can impact your out-of-pocket costs
- Assist with elder care needs such as finding adult day care, assisted living and other related issues facing parents and parents-in-law
- Obtain unbiased health information about complex medical conditions to help you make informed decisions
- Work with insurance companies to obtain appropriate approvals for needed services
- Reduce grievances and appeals
- Answer questions about test results, treatments and medications prescribed by your physician
- Assist in the transfer of medical records, x-rays and lab results
- Locate and research the newest treatments for a medical condition
- Assist with finding qualified wellness programs, providers and services

ABOUT HEALTH ADVOCATE

Founded in 2001, Health Advocate serves over 40 million Americans through its relationships with 10,000+ employers, unions, third-party administrators and insurers, including some of the nation's largest companies, as well as a wide range of local and regional organizations.

For more information, log in to HealthAdvocate.com.

Medical Bill Saver

The Medical Bill Saver program can help lower your out-of-pocket costs on your medical bills not covered by insurance. Health Advocate expert negotiators work with providers to lower the balance of any uncovered medical and dental bill over $400. Just send them your bill.

Here is how Medical Bill Saver can help:

- Negotiation can result in 25-50% savings
- Easy-to-read personal Savings Result Statement, summarizing outcome of payments terms
- If negotiations are successful, Health Advocate will share in 25% of the savings. If they are not successful, you pay nothing.

GENERAL NOTICE
OF COBRA CONTINUATION COVERAGE RIGHTS

** CONTINUATION COVERAGE RIGHTS UNDER COBRA**

Introduction

You are receiving this notice because you have recently become covered under the ADP TotalSource, Inc. Health and Welfare Plan (Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. COBRA applies to the following options under the Plan: medical, dental, vision and the health care flexible spending account. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.**

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs by using the notice available from the Plan Administrator. You must provide this notice to the ADP TotalSource Employee Service Center at the Plan contact address indicated at the end of this notice. You may contact the Employee Service Center at 1-800-554-1802 to obtain the appropriate form of notice.

How is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both)**,** your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion by using the form available from the Plan Administrator, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan on the form available from the Plan Administrator. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Health Care Flexible Spending Account

A special rule applies to the Health Care Flexible Spending Account. COBRA continuation coverage for the Health Care FSA is only available for the remainder of the Plan year in which your COBRA qualifying event occurs.

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan Contact Information

ADP TotalSource, Inc.
10200 Sunset Drive
Miami, FL 33173

Employee Service Center
1-800-554-1802

Important Notice From ADP TotalSource, Inc. 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 ADP TotalSource, Inc. (ADP TotalSource) 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:

1. **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.**

2. **ADP TotalSource has determined that the prescription drug coverage you have elected through the ADP TotalSource, Inc. Health and Welfare Plan (Plan) is, on average for all applicable 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 to December 7th.

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

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

If you decide to join a Medicare drug plan, your current ADP TotalSource, Inc. Health and Welfare Plan coverage will not be affected. If you keep your health coverage with the ADP TotalSource and enroll in a Medicare prescription drug plan, you will still be eligible to receive all of your current ADP TotalSource health and prescription drug benefits. The plan will coordinate with Part D coverage

If you do decide to join a Medicare drug plan and drop your current ADP TotalSource health coverage, be aware that you and your dependents may have to wait until the next open enrollment to get your ADP TotalSource 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 ADP TotalSource and don't join a Medicare drug plan within 63 continuous days after your current ADP TotalSource 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 Employee Service Center (ESC) for further information at 800-554-1802. **NOTE:** You'll get this notice each year. You will also get it if this coverage through ADP TotalSource 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 prescription drug plans.

