



ANDROSCOGGIN
Home Healthcare
+ Hospice

2022

EMPLOYEE BENEFITS GUIDE

*Regular Full Time and Part Time Employees
Effective January 1, 2022*

VARNEY
BENEFITS ADVISORS

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Overview

Providing employees with a comprehensive benefits package is an important priority of Androscoggin Home Healthcare + Hospice. This document provides an overview of your employee benefits and how to make the most of your coverage.

Eligibility

You and your dependents (varies by benefit) may participate in the following benefits if you are regular part-time or full-time employee regularly scheduled to work at least 20 hours per week:

- Health Insurance
- Dental Insurance
- Vision Insurance
- Flexible Spending Account (FSA)
- Basic Life & AD&D Insurance
- Voluntary Life & Voluntary AD&D Insurance
- Short Term Disability Insurance
- Voluntary Long Term Disability Insurance
- Employee Assistance Program (EAP)
- Voluntary Accident, Critical Illness, Hospital Indemnity

Dependents are defined as:

- Spouse or Domestic Partner, same or opposite sex.
- Employees and their domestic partner must sign an affidavit of domestic partnership. Please see Human Resources for this document.
- Premiums for a domestic partner are taken post-tax; the employer portion of premiums is considered imputed income and is also taxable to the employee.
- Children under the age of 26 years old.



Don't miss out: Open enrollment is the only time of the year that you can make changes to certain benefit elections unless you have a qualifying event.

There are a few opportunities to enroll in benefits:

New hire: At hire, employees eligible for insurance are immediately enrolled into the group/basic life insurance and short-term disability plans. Eligible exempt employees are also enrolled into the long-term disability plan. Eligibility for other benefits occurs on the first of the month following 30 days from your date of hire. You will have 30 days from your date of hire to make benefit elections.

Change in status: If your employment status at Androscoggin Home Healthcare + Hospice changes to regular part time or full time (i.e., you are regularly scheduled to work 20 hours per week or more), you will become eligible for benefits and you will have 30 days from the date of the status change to make benefit elections. Coverage begins the first of the month following 30 days from the date of the status change.

Open enrollment: During open enrollment employees can make changes to their benefit elections or enroll in new benefit programs. Information will be sent to all employees prior to the open enrollment dates that provide detailed instructions.

Qualified life event: If you experience a qualifying change in your life, you can make changes to certain benefits within 31 days of the event (or within 60 days if qualifying for Medicare or CHIP “Children’s Health Insurance Program” Page 24 for more information). Examples of qualified life events include:

- Marriage, divorce, or death of a spouse
- Birth or adoption of a child
- Change in your spouse’s or your enrollment status (e.g., full-time to part-time)
- Your spouse gains or loses coverage
- Turning 26 and losing health, dental, or vision coverage on a parent’s plan

For qualified life events, the change in coverage will occur the first of the month following the event. For the birth of a child, if you are enrolled in the medical plan, the child is covered the month of the birth. You will need to add the child to your plan and this will be effective first of the month following the birth.

How to Enroll

To enroll in benefits, you will log into your ADP account and make your benefit elections. Please contact your Human Resources Department to obtain more information.

Additional Benefit Information

Benefit related documents may be accessed through ADP. From the ADP Home Page, visit the Benefits Section. Please see a member of Human Resources if you have any questions.

Health Insurance

Health insurance provides coverage for medical expenses, including medications. Androscoggin Home Healthcare + Hospice offers two health plans Aetna: PPO 2000 and HDHP 3000.

Health Plan Summary

The table on the next page shows the comparison of the health plan options. The important points of both plans are summarized below.

- In order to receive the highest level of benefits under the Androscoggin Home Healthcare + Hospice medical plans, you must receive care from an in-network provider – that is, from a provider that participates in the Aetna network.
- You are not required to choose a primary care provider (PCP) to manage your care. However, it is recommended that you form a relationship with a personal doctor who will be able to assist you in managing your care.
- You are not required to obtain referrals in order to see specialty health care providers under a PPO plan.
- You can receive care from any licensed healthcare provider, including both those providers who are part of the plan's network of doctors, hospitals, and other healthcare providers, as well as providers who do not participate in the plan's network. Benefits paid at the out-of-network level will generally result in higher out-of-pocket cost for you.
- For those services that are paid subject to the deductible, you will be responsible for meeting the deductible each calendar year before any benefits will be paid.

Note that the tables on the following pages show only in-network benefits. You can obtain care from an out-of-network provider, but you will pay more out-of-pocket to do so. Please see the Summary of Benefits section or contact Human Resources to get more information about your out-of-network benefits.

Health Plan Comparison

The table below shows the comparison of the health plan options.

Comparison of In-Network Benefits

	HDHP 3000	PPO 2000
Deductible (Calendar Year)	Single - \$3,000 Family - \$6,000	Single - \$2,000 Family - \$4,000
Out-of-pocket maximum (Calendar Year)	Single - \$5,000 Family - \$10,000	Single - \$5,000 Family - \$10,000
Office visits	Deductible, then 20% Coinsurance	PCP - \$30 Copay Specialist - \$50 Copay
Preventive care	100% Covered	100% Covered
Urgent Care visits	Deductible, then 20% Coinsurance	\$50 Copay
Emergency Department visits	Deductible, then 20% Coinsurance	\$200 Copay
Inpatient hospital stay	Deductible, then 20% Coinsurance	Deductible, then 20% Coinsurance
Diagnostic test (X-ray, blood work)	Deductible, then 20% Coinsurance	Deductible, then 20% Coinsurance
Imaging (PET, MRI, CT Scan)	Deductible, then 20% Coinsurance	Deductible, then 20% Coinsurance
Mental health – in-patient	Deductible, then 20% Coinsurance	Deductible, then 20% Coinsurance
Mental health – office visits	Deductible, then 20% Coinsurance	\$50 Copay
Physical therapy, occupational therapy, or speech therapy (PT/OT/ST)*	Deductible, then 20% Coinsurance	\$50 Copay
Chiropractic Care*	Deductible, then 20% Coinsurance	\$50 Copay
Outpatient Surgery	Deductible, then 20% Coinsurance	Deductible, then 20% Coinsurance

*Calendar year limits apply



Know the lingo. You can find explanations of important terms in the glossary section of this benefits guide.

Comparison of Prescription Coverage Aetna Prescription Drug Formulary

	HDHP 3000		PPO 2000	
	30-day supply	90-day supply mail order	30-day supply	90-day supply mail order
Generic	Deductible, then \$20 Copay	Deductible, then \$40 Copay	\$20 Copay	\$40 Copay
Preferred Brand	Deductible, then \$30 Copay	Deductible, then \$60 Copay	\$30 Copay	\$60 Copay
Non-Preferred Brand	Deductible, then \$50 Copay	Deductible, then \$100 Copay	\$50 Copay	\$100 Copay
Specialty	Deductible, then \$250 Copay	N/A	\$250 Copay	N/A

*Deductible is waived for certain preventive medications on the HDHP 3000 Plan. Please see HR or the Aetna portal for the full listing of preventive medications.

*Advanced Control Formulary

Additional information on the Aetna plans may be found at the Androscoggin Home Healthcare + Hospice custom Aetna website: <https://www.aetnaresource.com/m/Androscoggin-Home-Health-Care-Hospice>

What is an HSA?

A health savings account (HSA) is a medical savings account that can be used with qualified high-deductible health plans (HDHP). To have an HSA, you must not be covered by Medicare (or any other Non-QDHP).

Androscoggin Home Healthcare + Hospice allows employees to set up an HSA account at the financial institution of your choice.

- To set up your account, contact your local bank or credit union.
- Once the account is set up, you can set up pre-tax payroll deductions for any amount to make contributions to your HSA.

When you or a dependent needs medical care, there are two ways that you can get reimbursed:

1. Utilize a debit card or check at the time of service.
 - Money will automatically be deducted from your HSA.
 - This is the most common and convenient method.
2. Pay out-of-pocket and obtain a detailed receipt.
 - Withdraw the money from your HSA account.



Save your receipt. When you reimburse yourself for a medical expense, you need to keep the receipt for tax purposes to show that it was a qualified expense. There is no time limit to reimburse yourself.

HSAs offer many benefits, including:

- **Contributions you make to your HSA are not subject to income tax up to the IRS limit.** IRS annual limits for 2022 are \$3,650 for individuals under the age of 55 and \$7,300 for a family. HSA holders older than 55 can contribute an extra \$1,000.
- **HSA funds carry over year-to-year and are owned by the individual.** HSA accounts offer much more flexibility than similar medical accounts, such as Flexible Spending Accounts (FSA). Any unused funds in your HSA account “rollover” every year. An HSA is also owned by you, meaning that you can keep the money in the account even if you are no longer employed at Androscoggin Home Healthcare + Hospice.
- **The money you withdraw for qualified medical expenses is not subject to income tax.** The funds in your HSA are available to you immediately and can be withdrawn at any time. If you choose to withdraw funds for any reason other than to reimburse yourself for a qualified medical expense, you will need to pay taxes on the amount of the withdrawal plus pay a penalty.
- **When you turn 65, the money in the account can be withdrawn for any reason with no penalty.** Many people use HSA accounts as part of their retirement

planning. Once you turn 65 there is no penalty to withdraw money from your HSA for any purpose.

- **The account can be used for some services that are not covered by the health plan.** Funds in the HSA account can be used for any qualified medical expense for either you or the dependents that may not be covered on your plan, which includes dental and vision expenses. For a complete list of qualified medical expenses, please visit: <https://www.irs.gov/publications/p502>

Which Plan is Right for Me?

Choosing the best health plan will depend on the health needs for you and your family. Depending on your situation, different aspects of the health plan coverage might be important to you, but a good place to start is to compare the differences in the **premiums**, **deductibles**, and **out-of-pocket maximums** for all the plans you are considering.

Below are some considerations as well as a sample expense comparison that can also help you make a more informed decision.

Things to consider when choosing a health plan:

- How many dependents will you be covering on the plan?
- Do you or a dependent have an ongoing health condition and you will incur medical expenses more quickly than you can fund an HSA?
- Do you anticipate a one-time medical expense that will cost more than the combined amount of the balance of your HSA from prior year contributions and the maximum you can contribute to your HSA on a tax-free basis (i.e., \$3,650 for individuals)?
- Do you prefer to pay lower health insurance premiums and make regular contributions to an HSA account instead?
- Do you like the flexibility and long-term investment benefits the HSA can provide?
- Do you or a dependent frequently seek care from a provider that would be considered out-of-network on any of the health plans?

Don't forget the tax savings. If you know you'll reach your deductible this year, you may wish to consider the HSA plan. Any money you contribute to your HSA account (up to the IRS maximum) is non-taxable income, which can save you money.

Dental Insurance

Dental insurance provides coverage for expenses related to your oral health, such as teeth cleaning and fillings. Androscoggin Home Healthcare + Hospice offers dental coverage through Aetna.

Description of Coverage

- Annual Calendar Year deductible of \$25 individual/\$75 family.
- Annual Benefit Maximum for the Calendar Year is \$1,000 per person.
- Lifetime Orthodontic Maximum is \$1,000 per person.
- Please log on to Aetna's website at www.aetna.com for more information.

Dental coverage through Aetna includes in and out of network benefits. While there are some in-network providers, please note that your dental offering with Aetna is a Passive PPO. This means that benefits are the same whether you are seeing an in-network or out of network provider. For out of network providers, claims are paid at the 95th percentile of the Usual and Customary Rate (UCR) for the geographic area of your provider. What does this mean to you? Minimal balance billing.

Summary of Dental Coverage

Benefit	Examples of Services	Plan pays:
Diagnostic and Preventive Services	Exams, 2 cleanings per year, bitewing x-rays, panoramic x-rays sealants, fluoride	<ul style="list-style-type: none">• 100%
Basic Services	Fillings, root canals, periodontics, routine extractions, oral surgery	<ul style="list-style-type: none">• 80%• Deductible applies
Major Services	Crowns, dentures, bridges	<ul style="list-style-type: none">• 50%• Deductible applies
Orthodontia	Correction of malposed (crooked) teeth; adults and children	<ul style="list-style-type: none">• 50%• Deductible does not apply• Up to a lifetime max of \$1,000

Vision Insurance

Vision insurance provides coverage for expenses related to your eye care, such as routine eye exams, contacts, and glasses. Androscoggin Home Healthcare + Hospice offers vision coverage through VSP.

Description of Coverage

- With the vision plan, you can see any eye care provider, but you will save money by going to a provider that is in-network.

Summary of In-Network Vision Benefits

Benefit	In-network	Frequency
Routine Eye Exams	\$10 Copay	One every 12 months
Eyeglass Frames	\$150 allowance, then 20% off any balance	One every 24 months
Eyeglass Lenses: Single, Bifocal, or Trifocal lenses	\$25 Copay	One every 12 months
Contact lenses (in lieu of eyeglass)	\$150 allowance	One every 12 months

*Please refer to the VSP website for information on out of network benefit reimbursements.

Flexible Spending Account

A Flexible Spending Account (FSA) allows you to save money on a pre-tax basis for eligible medical and/or dependent care expenses. Androscoggin Home Healthcare + Hospice offers a medical savings account, a dependent care savings account, and a limited-purpose medical savings account for people contributing to an HSA. All the FSAs are managed by Group Dynamic Inc.

Description of Benefit – Medical FSA

- You can contribute up to \$2,750 per year a pre-tax basis.
- This is a use-it-or lose it benefit. However, the unused balance in your account that remains at the end of a Plan Year may be used for expenses that you incur during the grace period. The grace period is the 2^{1/2}-month period after the end of the Plan Year.
- You are not eligible to participate in the medical FSA if you are contributing to an HSA account (but you can enroll in a limited-purpose FSA).
- Funds in this account can only be used for qualified medical expenses (which includes dental and vision).



