The
Orthodox HealthPlan

To New Enrollees to the Orthodox Health Plan:

Open Enrollment for The Orthodox Health Plan is here.

Open Enrollment runs from November 15th thru December 30th with an effective date of coverage of January 1, 2012.

The Orthodox Health Plan is the official health plan for the clergy of the Greek Orthodox Archdiocese of America, The Antiochian Orthodox Christian Archdiocese, The Orthodox Church in America, The Diocese of The Armenian Church, The Serbian Orthodox Church and The Russian Orthodox Church Outside Russia. The **Orthodox Health Plan (OHP)** is a PPO Plan which offers our clergy and lay employees the broadest and most flexible coverage and includes prescription, vision, and dental benefits. Our health insurance carrier is Aetna, one of the single largest healthcare providers in the nation.

Some of the advantages for your enrollment are: broad medical coverage, prescription drug benefits, parish transfer without interruption of coverage, just to name a few. You can find a full description of the plan, participating physicians and hospitals, on the website www.orthodoxhealthplans.com.

It is important to stress that you should not terminate any coverage you currently have **until you have received confirmation that your participation has been approved.** In order to be accepted, your completed enrollment form with your first month's premium must reach the Plan Administrator no later than the 30th of December. If your parish will be paying your monthly premiums, we will also need a dated, signed letter on church letterhead stating to bill them.

All completed enrollment material must be returned to the following address:

The Orthodox HealthPlan
929 Kings Highway East
1st Floor
Fairfield CT 06825

The completed application must include a binder check for the first month's premium, made payable to "Orthodox HealthPlan". Premium for single coverage is $899 and family coverage is $1,895.

The Orthodox Health Plan Committee continues to strive to provide the finest plans for you and your family.

For additional information on the plan, enrollment forms, or questions, please call our Plan Administrator at The GDC Financial Group at 1-203-367-4070 or visit the website at www.orthodoxhealthplans.com.

Yours in Christ,

Rev. Father Constantine L. Sitaras
Joint Orthodox Health Plans Committee, Chairperson

PO Box 321101 • Fairfield, Connecticut 06825
Telephone: 203-367-4070 • Facsimile: 203-367-4078

PLAN DESIGN & BENEFITS
Effective Date: 05-01-2011
Open Choice® (PPO)

PLAN FEATURES	IN NETWORK	OUT OF NETWORK
Deductible (per calendar year)	$1,000 Individual $2,000 Family	$1,500 Individual $3,000 Family
All covered expenses, excluding prescription drugs, accumulate simultaneously toward the in-network or non-preferred Deductible. Unless otherwise indicated, the Deductible must be met prior to benefits being payable. Once Family Deductible is met, all family members will be considered as having me their Deductible for the remainder of the calendar year.		
Member Coinsurance Applies to all expenses unless otherwise stated.	90%	70%
Payment Limit (per calendar year)	$3,000 Individual $6,000 Family	$4,000 Individual $8,000 Family
All covered expenses, excluding prescription drugs, accumulate simultaneously toward the in-network or non-preferred Payment Limit. Certain member cost sharing elements may not apply toward the Payment Limit. Only those out-of-pocket expenses resulting from the application of coinsurance percentage (except any deductibles, copays, and penalty amounts) may be used to satisfy the Payment Limit. Once Family Payment Limit is met, all family members will be considered as having met their Payment Limit for the remainder of the calendar year.		
Lifetime Maximum Unlimited except where otherwise indicated.		
Primary Care Physician Selection	Not Applicable	Not Applicable
Certification Requirements - Certification for certain types of Non-Preferred care must be obtained to avoid a reduction in benefits paid for that care. Certification for Hospital Admissions, Treatment Facility Admissions, Convalescent Facility Admissions, Home Health Care, Hospice Care and Private Duty Nursing is required - excluded amount applied separately to each type of expense is $400 per occurrence.		
Referral Requirement	None	None

