ADMINISTRATIVE MANUAL FOR THE

HEALTH BENEFITS TRUST

with the NC League of Municipalities
updated July 2024

NCLM
NC LEAGUE OF MUNICIPALITIES

The Health Benefits Trust is a nonprofit insurance pool established by the North Carolina League of Municipalities to provide health insurance for local government employees.

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INTRODUCTION

The purpose of the Administrative Manual is to assist you in the administration of your plan through the Health Benefit Trust and to answer commonly asked questions.

The contents of this manual shall in no way alter the benefits outlined in the Health Benefits Trust Master Plan Document and subsequent amendments.

ABOUT THE HEALTH BENEFITS TRUST

The Health Benefits Trust (HBT) is a self-insured pool sponsored by the North Carolina League of Municipalities (NCLM). It provides employer group health benefits paid by the employer, as well as medical, dental, vision and disability for North Carolina local government entities.

Local governmental entities include cities, towns, villages, counties, housing authorities, water and sewer districts, councils of government, transit authorities, ABC boards, regional libraries of North Carolina, and other eligible municipal organizations.

NCLM HEALTH BENEFITS

Each employer group is fully insured.

HBT is governed by the Risk Management Services Board of Trustees, which is comprised of local government elected officials and staff. The League Board of Directors appoints the 12 members of the Risk Management Services Board of Trustees. The Trustees establish overall policy, set rates and approve special services. In addition, the board retains professional consultants in the fields of investment management, actuarial study and financial auditing.

The Trustees rely upon consulting actuaries to determine rate levels and reserves that pay future losses. The pool is reinsured for catastrophic claims. The professional staff of the League handles underwriting, claims and risk management, and loss control consulting services.

SIMON: HBT ELIGIBILITY AND BILLING

WHAT IS SIMON?

Starting 7/1/2024, employer groups in the Health Benefits Trust will have access to eligibility and billing portal, SIMON. This portal houses employee eligibility information and will produce the monthly billing statements.

Useful Links:

- SIMON (simon365.com)
- SIMON Training Videos on Vimeo

The SIMON platform offers a user-friendly interface where you can:

- Perform Open Enrollment
- View your benefit plan details
- Access important documents and forms
- Check eligibility and coverage information
- Access Monthly Billing Statements
- And much more!

For commonly executed functions in SIMON, please reference the Employer Portal User Guide, the online Training Videos, email mit@nclm.org, or call (919) 715 4000 press 7.

NCLM HEALTH BENEFITS

Put the power of SIMON® to work for you!

SIMON, the benefits administration platform from Vimly, makes the administration of your benefits simpler than ever.

- Enroll members with ease via simple workflows
- Go green and save time by accessing and downloading invoices and bills digitially
- Download data and reports anytime, at your convenience, like census, ACA, activity data, and more!
- SIMON is HITRUST® Certified—the gold standard for data security

SIMON

- Ensure timely and secure payments, and even setup autopay to never miss a payment
- Protect member data from unsecured email exposure and reduce potential errors with a single point of data entry

Additional benefits include:

- Easy access to benefit materials
- Employee self-service
- Access SIMON online, anywhere, on practically any device

VIMLY® BENEFIT SOLUTIONS

MEDICAL

LARGE PROVIDER NETWORK, CUSTOMIZABLE OPTIONS

Medical benefits are administered by Aetna. Members have the flexibility to choose providers and facilities that are included in Aetna's large provider network. Qualified High Deductible Health Plans and Medical Employer Reimbursement Plans are also available and can be customized to meet your employer group's coverage needs.

ID CARDS

Medical ID cards are produced by Aetna with both HBT and Aetna logos. Cards will be mailed to the employee's home address. Each enrolled person will have the option to have an ID card. Aetna operates on a family style, if you have dependents on your medical plan, they will be listed on the ID card. Additional cards can be printed directly from the member's Aetna web portal or app, or requested by calling Aetna Concierge.

WORKING WITH A BROKER

We understand the service brokers provide and we are happy to work with your broker of choice if you have one. To provide a seamless experience, we will need a copy of your Agent of Record (AOR) agreement, a document you sign giving the broker permission to work on your behalf. It also gives them access to claims and other sensitive information. Please provide your AOR to your NCLM Business Services Consultant to file with the Health Benefits Trust department and the NCLM finance department. This action will enable your broker of choice to offer their services without interference and ensure that you restrict your sensitive information to the broker you selected explicitly per the AOR.

Below are things to remember when working with a broker:

- HBT will only work with a broker if you provide an AOR, and we will only work with one broker at a time for any group.
- Please inform us of any changes in your broker-of-choice relationships.
- We will provide the same rate to any broker you work with; changing brokers does not change your HBT rate.
- When looking at changing or adding a broker relationship, look at the services that this broker provides beyond shopping the market for you. A few examples include enrollment systems, training modules, Human Resource assistance, and voluntary products.
- Broker Services can be billed through HBT as a separate line item; we do not include this in the rates we provide.

PHARMACY

HBT contracts with CVS to provide pharmacy benefits with affordable copays based on drug tier. While we offer a standard copay plan, pharmacy copays can be customized for groups with 50 or more employees. Specialty drugs (i.e., injectables in doctors' offices) are also administered through CVS Specialty Pharmacy.

STANDARD COPAY PLAN

	Retail Pharmacy Copay covers up to a 30-day supply	Mail Order Copay covers up to a 90-day supply
Generic	$5	$10
Preferred Brand	$30	$50
Non-Preferred Brand	$50	$115
Mandatory Specialty Pharmacy	$75	See next page

Your pharmacy plan covers some drugs, and your medical plan covers others. Depending on your plan, you may need to pay a co-payment or coinsurance. And certain drugs require precertification. This just means you need approval from the plan before they'll be covered.

Talk with your provider or call us at the number on the back of your member ID card with any questions about your prescriptions.