When can I use my medical FSA? Examples of qualified medical expenses include:

- Acupuncture
- Chiropractic care
- Contact lenses and glasses (including readers)
- Diabetic testing supplies
- Eye exams
- Dental expenses
- Health plan co-payments and deductibles
- Hearing aids
- Medical monitoring & testing devices
- Orthopedic and surgical supports
- Prescription medications
- Walking aids and wheelchairs

For the complete list of eligible medical expenses, visit: <https://www.irs.gov/publications/p502>

Description of Benefit – Dependent Care FSA

A Dependent Care FSA can reimburse you for care provided to a dependent in order for you - and your spouse if you are married - to work or attend school.

- Available to all employees.
- You can contribute up to \$5,000 per year on a pre-tax basis.
- If you're married, filing single you can only contribute up to \$2,500.
- This is a use-it-or lose it benefit.

A dependent is defined as:

- A child under 13 that you claim on your federal tax return.
- A child over the age of 13 who is mentally or physically incapable of self-care.
- A parent who is unable to care for him/herself physically or mentally, needs full-time care, ***and*** depends on your financial support.

Description of Benefit – Limited Purpose FSA

- Available to employees contributing to an HSA account.
- You can contribute up to \$2,750 per year a pre-tax basis.
- This is a use-it-or lose it benefit. However, the unused balance in your account that remains at the end of a Plan Year may be used for expenses that you incur during the grace period. The grace period is the 2^{1/2}-month period after the end of the Plan Year.
- Funds in this account can only be used for a limited amount of qualified medical expenses, including post-deductible medical expenses, as well as expenses for dental, vision, and preventive care not covered by the health plan.

How do FSAs work?

FSA accounts are easy to use:

- Make contributions to your FSA through pre-tax payroll deductions.
- Specify any amount you wish to deduct on a per-payroll-period basis but *note that it cannot be changed during the benefit year.*

To get reimbursed from your ***Medical FSA account***:

- Use the Androscoggin Home Healthcare + Hospice Medical Debit Card and funds will be deducted directly from your FSA account; or
- Pay for the qualified expense out of your pocket at the time of service and then submit your claim to Group Dynamic to be reimbursed.

To get reimbursed from your ***Dependent Care FSA account***:

- Pay for the qualified expense at the time of service and get a receipt.
- Submit your claim to Group Dynamic to receive reimbursement.

Life Insurance/AD&D

Life insurance pays out a sum of money to your beneficiary(ies) in the event of your death. Accidental Death & Dismemberment (AD&D) is a limited form of life insurance that pays out in the event that the insured's death is an accident. AD&D also pays a benefit if you suffer a bodily injury that results in the loss of your hand, foot, or sight, or if you become paralyzed as the result of an accident. Androscoggin Home Healthcare + Hospice offers two types of life insurance: Basic Life Insurance with AD&D and Voluntary Life Insurance. These plans are offered through Unum.

Description of Benefit – Basic Life Insurance & AD&D

Regular part time and full-time employees who are regularly scheduled to work more than 20 hours per week are automatically enrolled in basic life insurance at no cost to the employee.

- Basic life insurance covers 2 times the equivalent of your annual salary rounded up to the next highest 1,000.
- The maximum benefit is \$200,000.
- Includes an equal amount of accidental death & dismemberment (AD&D) coverage.

Although you are enrolled automatically, you will still need to specify a beneficiary. Please see Human Resources to obtain the form.

Description of Benefit – Voluntary Life & Voluntary AD&D Insurance

You can purchase voluntary life and/or voluntary AD&D insurance for yourself, your spouse/domestic partner, and/or your child(ren). Below are the details of the coverage.

Voluntary Life Insurance Benefits

Covered Individual	Benefit Amount¹	Guaranteed Issue Amount²
Employee	\$10,000 increments, up to the lesser of \$500,000 or 5x annual salary	\$150,000
Spouse	\$5,000 increments, up to the lesser of 100% employee amount or \$500,000	\$25,000
Child	Live birth to 6 months - \$1,000 6 months to age 19, age 26 if full time student – increments of \$2,000 to a max of \$10,000	N/A

¹ Note that you cannot elect more coverage for your spouse or child than yourself. ² If you want to be insured for an amount greater than guaranteed issue, you must demonstrate proof of insurability.

Employees who are currently enrolled in voluntary life and wish to increase their amount of voluntary life insurance, may increase up to the guaranteed issue during the annual enrollment period without completing Evidence of Insurability (EOI). No medical questions will be asked. Pricing is based on age.

Voluntary AD&D Insurance Benefits

Covered Individual	Benefit Amount
Employee	\$10,000 increments, up to the lesser of \$500,000 or 5x annual salary
Spouse	\$5,000 increments, up to the lesser of 100% employee amount or \$500,000
Child	Live birth to 6 months - \$1,000 6 months to age 19, age 26 if full time student – increments of \$2,000 to a max of \$10,000

More information about costs can be found in the Benefit Plan Pricing section.

Disability Insurance

Androscoggin Home Healthcare + Hospice offers two types of disability insurance through Unum: short-term disability (STD) and long-term disability (LTD). Disability insurance replaces part of your income if you are unable to work for an extended period of time due to illness or injury.

Description of Coverage – Short-term Disability (STD)

STD is an insurance program that replaces a portion of your weekly income should you have a non-occupational sickness or injury and are unable to work. STD also provides a benefit for pregnancy-related claims. Once your claim is approved, benefits will begin after your elimination period and will continue through your plan's maximum duration. For further details and plan provisions, please refer to your insurance certificate. STD is an employer paid benefit.

- If you will be out of work for an extended period of time due to illness or injury, the first 14 days is considered an elimination period. During this time, you can use earned time or take unpaid leave; if your EBT is 2 weeks or less.
- Following the elimination period, you are eligible for short-term disability (STD).
- You are eligible to apply for long-term disability (LTD) benefits, when the STD benefit expires, if you have LTD coverage.

Summary of STD Coverage

	Coverage Details
Elimination Period	14 days if due to injury; 14 days if due to illness
Maximum Benefit	60% of income up to \$1,000 weekly
Benefit Duration	11 weeks
Benefit Taxation	Claim payments are tax free to employees
Pre-existing condition limitations	None

Description of Coverage – Voluntary Long-term Disability (LTD)

Voluntary LTD is an insurance program that replaces a portion of your monthly income should you have a sickness or injury and are unable to work. Voluntary LTD is designed to begin once you have exhausted your short-term disability benefits. Once your claim is approved, benefits will begin after your elimination period and may continue through your plan's maximum duration. For further details and plan provisions, please refer to your insurance certificate. Voluntary LTD is an employee paid benefit.

Summary of Voluntary LTD Coverage

	Coverage Details
Elimination Period	90 days
Maximum Benefit	60% of monthly income to a maximum of \$5,000
Benefit Duration	Benefits could be paid until you reach retirement age (according to Social Security)
Definition of Disability	24 Months Own Occupation
Benefit Taxation	Claim payments are tax free to employees
Pre-existing condition limitations	3/12*

**A pre-existing condition is an illness or injury for which you received treatment within the 3 months prior to your effective date of coverage. Disabilities that occur during the first 12 months of coverage due to a pre-existing condition are excluded.*

Why do I have to pay taxes on the disability premiums paid by my employer?

Your participation in the STD program is paid for by your employer, but the annual cost of this premium is taxable income. This is a benefit to you because when you pay taxes on the premium, any benefit payment you receive under the STD plan would be tax free.

Benefit Plan Pricing

Below you will find pricing information for all the benefit offerings described in this booklet. Note that the costs below reflect the deductions for each payroll period unless otherwise noted.

Pricing for Health, Dental, and Vision Insurance

Health Plan Payroll Biweekly Deductions (24 pay periods/year)

PPO 2000				
Hourly Status	Employee Only	Employee + Child(ren)	Employee + Spouse	Family
36-40	\$68.68	\$160.28	\$201.93	\$315.82
28-32	\$107.58	\$224.36	\$273.50	\$401.18
20-24	\$146.48	\$288.43	\$345.06	\$486.53

HDHP 3000				
Hourly Status	Employee Only	Employee + Child(ren)	Employee + Spouse	Family
36-40	\$15.64	\$57.29	\$78.83	\$153.63
28-32	\$46.00	\$108.02	\$135.47	\$221.19
20-24	\$76.80	\$158.75	\$192.13	\$288.75

Dental Plan Payroll Biweekly Deductions (24 pay periods/year)

	Deduction
Employee only	\$18.99
Employee + 1	\$39.64
Employee + 2 or more	\$67.62

Vision Plan Payroll Biweekly Deductions (24 pay periods/year)

	Deduction
Employee only	\$4.03
Employee + 1	\$5.84
Employee + 2 or more	\$10.48

*Note that payroll deductions are pre-tax. Portions attributed to domestic partners are post tax.

**Note that deductions will be taken in 24 pay periods/year, and not taken when there is a 3rd paycheck in a month.

Voluntary Long-Term Disability Pricing

The table below shows the payroll deductions for voluntary long-term disability coverage for each payroll period.

Rates shown are the monthly premiums. Your rate will increase as you move to the next age band.

Voluntary Long-Term Disability Cost of Coverage

Age Band	Monthly Rate per \$100 of Monthly Covered Earnings
0-24	\$0.24
25-29	\$0.40
30-34	\$0.73
35-39	\$1.08
40-44	\$1.72
45-49	\$2.24
50-54	\$2.75
55-59	\$3.40
60-64	\$3.43
65+	\$2.50

You can calculate your Voluntary Long-Term Disability premium by using the following formula:

- Use \$100,000 if your annual earnings exceed this amount. This is the maximum covered earnings under the plan.
- Multiply by your rate. Use the rate table to find the rate based on your age

Calculate your cost per paycheck				
\$ _____ / 100 = \$ _____ X \$ _____ = \$ _____ / 24 = \$ _____				
Your annual earnings		Rate	Number of paychecks	Total cost per paycheck

Basic Life and AD&D Insurance: Premiums are paid by your employer

Short Term Disability Insurance: Premiums are paid by your employer.

Voluntary Life and Voluntary AD&D Insurance Pricing

The table below shows the monthly pricing for voluntary life and voluntary AD&D coverage.
For voluntary life, your rate will increase as you move to the next age band.

Voluntary Life Monthly Pricing

Age Band	Employee per \$10,000	Spouse per \$5,000	Child per \$2,000
Up to 24	\$0.56	\$0.28	\$0.12
25-29	\$0.64	\$0.32	Applies to all covered children from live birth to age 19 / age 26 if a full-time student. The premium paid for child coverage is based on the cost of coverage for one child regardless of how many children you have.
30-34	\$0.79	\$0.395	
35-39	\$1.10	\$0.55	
40-44	\$1.52	\$0.76	
45-49	\$2.42	\$1.21	
50-54	\$3.71	\$2.85	
55-59	\$6.05	\$3.025	
60-64	\$9.67	\$4.835	
65-69	\$16.97	\$8.485	
70-74	\$30.63	\$15.315	
75-99	\$62.02	\$31.01	

**Please note: actual payroll deductions may vary slightly due to rounding.*

***Spouse coverage is based upon employee's age band.*

Voluntary AD&D Monthly Pricing

	Monthly Rate
Employee	\$0.15 per \$10,000
Spouse	\$0.075 per \$5,000
Child(ren)	\$0.03 per \$2,000

Calculate your costs:

1. Enter the coverage amount you want.
2. Divide by the amount shown.
3. Multiply by the rate. Use the rate table (above) to find the rate based on age.
4. Enter your cost. This is your monthly cost. Divide by 24 to determine payroll deduction.

	1	2	3	4
Employee	\$_____,000	/ \$10,000 = \$____	X \$____	= \$____
Spouse	\$_____,000	/ \$5,000 = \$____	X \$____	= \$____
Child	\$_____,000	/ \$2,000 = \$____	X \$____	= \$____
Total Monthly Cost				

Voluntary Benefits

Each year at Open Enrollment, Androscoggin Home Healthcare + Hospice offers employees the opportunity to enroll in Voluntary Benefits, which are insurance products that employees can elect to add to their plans to fill gaps created by unexpected medical bills or time away from work. These benefits are paid 100% by the employee, but the premiums can be set up as payroll deductions. They are all offered through Unum, and include accident, hospital, and critical illness coverage.

Please see the highlight sheets located in the back of this guide for information and pricing.

Employee Assistance Program (EAP)

An EAP is a program that helps employees and their family members resolve personal or work-related problems that may impact their job performance, physical health, or mental or emotional wellbeing. Androscoggin Home Healthcare + Hospice offers an EAP program through Unum that is designed to help employees with a variety of challenges.

A licensed professional counselor (3 in person visits are included) can help you with situations such as:

- Stress, depression, or anxiety
- Marital or relationship issues
- Job stress and work conflicts
- Family and parenting problems
- Addiction, eating disorders, and mental illness

You can also reach out to the EAP for assistance with work/life balance challenges. Work/Life specialists can help with questions about:

- Child care
- Elder care
- Legal issues
- Identity theft
- Financial planning, debt management, or credit report issues
- Reducing medical/dental bills

The EAP offers unlimited, **confidential**, 24/7 services to all employees as well as their dependents, parents, and parents-in-law.

To learn more, call 800-854-1446 or visit www.unum.com/lifebalance.



Androscoggin Home Healthcare
+ Hospice

Accident Insurance



How does it work?

Accident Insurance can pay a set benefit amount based on the type of injury you have and the type of treatment you need. It covers accidents that occur on and off the job. And it includes a range of incidents, from common injuries to more serious events.

What's included?

Be Well Benefit

Every year, each family member who has Accident coverage can also receive \$50 for getting a covered Be Well screening test, such as:

- Annual exams by a physician include sports physicals, well-child visits, dental and vision exams
- Screenings for cancer, including pap smear, colonoscopy
- Cardiovascular function screenings
- Screenings for cholesterol and diabetes
- Imaging studies, including chest X-ray, mammography
- Immunizations including HPV, MMR, tetanus, influenza



Why is this coverage so valuable?