PREVENTIVE CARE	IN NETWORK	OUT OF NETWORK
Routine Adult Physical Exams/ Immunizations 1 exam every 12 months for adults age 19 and older.	Covered 100%; deductible waived	Covered 70%; after deductible
Routine Well Child Exams/Immunizations 7 exams in the first 12 months of life, 3 exams in the second 12 months of life, 3 exams in the third 12 months of life, 1 exam per year thereafter to age 19. Includes coverage for blood lead level screenings.	Covered 100%; deductible waived	Covered 100%; deductible waived

Routine Gynecological Care Exams 2 exams per calendar year. Includes routine tests and related lab fees.	Covered 100%; deductible waived	Covered 70%; after deductible
Routine Mammograms	Covered 100%; deductible waived	Covered 70%; after deductible
Routine Digital Rectal Exam	Covered 100% deductible waived	Member cost sharing is based on the type of service performed and the place of service where it is rendered; after deductible
Prostate-specific Antigen Test	Covered 100% deductible waived	Member cost sharing is based on the type of service performed and the place of service where it is rendered; after deductible
Colorectal Cancer Screening For all members age 50 and over.	Member cost sharing is based on the type of service performed and the place of service where it is rendered.	Member cost sharing is based on the type of service performed and the place of service where it is rendered; after deductible
Routine Eye Exams	Not Covered	Not Covered
Routine Hearing Exams	Not Covered	Not Covered

PHYSICIAN SERVICES	IN NETWORK	OUT OF NETWORK
Office Visits to non-Specialist Includes services of an internist, general physician, family practitioner or pediatrician.	$30 office visit copay; deductible waived	Covered at 70%; after deductible
Specialist Office Visits	$45 office visit copay; deductible waived	Covered at 70%; after deductible
E-visit to non-Specialist An E-visit is an online internet consultation between a physician and an established patient about a non-emergency healthcare matter. This visit must be conducted through an Aetna authorized internet E-visit service vendor.	$30 office visit copay; deductible waived	Covered at 70%; after deductible
E-visit to Specialist An E-visit is an online internet consultation between a physician and an established patient about a non-emergency healthcare matter. This visit must be conducted through an Aetna authorized internet E-visit service vendor.	$45 office visit copay; deductible waived	Covered at 70%; after deductible

Walk-in Clinics	$30 office visit copay; deductible waived	Covered at 70%; after deductible

Walk-in Clinics are network, free-standing health care facilities. They are an alternative to a physician's office visit for treatment of unscheduled, non-emergency illnesses and injuries and the administration of certain immunizations. It is not an alternative for emergency room services or the ongoing care provided by a physician. Neither an emergency room, nor the outpatient department of a hospital, shall be considered a Walk-in Clinic.

Allergy Testing	Member cost sharing is based on the type of service performed and the place of service where it is rendered.; deductible waived.	Member cost sharing is based on the type of service performed and the place of service where it is rendered.
Allergy Injections	Member cost sharing is based on the type of service performed and the place of service where it is rendered.; after deductible.	Member cost sharing is based on the type of service performed and the place of service where it is rendered.
DIAGNOSTIC PROCEDURES	**IN NETWORK**	**OUT OF NETWORK**
Diagnostic Laboratory and X-ray (other than Complex Imaging Services)	Covered at 90%; deductible waived	Covered at 70%; after deductible

If performed as a part of a physician office visit and billed by the physician, expenses are covered subject to the applicable physician's office visit member cost sharing.

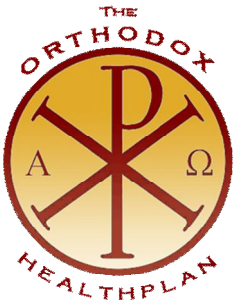
Diagnostic Outpatient Complex Imaging	Covered at 90%; deductible waived	Covered at 70%; after deductible
EMERGENCY MEDICAL CARE	**IN NETWORK**	**OUT OF NETWORK**
Urgent Care Provider	$45 office visit copay; deductible waived	Covered at 70%; after deductible
Non-Urgent Use of Urgent Care Provider	Not Covered	Not Covered
Emergency Room	Covered at 90% after $150 copay; deductible waived	Same as In-Network
Non-Emergency Care in an Emergency Room	Covered at 50% after deductible	Covered at 50% after deductible
Emergency Use of Ambulance	Covered at 80% after deductible	Covered at 70%; after deductible
Non-Emergency Use of Ambulance	Not Covered	Not Covered
HOSPITAL CARE	**IN NETWORK**	**OUT OF NETWORK**
Inpatient Coverage	Covered at 90% after $250 per admission copay; after deductible	Covered at 70% after $250 per admission copay

The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.