For more information about Medicare prescription drug coverage:

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

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For more 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:	June 1, 2011
Name of Entity/Sender:	ADP TotalSource, Inc. in its capacity as the Plan Administrator for the ADP TotalSource. Inc. Health and Welfare Plan
Contact--Position/Office:	Employee Service Center
Address:	10200 Sunset Drive Miami, Florida 33173
Phone Number:	800-554-1802

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for:** Individual + Family | **Plan Type:** HMO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at **www.HealthReformPlanSBC.com** or by calling **1-888-982-3862**.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	For each Calendar Year, In-network: Individual **$0** / Family **$0**.	See the chart starting on page 2 for your costs for the services this plan covers.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	Yes, In-network: Individual **$3,000** / Family **$9,000**.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Premiums and health care this plan does not cover.	Even though you pay these expenses, they don't count toward the **out-of pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of in-network **providers**, see www.aetna.com or call 1-888-982-3862.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	Yes, for in-network **specialists**.	This plan will pay some or all of the costs to see a **specialist** for covered services but only if you have the plan's permission before you see the **specialist**.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for:** Individual + Family | **Plan Type:** HMO

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **copayments**, and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-Of-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$30 copay per visit	Not covered	Includes Internist, General Physician, Family Practitioner or Pediatrician.
	Specialist visit	$50 copay per visit	Not covered	———— None ————
	Other practitioner office visit	$15 copay per visit	Not covered	Coverage is limited to 20 visits per calendar year for Chiropractic care.
	Preventive care /screening /immunization	No charge	Not covered	Age and frequency schedules may apply.
If you have a test	Diagnostic test (x-ray, blood work)	No charge for laboratory; $50 copay per visit for x-ray	Not covered	———— None ————
	Imaging (CT/PET scans, MRIs)	$50 copay per visit	Not covered	Pre-authorization may be required.

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for:** Individual + Family | **Plan Type:** HMO

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-Of-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More Information about **prescription drug coverage** is available at www.aetna.com/pharmacy-insurance/individuals-families	Generic drugs	$15 copay/ prescription (retail), $30 copay/ prescription (mail order)	Not covered	Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription). Includes performance enhancing medication, contraceptive drugs and devices obtainable from a pharmacy, oral fertility drugs. No charge for formulary generic FDA-approved women's contraceptives in-network. Precertification required. Step therapy required.
	Preferred brand drugs	$35 copay/ prescription (retail), $70 copay/ prescription (mail order)	Not covered	
	Non-preferred brand drugs	$60 copay/ prescription (retail), $120 copay/ prescription (mail order)	Not covered	
	Specialty drugs	Not covered	Not covered	Not covered.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	Not covered	———— None ————
	Physician/surgeon fees	No charge	Not covered	———— None ————
If you need immediate medical attention	Emergency room services	$200 copay per visit	$200 copay per visit	No coverage for non-emergency use.
	Emergency medical transportation	No charge	No charge	No coverage for non-emergency transport.
	Urgent care	$75 copay per visit	Not covered	No coverage for non-urgent use.
If you have a hospital stay	Facility fee (e.g., hospital room)	$600 copay per day	Not covered	$1,800 maximum copay per individual per stay.
	Physician/surgeon fee	No charge	Not covered	———— None ————
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$50 copay per visit	Not covered	———— None ————
	Mental/Behavioral health inpatient services	$600 copay per day	Not covered	$1,800 maximum copay per individual per stay.

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-Of-Network Provider	Limitations & Exceptions
	Substance use disorder outpatient services	$50 copay per visit	Not covered	——————— None ———————
	Substance use disorder inpatient services	$600 copay per day	Not covered	$1,800 maximum copay per individual per stay.
If you are pregnant	Prenatal and postnatal care	No charge	Not covered	——————— None ———————
	Delivery and all inpatient services	$30 copay for physician maternity services; $600 copay per day for facility services	Not covered	$1,800 maximum copay per individual per stay. Includes outpatient postnatal care.
If you need help recovering or have other special health needs	Home health care	No charge	Not covered	——————— None ———————
	Rehabilitation services	$50 copay per visit	Not covered	Coverage is limited to 60 consecutive days per condition for Speech, Physical and Occupational Therapy combined.
	Habilitation services	$50 copay per visit	Not covered	——————— None ———————
	Skilled nursing care	$600 copay per day	Not covered	$1,800 maximum copay per individual per stay.
	Durable medical equipment	No charge	Not covered	——————— None ———————
	Hospice service	$600 copay per day for inpatient; no charge for outpatient	Not covered	$1,800 maximum copay per individual per stay.
If your child needs dental or eye care	Eye exam	No charge	Not covered	Coverage is limited to 1 routine eye exam per 24 months.
	Glasses	Not covered	Not covered	Not covered.
	Dental check-up	Not covered	Not covered	Not covered.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other **excluded services**.)