- It can help you with out-of-pocket costs that your medical plan doesn't cover, like co-pays and deductibles.
- You're guaranteed base coverage, without answering health questions.
- The cost is conveniently deducted from your paycheck.
- You can keep your coverage if you change jobs or retire. You'll be billed directly.

Who can get coverage?

You	If you're actively at work*
Your spouse	Can get coverage as long as you have purchased coverage for yourself.
Your children	Dependent children from birth until their 26th birthday, regardless of marital or student status.

*Employees must be legally authorized to work in the United States and actively working at a U.S. location to receive coverage. Spouses and dependent children must reside in the United States to receive coverage.

How much does it cost?

Your monthly premium	Option 1
You	\$12.95
You and your spouse	\$22.86
You and your children	\$29.31
Family	\$39.22

Active employment: You are considered in active employment if, on the day you apply for coverage, you are being paid regularly for the required minimum 20 hours each week and you are performing the material and substantial duties of your regular occupation. Insurance coverage will be delayed if you are not in active employment because of an injury, sickness, temporary layoff, or leave of absence on the date that insurance would otherwise become effective. New employees have a 0 day waiting period to be eligible for coverage. Please contact your plan administrator to confirm your eligibility date. If enrolling, and eligible for Medicare (age 65+; or disabled) the Guide to Health Insurance for People with Medicare is available at www.medicare.gov/media/9486. See Schedule of Benefits for a complete listing of what is covered.

SCHEDULE OF BENEFITS

Accidental Death and Dismemberment

AD&D	
Employee	\$50,000
Spouse	\$25,000
Children	\$12,500
Common Carrier Benefit can pay if the insured individual is injured as a fare-paying passenger on a common carrier (examples include mass transit trains, buses and planes)	
Employee	\$50,000
Spouse	\$25,000
Children	\$12,500
Dismemberment	
Both Feet	\$50,000
Both Hands	\$50,000
One Foot	\$25,000
One Hand	\$25,000
Thumb and Index Finger of the same Hand	\$12,500
Coma	
Coma	\$10,000
Loss of Use	
Hearing	\$25,000
Sight of one Eye	\$25,000
Sight of both Eyes	\$50,000
Speech	\$25,000
Paralysis	
Uniplegia	\$12,500
Hemi/Paraplegia	\$25,000
Triplegia	\$37,500
Quadriplegia	\$50,000

Hospitalization

Admission	\$1,000
Admission – Hospital ICU	\$1,500
Daily Stay (amount)	\$200
Daily Stay – Hospital ICU (amount)	\$400
Short Stay	\$200

Injury

Burns	
2nd Degree Burns - At least 5%, but less than 20% of skin surface	\$500
2nd Degree Burns - 20% or greater of skin surface	\$1,000
3rd Degree Burns - Less than 5% of skin surface	\$2,000
3rd Degree Burns - At least 5%, but less than 20% of skin surface	\$5,000

Injury

3rd Degree Burns - 20% or greater of skin surface	\$10,000
Concussion	
Concussion	\$200
Connective Tissue Damage	
One Connective Tissue (tendon, ligament, rotator cuff, muscle)	\$90
Two or more Connective Tissues (tendon, ligament, rotator cuff, muscle)	\$150
Dislocations	
Knee joint (other than patella)	\$1,650
Ankle bone or bones of the foot (other than toes)	\$1,650
Hip joint	\$3,375
Collarbone (sternoclavicular)	\$825
Elbow joint	\$500
Hand (other than Fingers)	\$500
Lower Jaw	\$500
Shoulder	\$500
Wrist joint	\$500
Collarbone (acromioclavicular and separation)	\$325
Finger or Toe (Digit)	\$150
Kneecap (patella)	\$500
Incomplete Dislocation - Payable as a % of the applicable Dislocations benefit	25%
Eye Injury	
Eye Injury	\$200
Fractures	
Skull (except bones of Face or Nose), Depressed	\$4,500
Hip or Thigh (femur)	\$3,375
Skull (except bones of Face or Nose), Non-depressed	\$2,250
Vertebrae, body of (other than Vertebral Processes)	\$1,350
Leg (mid to upper tibia or fibula)	\$1,350
Pelvis	\$1,350
Bones of the Face or Nose (other than Lower Jaw, Mandible or Upper Jaw, Maxilla)	\$675
Upper Arm between Elbow and Shoulder (humerus)	\$675
Upper Jaw, Maxilla (other than alveolar process)	\$675
Ankle (lower tibia or fibula)	\$450

Injury

Collarbone (clavicle, sternum) or Shoulder Blade (scapula)	\$450
Foot or Heel (other than Toes)	\$450
Forearm (olecranon, radius, or ulna), Hand, or Wrist (other than Fingers)	\$450
Kneecap (patella)	\$450
Lower Jaw, Mandible (other than alveolar process)	\$450
Vertebral Processes	\$450
Rib	\$450
Tailbone (coccyx), Sacrum	\$450
Finger or Toe (Digit)	\$225
Chip Fracture - Payable as a % of the applicable Fractures benefit	25%
Same bone maximum incurred per accident	1 Fracture
Maximum payable multiplier for multiple bones	2 Times
Internal Injuries	
Internal Injuries	\$200
Lacerations	
No Repair	\$50
Repair Less than 2 inches	\$150
Repair At least 2 inches but less than 6 inches	\$300
Repair 6 inches or greater	\$600
Loss of a Digit	
One Digit (other than a Thumb or Big Toe)	\$750
One Digit (a Thumb or Big Toe)	\$1,125
Two or more Digits	\$1,500
Knee Cartilage	
Knee Cartilage (Meniscus) Injury	\$150
Ruptured or Herniated Disc	
One Disc	\$150
Two or more Discs	\$250
Recovery	
At-Home Care	\$100
Physician Follow-Up Visits	\$75
Physician Follow-Up Maximum Visits	2 Visits
Prescription Drug	\$25
Prescription Benefit Incidence per covered accident	1 Per Insured
Rehabilitation or Subacute Rehabilitation Unit	\$100
Therapy Services (chiro, speech, PT, occ)	\$20

SCHEDULE OF BENEFITS

Recovery

Therapy Services Maximum Days	15 Days
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Surgery

Dislocations	
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Dislocation, Surgical Repair - Payable as a % of the applicable Injury benefit	100%
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Anesthesia	
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Epidural or Regional Anesthesia	\$100
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General Anesthesia	\$250
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Connective Tissue	
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Exploratory without Repair	\$100
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Repair for One Connective Tissue	\$800
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Repair for Two or more Connective Tissues	\$1,200
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Eye Surgery	
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Eye Surgery, Requiring Anesthesia	\$300
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Fractures	
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Fractures, Surgical Repair - Payable as a % of the applicable Injury benefit	100%
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Surgical Repair same bone maximum incurred per accident	1 Fracture
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Surgical Repair same bone maximum payable multiplier for multiple bones	2 Times
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General Surgery	
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Abdominal, Thoracic, or Cranial	\$1,500
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Exploratory	\$150
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Incidence per covered accident	1 Per Insured
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Hernia Surgery	
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Hernia Surgery	\$150
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Knee Cartilage	
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Knee Cartilage (Meniscus) Exploratory without Repair	\$150
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Knee Cartilage (Meniscus) with Repair	\$750
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Outpatient Surgical Facility	
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Outpatient Surgical Facility	\$300
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Ruptured or Herniated Disc Surgery	
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Exploratory without Repair	\$125
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One Disc	\$675
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Two or more Discs	\$1,000
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Treatment

Ambulance	
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Air	\$1,500
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Ground	\$400
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Treatment

Durable Medical Equipment	
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Tier 1 (arm sling, cane, medical ring cushion)	\$50
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Tier 2 (bedside commode, cold therapy system, crutches)	\$100
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Tier 3 (back brace, body jacket, continuous passive movement, electric scooter)	\$200
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Emergency Dental Repair	
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Dental Crown	\$350
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Dental Extraction	\$115
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Filling or Chip Repair	\$90
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Imaging	
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Tier 1: X-rays or Ultrasound	\$50
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Tier 2: Bone Scan, CAT, CT, EEG, MR, MRA, or MRI	\$100
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Medical Imaging Incidence allowance covered accident per Tier	1 Per Insured Per Tier
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Lodging	
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Lodging (per night)	\$150
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Prosthetic Device	
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One Device or Limb	\$750
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Two or more Devices or Limbs	\$1,500
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Skin Grafts	
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For Burns - Payable as a % of the applicable Burn benefit	50%
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Not Burns - Less than 20% of skin surface	\$250
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Not Burns - 20% or greater of skin surface	\$500
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Treatment	
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Emergency Room Treatment	\$100
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Injections to Prevent or Limit Infection (tetanus, rabies, antivenom, immune globulin)	\$50
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Pain Management Injections (epidural, cortisone, steroid)	\$100
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Transfusions	\$400
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Transportation (per trip)	\$100
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Treatment in a Physician's Office or Urgent Care Facility (initial)	\$75
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Effective date of coverage

Coverage becomes effective on the first day of the month in which payroll deductions begin.

Exclusions and limitations

We will not pay benefits for a claim that is caused by, contributed to by, or occurs as the result any of the following:

- committing or attempting to commit a felony;
- being engaged in an illegal occupation or activity;
- injuring oneself intentionally or attempting or committing suicide, whether sane or not;
- active participation in a riot, insurrection, or terrorist activity. This does not include civil commotion or disorder, Injury as an innocent bystander, or Injury for self-defense;
- participating in war or any act of war, whether declared or undeclared;
- combat or training for combat while serving in the armed forces of any nation or authority, including the National Guard, or similar government organizations;
- a Covered Loss that occurs while an Insured is legally incarcerated in a penal or correctional institution;
- elective procedures, cosmetic surgery, or reconstructive surgery unless it is a result of trauma, infection, or other diseases; However, if an Insured sustains an Injury while performing their Regular Occupation, this will be considered a Covered Accident only for partners or sole proprietors Insureds who cannot be covered by workers' compensation;
- any Sickness, bodily infirmity, or other abnormal physical condition or Mental or Nervous Disorders, including diagnosis, treatment, or surgery for it;
- Infection. This exclusion does not apply when the infection is due directly to a cut or wound sustained in a Covered Accident;
- experimental or investigational procedures;
- operating any motorized vehicle while intoxicated;
- operating, learning to operate, serving as a crew member of any aircraft or hot air balloon, including those which are not motor-driven, unless flying as a fare paying passenger;
- jumping, parachuting, or falling from any aircraft or hot air balloon, including those which are not motor-driven;
- travel or flight in any aircraft or hot air balloon, including those which are not motor-driven, if it is being used for testing or experimental purposes, used by or for any military authority, or used for travel beyond the earth's atmosphere; practicing for or participating in any semi-professional or professional competitive athletic contests for which any type of compensation or remuneration is received;
- riding or driving an air, land or water vehicle in a race, speed or endurance contest; and
- engaging in hang-gliding, bungee jumping, sail gliding, parasailing, parakiting, or BASE jumping.

The Accidental Death and Dismemberment Benefits are also subject to the following Exclusions. We will not pay benefits for a claim that is caused by, contributed to by, or resulting from any of the following:

- being intoxicated; and
 - voluntary use of or treatment for voluntary use of any prescription or non-prescription drug, intoxicant, poison, fume, or other chemical substance unless taken as prescribed or directed by the Insured's Physician.
- Additionally, no benefits will be paid for a Covered Loss that occurs prior to the Coverage Effective Date.

Termination of employee coverage

If you choose to cancel your coverage your coverage ends on the first of the month following the date you provide notification to your employer. Otherwise, your coverage ends on the earliest of the:

- the date this policy is canceled by Unum or your employer;
- the date you are no longer in an eligible group;
- the date your eligible group is no longer covered;
- the date of your death;
- the last day of the period any required premium contributions are made;
- the last day you are in active employment.

However, as long as premium is paid as required, coverage will continue

- in accordance with the Continuation of your Coverage during Absences provision; or
- if you elect to continue coverage for you, your Spouse, and Children under Portability of Accident Insurance.

We will provide coverage for a Payable Claim that occurs while you are covered under this certificate

Accident Insurance

THIS IS A LIMITED BENEFITS POLICY

This information is not intended to be a complete description of the insurance coverage available. The policy or its provisions may vary or be unavailable in some states. The policy has exclusions and limitations which may affect any benefits payable. For complete details of coverage and availability, please refer to Policy Form GAP16-1 et al. or contact your Unum representative.

Unum complies with state civil union and domestic partner laws when applicable.

Underwritten by: Unum Insurance Company, Portland, Maine

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Hospital Insurance



How does it work?

Hospital Insurance helps covered employees and their families cope with the financial impacts of a hospitalization. You can receive benefits when you're admitted to the hospital for a covered accident, illness or childbirth.

Why is this coverage so valuable?

- The money is paid directly to you — not to a hospital or care provider. The money can also help you pay the out-of-pocket expenses your medical plan may not cover, such as co-insurance, co-pays and deductibles.
- You get affordable rates when you buy this coverage at work.
- The cost is conveniently deducted from your paycheck.
- The benefits in this plan are compatible with a Health Savings Account (HSA).
- You may take the coverage with you if you leave the company or retire, without having to answer new health questions. You'll be billed directly.

Be Well Benefit

Every year, each family member who has Hospital coverage can also receive \$50 for getting a covered Be Well screening test, such as:

- Annual exams by a physician include sports physicals, wellchild visits, dental and vision exams
- Screenings for cancer, including pap smear, colonoscopy
- Cardiovascular function screenings
- Screenings for cholesterol and diabetes
- Imaging studies, including chest X-ray, mammography
- Immunizations including HPV, MMR, tetanus, influenza

Hospital Insurance can pay benefits that help you with the costs of a covered hospital visit.

Who can get coverage?

You:	If you're actively at work.
Your spouse:	Can get coverage as long as you have purchased coverage for yourself.
Your children:	Dependent children newborn until their 26th birthday, regardless of marital or student status

Employee must purchase coverage for themselves in order to purchase spouse or child coverage. Employees must be legally authorized to work in the United States and actively working at a U.S. location to receive coverage. Spouses and dependent children must reside in the United States to receive coverage.