Inpatient Maternity Coverage	Covered at 90% after $250 per admission copay; after deductible	Covered at 70% after $250 per admission copay
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Outpatient Hospital Expenses (including surgery)	Covered at 90%; after deductible	Covered at 70%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.		

MENTAL HEALTH SERVICES	IN NETWORK	OUT OF NETWORK
Inpatient Biologically Based	Covered at 90% after $250 per admission copay; after deductible	Covered at 70% after $250 per admission deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Inpatient Non-Biologically Based	Covered at 90% after $250 per admission copay; after deductible	Covered at70% after $250 per admission deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Outpatient Biologically Based	$45 copay; deductible waived	Covered at 70%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.		
Outpatient Non-Biologically Based	$45 copay; deductible waived	Covered at 70%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.		
Crisis Intervention Services	$45 copay; deductible waived	Covered at 70%; after deductible

ALCOHOL/DRUG ABUSE SERVICES	IN NETWORK	OUT OF NETWORK
Inpatient	Covered at 90% after $250 per admission copay; after deductible	Covered at 70% after $250 per admission copay
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Residential Treatment Facility	Covered at 90% after $250 copay; after deductible	Covered at 70% after $250 copay
Outpatient	$45 copay; deductible waived	30%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.		



Aetna

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Open Choice® (PPO)

OTHER SERVICES	IN NETWORK	OUT OF NETWORK
Convalescent Facility	Covered at 90% after $250 per admission copay; after deductible Limited to 90 days per calendar year.	Covered at 70% after $250 per admission deductible
	The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	
Home Health Care Limited to 120 visits per calendar year.	Covered at 90% after deductible	Covered at 70%; after deductible
Each visit by a nurse or therapist is one visit. Each visit up to 4 hours by a home health care aide is one visit.Includes private Duty nursing limited to 70-eight hour shifts per calendar year.		
Hospice Care - Inpatient	Covered at 90%; after deductible	Covered at 70%; after deductible
	The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	
Hospice Care - Outpatient	Covered at 90%; after deductible	Covered at 70%; after deductible
	The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.	
Private Duty Nursing - Outpatient	Not Covered	Not Covered
Outpatient Short-Term Rehabilitation	Covered at 80% after deductible	Covered at 80%; after deductible
	Includes Speech, Physical, and Occupational Therapy	
Spinal Manipulation Therapy	$45 copay; deductible waived	Covered at 80%; after deductible
Durable Medical Equipment	Covered at 80%; after deductible	Covered at 80%; after deductible
Diabetic Supplies	Covered same as PCP office visit cost sharing	Covered same as any other medical expense.
Fertility Drugs (oral and injectable)	Covered at 90% after deductible	Covered at 70%; after deductible
Contraceptive drugs and devices not obtainable at a pharmacy (includes coverage for contraceptive visits)	Covered same as any other medical expense.	Covered same as any other medical expense.
Transplants	Covered at 90% after $250 copay; after deductible Preferred coverage is provided at an IOE contracted facility only.	Covered at 70% after $250 copay; after deductible Non-Preferred coverage is provided at a Non-IOE facility. Non-Preferred coverage is provided at a Non-IOE facility.

Bariatric Surgery	Covered at 90% after $250 per admission copay; after deductible	Covered at 70% after $250 per admission deductible

The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.

"Other" Health Care -- 20% member coinsurance after the preferred (per calendar year) deductible for services that are neither "preferred" nor "non-preferred".

FAMILY PLANNING	IN NETWORK	OUT OF NETWORK
Infertility Treatment	Member cost sharing is based on the type of service performed and the place of service where it is rendered.	Member cost sharing is based on the type of service performed and the place of service where it is rendered; after deductible

Diagnosis and treatment of the underlying medical condition.