- Acupuncture
- Cosmetic surgery
- Dental care (Adult & Child)
- Glasses (Child)
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Specialty drugs
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Bariatric surgery
- Chiropractic care - Coverage is limited to 20 visits per calendar year.
- Infertility treatment - Coverage is limited to the diagnosis and treatment of underlying medical condition; also includes artificial insemination and ovulation induction $5,000 lifetime maximum.
- Routine eye care (Adult) - Coverage is limited to 1 routine eye exam per 24 months.

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the **premium** you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-888-982-3862. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

- If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice or assistance, you can contact us by calling the toll free number on your Medical ID Card. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. You may also contact your State Department of Insurance at (916) 492-3500, www.insurance.ca.gov
- For all plans, you may also contact:
  California Department of Insurance, (916) 492-3500, www.insurance.ca.gov
  Additionally, a consumer assistance program can help you file your **appeal**. Contact:
  California Department of Managed Health Care and Department of Insurance, California Help Center, 980 9th Street, Suite #500, Sacramento, CA 95814, (888) 466-2219, http://www.healthhelp.ca.gov, helpline@dmhc.ca.gov

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for:** Individual + Family | **Plan Type:** HMO

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage". **This plan or policy does provide minimum essential coverage**.

Does this Coverage Provide Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides**.

Language Access Services:

Para obtener asistencia en Español, llame al 1-888-982-3862.

如果需要中文的帮助，请拨打这个号码 1-888-982-3862.

Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-982-3862.

Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-888-982-3862.

----------*To see examples of how this plan might cover costs for a sample medical situation, see the next page.*----------

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care also will be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays:** $6,120
- **Patient pays:** $1,420

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$0
Copays	$1,270
Coinsurance	$0
Limits or exclusions	$150
Total	**$1,420**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays:** $4,420
- **Patient pays:** $980

Sample care costs:

Prescriptions	$2,900
Medical equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$0
Copays	$900
Coinsurance	$0
Limits or exclusions	$80
Total	**$980**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✖ **No.** Treatments shown are just examples. The care you would receive for this condition could be different, based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✖ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✔ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✔ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Dental Benefits Summary

	FOC DMO	FOC Active PPO With PPOII Network	
		Participating	Non-participating
Annual Deductible*			
Individual	**None**	**$50**	**$50**
Family	**None**	**$150**	**$150**
Preventive Services	**100%**	**90%**	**70%**
Basic Services	**100%**	**60%**	**50%**
Major Services	**60%**	**50%**	**50%**
Annual Benefit Maximum	**None**	**$1,000**	**$1,000**
Office Visit Copay	**$5**	**N/A**	**N/A**
Orthodontic Services	**50%**	**Not Covered**	**Not Covered**
Orthodontic Deductible	**None**	**Not Covered**	**Not Covered**
Orthodontic Lifetime Maximum	***	**Not Covered**	**Not Covered**

***The deductible applies to: Preventive, Basic & Major services**
***** 24 months of comprehensive orthodontic treatment plus 24 months of retention**

Partial List of Services	FOC DMO	FOC Active PPO With PPOII Network	
Preventive		Participating	Non-
Oral examinations (a)	100%	90%	70%
Cleanings (a) Adult/Child	100%	90%	70%
Fluoride (a)	100%	90%	70%
Sealants (permanent molars only) (a)	100%	90%	70%
Bitewing X-rays (a)	100%	90%	70%
Full mouth series X-rays (a)	100%	90%	70%
Space Maintainers	100%	90%	70%
Basic			
Root canal therapy			
Anterior teeth / Bicuspid teeth	100%	60%	50%
Scaling and root planing (a)	100%	60%	50%
Gingivectomy*	100%	60%	50%
Amalgam (silver) fillings	100%	60%	50%
Composite fillings (anterior teeth only)	100%	60%	50%
Stainless steel crowns	100%	60%	50%
Incision and drainage of abscess*	100%	60%	50%
Uncomplicated extractions	100%	60%	50%
Surgical removal of erupted tooth*	100%	60%	50%
Surgical removal of impacted tooth (soft tissue)*	100%	60%	50%
Major			
Root canal therapy, molar teeth	60%	60%	50%
Osseous surgery (a)*	60%	60%	50%
Surgical removal of impacted tooth (partial bony/ full bony)*	60%	60%	50%
General anesthesia/intravenous sedation*	60%	60%	50%
Space Maintainers	60%	60%	50%
Inlays	60%	50%	50%
Onlays	60%	50%	50%
Crowns	60%	50%	50%
Crown lengthening	60%	50%	50%
Full & partial dentures	60%	50%	50%
Pontics	60%	50%	50%
Denture repairs	60%	50%	50%
Crown Build-Ups	60%	50%	50%