How much does it cost?

Your monthly premium	
You	\$34.48
You and your spouse	\$62.87
You and your children	\$48.77
Family	\$77.15

Please refer to the certificate for complete definitions about these covered conditions. Coverage may vary by state. See exclusions and limitations.

This plan has a childbirth limitation. See disclosures for more information.

If enrolling, and eligible for Medicare (age 65+; or disabled) the Guide to Health Insurance for People with Medicare is available at www.medicare.gov/media/9486.

Hospital		
Hospital Admission	Payable for a maximum of 1 day per year	\$1,500
ICU Admission	Payable for a maximum of 1 day per year	\$1,000
Hospital Daily Stay	Payable per day up to 365 days	\$100
ICU Daily Stay	Payable per day up to 15 days	\$200
Short Stay	Payable for a maximum of 1 day per year	\$250
Other Benefits		
Well Child Benefit	Payable for maximum of 4 days per child before child reaches age 1	\$50

Exclusions and Limitations

Hospital insurance filed policy name is Group Hospital Indemnity Insurance Policy

Active employment

You are considered in active employment if, on the day you apply for coverage, you are being paid regularly for the required minimum 20 hours per week and you are performing the material and substantial duties of your regular occupation. Insurance coverage will be delayed if you are not in active employment because of an injury, sickness, temporary layoff, or leave of absence on the date that insurance would otherwise become effective. New employees have a 0 day waiting period to be eligible for coverage. Please contact your plan administrator to confirm your eligibility date.

Continuity of coverage

We will provide coverage for an Insured if the Insured was covered by a similar prior policy on the day before the Policy Effective Date. Coverage is subject to payment of premium and all other terms of the certificate. If an employee is on a temporary Layoff or Leave of Absence on the Policy Effective Date of this certificate, we will consider your temporary Layoff or Leave of Absence to have started on that date and coverage will continue for the period provided temporary Layoff or Leave of Absence under Continuation of your Coverage During Extended Absences in the certificate. If you have not returned to Active Employment before any Insured's covered loss, any benefits payable will be limited to what would have been paid by the prior carrier.

Childbirth Limitation

We will not pay benefits due to Childbirth for any Insured within the first nine months after the Insured's Coverage Effective Date. Childbirth or Complications of Pregnancy will be covered to the same extent as any other Covered Sickness.

Exclusions and limitations

Unum will not pay benefits for a claim that is caused by, contributed to by, or resulting from any of the following:

- Committing or attempting to commit a felony;
- Being engaged in an illegal occupation or activity;
- Injuring oneself intentionally or attempting or committing suicide, whether sane or not;
- Active participation in a riot, insurrection, or terrorist activity. This does not include civil commotion or disorder, Injury as an innocent bystander, or Injury for self-defense;
- Participating in war or any act of war, whether declared or undeclared;
- Combat or training for combat while serving in the armed forces of any nation or authority, including the National Guard, or similar government organizations;
- Being intoxicated;
- A Covered Loss that occurs while an Insured is legally incarcerated in a penal or correctional institution;
- Elective procedures, cosmetic surgery, or reconstructive surgery unless it is a result of organ donation, trauma, infection, or other diseases;
- Treatment for dental care or dental procedures, unless treatment is the result of a Covered Accident;
- Any Admission or Daily Stay of a newborn Child immediately following Childbirth unless the newborn is Injured or Sick;
- Voluntary use of or treatment for voluntary use of any prescription or non-prescription drug, alcohol, poison, fume, or other chemical substance unless taken as prescribed or directed by the Insured's Physician; and
- Mental or Nervous Disorders. This exclusion does not include dementia if it is a result of:
- Stroke, Alzheimer's disease, trauma, viral infection; or
- Other conditions which are not usually treated by a mental health provider or other qualified provider using psychotherapy, psychotropic drugs, or other similar methods of treatment.

Additionally, no benefits will be paid for a Covered Loss that occurs prior to the Coverage Effective Date.

End of employee coverage

If you choose to cancel your coverage under this certificate, your coverage will end on the first of the month following the date you provide notification to your Employer. Otherwise, your coverage under this certificate ends on the earliest of:

- the date the Policy is cancelled by us or your Employer;
- the date you are no longer in an Eligible Group;
- the date your Eligible Group is no longer covered;
- the date of your death;
- the last day of the period any required premium contributions are made; or
- the last day you are in Active Employment.

However, as long as premium is paid as required, coverage will continue in accordance with the Continuation of your Coverage During Absences provision or if you elect to continue coverage for you under Portability of Hospital

Indemnity Insurance. We will provide coverage for a Payable Claim that occurs while you are covered under this certificate. THIS INSURANCE PROVIDES LIMITED BENEFITS This coverage is a supplement to health insurance. It is not a substitute for comprehensive health insurance and does not qualify as minimum essential health coverage as defined in federal law. Some states may require individuals to have comprehensive medical coverage before purchasing hospital insurance. This information is not intended to be a complete description of the insurance coverage available. The policy or its provisions may vary or be unavailable in some states. The policy has exclusions and limitations which may affect any benefits payable. For complete definitions of coverage and availability, please refer to Certificate Form GHIP16-1 or contact your Unum representative. Unum complies with all state civil union and domestic partner laws when applicable.

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Critical Illness Insurance

can pay money directly to you when you're diagnosed with certain serious illnesses.

How does it work?

If you're diagnosed with an illness that is covered by this insurance, you can receive a lump sum benefit payment. You can use the money however you want.

Why is this coverage so valuable?

- The money can help you pay out-of-pocket medical expenses, like co-pays and deductibles.
- You can use this coverage more than once.
Even after you receive a payout for one illness, you're still covered for the remaining conditions and for the reoccurrence of any critical illness with the exception of skin cancer. The reoccurrence benefit pays 100% of your coverage amount. Diagnoses must be at least 180 days apart or the conditions can't be related to each other.

What's covered?

Critical illnesses	
<ul style="list-style-type: none"> • Heart attack • Stroke • Major organ failure • End-stage kidney failure 	<ul style="list-style-type: none"> • Coronary artery disease Major (50%): Coronary artery bypass graft or valve replacement • Minor (10%): Balloon angioplasty or stent placement
Cancer conditions	
<ul style="list-style-type: none"> • Invasive cancer — all breast cancer is considered invasive 	<ul style="list-style-type: none"> • Non-invasive cancer (25%) • Skin cancer — \$500
Progressive diseases	Supplemental conditions
<ul style="list-style-type: none"> • Amyotrophic Lateral Sclerosis (ALS) • Dementia, including Alzheimer's disease • Multiple Sclerosis (MS) • Parkinson's disease • Functional loss 	<ul style="list-style-type: none"> • Loss of sight, hearing or speech • Benign brain tumor • Coma • Permanent Paralysis • Occupational HIV, Hepatitis B, C or D • Infectious Diseases (25%)

Why should I buy coverage now?

- It's more affordable when you buy it through your employer and the premiums are conveniently deducted from your paycheck.
- Coverage is portable. You may take the coverage with you if you leave the company or retire. You'll be billed at home.

Be Well Benefit

Every year, each family member who has Critical Illness coverage can also receive a payment for getting a covered Be Well Benefit screening test, such as:

- Annual exams by a physician include sports physicals, well-child visits, dental and vision exams
- Screenings for cancer, including pap smear, colonoscopy
- Cardiovascular function screenings
- Screenings for cholesterol and diabetes
- Imaging studies, including chest X-ray, mammography
- Immunizations including HPV, MMR, tetanus, influenza

Who can get coverage?

You:	Choose \$10,000, \$20,000 or \$30,000 of coverage with no medical questions if you apply during this enrollment.
Your spouse:	Spouses can get 50% of the employee coverage amount as long as you have purchased coverage for yourself.
Your children:	Children from live birth to age 26 are automatically covered at no extra cost. Their coverage amount is 50% of yours. They are covered for all the same illnesses plus these specific childhood conditions: cerebral palsy, cleft lip or palate, cystic fibrosis, Down syndrome and spina bifida. The diagnosis must occur after the child's coverage effective date.

Active employment: You are considered in active employment if, on the day you apply for coverage, you are being paid regularly for the required minimum 20 hours each week and you are performing the material and substantial duties of your regular occupation. Insurance coverage will be delayed if you are not in active employment because of an injury, sickness, temporary layoff, or leave of absence on the date that insurance would otherwise become effective. New employees have a day waiting period to be eligible for coverage. Please contact your plan administrator to confirm your eligibility date.

If enrolling, and eligible for Medicare (age 65+; or disabled) the Guide to Health Insurance for People with Medicare is available at www.medicare.gov/media/9486.

Please refer to the certificate for complete definitions about these covered conditions. Coverage may vary by state. See exclusions and limitations.

Critical Illness Insurance benefit and cost

Monthly costs		
Age	Employee coverage: \$10,000 Spouse coverage: \$5,000 Be Well benefit: \$50	
	Employee	Spouse
under 25	\$3.86	\$2.86
25 - 29	\$4.66	\$3.26
30 - 34	\$5.76	\$3.81
35 - 39	\$7.66	\$4.76
40 - 44	\$9.96	\$5.91
45 - 49	\$12.76	\$7.31
50 - 54	\$15.36	\$8.61
55 - 59	\$20.16	\$11.01
60 - 64	\$27.66	\$14.76
65 - 69	\$40.26	\$21.06
70 - 74	\$63.66	\$32.76
75 - 79	\$95.76	\$48.81
80 - 84	\$141.66	\$71.76
85+	\$229.96	\$115.91

Monthly costs		
Age	Employee coverage: \$20,000 Spouse coverage: \$10,000 Be Well benefit: \$75	
	Employee	Spouse
under 25	\$7.72	\$5.72
25 - 29	\$9.32	\$6.52
30 - 34	\$11.52	\$7.62
35 - 39	\$15.32	\$9.52
40 - 44	\$19.92	\$11.82
45 - 49	\$25.52	\$14.62
50 - 54	\$30.72	\$17.22
55 - 59	\$40.32	\$22.02
60 - 64	\$55.32	\$29.52
65 - 69	\$80.52	\$42.12
70 - 74	\$127.32	\$65.52
75 - 79	\$191.52	\$97.62
80 - 84	\$283.32	\$143.52
85+	\$459.92	\$231.82

Monthly costs		
Age	Employee coverage: \$30,000 Spouse coverage: \$15,000 Be Well benefit: \$100	
	Employee	Spouse
under 25	\$11.58	\$8.58
25 - 29	\$13.98	\$9.78
30 - 34	\$17.28	\$11.43
35 - 39	\$22.98	\$14.28
40 - 44	\$29.88	\$17.73
45 - 49	\$38.28	\$21.93
50 - 54	\$46.08	\$25.83
55 - 59	\$60.48	\$33.03
60 - 64	\$82.98	\$44.28
65 - 69	\$120.78	\$63.18
70 - 74	\$190.98	\$98.28
75 - 79	\$287.28	\$146.43
80 - 84	\$424.98	\$215.28
85+	\$689.88	\$347.73

Pre-existing conditions

We will not pay benefits for a claim when the Covered Loss occurs in the first 6 months following an Insured's Coverage Effective Date and the Covered Loss is caused by, contributed to by or occurs as the result of any of the following:

- a Pre-existing Condition; or
- complications arising from treatment or surgery for, or medications taken for, a Pre-existing Condition.

An Insured has a Pre-existing Condition if, within the 6 months just prior to their Coverage Effective Date, they have an Injury or Sickness, whether diagnosed or not, for which:

- medical treatment, consultation, care or services, or diagnostic measures were received or recommended to be received during that period; or
- drugs or medications were taken, or prescribed to be taken during that period; or
- symptoms existed; or

The Pre-existing Condition provision applies to any Insured's initial coverage and any increases in coverage. Coverage Effective Date refers to the date any initial coverage or increases in coverage become effective.

Pre-existing Condition requirements are not applicable to children who are newly acquired after your Coverage Effective Date.

Continuity of coverage

We will provide coverage for an Insured if the Insured was covered by a similar prior policy on the day before the Policy Effective Date. Coverage is subject to payment of premium and all other terms of the certificate. If an employee is on a temporary Layoff or Leave of Absence on the Policy Effective Date of this certificate, we will consider your temporary Layoff or Leave of Absence to have started on that date and coverage will continue for the period provided temporary Layoff or Leave of Absence under Continuation of your Coverage During Extended Absences in the certificate. If you have not returned to Active Employment before any Insured's Date of Diagnosis, any benefits payable will be limited to what would have been paid by the prior carrier.

If the Employer replaces a critical illness policy with this Policy, or the employee becomes insured due to a merger, acquisition or affiliation, and the prior carrier's pre-existing condition requirement has been satisfied, the Pre-existing Condition requirement under this coverage will not apply. However, if the Unum certificate provides a higher level of coverage at the time it becomes effective, its Pre-existing Condition requirement will apply to any increase in coverage. If the prior carrier's pre-existing condition requirement has not been satisfied, periods of coverage applicable to the prior carrier's Pre-existing Condition will count towards satisfying the Pre-existing Condition requirement under this coverage.

Date of diagnosis must be after the coverage effective date.

Exclusions and limitations

Unum will not pay benefits for a claim that is caused by, contributed to by, or occurs as a result of any of the following:

committing or attempting to commit a felony; being engaged in an illegal occupation or activity; injuring oneself intentionally or attempting or committing suicide, whether sane or not; active participation in a riot, or insurrection. This does not include civil commotion or disorder, injury as an innocent bystander, or injury for self-defense; participating in war or any act of war, whether declared or undeclared; combat or training for combat while serving in the armed forces of any nation or authority, including the National Guard, or similar government organizations; voluntary use of or treatment for voluntary use of any prescription or non-prescription drug, alcohol, poison, fume, or other chemical substance unless taken as prescribed or directed by the insured's physician; being intoxicated; and a Date of Diagnosis that occurs while an insured is legally incarcerated in a penal or correctional institution.