Comprehensive Infertility Services	Member cost sharing is based on the type of service performed and the place of service where it is rendered.	Member cost sharing is based on the type of service performed and the place of service where it is rendered.

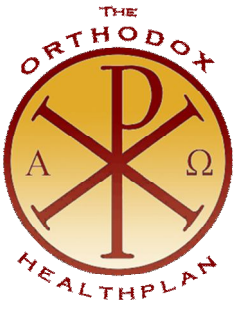
Coverage includes Artificial Insemination and Ovulation Induction.

Advanced Reproductive Technology (ART)	Member cost sharing is based on the type of service performed and the place of service where it is rendered.	Member cost sharing is based on the type of service performed and the place of service where it is rendered.

ART coverage includes: In vitro fertilization (IVF), zygote intra-fallopian transfer (ZIFT), gamete intrafallopian transfer (GIFT), cryopreserved embryo transfers, intracytoplasmic sperm injection (ICSI) or ovum microsurgery.Limited to $10,000 in member's lifetime. Maximum applies to all procedures covered by any Aetna plan except where prohibited by law.

Voluntary Sterilization	Member cost sharing is based on the type of service performed and the place of service where it is rendered.; after deductible	Member cost sharing is based on the type of service performed and the place of service where it is rendered.

Including tubal ligation and vasectomy.



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PHARMACY	IN NETWORK	OUT OF NETWORK
Retail	$15 copay for generic drugs, $25 copay for formulary brand-name drugs, and $40 copay for non-formulary brand-name drugs up to a 30 day supply at participating pharmacies.	30% of submitted cost after the applicable preferred copay
Mail Order	$30 copay for generic drugs, $50 copay for formulary brand-name drugs, and $80 copay for non-formulary brand-name drugs up to a 31-90 day supply from Aetna Rx Home Delivery®.	Not Applicable

Aetna Specialty CareRx
First prescription fill at any retail drug facility. Subsequent fills must be through Aetna Specialty Pharmacy®

No Mandatory Generic (NO MG) - Member is responsible to pay the applicable copay only.

Plan Includes: Diabetic supplies and medication covered at PCP cost sharing and Contraceptive drugs and devices obtainable from a pharmacy.

Oral and injectable fertility drugs included (physician charges for injections are not covered under RX, medical coverage is limited). Includes performance enhancement drugs. Precertification for growth hormones included.

GENERAL PROVISIONS	
Dependents Eligibility	Spouse, children from birth to age 26.
Pre-existing Conditions Exclusion	On effective date: Waived After effective date: Waived

For members age 19 or over this plan imposes a pre-existing condition exclusion, which may be waived in some circumstances and may not be applicable to you. A pre-existing condition exclusion means that if you have a medical condition before coming to this plan, you may have to wait a certain period of time before the plan will provide coverage for that condition. This exclusion applies only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received or for which the individual took prescribed drugs within 90 days. Generally, this period ends the day before your coverage becomes effective. However, if you were in a waiting period for coverage, 90 days ends on the day before the waiting period begins. The exclusion period, if applicable, may last up to 365 days from your first day of coverage, or, if you were in a waiting period, from the first day of your waiting period. If you had prior creditable coverage within 90 days immediately before the date you enrolled under this plan, then the pre-existing conditions exclusion in your plan, if any, will be waived.
If you had no prior creditable coverage within the 90 days prior to your enrollment date (either because you had no prior coverage or because there was more than a 90 day gap from the date your prior coverage terminated to your enrollment date), we will apply your plan's pre-existing conditions exclusion. In order to reduce or possibly eliminate your exclusion period based on your creditable coverage, you should provide us a copy of any certificates of creditable coverage you have. Please contact Aetna Member Services at 1-888-982-3862 if you need assistance in obtaining a certificate of creditable coverage from your prior carrier or if you have any questions on the information noted above. The pre-existing condition exclusion does not apply to pregnancy nor to a child who is enrolled in the plan within 31 days of birth, adoption, or placement for adoption. Note: For late enrollees, coverage will be delayed until the plan's next open enrollment, and the pre-existing condition exclusion will be applied from the individual's effective date of coverage.

Plans are provided by: Aetna Life Insurance Company. While this material is believed to be accurate as of the production date, it is subject to change.