How to get started

You can manage your medications at **CVSSpecialty.com**.

- **Existing prescriptions?** Call **1-800-237-2767 (TTY: 711)** to transfer your prescription
- **New prescriptions?** Your doctor can:
  - E-prescribe to CVS Specialty
  - Call one of our registered pharmacists at **1-800-237-2767 (TDD: 1-800-863-5488),** Monday through Friday, 7:30 AM to 9:00 PM ET
  - Fax the prescription to 1-800-323-2445

Need help?

Live chat is available at **CVSSpecialty.com** during hours of operation.

WELLNESS BENEFITS/PREVENTATIVE SERVICES

The Wellness Benefit provides coverage for preventive services such as routine physical exams, mammograms, prostate screenings, immunizations, and routine laboratory tests. The services may not be related to the treatment of an illness or injury.

Think of the wellness benefit as a way to cover the routine tests and exams you need in order to determine the state of your health, saving your regular coverage for illness or injury. The benefit is unlimited and payable at 100% for in-network providers; out-of-network coverage is based on each particular plan design coinsurance. Age and frequency limits do not apply.

Implementing wellness incentives that help prevent and identify illness is a proven way to achieve long-term cost savings. Employers benefit by having reduced claims, and employees have access to health education and earlier interventions if health issues do arise.

Members also have six visits annually for Medical Nutritional Counseling. This benefit is covered at 100% in-network for those with a diagnosed disease such as diabetes, obesity, high cholesterol or high blood pressure.

WELLNESS PARTICIPATION REQUIREMENTS

The League's Risk Management Board of Trustees has wellness requirements in place designed to help members become healthier and to better control premium costs for all participants.

Compliance with the requirements must be met by the end of the calendar year to avoid a 10% surcharge to monthly rates starting on the following renewal. Dependent children and retirees are not required to participate. Surcharges are not to be paid by the employer but will be passed along via the employee's payroll deductions for 12 months. Employees have only three months (July - September) to appeal from the time surcharges apply.

Member entities can check the noncompliance list in the SIMON Portal throughout the year and encourage their employees to meet these requirements before the end of the calendar year, therefore avoiding a 10% premium surcharge.

All covered individuals (employee and spouse) will need to meet the following wellness participation guidelines:

- Annual wellness visit/routine physical to check blood pressure, cholesterol, blood glucose levels, etc., either through a primary physician, urgent care or employer-sponsored (and approved by HBT) on-site screening.
- Although not required, age-appropriate cancer screenings remain covered at 100%. Health Benefits Trust encourages its members to talk to their doctor and schedule these screenings.

TOBACCO CESSATION

The North Carolina League of Municipalities is committed to wellness benefits that improve employees' health and lives. Members are eligible for additional tobacco cessation benefits if they are enrolled in a League medical program. These are included with a prescription without cost share:

- Nicotine replacement therapy (i.e., gum, lozenge, transdermal patches, inhaler and nasal spray).
- Sustained release Bupropion, Chantix (or generic equivalent, if available).
- Preventive Medications: Includes certain prescribed over-the-counter products without cost share as required by PPACA.

The League encourages members to have a conversation with their Primary Care Physicians about quitting the use of tobacco products.

CVS VIRTUAL CARE

From your therapy appointments to quick care, we've got you covered. Easily schedule a virtual care appointment from anywhere. You can use CVS Health Virtual Care™ in addition to your traditional network of providers. Access is included in your medical plan, made available through Aetna, a CVS Health company because healthier happens together.

On-demand care

- Available to adults and children over 18 months
- Coughs, colds, flu and strep
- Joint, head, and stomach pain
- Infections (ear, sinus, skin, UTI)
- Medication refills

Mental health services

- Available to adults ages 18 and up
- Anxiety and mood disorders
- Depression screening
- Medication management
- Support with stress, life adjustments and conflict resolution
- Sleep and related health behaviors

Get started today

Scan the QR code or go to **CVS.com/virtual-care** to register and schedule an appointment.

WONDR HEALTH

Wondr™ is a skills-based digital weight loss program offered by the Health Benefits Trust that has helped thousands of people in different stages of health:

- Lose weight
- Feel their best mentally and physically
- Use practical, clinically proven health skills that become life skills

Wondr is a digital behavioral change program that teaches clinically proven weight management skills. A master class of sorts, their renowned team of doctors and clinicians teaches the behavioral science behind eating the foods you love while still losing weight and improving your overall physical and mental well-being.

Wondr is a personalized, 100% digital program that is built in three stages for results throughout the year and beyond. It starts with weight loss to teach the science of better sleep, less stress, improved emotional health, and so much more.

ENHANCED MATERNITY

Exciting changes are coming your way. And with the Aetna Enhanced Maternity Program, you can count on us to support you throughout your entire pregnancy journey. The program is included in your Aetna® plan. Rest assured, you're getting support and resources at no extra cost to you.

This no-extra-cost resource is available through your member website and offers information about the maternity journey. Whether you're planning for a baby, already pregnant, or post-delivery, it's personalized for you and where you can find:

Getting started is easy

- Text BABY to 66902. *
- Enroll on your Aetna member website.
- Call us at 1-800-272-3531 (TTY: 711) weekdays from 8 AM to 7 PM ET.
- You'll learn about what to expect before and after delivery, early labor symptoms, newborn care and more.

For participating in this program, moms who sign up in the first trimester will receive $150; if they sign up in the second trimester, receive $75.

DIABETES MANAGEMENT PROGRAM

NCLM's Diabetes Management program, offered through HealthMapRx and available to all Health Benefits Trust members enrolled in a medical plan, is a valuable and tremendous resource for your employees — and it's free.

This voluntary program keeps our diabetic and pre-diabetic members healthy and in control.