***Certain services may be covered under the Medical Plan. Contact Member Services for more details.**
(a) Frequency and/or age limitations may apply to these services. These limits are described in the booklet/certificate.

Other Important Information

This benefits summary of the Aetna Dental DMO® (Dental Maintenance Organization) provides information on benefits provided when services are rendered by a participating dentist. In order for a covered person to be eligible for benefits, dental services must be provided by a primary care dentist selected from the network of participating DMO dentists. Under the Dental® Preferred Provider Organization (PPO) plan, you may choose at the time of service either a PPO participating dentist or any nonparticipating dentist. With the PPO plan, savings are possible because the participating dentists have agreed to provide care for covered services at negotiated rates. Non-participating benefits are subject to usual and prevailing charge limits, as determined by Aetna.

Due to state law, limited (varying by state) DMO® benefits for non-emergency services rendered by non-participating providers are available for plan contracts written in: CT, IL, KY and OH and for members residing in MA and OK (regardless of contract situs state).

Emergency Dental Care

If you are covered under the DMO plan and need emergency dental care for the palliative treatment (pain relieving, stabilizing) of a dental emergency, you are covered 24 hours a day, 7 days a week. You should contact your Primary Care Dentist to receive treatment. If you are unable to contact your PCD, contact Member Services for assistance in locating a dentist. Refer to your plan documents for details. Subject to state requirements. Out-of-area emergency dental care may be reviewed by our dental consultants to verify appropriateness of treatment.

When emergency services are provided by a participating PPO dentist, your co-payment/coinsurance amount will be based on a negotiated fee schedule. When emergency services are provided by a non-participating dentist, you will be responsible for the difference between the plan payment and the dentist's usual charge. Refer to your plan documents for details. Subject to state requirements. Out-of-area emergency dental care may be reviewed by our dental consultants to verify appropriateness of treatment.

Partial List of Exclusions and Limitations* - Coverage is not provided for the following:

1. Services or supplies that are covered in whole or in part:
   (a) under any other part of this Dental Care Plan; or
   (b) under any other plan of group benefits provided by or through your employer.
2. Services and supplies to diagnose or treat a disease or injury that is not:
   (a) a non-occupational disease; or
   (b) a non-occupational injury.
3. Services not listed in the Dental Care Schedule that applies, unless otherwise specified in the Booklet-Certificate.
4. Those for replacement of a lost, missing or stolen appliance, and those for replacement of appliances that have been damaged due to abuse, misuse or neglect.
5. Those for plastic, reconstructive or cosmetic surgery, or other dental services or supplies, that are primarily intended to improve, alter or enhance appearance. This applies whether or not the services and supplies are for psychological or emotional reasons. Facings on molar crowns and pontics will always be considered cosmetic.
6. Those for or in connection with services, procedures, drugs or other supplies that are determined by Aetna to be experimental or still under clinical investigation by health professionals.
7. Those for dentures, crowns, inlays, onlays, bridgework, or other appliances or services used for the purpose of splinting, to alter vertical dimension, to restore occlusion, or to correct attrition, abrasion or erosion. (This item does not apply to California residents under the DMO plan)
8. Those for any of the following services (Does not apply to the DMO plan in TX):
   (a) an appliance or modification of one if an impression for it was made before the person became a covered person;
   (b) a crown, bridge, or cast or processed restoration if a tooth was prepared for it before the person became a covered person; or
   (c) root canal therapy if the pulp chamber for it was opened before the person became a covered person.

9. Services that Aetna defines as not necessary for the diagnosis, care or treatment of the condition involved. This applies even if they are prescribed, recommended or approved by the attending physician or dentist.
10. Those for services intended for treatment of any jaw joint disorder, unless otherwise specified in the Booklet-Certificate.