Health benefits and health insurance plans contain exclusions and limitations. Not all health services are covered.

See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by location and are subject to change. You may be responsible for the health care provider's full charges for any non-covered services, including circumstances where you have exceeded a benefit limit contained in the plan. Providers are independent contractors and are not agents of Aetna. Provider participation may change without notice. Aetna does not provide care or guarantee access to health services.

If you are in a plan that requires the selection of a primary care physician and your primary care physician is part of an integrated delivery system or physician group, your primary care physician will generally refer you to specialists and hospitals that are affiliated with the delivery system or physician group.

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

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

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

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

Orthodox HealthPlans Summary of Benefits
PPO Dental Plan

Plan Features	***In-Network***	***Out-of-Network***
Plan Deductible (per calendar year; Applies to all covered services)	$50 Individual $150 Family	$50 Individual $150 Family
Routine Oral Exams, Prophylaxis, Diagnostic X-Rays Fluoride Treatment (for dependent children to age 15)	100% (Deductible waived)	100% (Deductible waived)
General Dental Expenses*	90% after deductible	80% after deductible
Crown, Inlays, Gold Fillings Fixed Bridgework and Orthodontia	60% after deductible	50% after deductible
Calendar year maximum	$1,500 per person	
Orthodontia Lifetime Maximum	$1,500 per person	
Orthodontia Eligibility	Dependent children to age 19 only	

*General Dental Expenses-Includes non-surgical extractions; fillings; general anesthetics; non-surgical endodontic treatment; non-surgical periodontal treatment; initial installation of dentures; space maintainers (dependent children only); repair or recementing of crowns, inlays, bridgework or dentures; relining of dentures; and administration of drugs for prevention, alleviation or cure of disease or pain.

This is a Summary of Plan Benefits Only. The Master Policy Contract holds more detailed information on coverage. In the event of any discrepancies, the Master Contract shall be binding, subject to State Mandates.

Aetna, Inc.

Enrollment/Change Request
Aetna Life Insurance Company

Employer Group Information: (To Be Completed by Employer)	Employer Name - Full Name of Business or Organization: Orthodox Health Plan	Control: 658408	Suffix	Account	Plan Number
	Employer Address (Street, City, State, ZIP Code) - Primary Location of Business or Organization	Group Number (IMO Only)		Customer Code (Optional)	

A. Type of Activity - Employee Completes Sections A - E. *Please Print Clearly.*

Instructions: Refer to the instructions on the back before completing this form. You, the employee, must complete this application in full or it will be returned to you resulting in a delay in processing. You are solely responsible for its accuracy and completeness.

Enrollment - *Check one.*
- ☐ New Enrollee/Subscriber — Effective Date / / — Date of Hire / /
- ☐ Rehire/Reinstatement — Date of Rehire/Reinstatement / /

Change - *Check all that apply.*
- ☐ Add Spouse
- ☐ Add Dependent Child
- ☐ Name Change
- ☐ Other
- ☐ Control/Suffix/Acct/Plan

Date of Event / / — Reason

Remove or Terminate - *Check all that apply.*
- ☐ Remove Spouse
- ☐ Remove Dependent Child
- ☐ Employee Withdrawal/ Termination
- ☐ Cancel Coverage

Effective Date / / — Reason

Continuation of Coverage, i.e., COBRA, State - ***Not all options are available. Contact Employer for available options.***
- Coverage For: ☐ Employee ☐ Dependents
- Length of Continuation: ☐ 18 ☐ 36 ☐ Other ____
- ☐ 29 - Attach disability determination from the Social Security Admin.
- Date of Loss of Coverage: / /
- Date of Qualifying Event: / /

B. Employee Information

Social Security Number	Last Name, First Name, M.I.	Home Telephone ( )	Work Telephone ( )
Employee Status ☐ Active ☐ Retired	Home Address	Apt. No. / City, State	ZIP Code

Beneficiary Designation - Full Beneficiary Name (First, Middle, Last) If more than one beneficiary, use Special Remarks (Section D).	Social Security Number of Beneficiary	Relationship to Employee	Earnings	
N/A	N/A	N/A	☐ Annually $ N/A ☐ Weekly $	☐ Insurance Amount $ N/A ☐ Supplemental Life $ ☐ AD&D Amount $