Through Diabetes Management, your covered employees are paired with a Pharmacist Care Manager, who they'll meet for coaching and consultation four to six times per year. Co-pays are 100% covered for condition-related preferred medications. Not only are these services provided at no cost, but compliant participants will additionally be awarded up to $120 per year!

Benefits of HealthMapRx™ Diabetes Management

- Health coaching: A personalized Pharmacist Care Manager will meet with employees throughout the year for consultation and assistance.
- Help with expensive medications: Co-pays are 100% covered for condition-related preferred medications through this program.
- Awards: Complete the program, and employees will earn $120 per year.
- Eligibility: Participant is a covered HBT member. Takes medication for diabetes or pre-diabetes.

Three Enrollment Options Available

1. Enroll online: https://www.ppcn.org/nclm.html
2. Fax or scan/email the completed Participant Information Form to PPCN
3. Contact Jessica Bridges, PPCN Health Promotions, at (704) 618-7719 or jessica.bridges@emailmm.com

AETNA ONE FLEX PROGRAM

Our care management model takes a holistic approach to physical and emotional well-being.

There's one-on-one support for acute and chronic condition care through a single nurse. Our Aetna Advice program uses advanced artificial intelligence (AI), exclusive member data and progressive analytics. Working together, they create a predictive, custom engagement. Our clinical data comes from an analysis of social determinants of health to help close equity gaps in care. All of which lead to better health outcomes and lower medical costs.

COMPLEMENTARY ALTERNATIVE MEDICINES (CAM) BENEFITS

Our local governments have unique responsibilities and unique leaders to carry them out. It's critical that the wellness needs of those leaders are met.

To that end, the Health Benefits Trust offers the CAM Program (Complementary or Alternative Medicine). The CAM Program is available to groups that have medical coverage through HBT, and provides coverage of the following complementary and alternative medical treatments:

- Acupuncture/Dry Needling: a practice in which fine needles are inserted into the skin to stimulate specific points in the body.
- Acupressure: massaging certain points on the body to relax muscles, balance your natural energy flow, and relieve stress and pain.
- Ayurvedic medicine: treatment based on the belief that health and wellness depend on a delicate balance between the mind, body, and spirit. Its main goal is to promote good health, not fight disease.
- Biofeedback: a method used to help a person learn stress-reduction skills by providing information about muscle tension, heart rate, and other vital signs as the person attempts to relax.
- Energy medicine: (see Qi Gong and Reiki)
- Functional medicine: (see Appendix B in Master Medical SPD for more information)
- Homeopathy: a medical system based on the belief that the body can cure itself. Those who practice it use tiny amounts of natural substances, like plants and minerals.
- Hypnotherapy: treatment using guided relaxation, intense concentration, and focused attention to achieve a heightened state of awareness. Hypnotherapy can help some people change certain behaviors, such as to stop smoking or nail-biting. It can also help in treating certain kinds of pain.
- Integrative medicine: (see Appendix B in Master Medical SPD for more information)
- Massage therapy: a form of hand-applied pressure-point treatment that can reduce pain, anxiety, fatigue, and nausea. (Note that claims are based on individual massage sessions.)
- Naturopathy: a system that uses natural remedies (including, massage, acupuncture, exercise, and nutritional counseling) to help the body heal itself.
- Qi Gong: a Chinese form of moving meditation.
- Reiki: a form of "touch" therapy that realigns your body's energy balance. It can make it easier to manage pain, stress, and worry.

- Traditional Chinese / Asian medicine
- Yoga therapy: a form of exercise with specific poses or sets of movements that can be combined with deep breathing to help ease stress, anxiety, and fatigue, and help you sleep better. (Not to exceed a six-session package per claim submission and must be submitted after the last date of the package.)

Enjoying these treatments is simple! When the Plan Participant participates in a CAM Program treatment, the fee should be paid to the provider at the time the service is rendered.

After participation and payment, fill out a Medical Claim form and send it to camsprogram@aetna.com with your receipt. You can find this form at www.aetna.com/individuals-families/using-your-aetna- benefits/find-form.html.

Members with a copay structured plan are responsible for a $30 copay for CAM benefits. After services are received (like a massage) the employee will pay 100% of the cost to the provider. The employee will then fill out a claim form and attach a receipt for services. The employee will be reimbursed all but $30.

For example, if I received a $100 massage, I would pay the provider in full. I would then file a claim. A reimbursement of $70 would arrive in the mail.

Members with a High Deductible Health Plan (HDHP) must meet their deductible before reimbursement. When services are rendered (like a massage) the employee will pay 100% of the cost to the provider. The employee will then fill out a claim form and attach a receipt for services. The employee will not be reimbursed until their deductible is met. This will count towards their deductible accumulation. After the deductible is met, CAM Benefits will be reimbursed at 100%.

For example, if I received a $100 massage, I would pay the provider in full and then file a claim. If my deductible has already been met, I would receive all $100 back in the mail. This benefit has a $1,000 per year max per individual.

Questions? Call your HBT team (919)-715-4000 ext. 7 or Aetna at (855)-221-1536.

WELLNESS AND EAP GRANT PROGRAMS

The Health Benefits Trust, under the direction of the RMS Board, budgeted $100,000 for wellness and EAP grants this fiscal year. Wellness grants are intended to promote health and wellness for employees and work toward reducing medical claims and insurance costs for pool members.

Groups that participate in the Health Benefits Trust medical program are eligible to apply for the Wellness Grant to assist with a number of health-related initiatives as outlined below. Groups can apply once a year with a varying funding model based on employees.

Eligible funding is based on the number of employees in the member's group

- Groups with 1-49 employees: $2,500
- Groups with 50-100 employees: $3,500
- Groups with 100+ employees: $5,000

Applications for the Wellness Grant are to be submitted electronically through the NCLM website. Wellness Grant application submission period opens September through November with awards in February.

There is no guarantee that a grant will be awarded or fully funded. Please keep this in mind if items are purchased prior to receiving an award letter.