Additionally, no benefits will be paid for a Date of Diagnosis that occurs prior to the Coverage Effective Date.

End of employee coverage

If you choose to cancel your coverage your coverage ends on the first of the month following the date you provide notification to your employer. Otherwise, your coverage ends on the earliest of the: date this policy is canceled by Unum or your employer; date you are no longer in an eligible group; date your eligible group is no longer covered; date of your death; last day of the period any required premium contributions are made; or last day you are in active employment.

However, as long as premium is paid as required, coverage will continue in accordance with the Continuation of your Coverage during Absences provision or if you elect to continue coverage for you, your Spouse, and Children under Portability of Critical Illness Insurance.

Unum will provide coverage for a payable claim that occurs while you are covered under this certificate.

THIS INSURANCE PROVIDES LIMITED BENEFITS

This information is not intended to be a complete description of the insurance coverage available. The policy or its provisions may vary or be unavailable in some states. The policy has exclusions and limitations which may affect any benefits payable. For complete details of coverage and availability, please refer to Policy Form GCIP16-1 or the Certificate Form GCIC16-1 or contact your Unum representative.

Underwritten by: Unum Insurance Company, Portland, Maine

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Should you buy Cancer Insurance?

Cancer Insurance Is Not A Substitute for Comprehensive Coverage

Caution: Limitations on Cancer Insurance

Prepared by the National Association of Insurance Commissioners

Cancer insurance provides benefits only if you get cancer. No policy will cover you for cancer diagnosed before you applied for the policy. Examples of other specified disease policies are heart attack or stroke policies. The information in this booklet applies to cancer insurance, but could very well apply to other specified disease policies.

CANCER INSURANCE IS NOT A SUBSTITUTE FOR COMPREHENSIVE COVERAGE...

Cancer treatment accounts for about 10% of U.S. health expenses. In fact, no single disease accounts for more than a small proportion of the American public's health care bill. This is why it is essential to have insurance coverage for all conditions, not just cancer.

If you and your family are not protected against catastrophic medical costs, you should consider a major medical policy. These policies pay a large percentage of your covered costs after a deductible is paid either by you or your basic insurance. They often have very high maximums, such as \$100,000 to \$1,000,000. Major medical policies will cover you for any accident or sickness, including cancer. They cost more than cancer policies because they cover more, but they are generally considered a better buy.

SHOULD YOU BUY CANCER INSURANCE?... MANY PEOPLE DON'T NEED IT

If you are considering cancer insurance, ask yourself three questions: Is my current coverage adequate for these costs? How much will the treatment cost if I do get cancer? How likely am I to contract the disease?

If you have Medicare and want more insurance, a comprehensive Medicare supplement policy is what you need.

Low-income people who are Medicaid recipients don't need more insurance. If you think you might qualify, contact your local social service agency.

Duplicate Coverage is Expensive and Unnecessary. Buy basic coverage first such as a major medical policy. Make sure any cancer policy will meet needs not met by your basic insurance. You cannot assume that double coverage will result in double benefits. Many cancer policies advertise that

they will pay benefits no matter what your other insurance pays. However, your basic policy may contain a coordination of benefits clause. That means it will not pay duplicate benefits. To find out if you can get benefits from both policies, check your regular insurance as well as the cancer policy.

Some Cancer Expenses May not be Covered Even by a Cancer Policy. Medical costs of cancer treatment vary. On the average, hospitalization accounts for 78% of such costs and physician services make up 13%. The remainder goes for other professional services, drugs, and nursing home care. Cancer patients often face large nonmedical expenses which are not usually covered by cancer insurance. Examples are home care, transportation, and rehabilitation costs.

Don't be Mislead by Emotions. While three in ten Americans will get cancer over a lifetime, seven in ten will not. In any one year, only one American in 250 will get cancer. The odds are against you receiving any benefits from a cancer policy. Be sure you know what conditions must be met before the policy will start to pay your bills.

CAUTION: LIMITATIONS OF CANCER INSURANCE...

Cancer policies sold today vary widely in cost and coverage. If you decide to purchase a cancer policy, contact different companies and agents, and compare the policies before you buy. Here are some common limitations:

Some policies pay only for hospital care. Today cancer care treatment, including radiation, chemotherapy and some surgery, is often given on an out-patient basis. Because the average stay in the hospital for a cancer patient is only 13 days, a policy which pays only when you are hospitalized has limited value.

Many policies promise to increase benefits after a patient has been in the hospital for 90 consecutive days. However since the average stay in a hospital for a cancer patient is 13 days, large dollar amounts for extended benefits have very little value for most patients.

Most cancer insurance policies have fixed dollar limits. For example, a policy might pay only up to \$1,500 for surgery costs or \$1,000 for radiation therapy, or it may have fixed payments such as \$50 or \$100 for each day in the hospital. Others limit total benefits to a fixed amount such as \$5,000 or \$10,000.

No policy will cover cancer diagnosed before you applied for the policy. Some policies will deny coverage if you are later found to have had cancer at the time of purchase, even if you did not know it.

Most cancer insurance does not cover cancer-related illnesses. Cancer or its treatment may lead to other physical problems, such as infection, diabetes, or pneumonia.

Many policies contain time limits. Some policies require waiting periods of 30 days or even several months before you are covered. Others stop paying benefits after a fixed period of two or three years.

FOR ADDITIONAL HELP...

If you are considering a cancer policy, the company or agent selling you the policy should answer your questions. You do not need to make a decision to purchase a policy the same day you talk to the agent. Be sure to ask how long you have to make your decision.

If you do not get the information you want, call or write your Insurance Department:

In Maine

Department of Professional and Financial Regulation
Bureau of Insurance
#34 State House Station
August, ME 04333-0034
(800) 300-5000
(207) 624-8475]

In New Hampshire

New Hampshire Department of Insurance
21 South Fruit Street, Suite 14
Concord, NH 03301
(800) 852-3416
(603) 271-2261

In Vermont

Department of Financial Regulations
89 Main Street
Montpelier, VT 05620
(802) 828-3301

In Utah

Utah Department of Insurance
3110 State Office Building
Salt Lake City, UT 84114
(800) 439-3805
(801) 538-3800

Glossary

Beneficiary – The person(s) who receive the proceeds from a life insurance policy or a retirement account upon the death of the insured. See also “contingent beneficiary.”

Co-insurance – The percent of a claim the insured pays until the out-of-pocket maximum is reached.

Contingent Beneficiary – The person(s) who receive the proceeds from a life insurance policy or a retirement account upon the death of the insured if the primary beneficiary is unable to receive them.

Co-payment or Co-pay – A fixed out-of-pocket amount the insured must pay for certain services, such as doctor’s office visits or medications.

Deductible – The amount of money that the insured must pay out of pocket before an insurance company will pay a claim.

Elimination Period – With disability insurance, this is the time period between an injury and the receipt of benefit payments. In other words, it is the length of time between the beginning of an injury or illness and receiving benefit payments from an insurer.

Flexible Spending Account (FSA) – A special account into which you can put pre-tax money in to pay for certain out-of-pocket health care costs.

Health Savings Account (HSA) – A type of savings account that can be used with a designated high-deductible health plan (HDHP) that lets you set aside money on a pre-tax basis to pay for qualified medical expenses.

High-deductible Health Plan (HDHP) – A health insurance plan in which the insured is responsible for covering a greater portion of medical expenses in exchange for lower premiums. Also known as a QHDHP “Qualified High-deductible Health Plan”.

In-network Provider – A provider network is a list of the doctors, other healthcare providers, and hospitals with which a plan has contracted to provide medical care to its members. These providers are called “network providers” or “in-network providers.”

Out-of-network Provider – A provider network is a list of the doctors, other healthcare providers, and hospitals with which a plan has contracted to provide medical care to its members. Providers that are not part of this network are considered “out-of-network.” Most (but not all) health plans offer out-of-network coverage, but out-of-pocket costs are higher.

Out-of-pocket Maximum – The out-of-pocket maximum is the most you have to pay for covered services in a plan year. After you spend this amount on deductibles, copayments, and coinsurance, your health plan pays 100% of the costs of covered benefits.

Pre-existing Condition – Any condition for which the patient has already received medical advice or treatment prior to enrollment in a new medical insurance plan. Health insurers can no longer charge more or deny coverage to you or your child because of a pre-existing health condition.

Preferred Provider Organization (PPO) – A type of health plan that contracts with medical providers, such as hospitals and doctors, to create a network of participating providers. You pay less if you use providers that belong to the plan's network.

Prescription Formulary – A drug formulary is a list of prescription drugs, both generic and brand name, used by practitioners to identify drugs that offer the greatest overall value. With most health plans, you will pay less out of pocket in co-pays or co-insurance to use medications that are included on the formulary. Prescription coverage is sometimes referred to in “tiers.”

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2021. Contact your State for more information on eligibility –

ALABAMA – Medicaid	COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442
ALASKA – Medicaid	FLORIDA – 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: https://www.flmedicaidtprecovery.com/flmedicaidtprecovery.com/hipp/index.html Phone: 1-877-357-3268

ARKANSAS – Medicaid	GEORGIA – Medicaid
Website: http://myarhipp.com/ Phone: 1-855-MyARHIP (855-692-7447)	Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext 2131
CALIFORNIA – Medicaid	INDIANA – Medicaid
Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Email: hipp@dhcs.ca.gov	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584
OKLAHOMA – Medicaid and CHIP	UTAH – Medicaid and CHIP
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
OREGON – Medicaid	VERMONT– Medicaid
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
PENNSYLVANIA – Medicaid	VIRGINIA – Medicaid and CHIP
Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx Phone: 1-800-692-7462	Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-800-432-5924
RHODE ISLAND – Medicaid and CHIP	WASHINGTON – Medicaid
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
SOUTH CAROLINA – Medicaid	WEST VIRGINIA – Medicaid
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIP (1-855-699-8447)
SOUTH DAKOTA - Medicaid	WISCONSIN – Medicaid and CHIP
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
TEXAS – Medicaid	WYOMING – Medicaid
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/

	Phone: 1-800-251-1269
IOWA – Medicaid and CHIP (Hawki)	MONTANA – Medicaid
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084
KANSAS – Medicaid	NEBRASKA – Medicaid
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
KENTUCKY – Medicaid	NEVADA – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPPPROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
LOUISIANA – Medicaid	NEW HAMPSHIRE – Medicaid
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218
MAINE – Medicaid	NEW JERSEY – Medicaid and CHIP
Enrollment Website: https://www.maine.gov/dhhs/ofa/applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofa/applications-forms Phone: 1-800-977-6740. TTY: Maine relay 711	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

MASSACHUSETTS – Medicaid and CHIP	NEW YORK – Medicaid
Website: https://www.mass.gov/info-details/masshealth-premium-assistance-pa Phone: 1-800-862-4840	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MINNESOTA – Medicaid	NORTH CAROLINA – Medicaid
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100
MISSOURI – Medicaid	NORTH DAKOTA – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825

To see if any other states have added a premium assistance program since July 31, 2021, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/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

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2023)

Newborns and Mother's Health Protection Act

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with 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 or 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).

Notice of HIPAA Privacy Practices

Your Information. Your Rights. Our Responsibilities.

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

Your Rights

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

Our Uses and Disclosures

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say “no” to your request, but we’ll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests and must say “yes” if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say “no” if it would affect your care.

Get a list of those with whom we’ve shared information

- You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we *never* share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Help manage the health care treatment you receive

We can use your health information and share it with professionals who are treating you.

Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Run our organization

- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.
- *Example: We use health information about you to develop better services for you.*

Pay for your health services

We can use and disclose your health information as we pay for your health services. *Example: We share information about you with your dental plan to coordinate payment for your dental work.*

Administer your plan

We may disclose your health information to your health plan sponsor for plan administration.

Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see:

www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- **We are required by law to maintain the privacy and security of your protected health information.**
- **We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.**
- **We must follow the duties and privacy practices described in this notice and give you a copy of it.**
- **We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind. For more information see:**

www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

Effective date: 01/01/2022

Androscoggin Home Healthcare + Hospice Contact: Katy Sperl
(207)795-9419

Women's Health and Cancer Rights Act (WHCRA)

The Women's Health and Cancer Rights Act of 1998 (WHCRA) is a federal law that provides protections to patients who choose to have breast reconstruction in connection with a mastectomy.

If WHCRA applies to you and you are receiving benefits in connection with a mastectomy and you elect breast reconstruction, coverage must be provided for:

- All stages of reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications of all stages of the mastectomy, including lymphedema.

This law applies to two different types of coverage:

1. Group health plans (provided by an employer or union);
2. Individual health insurance policies (not based on employment).

Group health plans can either be “insured” plans that purchase health insurance from a health insurance issuer, or “self-funded” plans that pay for coverage directly. How they are regulated depends on whether they are sponsored by private employers, or state or local (“non-federal”) governmental employers. Private group health plans are regulated by the Department of Labor. State and local governmental plans, for purposes of WHCRA, are regulated by CMS. If any group health plan buys insurance, the insurance itself is regulated by the State’s insurance department.

Contact your employer’s plan administrator to find out if your group coverage is insured or self-funded, to determine what entity or entities regulate your benefits. Health insurance sold to individuals (not through employment) is primarily regulated by State insurance departments.

WHCRA requires group health plans and health insurance companies (including HMOs), to notify individuals regarding coverage required under the law. Notice about the availability of these mastectomy-related benefits must be given:

1. To participants and beneficiaries of a group health plan at the time of enrollment, and to policyholders at the time an individual health insurance policy is issued; and
2. Annually to group health plan participants and beneficiaries, and to policyholders of individual policies.

Contact your State's insurance department to find out whether additional state law protections apply to your coverage if you are in an insured group health plan or have individual (non-employment based) health insurance coverage.

WHCRA does not apply to high risk pools since the pool is a means by which individuals obtain health coverage other than through health insurance policies or group health plans.