C. Plan Option - Your selection must be offered by your employer.

Check One:
- ☐ Aetna Choice™ POS II
- ☐ Aetna HealthFund™
- ☐ Aetna Open Access™ Elect Choice
- ☐ Aetna Open Access™ Managed Choice
- ☐ Elect Choice® EPO
- ☐ Managed Choice® POS
- ☑ Open Choice® PPO
- ☐ Traditional Choice®
- ☐ Aexcel℠
- ☐ Aexcel℠ Plus
- ☐ Other ____

D. Individuals Covered - List individuals for whom you are adding/changing/removing coverage. Attach sheet to list additional children. ☐ **Check this box if you are refusing coverage for your dependents.**

(A)dd (C)hange (R)emove	Name (First, Middle Initial, Last) (Explain difference in last names in Special Remarks.)	Relation. Code	Sex M F	Birthdate MM DD YYYY	Social Security Number (If dependent has no SSN, write "None")	Prior Insur. Plan	Other Medical Coverage	Other Rx Drug Coverage	Handi-capped	Student	Primary Medical Office ID Number	Current Patient	Race/Ethnicity - Optional (This information is designed for the purpose of data collection and will not be used for determining eligibility, rating or claim payment.)
		Self	☐ ☐	/ /		Yes ☐	Yes ☐	Yes ☐	Yes N/A	Yes N/A		Yes ☐	☐ White - 01 ☐ African American or Black - 02 ☐ Hispanic or Latino - 03 ☐ Asian - 04 ☐ Other - 05 ____
			☐ ☐	/ /		☐	☐	☐	☐	☐		☐	☐ White - 01 ☐ African American or Black - 02 ☐ Hispanic or Latino - 03 ☐ Asian - 04 ☐ Other - 05 ____
			☐ ☐	/ /		☐	☐	☐	☐	☐		☐	☐ White - 01 ☐ African American or Black - 02 ☐ Hispanic or Latino - 03 ☐ Asian - 04 ☐ Other - 05 ____
			☐ ☐	/ /		☐	☐	☐	☐	☐		☐	☐ White - 01 ☐ African American or Black - 02 ☐ Hispanic or Latino - 03 ☐ Asian - 04 ☐ Other - 05 ____
			☐ ☐	/ /		☐	☐	☐	☐	☐		☐	☐ White - 01 ☐ African American or Black - 02 ☐ Hispanic or Latino - 03 ☐ Asian - 04 ☐ Other - 05 ____

If "Yes" to Prior Insurance Plan, Other Medical Coverage and/or Other Rx Drug Coverage above, provide effective date, name & policy number of insurance carrier, HMO, or other source.

Does any dependent listed in above live at a different address than the Employee? If "Yes," who and what address?
☐ Yes ☐ No

Special Remarks

E. Employee Signature

I represent that all the information supplied in this application is true and complete. I hereby agree to the conditions of enrollment on the reverse side of this application.

Employee Signature - *Required*
X

Date / / — E-Mail Address

Primary Language Spoken

F. Employer Verification - To Be Completed by Employer

Employer Signature
X

Title — Date / /

Instructions

Employer

- Complete the **Employer Group Information** at the top of the form.
- Complete **Section F - Employer Verification** in the lower right corner of the form.
  - Employer must complete this section for all new enrollments or coverage changes.
  - Employer must sign and date the Enrollment/Change Request in order for it to be processed.

Employee - Complete Sections A - E.

Section A - Type of Activity:

- Check box(es) indicating reason(s) for submitting this Enrollment/Change Request. Provide Effective Date(s) and Date of Event(s) where requested.

Section B - Employee Information:

- Complete **all** information in order for your Enrollment/Change Request to be processed.
- Beneficiary Designation - Complete only if your employer is offering Aetna Life Insurance coverage.

Section C - Plan Option:

- Select only an option offered by your employer.