Grant awards are valid for six months from the date that the award letter or email was issued to the member. After that time, they expire. Unused grant awards will immediately expire if a member leaves the HBT health

insurance program.

A member that does not use at least some portion of a grant award before it expires will be ineligible for the grant program for a period of one year.

Don't miss your chance for funding toward your municipality's wellness efforts! Grants can be used for a variety of health and wellness activities and improvements.

WELLNESS GRANT ACTIVITIES FOR FUNDING

- Health Fair – Excluding giveaway items
- Red Cross Training and Recertification
- Financial Management
- Fitness Instruction of Equipment
- Health Educational of Wellness Speaker
- Nutritional Educational Speaker
- Stress Management
- Lunch n' Learn

APPLICATION GUIDELINES

Applications will be considered only when they meet the following requirements:

- All members applying must be in Medical Program to apply for the Wellness Grant.
- All applications must be signed by the senior municipal official (based on the member's form of government - e.g. manager/ administrator, executive director, or mayor). For the purpose of this grant, department heads are not considered senior municipal officials.
- All applications must include a letter describing how the intended wellness event, equipment, etc. will benefit and/or improve the overall health and wellness of all employees and a detailed estimate that indicates the product or service and the associated cost (Taxes and Shipping not applicable).

Eligibility and Award Rules

- Each member group in the medical program is eligible to receive one grant annually
- The total for all grants will not exceed its number of employees in the group.
    - See amounts based on the number of employees in group
- Grant awards are valid for six months from the date that the award letter and check are received.
    - A member that does not use all or any portion of a grant award in the 6 months will be asked to refund the amount awarded and will be ineligible for the grant program for a period of one year
- All grants approved will require a post-activity letter, receipts, and/or pictures describing the activity and participation paid for with the awarded grant funds within 6 months of funding
- Additional grants will not be considered if the requested proof of purchase is not received
- The Wellness Grant programs will not be provided to offset salary for any
- There is no guarantee that a grant will be awarded or fully funded.
- Please keep this in mind if items are purchased prior to being notified to receive a Wellness Grant Award.

DENTAL BENEFITS

PLANS

As the nation's leading provider of dental insurance, Delta Dental works with the Health Benefits Trust and our members to protect their employees' smiles with the largest network of dentists, quick answers, and personalized service. The Health Benefits Trust offers benefit plan designs to give your employees flexibility on the coverage they need. Coverage is available for a variety of services.

NETWORK

When you enroll in dental benefits with the Health Benefits Trust, you get access to the Delta Dental Network of providers. As a client of Delta Dental of North Carolina, your employees will have access to the nation's largest dental networks: **Delta Dental PPO** and **Delta Dental Premier.** With four out of five dentists participating nationwide, these two networks provide superior access to care as well as reduced fees through our agreements with participating dentists. Lower claims costs mean lower rates!

Moreover, your employees cannot be balance billed – giving employees added savings. Enrollees can visit nonparticipating dentists, but they can be balance billed and may have to pay more.

ID CARDS

Dental ID cards are produced by Delta Dental with both Delta Dental and HBT logos. Cards will be mailed to the employee's home address. Each employee will receive one card if they are an employee only and two cards if they cover dependents. This card has employee information only. Additional cards can be printed directly from the member's Delta Dental portal or requested by calling any member of the Health Benefits Trust staff.

ADMINISTRATION

- General administration (eligibility and billing) will be handled by HBT through SIMON
- Any changes to dental enrollment will need to be filed with SIMON
- Claims are processed by Delta Dental NC
- Expenses (administration and claims) will be paid by HBT on a self-funded basis
- COBRA administration through HBT and Delta Dental.
- Covered individuals can set up an account online at deltadentalnc.com/hbt to see benefit details, when they are eligible for benefits, claims, etc.

Delta Dental PPOSM dentists

- No balance billing on covered services
- Most significant network discounts with more than 2,681 dentists in North Carolina*
- Dentists file claims for member

Delta Dental Premier dentists

- No balance billing on covered services
- Significant network discounts with more than 3,705 dentists in North Carolina*
- Dentists file claims for member

Out-of-network dentists

- Delta Dental Premier dentists
- May be balance billed
- No network discounts
- May need to file own claims

*Delta Dental of North Carolina internal data, 2021.

How it works—As shown below, your lowest out-of-pocket costs result from going to a Delta Dental PPO dentist.

Example savings for a crown by network	Estimated charge	Maximum allowed fees	Percentage paid by Delta Dental	Amount Delta Dental pays	Amount dentist can balance bill	Total amount you pay	Your total cost savings
Delta Dental PPO	$1,500	$900	50%	$450	$0	$450	$600
Delta Dental Premier	$1,500	$1,000	50%	$500	$0	$500	$500
Out-of-network	$1,500	$1,200	50%	$600	$300	$900	$0

Delta Dental PPO dentists

Delta Dental PPO dentists have agreed to charge $900 for the $1,500 service, a savings of $600. Your Delta Dental plan covers 50 percent of the cost. Assuming you've already met your deductible for the year, Delta Dental will pay $450 and you'll pay $450.

Delta Dental Premier dentists

Delta Dental Premier dentists have agreed to charge $1,000—a savings of $500 compared to the fee the dentist usually charges. Assuming you've met your deductible, Delta Dental will cover 50 percent of that $1,000, paying $500. You'll also pay $500. That's an extra $50 tacked on to your share of the bill when compared to what you would have paid with a Delta Dental PPO dentist.

Out-of-network dentists

Out-of-network dentists have not agreed to charge lower fees and can bill the full $1,500. Delta Dental has set a limit on the accepted amount at $1,200, which means Delta Dental's share of the tab is $600. The dentist can bill you the difference between Delta Dental's payment and what they charge. This leaves you with a bill of $900, which includes the $300 the out-of-network dentist can "balance bill."