11. Those for space maintainers, except when needed to preserve space resulting from the premature loss of deciduous teeth.

12. Those for orthodontic treatment, unless otherwise specified in the Booklet-Certificate.
13. Those for general anesthesia and intravenous sedation, unless specifically covered. For plans that cover these services, they will not be eligible for benefits unless done in conjunction with another necessary covered service.

14. Those for treatment by other than a dentist, except that scaling or cleaning of teeth and topical application of fluoride may be done by a licensed dental hygienist. In this case, the treatment must be given under the supervision and guidance of a dentist.
15. Those in connection with a service given to a person age 5 or older if that person becomes a covered person other than:

(a) during the first 31 days the person is eligible for this coverage, or
(b) as prescribed for any period of open enrollment agreed to by the employer and Aetna. This does not apply to charges incurred:
(i) after the end of the 12-month period starting on the date the person became a covered person; or
(ii) as a result of accidental injuries sustained while the person was a covered person; or
(iii) for a primary care service in the Dental Care Schedule that applies as shown under the headings Visits and Exams, and X-rays and Pathology.

16. Services given by a nonparticipating dental provider to the extent that the charges exceed the amount payable for the services shown in the Dental Care Schedule that applies.
17. Those for a crown, cast or processed restoration unless:
(a) it is treatment for decay or traumatic injury, and teeth cannot be restored with a filling material; or
(b) the tooth is an abutment to a covered partial denture or fixed bridge.
18. Those for pontics, crowns, cast or processed restorations made with high-noble metals, unless otherwise specified in the Booklet-Certificate.
19. Those for surgical removal of impacted wisdom teeth only for orthodontic reasons, unless otherwise specified in the Booklet-Certificate.
20. Services needed solely in connection with non-covered services.
21. Services done where there is no evidence of pathology, dysfunction or disease other than covered preventive services. (This item does not apply to California residents under the DMO plan)

Any exclusion above will not apply to the extent that coverage of the charges is required under any law that applies to the coverage.
*This is a partial list of exclusions and limitations, others may apply. Please check your plan booklet for details.

Your Dental Care Plan Coverage Is Subject to the Following Rules:

Replacement Rule
The replacement of; addition to; or modification of: existing dentures; crowns; casts or processed restorations; removable denture; fixed bridgework; or other prosthetic services is covered only if one of the following terms is met:

The replacement or addition of teeth is required to replace one or more teeth extracted after the existing denture or bridgework was installed. This coverage must have been in force for the covered person when the extraction took place.

The existing denture, crown; cast or processed restoration, removable denture, bridgework, or other prosthetic service cannot be made serviceable, and was installed at least 5 years before its replacement.

The existing denture is an immediate temporary one to replace one or more natural teeth extracted while the person is covered, and cannot be made permanent, and replacement by a permanent denture is required. The replacement must take place within 12 months from the date of initial installation of the immediate temporary denture.

The extraction of a third molar does not qualify. Any such appliance or fixed bridge must include the replacement of an extracted tooth or teeth.

Tooth Missing But Not Replaced Rule - (This item does not apply to California or Texas residents under the DMO plan)
Coverage for the first installation of removable dentures; fixed bridgework and other prosthetic services is subject to the requirements that such removable dentures; fixed bridgework and other prosthetic services are (i) needed to replace one or more natural teeth that were removed while this policy was in force for the covered person; and (ii) are not abutments to a partial denture; removable bridge; or fixed bridge installed during the prior 5 years.

Alternate Treatment Rule: If more than one service can be used to treat a covered person's dental condition, Aetna may decide to authorize coverage only for a less costly covered service provided that all of the following terms are met:
(a) the service must be listed on the Dental Care Schedule;
(b) the service selected must be deemed by the dental profession to be an appropriate method of treatment; and
(c) the service selected must meet broadly accepted national standards of dental practice.

If treatment is being given by a participating dental provider and the covered person asks for a more costly covered service than that for which coverage is approved, the specific copayment for such service will consist of:
(a) the copayment for the approved less costly service; plus
(b) the difference in cost between the approved less costly service and the more costly covered service.