WHCRA does NOT require group health plans or health insurance issuers to cover mastectomies in general. If a group health plan or health insurance issuer chooses to cover mastectomies, then the plan or issuer is generally subject to WHCRA requirements.

Note: A non-Federal governmental employer that provides self-funded group health plan coverage to its employees (coverage that is not provided through an insurer) may elect to exempt its plan (opt out) from the requirements of WHCRA by following the “Procedures & Requirements for HIPAA Exemption Election” posted on the Self-Funded Non-Federal Governmental Plans webpage at http://cms.gov/ccio/resources/files/hipaa_exemption_election_instructions_04072011.html. This includes a requirement to issue a notice of opt-out to enrollees at the time of enrollment and on an annual basis. For a list of plans that have opted out of WHCRA, go to <http://cms.gov/ccio/resources/other/index.html#nonfed> and click on “List of HIPAA Opt-out Elections for Self-funded Non-Federal Governmental Plans.”

If you have concerns about your plan’s compliance with WHCRA, contact our help line at 1-877-267-2323 extension 6-1565 or at phig@cms.hhs.gov.

Notice of Credible Coverage

Important Notice 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 Androscoggin Home Healthcare + Hospice 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.

Androscoggin Home Healthcare + Hospice has determined that the prescription drug coverage offered by the Aetna HDHP 3000 and the Aetna PPO 2000, 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 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 coverage with Androscoggin Home Healthcare + Hospice will not be affected.

If you keep the prescription drug coverage offered under Androscoggin Home Healthcare + Hospice Plan, you will continue to receive all the medical and prescription drug benefits available under the plan.

If you drop the prescription drug coverage provided through Androscoggin Home Healthcare + Hospice Plan, coverage of your other medical benefits under the Plan will also be terminated since these benefits are provided on a combined basis.

If you do decide to join a Medicare drug plan and drop your coverage with Androscoggin Home Healthcare + Hospice, 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 Androscoggin Home Healthcare + Hospice 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...

See below for further information. 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 Androscoggin Home Healthcare + Hospice changes. You also may request a copy of this notice at any time.

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

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

For more information about Medicare prescription drug coverage: Visit www.medicare.gov

- Call your State Health Insurance Assistance Program
- 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: January 1, 2022
Name of Entity/Sender: Androscoggin Home Healthcare + Hospice
Contact—Position/Office: Katy Sperl, Human Resources

Contact Information

Medical and Dental

Aetna

888-478-9498

<https://www.aetnaresource.com/m/Androscoggin-Home-Health-Care-Hospice>

www.aetna.com

Vision

VSP

800-877-7195

www.vsp.com

Flexible Spending Accounts (FSA)

Group Dynamic

800-626-3539

www.gdynamic.com

Life Insurance

Unum

1-800-445-0402

www.unum.com

Short-term & Long-term Disability

Unum

1-800-858-6843

www.unum.com/claims

Critical Illness, Accident, Hospital Insurance

Unum

1-800-858-6843

www.unum.com

Employee Assistance Program

Unum's Life Balance

1-800-854-1446

www.unum.com/lifebalance

403B Retirement Savings Plan

Principal

800-986-3343

www.principal.com

VARNEY
BENEFITS ADVISORS
(207) 883-8229
www.varneybenefits.com

Summary of Benefits and Coverage



The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. **NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, <https://www.aetna.com/sbcsearch/getpolicydocs?u=080600-070020-112143> or by calling 1-888-982-3862. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at <https://www.healthcare.gov/sbc-glossary/> or call 1-888-982-3862 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u>?	In- <u>Network</u> : Individual \$3,000 / Family \$6,000. Out-of- <u>Network</u> : Individual \$15,000 / Family \$30,000.	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u>?	Yes. In- <u>network</u> <u>preventive care</u> is covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u>?	In- <u>Network</u> : Individual \$5,000 / Family \$10,000. Out-of- <u>Network</u> : Individual \$30,000 / Family \$60,000.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u>?	<u>Premiums</u> , <u>balance-billing</u> charges, health care this <u>plan</u> doesn't cover & penalties for failure to obtain <u>pre-authorization</u> for services.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u>?	Yes. See http://www.aetna.com/docfind or call 1-888-982-3862 for a list of in- <u>network</u> <u>providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u>?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .



All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	<u>Specialist</u> visit	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	<u>Preventive care</u> / <u>screening</u> /immunization	No charge	20% <u>coinsurance</u> , except <u>deductible</u> doesn't apply to gynecological exams	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.aetnapharmacy.com/advancedcontrolaetna	Preferred generic drugs	<u>Copay</u> /prescription: \$20 for 30 day supply (retail), \$40 for 31-90 day supply (retail & mail order)	20% <u>coinsurance</u> after <u>copay</u> /prescription: \$20 for 30 day supply (retail), \$40 for 31-90 day supply (retail & mail order)	Covers 30 day supply (retail), 31-90 day supply (retail & mail order). Includes contraceptive drugs & devices obtainable from a pharmacy. No charge for preferred generic FDA-approved women's contraceptives in- <u>network</u> . Review your <u>formulary</u> for prescriptions requiring precertification or step therapy for coverage. Your cost will be higher for choosing Brand over Generics unless prescribed Dispense as Written. <u>Deductible</u> doesn't apply to certain preventive medications.
	Preferred brand drugs	<u>Copay</u> /prescription: \$30 for 30 day supply (retail), \$60 for 31-90 day supply (retail & mail order)	20% <u>coinsurance</u> after <u>copay</u> /prescription: \$30 for 30 day supply (retail), \$60 for 31-90 day supply (retail & mail order)	
	Non-preferred generic/brand drugs	<u>Copay</u> /prescription: \$50 for 30 day supply (retail), \$100 for 31-90 day supply (retail & mail order)	20% <u>coinsurance</u> after <u>copay</u> /prescription: \$50 for 30 day supply (retail), \$100 for 31-90 day supply (retail & mail order)	
	<u>Specialty drugs</u>	<u>Copay</u> /prescription: \$250	20% <u>coinsurance</u> after <u>copay</u> /prescription: \$250	None
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you need immediate medical attention	<u>Emergency room care</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	No coverage for non-emergency use.
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Non-emergency transport: not covered, except if pre-authorized.
	<u>Urgent care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	No coverage for non-urgent use.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Penalty of \$400 for failure to obtain <u>pre-authorization</u> for out-of-network care.
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office & other outpatient services: 20% <u>coinsurance</u>	Office & other outpatient services: 40% <u>coinsurance</u>	None
	Inpatient services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Penalty of \$400 for failure to obtain <u>pre-authorization</u> for out-of-network care.
If you are pregnant	Office visits	No charge	20% <u>coinsurance</u>	<u>Cost sharing</u> does not apply for <u>preventive services</u> . Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) Penalty of \$400 for failure to obtain <u>pre-authorization</u> for out-of-network care may apply.
	Childbirth/delivery professional services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
	Childbirth/delivery facility services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Penalty of \$400 for failure to obtain <u>pre-authorization</u> for out-of-network care.
	<u>Rehabilitation services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	60 visits/calendar year for Physical, Occupational & Speech Therapy combined.
	<u>Habilitation services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	100 days/calendar year. Penalty of \$400 for failure to obtain <u>pre-authorization</u> for out-of-network care.
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Limited to 1 <u>durable medical equipment</u> for same/similar purpose. Excludes repairs for misuse/abuse.
	<u>Hospice services</u>	0% <u>coinsurance</u>	20% <u>coinsurance</u>	Penalty of \$400 for failure to obtain <u>pre-authorization</u> for out-of-network care.
If your child needs dental or eye care	Children's eye exam	No charge	20% <u>coinsurance</u>	1 routine eye exam/12 months.
	Children's glasses	Not covered	Not covered	Not covered.
	Children's dental check-up	Not covered	Not covered	Not covered.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- | | | |
|-------------------------------|--|---|
| • Cosmetic surgery | • Long-term care | • Routine foot care |
| • Dental care (Adult & Child) | • Non-emergency care when traveling outside the U.S. | • Weight loss programs - Except for required <u>preventive services</u> . |
| • Glasses (Child) | | |

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- | | | |
|---|---|--|
| • Acupuncture - 20 visits/calendar year for disease, injury & chronic pain. | • Hearing aids - 1 hearing aid per ear/36 months. | • Routine eye care (Adult) - 1 routine eye exam/12 months. |
| • Bariatric surgery | • Infertility treatment - Limited to the diagnosis & treatment of underlying medical condition. | |
| • Chiropractic care - 40 visits/calendar year. | • Private-duty nursing | |

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Professional & Financial Regulation, Maine Bureau of Insurance, (207) 624-8475 (In Maine), (800) 300-5000 (Toll Free), <http://www.maine.gov/pfr/insurance/>.

- If your group health coverage is subject to ERISA, 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.

- For more information on your rights to continue coverage, contact the plan at 1-888-982-3862.
- For non-federal governmental group health plans, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.
- If your coverage is a church plan, church plans are not covered by the Federal COBRA continuation coverage rules. If the coverage is insured, individuals should contact their State insurance regulator regarding their possible rights to continuation coverage under State law.

Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact:

- If your group health coverage is subject to ERISA, you may contact Aetna directly by calling the toll-free number on your Medical ID Card, or by calling our general toll free number at 1-888-982-3862. 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.
- Department of Professional & Financial Regulation, Maine Bureau of Insurance, (207) 624-8475 (In Maine), (800) 300-5000 (Toll Free), <http://www.maine.gov/pfr/insurance/>.
- For non-federal governmental group health plans, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.
- Additionally, a consumer assistance program can help you file your appeal. Contact Consumers for Affordable Health Care, Maine Health Insurance Consumer Assistance Program (MHICAP), P.O. Box 2490, Augusta, ME 04338-2490, (800) 965-7476, www.maineahc.org

Does this plan provide Minimum Essential Coverage? Yes.

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet Minimum Value Standards? Yes.

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

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

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

- The plan's overall deductible **\$3,000**
- Specialist coinsurance **20%**
- Hospital (facility) coinsurance **20%**
- Other coinsurance **20%**

This EXAMPLE event includes services like:

Specialist office visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	\$12,700
In this example, Peg would pay:	
<u>Cost Sharing</u>	
<u>Deductibles</u>	\$3,000
<u>Copayments</u>	\$10
<u>Coinsurance</u>	\$1,700
<u>What isn't covered</u>	
Limits or exclusions	\$60
The total Peg would pay is	\$4,770

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- The plan's overall deductible **\$3,000**
- Specialist coinsurance **20%**
- Hospital (facility) coinsurance **20%**
- Other coinsurance **20%**

This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	\$5,600
In this example, Joe would pay:	
<u>Cost Sharing</u>	
<u>Deductibles</u>	\$3,000
<u>Copayments</u>	\$500
<u>Coinsurance</u>	\$80
<u>What isn't covered</u>	
Limits or exclusions	\$20
The total Joe would pay is	\$3,600

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- The plan's overall deductible **\$3,000**
- Specialist coinsurance **20%**
- Hospital (facility) coinsurance **20%**
- Other coinsurance **20%**

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	\$2,800
In this example, Mia would pay:	
<u>Cost Sharing</u>	
<u>Deductibles</u>	\$2,800
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$0
<u>What isn't covered</u>	
Limits or exclusions	\$0
The total Mia would pay is	\$2,800

The plan would be responsible for the other costs of these EXAMPLE covered services.

Assistive Technology

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 1-888-982-3862.

Smartphone or Tablet

To view documents from your smartphone or tablet, the free WinZip app is required. It may be available from your App Store.

Non-Discrimination

Aetna complies with applicable Federal civil rights laws and does not unlawfully discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, disability, gender identity or sexual orientation.

We provide free aids/services to people with disabilities and to people who need language assistance.

If you need a qualified interpreter, written information in other formats, translation or other services, call the number on your ID card.

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:

Civil Rights Coordinator,
P.O. Box 14462, Lexington, KY 40512 (CA HMO customers: P.O. Box 24030, Fresno, CA 93779),
1-800-648-7817, TTY: 711,
Fax: 859-425-3379 (CA HMO customers: 860-262-7705), CRCoordinator@aetna.com.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, or at 1-800-368-1019, 800-537-7697 (TDD).

Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company, Coventry Health Care plans and their affiliates.

TTY: 711

Language Assistance:

For language assistance in your language call 1-888-982-3862 at no cost.

Albanian -	Për asistencë në gjuhën shqipe telefononi falas në 1-888-982-3862.
Amharic -	ለቋንቋ እገዛ በ አማርኛ በ 1-888-982-3862 በነጻ ይደውሉ
Arabic -	1-888-982-3862 للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني
Armenian -	Լեզվի ցուցաբերած աջակցության (հայերեն) զանգի 1-888-982-3862 առանց գնով:
Bahasa-Indonesia -	Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-888-982-3862 tanpa dikenakan biaya.
Bantu-Kirundi -	Niba urondera uwugufasha mu Kirundi, twakure kuri iyi numero 1-888-982-3862 ku busa
Bengali-Bangala -	বাংলায় ভাষা সহায়তার জন্য বিনামূল্যে 1-888-982-3862-তে কল করুন।
Bisayan-Visayan -	Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawag sa 1-888-982-3862 nga walay bayad.
Burmese -	ငွေကုန်ကျခံစရာမလိုဘဲ (မြန်မာဘာသာစကား)ဖြင့် ဘာသာစကားအကူအညီရယူရန် 1-888-982-3862 ကို ခေါ်ဆိုပါ။
Catalan -	Per rebre assistència en (català), truqui al número gratuït 1-888-982-3862.
Chamorro -	Para ayuda gi fino' (Chamoru), ágang 1-888-982-3862 sin gástu.
Cherokee -	ፀፀፃፀ ᑭᑭᑭᑭᑭ ᑭᑭᑭᑭᑭᑭ ᑭᑭᑭᑭᑭᑭ ፀፀᑭᑭ (ᑭᑭᑭᑭ) ፀᑭᑭᑭᑭᑭᑭ 1-888-982-3862 ፀፀᑭᑭ ᑭ ᑭᑭᑭᑭ ᑭᑭᑭᑭᑭ ᑭᑭᑭᑭᑭᑭ.
Chinese -	欲取得繁體中文語言協助，請撥打 1-888-982-3862，無需付費。
Choctaw -	(Chahta) anumpa ya apela a chi l paya hinla 1-888-982-3862.
Cushite -	Gargaarsa afaan Oromiffa hiikuu argachuuf lakkokkofsa bilbilaa 1-888-982-3862 irratti bilisaan bilbilaa.
Dutch -	Bel voor tolk- en vertaaldiensten in het Nederlands gratis naar 1-888-982-3862.
French -	Pour une assistance linguistique en français appeler le 1-888-982-3862 sans frais.
French Creole -	Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo 1-888-982-3862 gratis.
German -	Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 1-888-982-3862 an.
Greek -	Για γλωσσική βοήθεια στα Ελληνικά καλέστε το 1-888-982-3862 χωρίς χρέωση.
Gujarati -	ગુજરાતીમાં ભાષામાં સહાય માટે કોઈ પણ ખર્ચ વગર 1-888-982-3862 પર કોલ કરો.