VISION

HBT offers three vision (group) plans for employees through VSP: Basic, Premier and Premier Plus.

PARTICIPATION REQUIREMENTS

- Governmental Units must purchase medical and/or dental coverage from HBT
- All employees must be covered
- Employees must choose whether to cover dependents
- Employees and dependents are required to remain on the vision plan for a period of 24 months

ADMINISTRATION

- General administration (eligibility and billing) will be handled by HBT and each employer group through SIMON
- Benefits will be scheduled and claims processed by Vision Service Plan (VSP), a national network of non-profit Vision Service Plans
- Expenses (administration and claims) will be paid by HBT on a self-funded basis
- COBRA administration provided by HBT and VSP
- Covered individuals can setup an account online at www.VSP.com to see benefit details, when they are eligible for benefits, claims, etc.

NETWORK OF DOCTORS AND SUPPLIERS

VSP has a network of doctors and suppliers who have agreed to provide services at discount prices.

Currently, 952 doctors are “in-network” in cities and towns in North Carolina (more can and will be added as the need arises.

ID CARDS

No personalized ID cards are printed. Covered individuals ID number is their social security number. If you’d like a reference card, you can print one on www.vsp.com

LIFE

The Health Benefits Trust offers life insurance, accidental death and dismemberment, supplemental life insurance, and dependent life insurance underwritten by Unum. Each type of coverage has its own plan options and premiums.

The Health Benefits Trust's standard life insurance benefit offers nine benefit designs and allows an employer to create a plan that meets its needs. Benefits are 100% employer-paid and are paid regardless of the cause of death. Elected officials are eligible for coverage. Benefits are reduced at ages 65, 70, 75 and upon retirement.

ACCIDENTAL DEATH AND DISMEMBERMENT

Plan pays a benefit equal to the basic life amount for loss due to accidental injury. The loss must occur within 90 days after the date of the accident.

AD&D pays for the following losses:

- Loss of life;
- Loss of more than one member;
- Loss of one member (one-half benefit);
- Loss of a hand by total severance at or above the wrist;
- Loss of a foot by total severance at or above the ankle joint;
- Total loss of the sight of an eye.

ACCELERATED LIFE BENEFIT

Fifty percent of the life benefit can be obtained by the covered individual while alive if a doctor has diagnosed with a terminal illness with 12 months or less to live. The life benefit will be reduced to 50% at the time of death.

DEPENDENT LIFE INSURANCE

HBT offers four standard term life plans for employees' dependents through Unum/ Provident. All life plans are underwritten by Unum/Provident. Dependent life coverage is available on all eligible dependents.

During renewal, your group may select from these standard Dependent Life plan offerings:

- Plan A $2,000
- Plan B $2,500
- Plan C $5,000
- Plan D $10,000

Note: dependent life coverage cannot exceed the employee life benefit amount.

GROUP LIFE

During renewal, your group may select from these standard plan offerings:

- Plan A $10,000 Department Heads and $5,000 General Employees
- Plan B 1 x salary
- Plan C 1.5 x salary
- Plan D 2 x salary
- Plan E $25,000 Manager, $15,000 Department Heads and $10,000 General Employees
- Plan F $50,000 Manager, $25,000 Department Heads and $15,000 General Employees
- Plan G $10,000 All Employees
- Plan H $25,000 All Employees
- Plan O $50,000 All Employees
- Plan 1X $20,000 All Employees
- Plan 20X 2 x salary with a maximum of $100,000
- Plan 21X $75,000 All Employees
- Plan 22X $100,000 Department Heads and $50,000 General Employees

The life policies offered by the League are group life policies and are non-voluntary. If your organization offers these programs, all eligible employees must participate. One hundred percent of the premium is employer-sponsored.

Note: to ensure accurate billing, if your life plan is based on salary, please update salaries in SIMON biannually.

SUPPLEMENTAL LIFE INSURANCE

HBT offers supplemental term life for employees through Unum/Provident. All life plans are underwritten by Unum/Provident. The following applies:

25% participation or must have evidence of insurability

- No disability premium waiver
- $10,000 increments up to $100,000 maximum; after initial enrollment, an annual increase of $10,000 will be allowed without evidence of insurability
- Only available to active employees; coverage is portable upon termination of employment or retirement unless the employer provides retiree life benefits
- Benefits reduce at ages 65, 70 and 75 (see benefit booklet)
- Premium based on age

Tips on Health Benefits Trust Life Program

- Elected officials' stipulation: if based on salary and have elected officials there is a cap of $20,000 in benefits. If not based on salary, they get that set amount.
- The waiting period for Unum products is 30 days minimum. If the municipality's policy is longer than 30 days, the longer period applies.
- Billing: Unum rounds up to determine the life insurance amount.
- Use the SIMON portal and the paper enrollment forms for record-keeping for any and all enrollment documents.
- HBT recommends asking your employees to update their employee's beneficiary forms yearly at open enrollment.
- Beneficiary forms are kept at the member group's HR level but can be added to the SIMON eligibility platform.

Questions About Unum Coverage? Start with your HBT team.

If your questions are regarding a specific claim, your employee will have an assigned benefit consultant found on their letter or paperwork. If you need help finding that contact, reach out to your HBT team.

Elected officials and special categories (such as volunteer firefighters) are not subject to the hourly minimum for eligibility.

SHORT AND LONG TERM DISABILITY

SHORT TERM DISABILITY BENEFITS FOR EMPLOYEES

Summary of Benefits

- Employees working 30 hours or more are eligible for short-term disability benefits.
- If you have an approved disability your benefit would be 60% of your basic weekly salary for a maximum of 26 weeks.
- Benefits will begin on the 8th day of disability due to an accident or sickness.

If a Participant while covered under this Plan for short term disability benefits shall become wholly and continuously disabled so as to be actually prevented from the performance of every duty of his or her occupation or employment for salary or wages, due to bodily injury or sickness, the MITNC will pay benefits to such Participant according to the Schedule of Benefits.