Reinstatement Rule: If your Employee and Dependents coverage terminates because your contributions are not paid when due, you may not be covered again for a period of two years from the date your coverage terminates. If you are in an eligible class, you may re-enroll yourself and your eligible dependents at the end of such two-year period. Your dental coverage will be effective as described in the Effective date of Coverage section of the Booklet-Certificate. Your dental coverage will be subject to any rules that apply to a person who enrolls after the first 31 days the person is eligible for the coverage.

Finding Participating Providers

Consult Aetna Dental's online provider directory, DocFind®, for the most current provider listings. Participating providers are independent contractors in private practice and are neither employees nor agents of Aetna Dental or its affiliates. The availability of any particular provider cannot be guaranteed, and provider network composition is subject to change without notice. Not every provider listed in the directory will be accepting new patients. Although Aetna Dental has identified providers who were not accepting patients in our DMO plan as known to Aetna Dental at the time the provider directory was created, the status of a provider's practice may have changed. For the most current information, please contact the selected provider or Aetna Member Services at the toll-free number on your ID card, or use our Internet-based provider directory (DocFind) available at www.aetna.com.

Specific products may not be available on both a self-funded and insured basis. The information in this document is subject to change without notice. In case of a conflict between your plan documents and this information, the plan documents will govern.

In the event of a problem with coverage, members should contact Member Services at the toll-free number on their ID cards for information on how to utilize the grievance procedure when appropriate.
All member care and related decisions are the sole responsibility of participating providers. Aetna Dental does not provide health care services and, therefore, cannot guarantee any results or outcomes.

Dental plans are provided or administered by Aetna Life Insurance Company, Aetna Dental Inc., Aetna Dental of California Inc. and/or Aetna Health Inc.

In Arizona, DMO®, Advantage Dental, Basic Dental and Family Preventive Dental Plans are provided or administered by Aetna Health Inc. In Texas, the Dental Preferred Provider Organization (PPO) is known as the Participating Dental Network (PDN), and Indemnity Dental plans are provided or administered by Aetna Life Insurance Company.

This material is for informational purposes only and is neither an offer of coverage nor dental advice. It contains only a partial, general description of plan or program benefits and does not constitute a contract. The availability of a plan or program may vary by geographic service area. Certain dental plans are available only for groups of a certain size in accordance with underwriting guidelines. Some benefits are subject to limitations or exclusions. Consult the plan documents (Schedule of Benefits, Certificate/Evidence of Coverage, Booklet, Booklet-Certificate, Group Agreement, Group Policy) to determine governing contractual provisions, including procedures, exclusions and limitations relating to your plan.

Keep your eyes healthy with ADP TOTAL SOURCE and VSP® Vision Care.

Why enroll in VSP? Your eyes deserve the best care to keep them healthy year after year. Plus with VSP, you'll get a great value on your eyecare and eyewear.

You'll like what you see with VSP.

- **Value and Savings.** You'll get great benefits on your exam and eyewear at an affordable price.
- **Personalized Care.** You'll get quality care that focuses on your eyes and overall wellness through a WellVision Exam® from a VSP doctor. When you see a VSP doctor, you'll get the most out of your benefit and have lower out-of-pocket costs. Plus, with a VSP doctor your satisfaction is guaranteed—if you're not 100% happy, we'll make it right.
- **Great Eyewear.** Choose the eyewear that's right for you and your budget.
- **Choice of Providers.** With open access to see any eyecare provider, you can see the one who's right for you. Choose a VSP doctor or any other provider.

Using your VSP benefit is easy.

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

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

Choice in Eyewear

From classic styles to the latest designer frames, you'll find hundreds of options. Choose from featured frame brands like bebe®, ck Calvin Klein, Flexon®, Lacoste, Michael Kors, Nike, Nine West, and more. Visit **vsp.com** to find a doctor who carries these brands.

Enroll in VSP today. You'll be glad you did.

Contact us.
vsp.com
800.877.7195

Your VSP Vision Benefits Summary

ADP TOTAL SOURCE and VSP provide you with an affordable eyecare plan.

VSP Coverage Effective Date: 06/01/2014
VSP Doctor Network: VSP Choice

Visit **vsp.com** for more details on your vision benefit and for exclusive savings and promotions for VSP members.