Hawaiian -	No ke kōkua ma ka ‘ōlelo Hawai‘i, e kahea aku i ka helu kelepona 1-888-982-3862. Kāki ‘ole ‘ia kēia kōkua nei.
Hindi -	हन्दिी में भाषा सहायता के लएि, 1-888-982-3862 पर मुफ्त कॉल करें।
Hmong -	Yog xav tau kev pab txhais lus Hmoob hu dawb tau rau 1-888-982-3862.
Ibo -	Maka enyemaka asụsụ na Igbo kpọọ 1-888-982-3862 na akwughị ugwo ọ bụla
Ilocano -	Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-888-982-3862 nga awan ti bayadanyo.
Italian -	Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 1-888-982-3862.
Japanese -	日本語で援助をご希望の方は、1-888-982-3862 まで無料でお電話ください。
Karen -	လၢတၢ်မၤစၢတၢ်ကတိၤကျိၣ်အဂီၢ် ကျိၣ် ကိး 1-888-982-3862 လၢတအိၣ်ဒီးတၢ်လၢာ်ၣ်သ့ၣ်လၢာ်စ့ၤသ့ၣ်
Korean -	한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-888-982-3862 번으로 전화해 주십시오.
Kru-Bassa -	Be´m`ké gbo-kpá-kpá dyé pídyi dé Bašwá-wuḍuñ wɛɛ, dǎ 1-888-982-3862
Kurdish -	برای راهنمایی به زبان فارسی با شماره 1-888-982-3862 به خۆرای پهیوهندی بکەن.
Laotian -	ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ, ກະລຸນາໂທຫາ 1-888-982-3862 ໂດຍບໍ່ເສຍຄ່າໂທ.
Marathi -	कोणत्याही शुल्काशुवाय भाषा सेवा प्राप्त करण्यासाठी, 1-888-982-3862 वर फोन करा.
Marshallese -	Ñan bōk jipañ ilo Kajin Majol, kallok 1-888-982-3862 ilo ejjelok wōnān.
Micronesian - Pohnpeyan	Ohng palien sawas en soun kawewe ni omw lokaia Ponape koahl 1-888-982-3862 ni sohte isais.
Mon-Khmer, Cambodian -	សម្រាប់ជំនួយភាសាជា ភាសាខ្មែរ សូមទូរស័ព្ទទៅកាន់លេខ 1-888-982-3862 ដោយឥតគិតថ្លៃ។
Navajo -	T'áá shi shizaad k'ehjí bee shíká a'doowol nínízingo Diné k'ehjí koji' t'áá jíík'e hólne' 1-888-982-3862
Nepali -	(नेपाली) मा नःशुल्क भाषा सहायता पाउनका लागि 1-888-982-3862 मा फोन गर्नुहोस् ।
Nilotic-Dinka -	Tèn kuɔɔny ë thok ë Thuɔŋjäŋ ɔl 1-888-982-3862 kec'in ayöc.
Norwegian -	For språkassistanse på norsk, ring 1-888-982-3862 kostnadsfritt.
Panjabi -	ਪੰਜਾਬੀ ਵੱਲੋਂ ਭਾਸ਼ਾਈ ਸਹਾਇਤਾ ਲਈ, 1-888-982-3862 'ਤੇ ਮੁਫ਼ਤ ਕਾਲ ਕਰੋ।
Pennsylvania Dutch -	Fer Hilfe in Deitsch, ruf: 1-888-982-3862 aa. Es Aaruf koschtet nix.

Persian -	برای راهنمایی به زبان فارسی با شماره 1-888-982-3862 بدون هیچ هزینه ای تماس بگیرید. انگلیسی
Polish -	Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-888-982-3862.
Portuguese -	Para obter assistência linguística em português ligue para o 1-888-982-3862 gratuitamente.
Romanian -	Pentru asistență lingvistică în românește telefonați la numărul gratuit 1-888-982-3862
Russian -	Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-888-982-3862.
Samoan -	Mo fesoasoani tau gagana I le Gagana Samoa vala'au le 1-888-982-3862 e aunoa ma se totogi.
Serbo-Croatian -	Za jezičnu pomoć na hrvatskom jeziku pozovite besplatan broj 1-888-982-3862.
Spanish -	Para obtener asistencia lingüística en español, llame sin cargo al 1-888-982-3862.
Sudanic-Fulfude -	Fii yo on hebu balal e ko yowitii e haala Pular noddee e oo numero doo 1-888-982-3862 Njodi woo fawaaki on.
Swahili -	Ukihitaji usaidizi katika lugha ya Kiswahili piga simu kwa 1-888-982-3862 bila malipo.
Syriac -	ܠܚܥܠܐ ܕܡܕܢܬܐ ܕܡܕܢܬܐ ܕܡܕܢܬܐ ܕܡܕܢܬܐ ܕܡܕܢܬܐ ܕܡܕܢܬܐ ܕܡܕܢܬܐ ܕܡܕܢܬܐ 1-888-982-3862 ܕܡܕܢܬܐ.
Tagalog -	Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-888-982-3862 nang walang bayad.
Telugu -	భృషణ్ సాయం కిరకు ఎలాంటి ఖరీచు లేకుండా 1-888-982-3862 కు కల్ చేయండి. (తెలుగు)
Thai -	สำหรับความช่วยเหลือทางด้านภาษาเป็น ภาษาไทย โทร 1-888-982-3862 ฟรีไม่มีค่าใช้จ่าย
Tongan -	Kapau ‘oku fiema’u hā tokoni ‘i he lea faka-Tonga telefoni 1-888-982-3862 ‘o ‘ikai hā tōtōngi.
Trukese -	Ren ánninnisin chiakú ren (Kapasen Chuuk) kopwe kékkéeri 1-888-982-3862 nge esapw kamé ngonuk.
Turkish -	(Dil) çağrısı dil yardım için. Hiçbir ücret ödemedi 1-888-982-3862.
Ukrainian -	Щоб отримати допомогу перекладача української мови, зателефонуйте за безкоштовним номером 1-888-982-3862.
Urdu -	بلا قیمت زبان سے متعلقہ خدمات حاصل کرنے کے لیے ، 1-888-982-3862 . پر بات کریں
Vietnamese -	Đê`được hỗ trợ ngôn ngữ bằng (ngôn ngữ), hãy gọi miễn phí đến số` 1-888-982-3862.
Yiddish -	פאר שפראך הילף אין אידיש רופט 1-888-982-3862 פאר פון אפצאל.
Yoruba -	Fún iranlọwọ nípa èdè (Yorùbá) pe 1-888-982-3862 láí san owó kankan rárá.



The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. **NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, <https://www.aetna.com/sbcsearch/getpolicydocs?u=080600-070020-112144> or by calling 1-888-982-3862. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at <https://www.healthcare.gov/sbc-glossary/> or call 1-888-982-3862 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u>?	In- <u>Network</u> : Individual \$2,000 / Family \$4,000. Out-of- <u>Network</u> : Individual \$15,000 / Family \$30,000.	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u>?	Yes. Emergency care & <u>prescription drugs</u> ; plus in- <u>network</u> office visits & <u>preventive care</u> are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u>?	In- <u>Network</u> : Individual \$5,000 / Family \$10,000. Out-of- <u>Network</u> : Individual \$30,000 / Family \$60,000.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u>?	<u>Premiums</u> , <u>balance-billing</u> charges, health care this <u>plan</u> doesn't cover & penalties for failure to obtain <u>pre-authorization</u> for services.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u>?	Yes. See http://www.aetna.com/docfind or call 1-888-982-3862 for a list of in- <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u>?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .



All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$30 <u>copay</u> /visit, <u>deductible</u> doesn't apply	20% <u>coinsurance</u>	None
	<u>Specialist</u> visit	\$50 <u>copay</u> /visit, <u>deductible</u> doesn't apply	20% <u>coinsurance</u>	None
	<u>Preventive care</u> / <u>screening</u> /immunization	No charge	20% <u>coinsurance</u> , except <u>deductible</u> doesn't apply to gynecological exams	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.aetnapharmacy.com/advancedcontrolaetna	Preferred generic drugs	<u>Copay</u> /prescription, <u>deductible</u> doesn't apply: \$20 for 30 day supply (retail), \$40 for 31-90 day supply (retail & mail order)	20% <u>coinsurance</u> after <u>copay</u> /prescription, <u>deductible</u> doesn't apply: \$20 for 30 day supply (retail), \$40 for 31-90 day supply (retail & mail order)	Covers 30 day supply (retail), 31-90 day supply (retail & mail order). Includes contraceptive drugs & devices obtainable from a pharmacy. No charge for preferred generic FDA-approved women's contraceptives in- <u>network</u> . Review your <u>formulary</u> for prescriptions requiring precertification or step therapy for coverage. Your cost will be higher for choosing Brand over Generics unless prescribed Dispense as Written.
	Preferred brand drugs	<u>Copay</u> /prescription, <u>deductible</u> doesn't apply: \$30 for 30 day supply (retail), \$60 for 31-90 day supply (retail & mail order)	20% <u>coinsurance</u> after <u>copay</u> /prescription, <u>deductible</u> doesn't apply: \$30 for 30 day supply (retail), \$60 for 31-90 day supply (retail & mail order)	
	Non-preferred generic/brand drugs	<u>Copay</u> /prescription, <u>deductible</u> doesn't apply: \$50 for 30 day supply (retail), \$100 for 31-90 day supply (retail & mail order)	20% <u>coinsurance</u> after <u>copay</u> /prescription, <u>deductible</u> doesn't apply: \$50 for 30 day supply (retail), \$100 for 31-90 day supply (retail & mail order)	
	<u>Specialty drugs</u>	<u>Copay</u> /prescription,	20% <u>coinsurance</u> after	
				None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
		<u>deductible</u> doesn't apply: \$250	<u>copay</u> /prescription, <u>deductible</u> doesn't apply: \$250	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you need immediate medical attention	<u>Emergency room care</u>	\$200 <u>copay</u> /visit, <u>deductible</u> doesn't apply	\$200 <u>copay</u> /visit, <u>deductible</u> doesn't apply	No coverage for non-emergency use.
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Non-emergency transport: not covered, except if pre-authorized.
	<u>Urgent care</u>	\$50 <u>copay</u> /visit, <u>deductible</u> doesn't apply	20% <u>coinsurance</u>	No coverage for non-urgent use.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Penalty of \$400 for failure to obtain <u>pre-authorization</u> for out-of-network care.
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office: \$50 <u>copay</u> /visit, <u>deductible</u> doesn't apply; other outpatient services: 20% <u>coinsurance</u>	Office: 20% <u>coinsurance</u> ; other outpatient services: 40% <u>coinsurance</u>	None
	Inpatient services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Penalty of \$400 for failure to obtain <u>pre-authorization</u> for out-of-network care.
If you are pregnant	Office visits	No charge	20% <u>coinsurance</u>	<u>Cost sharing</u> does not apply for <u>preventive services</u> . Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) Penalty of \$400 for failure to obtain <u>pre-authorization</u> for out-of-network care may apply.
	Childbirth/delivery professional services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
	Childbirth/delivery facility services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Penalty of \$400 for failure to obtain <u>pre-authorization</u> for out-of-network care.
	<u>Rehabilitation services</u>	\$50 <u>copay</u> /visit, <u>deductible</u> doesn't apply	20% <u>coinsurance</u>	40 visits/calendar year for Physical, Occupational & Speech Therapy combined.
	<u>Habilitation services</u>	\$50 <u>copay</u> /visit, <u>deductible</u> doesn't apply	20% <u>coinsurance</u>	None
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	100 days/calendar year. Penalty of \$400 for failure to obtain <u>pre-authorization</u> for out-of-network care.
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Limited to 1 <u>durable medical equipment</u> for same/similar purpose. Excludes repairs for misuse/abuse.
	<u>Hospice services</u>	No charge	20% <u>coinsurance</u>	Penalty of \$400 for failure to obtain <u>pre-authorization</u> for out-of-network care.
If your child needs dental or eye care	Children's eye exam	No charge	20% <u>coinsurance</u>	1 routine eye exam/12 months.
	Children's glasses	Not covered	Not covered	Not covered.
	Children's dental check-up	Not covered	Not covered	Not covered.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- | | | |
|--|--|---|
| <ul style="list-style-type: none"> • Cosmetic surgery • Dental care (Adult & Child) • Glasses (Child) | <ul style="list-style-type: none"> • Long-term care • Non-emergency care when traveling outside the U.S. | <ul style="list-style-type: none"> • Routine foot care • Weight loss programs - Except for required <u>preventive services</u>. |
|--|--|---|

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- | | | |
|---|---|--|
| <ul style="list-style-type: none"> • Acupuncture - 20 visits/calendar year for disease, injury & chronic pain. • Bariatric surgery • Chiropractic care | <ul style="list-style-type: none"> • Hearing aids - 1 hearing aid per ear/36 months. • Infertility treatment - Limited to the diagnosis & treatment of underlying medical condition • Private-duty nursing | <ul style="list-style-type: none"> • Routine eye care (Adult) - 1 routine eye exam/12 months. |
|---|---|--|

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is:

Department of Professional & Financial Regulation, Maine Bureau of Insurance, (207) 624-8475 (In Maine), (800) 300-5000 (Toll Free), <http://www.maine.gov/pfr/insurance/>.