Employees must be actively at work on the effective date of the short-term disability benefit plan to be eligible for benefits. If the employee is not actively at work, short-term disability benefits will be postponed until the employee returns to work for at least five consecutive workdays. For the purpose of this plan, actively at work shall mean the active expenditure of time and energy in the service of the governmental unit, except that a Participant shall be

deemed actively at work on each day of a regular paid vacation, or on a regular non-working day, on which he or she is not disabled, provided he or she was actively at work on the last preceding regular working day.

Successive periods of disability shall be considered as one continuous period of disability unless: (1) the subsequent disability is due to causes entirely unrelated to the causes of the previous disability; or (2) they are separated by a continuous period of at least two weeks during which the Participant is not absent from active work on a full-time basis.

Changes in the amount of benefit due to change in occupation, position, salary or wage will become effective on the first day of the month following the date of change, except if the Participant is away from work due to disability on the date an increase in the amount of benefit would become effective, it will be postponed until the Participant returns to active full-time work.

Exclusions

- War -- You are not covered for disabilities caused or contributed to by war or any act of War. War means declared or undeclared War, whether civil or international and any substantial armed conflict between organized forces of a military nature.
- Intentionally Self-Inflicted Injury -- You are not covered for Disabilities caused or contributed to by an intentionally self-inflicted injury, while sane or insane.
- Employment -- You are not covered for Disabilities arising out of or in the course of any employment for wage or profit.

Limitations

- Occupational Benefits -- You are not eligible for benefits during any period you are receiving or are eligible to receive benefits under a Workers' Compensation law or similar law. If your claims for these benefits are accepted, compromised, or settled, you must repay us for the full amount of any payments we make to you while your claims for occupational benefits were pending.
- Long Term Disability -- You are not eligible for STD benefits during any period you are receiving or are eligible to receive LTD benefits under any policy issued by Provident.

Benefit Offsets

- Salary continuation from the Employer; and
- Any amount you receive or are eligible to receive because of your Disability under any state disability income benefit law or similar law.

LONG TERM DISABILITY BENEFITS

Summary of Benefits

Employees working 30 hours per week on the day after 1 month of eligible service.

If you have an approved disability your benefit would be 50% of your base monthly earnings to a maximum of $5,000 per month.

Benefits can continue for up to 5 years based on your age at the time of disability and as long as you continue to meet the definition of disability.

Maximum Benefit Period

Age at Disability	Benefit Period
69 or younger	Five years or to age 70 (whichever occurs first, but not less than one year)
70 or older	One year

Additional Important Information

Can I be considered disabled and also work?

Yes, the contract has a proportional formula that encourages a claimant to begin building up towards a full work schedule. While your LTD benefit is proportionally reduced by your work earnings the overall result of the LTD benefit plus the work benefit is that your total income is higher than the disability benefit alone.

Are there any exclusions on conditions I already have?

This has a two-part answer. If you are one of the people currently covered by the LTD plan for at least 12 months then you are past the pre-existing conditions period.

For all others, there is a pre-existing conditions clause for the first 12 months of coverage. This excludes any disability that occurs during the first 12 months of coverage if, during the three months immediately prior to your coverage effective date, you received treatment or took Rx drugs for the condition.

What if I die while I am receiving LTD benefits?

Unum will pay a survivor benefit to your spouse or qualified surviving children. The benefit is equal to three times the LTD monthly benefit

How long do I have to be disabled before the LTD benefit can be paid?

The disability elimination period is 180 days.

The information on these pages is not the policy and is intended for a summary discussion purposes only. You should refer to the policy for details regarding various restrictions, limitations or exclusions that are contained in the actual policy. In the event of a claim the formal policy language will be used to adjudicate the claim. Group certificates will be distributed as soon as possible.

HBT ENROLLMENT

INITIAL ENROLLMENT AND ELIGIBILITY

All enrollment and change forms can be entered online at SIMON (simon365.com) by the member's HBT contact under the administrative account. If you need to send a paper form, make sure to send in a secure environment. Please contact HBT Eligibility for a secure email MIT@nclm.org. This form can be found in the SIMON portal. Please see the section of the Administrative Manual with information on SIMON for more details on enrollment.

Note: All paper or electronic forms must be keyed into SIMON for eligibility to be accurately reflected.

IMPORTANT NOTICES – SPECIAL ENROLLMENT REQUIREMENTS
Please provide each new employee with the Special Enrollment Requirements Notice. This Notice should be provided to employees whether or not they elect coverage under your health plan. HIPAA Federal laws require that this information be disclosed to all newly eligible participants.

Employee Waiting Period

When a new employee is hired, he/she must complete the waiting period elected by the employer for benefits. The UNUM products require at least a one-month waiting period for any of the Life, Short Term Disability and Long Term Disability before coverage can become effective. If your personnel policy requires a longer waiting period, this must be adhered to for all new employees and a copy of your personnel policy must be on file with MIT. This must be entered online in the SIMON portal under the administrative account or a group enrollment card must be completed when the employee is first hired and forwarded as soon as possible to mit@nclm.org.

This will ensure the addition of the employee to the claims system and monthly billing as well as the production of a medical identification card.

Direct Transfers

The waiting period may only be waived for new employees who are transferring directly from one governmental unit to another, both of whom are HBT participants. Direct transfers are employees who leave one governmental unit and begin active work for a new governmental unit within seven calendar days. If the time period between termination at one unit and active work at the next unit is greater than seven days, the full waiting period applies. A new group enrollment card is required for direct transfers.

Late Enrollment

If an employee elects coverage for himself when first hired and the group enrollment card is received 14 days after the date coverage should take effect, coverage will not become effective until contributions are paid retroactively to the original date of coverage. It is important that required contributions are paid to reflect the coverage that is provided.