Benefit	Description	Copay	Frequency
Your Coverage with a VSP Doctor			
WellVision Exam	• Focuses on your eyes and overall wellness	$5	Every plan year*
Prescription Glasses		$10	See frame and lenses
Frame	• $180 allowance for a wide selection of frames • 20% off amount over your allowance	Included in Prescription Glasses	Every plan year
Lenses	• Single vision, lined bifocal, and lined trifocal lenses • Polycarbonate lenses for dependent children	Included in Prescription Glasses	Every plan year
Lens Options	• Standard progressive lenses • Premium progressive lenses • Custom progressive lenses • Average 20-25% off other lens options	$55 $95 - $105 $150 - $175	Every plan year
Contacts (instead of glasses)	• $150 allowance for contacts and contact lens exam (fitting and evaluation) • 15% off contact lens exam (fitting and evaluation)	$0	Every plan year
Laser VisionCare Preferred Program			
Laser VisionCare Preferred Program	• $150 allowance both eyes for LASIK, Custom LASIK, and PRK • Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities • After surgery, use your frame allowance (if eligible) for sunglasses from any VSP doctor	$0	Every plan year
Extra Savings and Discounts	**Glasses and Sunglasses** • 20% off additional glasses and sunglasses, including lens options, from any VSP doctor within 12 months of your last WellVision Exam.		

Your Coverage with Other Providers

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

Exam .....up to $45	Single Vision Lenses .....up to $45	Lined Trifocal Lenses .....up to $85	Contacts .....up to $150
Frame .....up to $70	Lined Bifocal Lenses .....up to $65	Progressive Lenses .....up to $65	

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

Enroll in VSP today.
You'll be glad you did.
Contact us. **vsp.com**
800.877.7195

IN THE BUSINESS OF YOUR SUCCESS℠

2014/2015

Plan Description: Basic Life $50K
Product: Life Plan

Provider: AETNA
Member Services: 1-800-554-1802 (Claim Submission & Eligibility Inquiries)
Life Claims Center: 1-800-523-5065 (Claim Status Inquiries)
Plan Website Address: www.Aetna Life Essentials.com

Eligibility	Covers a regular full-time or part-time employee eligible for the Basic plan who is residing or working in the United States; is working 30 hours or more per week; is in an eligible class; has satisfied the plan's Actively at Work Provision; and has satisfied the worksite employer's specified waiting period from the date of hire with the worksite employer.
Date Coverage Starts	Coverage starts on the first day of the month coinciding with or following completion of the worksite employer's waiting period; or the day the worksite employer becomes covered under the plan. If not actively at work on the effective date, coverage will not take effect until employee returns to active work for one full day.
Benefit Options	An amount equal to $50,000 for Life; $50,000 for Accidental Death & Personal Loss (AD&PL)
Age Reduction	Total amount of Term automatically reduces as follows: to 65% at age 65 to 69, to 50% at age 70 to 74,and to 35% at age 75 and over. Benefit Reduction Rule will be based on the employee's age as of the June 1st that coincides with or follows the member's date of birth.
Benefit Features	
Conversion	Employee will have the opportunity to convert their term life insurance to an individual policy at termination, if no longer eligible for coverage, or if coverage reduces due to age. There is a 60-day conversion application period. Should the employee die during the conversion period, benefits will be payable equal to the maximum amount the employee had a Right to Convert, whether or not he or she applied for an individual policy.
Portability	Employees can port their Life coverage and the Accidental Death rider in the same amount at termination. There is a 60-day application period for portability. Associates may NOT port coverage for themselves if they are sick or injured and away from active work when their life insurance coverage ends. Coverage ported will reduce starting at age 65 and reduced amounts may NOT be converted.
Accelerated Death Benefit (ADB)	If the employee has a terminal illness with a life expectancy of no longer than 24 months, the policy will pay, while employee is still alive, up to75% of the life insurance benefit up to a maximum of $500,000.00. This benefit can help with expenses not covered by the employee's medical plan, pay other bills, enable the employee to visit relatives and help the employee get his or her affairs in order. It pays an advance benefit and ensures that the employee's beneficiary will receive the rest of the life insurance benefit upon the employee's death. Repayment is not required should the employee recover within 24 months. The advance benefit may be requested once for the employee. The employee should consult with a tax advisor prior to making the request because the benefit received may be subject to income tax.
Passenger Restraint and Airbag	In the event that a covered person is properly using a passengers restraining device and an airbag is activated, and neither contributes to saving the person's life, this benefit will supplement the accidental death benefit.
Repatriation of Remains	In the unfortunate event that a covered person dies while 200 or more miles from home, this benefit offers financial assistance for preparation and return of the deceased's body to a mortuary. For additional benefit features, please refer to the Certificate of Coverage.
Premium Waiver	If the employee is less than age 60 and has been permanently and totally disabled for at least 6 months (as approved by Aetna), premium payments are waived until the employee recovers or reaches age 65.