Section D - Individuals Covered:

- Add/Change/Remove - Use "A", "C", or "R" to indicate whether you are adding, changing or removing coverage for an individual.
- Print your full name along with the name(s) of your dependent(s), if applicable. Indicate Sex, Birthdate, and Social Security Number for each individual listed.
  - Relationship Code - Use **ONLY**: H=Husband, W=Wife, S=Son, D=Daughter, Y=Sponsored Male, X=Sponsored Female. **If the dependent is NOT your spouse or a biological or legally adopted child, please indicate relationship to employee in Special Remarks.**
- If you or your dependent(s) were covered under your employer's or other prior insurance plan, check the "Yes" box(es) and provide name and policy number of insurance carrier, HMO or other source in the space provided.
- If you or your dependent(s) have other Health or Rx Drug Coverage, check the "Yes" box(es) and provide name and policy number of insurance carrier, HMO or other source in the space provided.
- If a dependent is Handicapped and financially dependent, check "Yes" and provide proof of handicapped status from the attending physician.
- If a dependent is Student, check "Yes". Refer to your Summary Coverage for plan definitions. (Defined as: Unmarried dependent child age 19 or older, regularly attends school and depends solely on the enrollee for support. Aetna may request that you provide proof from the educational institution.)
- Primary Medical Office ID Number - Locate the office ID number for the primary care physician from the appropriate provider directory or from "DocFind®", Aetna's online provider directory at "www.aetna.com".
- If you are a current patient, please check the "Yes" box under Current Patient.
- *Optional* - Indicate the Race/Ethnicity for yourself and your dependents by checking the appropriate box(es). If your Race/Ethnicity is other than the selections listed, please check the "Other" box and print the Race/Ethnicity for yourself and your dependents in the space provided.

Section E - Employee Signature:

- Complete this section for all new enrollments or coverage changes.
- Employee must sign and date the Enrollment/Change Request in order for it to be processed.

Section F - Employer Verification:

- Employer must complete this section for all new enrollments or coverage changes.
- Employer must sign and date the Enrollment/Change Request in order for it to be processed.

Conditions of Enrollment

Applicant Acknowledgments and Agreements

On behalf of myself and the dependents listed on the reverse side, I agree to or with the following:

1. I acknowledge that by enrolling in an Aetna plan coverage is provided by Aetna Life Insurance Company (referred to as "Aetna").
2. I authorize deductions from my earnings for any contributions required for coverage and I agree to make any necessary payments as required for coverage.
3. I understand and agree that this Enrollment/Change Request may be transmitted to Aetna or its agent by my employer or its agent. I authorize any physician, other healthcare professional, hospital or any other healthcare organization ("Providers") to give Aetna or its agent information concerning the medical history, services or treatment provided to anyone listed on this Enrollment/Change Request form, including those involving mental health, substance abuse and HIV/AIDS. I further authorize Aetna to use such information and to disclose such information to affiliates, providers, payors, other insurers, third party administrators, vendors, consultants and governmental authorities with jurisdiction when necessary for my care or treatment, payment for services, the operation of my health plan, or to conduct related activities. I have discussed the terms of this authorization with my spouse and competent adult dependents and I have obtained their consent to those terms. I understand that this authorization is provided under state law and that it is not an "authorization" within the meaning of the federal Health Insurance Portability and Accountability Act. This authorization will remain valid for the term of the coverage and so long thereafter as allowed by law. I understand that I am entitled to receive a copy of this authorization upon request and that a photocopy is as valid as the original.
4. The plan documents will determine the rights and responsibilities of member(s) and will govern in the event they conflict with any benefits comparison, summary or other description of the plan.
5. I understand and agree that with the exception of Aetna Rx Home Delivery, all participating providers and vendors are independent contractors and are neither agents nor employees of Aetna. Aetna Rx Home Delivery, LLC, is a subsidiary of Aetna Inc. The availability of any particular provider cannot be guaranteed and provider network composition is subject to change. Notice of the change shall be provided in accordance with applicable state law.

Misrepresentation

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto may have violated state law.

Attention Colorado Residents: An insurer/agent who knowingly provides false or misleading information to defraud a Colorado claimant regarding insurance proceeds must be reported to the insurance division.

Attention Kentucky and Pennsylvania Residents: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.