- If your group health coverage is subject to ERISA, 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.
- For more information on your rights to continue coverage, contact the [plan](#) at 1-888-982-3862.
- For non-federal governmental group health [plans](#), you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.
- If your coverage is a church [plan](#), church [plans](#) are not covered by the Federal COBRA continuation coverage rules. If the coverage is insured, individuals should contact their State insurance regulator regarding their possible rights to continuation coverage under State law.

Other coverage options may be available to you too, including buying individual insurance coverage through the [Health Insurance Marketplace](#). For more information about the [Marketplace](#), visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information on how to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact:

- If your group health coverage is subject to ERISA, you may contact Aetna directly by calling the toll-free number on your Medical ID Card, or by calling our general toll free number at 1-888-982-3862. 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.
- Department of Professional & Financial Regulation, Maine Bureau of Insurance, (207) 624-8475 (In Maine), (800) 300-5000 (Toll Free), <http://www.maine.gov/pfr/insurance/>.
- For non-federal governmental group health [plans](#), you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.
- Additionally, a consumer assistance program can help you file your [appeal](#). Contact Consumers for Affordable Health Care, Maine Health Insurance Consumer Assistance Program (MHICAP), P.O. Box 2490, Augusta, ME 04338-2490, (800) 965-7476, www.maineahc.org

Does this plan provide Minimum Essential Coverage? Yes.

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

Does this plan meet Minimum Value Standards? Yes.

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

- The plan's overall deductible **\$2,000**
- Specialist copayment **\$50**
- Hospital (facility) coinsurance **20%**
- Other coinsurance **20%**

This **EXAMPLE** event includes services like:

Specialist office visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	\$12,700
In this example, Peg would pay:	
<u>Cost Sharing</u>	
<u>Deductibles</u>	\$2,000
<u>Copayments</u>	\$10
<u>Coinsurance</u>	\$1,900
<u>What isn't covered</u>	
Limits or exclusions	\$60
The total Peg would pay is	\$3,970

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- The plan's overall deductible **\$2,000**
- Specialist copayment **\$50**
- Hospital (facility) coinsurance **20%**
- Other coinsurance **20%**

This **EXAMPLE** event includes services like:

Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	\$5,600
In this example, Joe would pay:	
<u>Cost Sharing</u>	
<u>Deductibles</u>	\$100
<u>Copayments</u>	\$1,300
<u>Coinsurance</u>	\$0
<u>What isn't covered</u>	
Limits or exclusions	\$20
The total Joe would pay is	\$1,420

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- The plan's overall deductible **\$2,000**
- Specialist copayment **\$50**
- Hospital (facility) coinsurance **20%**
- Other coinsurance **20%**

This **EXAMPLE** event includes services like:

Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	\$2,800
In this example, Mia would pay:	
<u>Cost Sharing</u>	
<u>Deductibles</u>	\$900
<u>Copayments</u>	\$500
<u>Coinsurance</u>	\$0
<u>What isn't covered</u>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,400

The plan would be responsible for the other costs of these **EXAMPLE** covered services.

Assistive Technology

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 1-888-982-3862.

Smartphone or Tablet

To view documents from your smartphone or tablet, the free WinZip app is required. It may be available from your App Store.

Non-Discrimination

Aetna complies with applicable Federal civil rights laws and does not unlawfully discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, disability, gender identity or sexual orientation.

We provide free aids/services to people with disabilities and to people who need language assistance.

If you need a qualified interpreter, written information in other formats, translation or other services, call the number on your ID card.

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:

Civil Rights Coordinator,
P.O. Box 14462, Lexington, KY 40512 (CA HMO customers: P.O. Box 24030, Fresno, CA 93779),
1-800-648-7817, TTY: 711,
Fax: 859-425-3379 (CA HMO customers: 860-262-7705), CRCoordinator@aetna.com.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, or at 1-800-368-1019, 800-537-7697 (TDD).

Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company, Coventry Health Care plans and their affiliates.

Language Assistance:

Albanian -	Për asistencë në gjuhën shqipe telefononi falas në 1-888-982-3862.
Amharic -	ለቋንቋ እገዛ በ አማርኛ በ 1-888-982-3862 በነጻ ይደውሉ
Arabic -	1-888-982-3862 للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني
Armenian -	Լեզվի ցուցաբերած աջակցության (հայերեն) զանգի 1-888-982-3862 առանց գնով:
Bahasa-Indonesia -	Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-888-982-3862 tanpa dikenakan biaya.
Bantu-Kirundi -	Niba urondera uwugufasha mu Kirundi, twakure kuri iyi numero 1-888-982-3862 ku busa
Bengali-Bangala -	বাংলায় ভাষা সহায়তার জন্য বনিমূল্যে 1-888-982-3862-তে কল করুন।
Bisayan-Visayan -	Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawag sa 1-888-982-3862 nga walay bayad.
Burmese -	ငွေကုန်ကျခံစရာမလိုဘဲ (မြန်မာဘာသာစကား)ဖြင့် ဘာသာစကားအကူအညီရယူရန် 1-888-982-3862 ကို ခေါ်ဆိုပါ။
Catalan -	Per rebre assistència en (català), truqui al número gratuït 1-888-982-3862.
Chamorro -	Para ayuda gi fino' (Chamoru), ágang 1-888-982-3862 sin gástu.
Cherokee -	ፀፌፃፀ ሀህክፀፌፂ ሃክፌሆፌፃ ፀፄፐ (ፀፄፃ) ፀፄፃፀፀፀ 1-888-982-3862 ፀፀፐ ፐ ለፀፌፂ ፀፀፀፀፀ ፀፀፀፀፀ.
Chinese -	欲取得繁體中文語言協助，請撥打 1-888-982-3862，無需付費。
Choctaw -	(Chahta) anumpa ya apela a chi l paya hinla 1-888-982-3862.
Cushite -	Gargaarsa afaan Oromiffa hiikuu argachuuf lakkokkofsaa bilbilaa 1-888-982-3862 irratti bilisaan bilbilaa.
Dutch -	Bel voor tolk- en vertaaldiensten in het Nederlands gratis naar 1-888-982-3862.
French -	Pour une assistance linguistique en français appeler le 1-888-982-3862 sans frais.
French Creole -	Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo 1-888-982-3862 gratis.
German -	Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 1-888-982-3862 an.
Greek -	Για γλωσσική βοήθεια στα Ελληνικά καλέστε το 1-888-982-3862 χωρίς χρέωση.
Gujarati -	ગુજરાતીમાં ભાષામાં સહાય માટે કોઈ પણ ખર્ચ વગર 1-888-982-3862 પર કોલ કરો.

Hawaiian -	No ke kōkua ma ka ‘ōlelo Hawai‘i, e kahea aku i ka helu kelepona 1-888-982-3862. Kāki ‘ole ‘ia kēia kōkua nei.
Hindi -	हन्दिी में भाषा सहायता के लएि, 1-888-982-3862 पर मुफ्त कॉल करें।
Hmong -	Yog xav tau kev pab txhais lus Hmoob hu dawb tau rau 1-888-982-3862.
Ibo -	Maka enyemaka asụsụ na Igbo kpọọ 1-888-982-3862 na akwughị ugwo ọ bụla
Ilocano -	Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-888-982-3862 nga awan ti bayadanyo.
Italian -	Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 1-888-982-3862.
Japanese -	日本語で援助をご希望の方は、1-888-982-3862 まで無料でお電話ください。
Karen -	လၢတၢ်မၤစၢၤတၢ်ကတိၤကျိၣ်အဂီၢ် ကျိၣ် ကိး 1-888-982-3862 လၢတအိၣ်ဒီးတၢ်လၢာ်ၣ်သ့ၣ်လၢာ်စ့ၤသ့ၣ်
Korean -	한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-888-982-3862 번으로 전화해 주십시오.
Kru-Bassa -	Be´m`ké gbo-kpá-kpá dyé pídyi dé Bašwá-wuḍuñ wɛɛ, dǎ 1-888-982-3862
Kurdish -	برای راهنمایی به زبان فارسی با شماره 1-888-982-3862 به خۆرای پهیوهندی بکەن.
Laotian -	ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ, ກະລຸນາໂທຫາ 1-888-982-3862 ໂດຍບໍ່ເສຍຄ່າໂທ.
Marathi -	कोणत्याही शुल्काशुवाय भाषा सेवा प्राप्त करण्यासाठी, 1-888-982-3862 वर फोन करा.
Marshallese -	Ñan bōk jipañ ilo Kajin Majol, kallok 1-888-982-3862 ilo ejjelok wōnān.
Micronesian - Pohnpeyan	Ohng palien sawas en soun kawewe ni omw lokaia Ponape koahl 1-888-982-3862 ni sohte isais.
Mon-Khmer, Cambodian -	សម្រាប់ជំនួយភាសាជា ភាសាខ្មែរ សូមទូរស័ព្ទទៅកាន់លេខ 1-888-982-3862 ដោយឥតគិតថ្លៃ។
Navajo -	T'áá shi shizaad k'ehjí bee shíká a'doowol nínízingo Diné k'ehjí koji' t'áá jíík'e hólne' 1-888-982-3862
Nepali -	(नेपाली) मा नःशुल्क भाषा सहायता पाउनका लागि 1-888-982-3862 मा फोन गर्नुहोस् ।
Nilotic-Dinka -	Tèn kuɔɔny ë thok ë Thuɔŋjäŋ ɔl 1-888-982-3862 kec'in ayöc.
Norwegian -	For språkassistanse på norsk, ring 1-888-982-3862 kostnadsfritt.
Panjabi -	ਪੰਜਾਬੀ ਵੱਲੋਂ ਭਾਸ਼ਾਈ ਸਹਾਇਤਾ ਲਈ, 1-888-982-3862 'ਤੇ ਮੁਫ਼ਤ ਕਾਲ ਕਰੋ।
Pennsylvania Dutch -	Fer Hilfe in Deitsch, ruf: 1-888-982-3862 aa. Es Aaruf koschtet nix.

Persian -	برای راهنمایی به زبان فارسی با شماره 1-888-982-3862 بدون هیچ هزینه ای تماس بگیرید. انگلیسی
Polish -	Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-888-982-3862.
Portuguese -	Para obter assistência linguística em português ligue para o 1-888-982-3862 gratuitamente.
Romanian -	Pentru asistență lingvistică în românește telefonați la numărul gratuit 1-888-982-3862
Russian -	Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-888-982-3862.
Samoan -	Mo fesoasoani tau gagana I le Gagana Samoa vala'au le 1-888-982-3862 e aunoa ma se totogi.
Serbo-Croatian -	Za jezičnu pomoć na hrvatskom jeziku pozovite besplatan broj 1-888-982-3862.
Spanish -	Para obtener asistencia lingüística en español, llame sin cargo al 1-888-982-3862.
Sudanic-Fulfude -	Fii yo on hebu balal e ko yowitii e haala Pular noddee e oo numero doo 1-888-982-3862 Njodi woo fawaaki on.
Swahili -	Ukihitaji usaidizi katika lugha ya Kiswahili piga simu kwa 1-888-982-3862 bila malipo.
Syriac -	ܠܚܥܠܐ ܕܡܕܢܬܐ ܕܡܕܢܬܐ ܕܡܕܢܬܐ ܕܡܕܢܬܐ ܕܡܕܢܬܐ ܕܡܕܢܬܐ ܕܡܕܢܬܐ ܕܡܕܢܬܐ 1-888-982-3862 ܕܡܕܢܬܐ.
Tagalog -	Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-888-982-3862 nang walang bayad.
Telugu -	భృషణి సాయం కోరకు ఎలాంటి ఖర్చు లేకుండా 1-888-982-3862 కు కాల్ చేయండి. (తెలుగు)
Thai -	สำหรับความช่วยเหลือทางด้านภาษาเป็น ภาษาไทย โทร 1-888-982-3862 ฟรีไม่มีค่าใช้จ่าย
Tongan -	Kapau ‘oku fiema’u hā tokoni ‘i he lea faka-Tonga telefoni 1-888-982-3862 ‘o ‘ikai hā tōtōngi.
Trukese -	Ren ánninnisin chiakú ren (Kapasen Chuuk) kopwe kékkéeri 1-888-982-3862 nge esapw kamé ngonuk.
Turkish -	(Dil) çağrısı dil yardım için. Hiçbir ücret ödemedi 1-888-982-3862.
Ukrainian -	Щоб отримати допомогу перекладача української мови, зателефонуйте за безкоштовним номером 1-888-982-3862.
Urdu -	بلا قیمت زبان سے متعلقہ خدمات حاصل کرنے کے لیے ، 1-888-982-3862 پر بات کریں
Vietnamese -	Đê`được hỗ trợ ngôn ngữ bằng (ngôn ngữ), hãy gọi miễn phí đến số` 1-888-982-3862.
Yiddish -	פאר שפראך הילף אין אידיש רופט 1-888-982-3862 פאר פון אפצאל.
Yoruba -	Fún iranlọwọ nípa èdè (Yorùbá) pe 1-888-982-3862 láí san owó kankan rárá.

Disclaimer. This booklet is a brief overview of the benefit plans and policies available to you as an employee of Androscoggin Home Healthcare + Hospice. The booklet is only a summary. It does not include all of the details of your plan coverage. If there is a conflict between this Employee Benefits Guide and the Summary Plan Descriptions, Plan Documents or Certificates of Coverage, the terms of the Summary Plan Descriptions, Plan documents or Certificates of Coverage will govern. Please note that the benefits described in this guide may be changed at any time, and do not represent a contractual obligation on the part of the employer.