Both timely enrollment and payment of contributions ensure coverage for

your employees and eligible dependents. If “back” contributions are not paid within 30 days of notice from HBT, coverage will be terminated.

Changes during the Waiting Period

The employee may make changes to coverage for himself and/or dependents until his effective date. Changes made during the waiting period will be effective on the employee’s effective date assuming the appropriate contribution payment is made.

Late Enrollees

Late enrollees (employees who do not elect coverage for themselves or eligible dependents during the waiting period or during a qualifying event) may be subject to plan limitations. Payment of claims may be delayed until contribution payments are received.

Please refer to the employee benefit plan book for more information. Employees and/ or dependents requesting life coverage after the date coverage should have become effective will have to complete an Evidence of Insurability Form and apply for the desired amount of coverage. Life coverage will become effective only if and when UnumProvident gives their written permission.

Rehired Employees

If an employee is terminated and not rehired within a seven-day period by the governmental unit, he must complete the employers required waiting period from the date of rehire before coverage is effective. A minimum of one month is required for all UNUM benefits (life, STD and LTD). A new group enrollment card must be completed when a former employee is rehired either online or completed and emailed.

WAIVER OF COVERAGE

The HBT requires 80% employee participation in each line of coverage offered by the governmental unit, whether the coverage is paid for by the governmental unit or the employee. However, if, with prior approval from the MIT for certain circumstances, an employee or elected official chooses NOT to elect coverage, this must be indicated on the Group Enrollment Card. Please be specific in indicating coverage declined and the reason.

Waiving one line of coverage does not prohibit an employee from enrolling in another line of coverage offered by the governmental unit. This section is located just above the employee signature line on the Group Enrollment Card.

IDENTIFICATION CARDS

After an employee has completed the group enrollment card and has satisfied the required waiting period, he should receive an identification card for medical, prescription, and/or dental coverage.

Medical ID cards are produced by Aetna with both HBT and Aetna logos.

Cards will be mailed to the employee's home address. Each employee will receive one card if they are employee only and two cards if they cover dependents. Additional cards can be printed directly from the employee's Aetna web portal or requested by calling Aetna concierge.

Dental ID cards are produced by Delta Dental with both Delta Dental and HBT logos. Cards will be mailed to the employee's home address. Each employee will receive one card if they are employee only and two cards if they cover dependents. This card has employee information only. Additional cards can be printed directly from the member's Delta Dental portal or requested by calling any member of the Health Benefits Trust staff.

The Vision Service Plan does not require ID cards. However, the insured must inform their vision provider they have VSP coverage when scheduling their appointment. The provider will verify the member's eligibility with VSP and obtain authorization prior to the appointment. If the member does not inform their vision provider that they have VSP coverage in advance of their appointment, benefits may be reduced. Eligibility and coverage information is available online at www.vsp.com.

CHANGES OF COVERAGE

There are two basic types of changes in coverage for your employees. The first is a change that affects all your employees at the same time (plan change). The other type of change occurs when an individual employee desires a change to his coverage.

All enrollment and changes can be entered online via the SIMON portal. If you need to send a paper form, be sure to send it in a secure environment. Please contact mit@nclm.org. This form can be found in the Appendix as well as on the SIMON portal.

Note: to ensure accurate billing, if your life plan is based on salary, please update salaries in SIMON biannually.

PLAN CHANGES

Your governmental unit may desire a change in coverage at some point after the initial Proposal Acceptance Form is signed. Changes that affect the types of coverage offered to all employees are initiated by calling the MIT and signing a new Proposal Acceptance Form. A 30-day advance notice is required by the MIT in order to make a change to your governmental unit's coverage offerings. Proposal Acceptance Forms should be obtained from and returned to MIT.

If a plan change would affect individual employees differently, change cards must be completed for each employee. If a new coverage is offered to employees and dependents, each employee must complete a group change card to add coverage for himself. Each eligible dependent to be covered must also be listed. The MIT is unable to assume which employees and dependents are electing coverages.

EMPLOYEE CHANGE

Employees may be allowed to change their coverage elections after the initial enrollment. Some changes, if made more than 31 days after the date of eligibility or after the effective date of coverage, may be subject to coverage limitations and are subject to the governmental unit's Section 125 guidelines if applicable.

Please complete the applicable section of the group change card indicating the type of change(s) desired. After making a copy for your files, please make the appropriate changes in the SIMON portal. This form can be found in the Appendix.

Attach the copy of the group change card to the back of your copy of the employee's original group enrollment card for your records. This will provide a historical record of the coverage elections and changes made by your employees.

OTHER CHANGES

The group change card would be used for other changes to the employee's coverage including, but not limited to:

- Change of Name
- Change of Beneficiary
- Change of Life Benefit (see Life Insurance Calculations in Life tab) - Updating salaries for life & disability benefits.
- Change of Address
- Change to Retiree or Medicare Supplement

TERMINATIONS

The member is responsible for updating employment status for individuals covered under any MITNC plans (Health, Dental, Vision, Short- or Long-Term Disability or Life plans) within a 48-hour period with any changes or updates. All terminations must be indicated on a group change card.

Terminations that are not received within 30 days of the qualifying event may not be eligible for a premium refund. The governmental unit will be responsible for payment of prescription drug usage after the date of termination unless the termination has been input into SIMON on the date of termination.