This Benefits Highlight Sheet and the accompanying Brochure and Enrollment Form explain the general purpose of the insurance described, but in no way change or affect the policy as it is actually issued. In the event of any discrepancy between any of these documents and the policy, the terms of the policy apply. Complete coverage information is in the certificate of insurance booklet issued to each insured individual. Please read it carefully and keep it in a safe place with other important papers.

IN THE BUSINESS OF YOUR SUCCESS℠

2014/2015

Plan Description: LTD 60% $5,000/mo-180
Product: Long Term Disability

Provider: AETNA
Member Services Phone #: 1-800-554-1802
Disability Call Center: 1-888-200-6790 (Claims Submission/Status/Questions
Plan Website Address: www.AetnaLifeEssentials.com

This benefit option may not be available to all industries

Eligibility	Covers an active member of an employer that elected to provide LTD benefits to its employees under the Policyholder's Flexible Benefits Plan and is working 30 hours or more per week; is in an eligible class; has satisfied the plan's Actively at Work Provision; and has satisfied the worksite employer's specified waiting period from the date of hire with the worksite employer.
Date Coverage Starts	Coverage starts on the first day of the month coinciding with or next following completion of the worksite employer's waiting period; or day worksite employer becomes covered under the plan. If not actively at work on the effective date, coverage will not take effect until employee returns to active work for one full day.
Elimination Period	To be eligible for benefits, the employee must be out of work for 180 continuous days due to an occupational or non-occupational injury or illness.
Monthly Benefit	The plan provides income protection to replace up to 60% of the employee's pre-disability monthly earnings.
Minimum Monthly Benefit	$100 or 10% of gross monthly benefit level, whichever is greater.
Maximum Monthly Benefit	$5,000 *(combined with other income benefits, as specified, in the Certificate Booklet/ Summary).*
Benefit Duration	As long as the employee remains totally disabled, LTD benefit payments will continue according to the certificate booklet. **Normal retirement age means the Social Security normal retirement age as stated in the 1983 according revision of the United States Social Security Act.* ** Mental Health & Substance Abuse are limited to 24 months. See the Certificate Booklet/Summary for more details.*
Disability Provision	Own Occupation Period is the first 24 months for which LTD Benefits are paid. Any Occupation Period is from the end of the Own Occupation period to the end of the Maximum Benefit Period.
Feature and Limitations	
Rehabilitation	Our ultimate goal is to help the employee return to gainful employment. Our consultants review each Disability claim and determine if Aetna rehabilitation services would be appropriate and effective. After reviewing the employee's claim, if Aetna feels the employee would benefit from our services, we will contact the employee.
Pre-existing Conditions	A disease or injury if, during the 3 months prior to the employee's effective date of coverage: -it was diagnosed or treated; or -services were received for the diagnosis or treatment of the illness or injury; or the employee took drugs or -the employee took drugs or medicines prescribed or recommended by a physician for that condition and the employee has been covered under The Plan for 12 consecutive months.
Benefit Coordination & Deductible Income	LTD benefits are coordinated with Social Security, Workers Compensation, State or Federal government disability or retirement benefits. For details regarding coordination of benefits please refer to the Certificate Booklet/Summary
Conversion Option	None

This Benefits Highlight Sheet and the accompanying Brochure and Enrollment Form explain the general purpose of the insurance described, but in no way change or affect the policy as it is actually issued. In the event of any discrepancy between any of these documents and the policy, the terms of the policy apply. Complete coverage information is in the certificate of insurance booklet issued to each insured individual. Please read it carefully and keep it in a safe place with other important papers.