Use this chart to determine when a termination or loss of eligibility will take effect:

TERMINATION EVENT	DATE OF TERMINATION	COBRA ALLOWABLE TIME PERIOD
Employee terminates	Last day of employment; as shared with MedCost and Vimly during Enrollment	18 months
Employee retires and the governmental unit does not offer retiree coverage	Last day of employment	18 months
Employee terminates due to disability	Last day of employment	18 months
*29 months if declared disabled by SSA (see COBRA section)		
Employee does not return from FMLA	Last day of FMLA	18 months
Reduction of hours worked (less than 20 hours)	Last day employee worked 20 hours or more	18 months
Legal separation (spouse & step-children are no longer eligible)	Date of legal separation with legal documentation	36 months
Divorce (spouse & step-children are no longer eligible)	Date of divorce	36 months
Child exceeds age limits	Day before child 26	36 months
Voluntary termination of spouse and/or dependent children	Date employee specifies (refer to Section 125 guidelines if applicable)	Not Applicable

Failure to Follow Termination Notice Requirements

Retroactive Termination – A situation that arises when an employee of a covered employer group is separated from employment for whatever reason, and subsequently the Employer Group fails to submit the required Termination Form or make the adjustments in SIMON within 48 hours.

Lengthy gaps in providing notice that an employee is no longer entitled to receive health insurance benefits have the detrimental effect of using pool funds to pay for claims that are not covered. Widespread failure in this regard, no matter how small or incremental, can ultimately add up to the loss or misuse of hundreds of thousands of dollars of pool money every year that

could have been spent assisting members and their covered employees.

Policy – When a Member group shows up on a retroactive termination report (done on a rolling 12-month basis by MIT staff):

1st Incident: MIT Staff sets up a meeting with the Member group to review the applicable MIT policies, answer any questions and provide other needed resources.

2nd Incident: MIT sends a formal letter to the Member group's Human Resources or equivalent point of contact.

3rd Incident: MIT sends a certified letter to the Town Manager or equivalent of the Member group.

4th Incident: NCLM Associate Executive Director of RMS sends a certified letter to the Mayor or equivalent of the Member group.

5th Incident: Member is invoiced for the complete amount of the overpayment caused by Member's failure to adhere to this policy.

Life Benefit Conversion

Upon termination, the covered employee has the option to convert the group term life benefit either all or a portion of the benefit to a private policy (either term or whole life) within

30 days of the termination date. The employer is responsible for notifying the employee and providing the conversion form to the employee prior to terminating employment.

ACTIVE MILITARY DUTY – COVERAGE ISSUES

The Federal Uniform Services Employment and Re-Employment Act of 1994 (USERRA) describes an employer's responsibility to an employee who is a member of the uniformed services who take a leave of absence due to active military service and the requirements imposed on group health plans. Listed below is information designed to help you and your employees understand how their coverages will be affected.

Employees called to active military duty and their dependents are automatically covered under the military's coverage (Tricare) after 31 days of active military service.

Employees called to active military duty must be given the same opportunities as any employee on a non-medical leave of absence. The MIT plan mandates that coverage will not be continued for more than 60 days past the date their active employment ends.

The employee and their covered dependents must be offered the option to continue their coverage for a period of 18 months (COBRA). A group change card must be submitted to terminate their coverage for the COBRA process to begin. The employee's coverages must be provided during their first 31 days of active military service. Therefore, the effective date of termination must not be less than 31 days after their active military service begins.

Vimly will send the COBRA Notification and Application form to the

employee's last known address and will administer their medical and dental COBRA coverage. A separate COBRA form for vision coverage will also be sent to their last known address and is administered by VSP.

Employees called to active military duty and their dependents are entitled to convert their life coverage to an individual plan. A sample Life Conversion form is provided in this Manual. A separate notification of the life conversion option will not be sent to each employee called to active military duty. An additional supply of these forms can be requested by calling the MIT.

Coverage for qualified employees returning to active employment status will be reinstated immediately upon their return to active employment without the application of a waiting period requirement. A new group enrollment card must be completed for coverage to be reinstated.

For complete information regarding the employer's responsibilities please visit the Department of Labor's website at www.dol.gov.

COBRA

COBRA Timeline

1. Employee terminates employment or qualifying event occurs (employee must notify employer of qualifying event within 60 days of the event otherwise COBRA rights are forfeited).
2. Employer and/or employee completes group change card (must include authorized signature).
3. Employer immediately emails (mit@nclm.org) termination card or enters in online system to SIMON.
4. Vimly mails a COBRA Notification Package to qualified beneficiary (employee or dependent with qualifying event) to last known address within 14 days. The employer should indicate the employee's current mailing address, if known, on the group change card at the time of termination notice.
5. Qualified beneficiary receives COBRA Notification Package. The qualified beneficiary has 60 days from the date of the COBRA Notice to elect COBRA coverage.
6. The qualified beneficiary completes COBRA application form and emails to Vimly
7. The qualified beneficiary can mail premium payment at this time with their application. If payment is not submitted at the time of election, the participant must send payment within 45 days of electing COBRA. Eligibility will not be updated until payment has been received. The initial payment includes all past-due premiums beginning on the date of termination.
8. Vimly receives application form and enters in database. If payment has been received, the benefits are updated to an active status as a COBRA participant.
9. Qualified beneficiary contacts healthcare providers and requests medical, prescription and/or dental claims are resubmitted.

10. Qualified beneficiary receives monthly COBRA invoices from Vimly. Qualified beneficiary must pay all COBRA invoices within 30 days of the date on the invoice; otherwise, coverage will be terminated.

DISABILITY EXTENSION

Current law gives you or your covered dependents the right to up to twenty-nine (29) months of coverage if found disabled by the Social Security Administration at the time of your termination of employment and if you provide timely notification of the disability finding.

Effective January 1, 1997, the disability extension law changed to allow you or your covered dependent the right to additional coverage, if disability under the Social Security Act is found to exist within the first 60 days of COBRA coverage. Under COBRA, your employer may charge up to 150% of the applicable premium for the last eleven (11) months of extended coverage. Your extended coverage will terminate if, during the eleven (11) month-extended period, there is a final determination that you are no longer disabled. If this occurs, COBRA requires you to notify the plan administrator within thirty (30) days of its date. Your coverage will terminate on the first of the month that begins with more than thirty (30) days following the date of termination. Your coverage can also terminate for the same reasons that your coverage can terminate during the initial 18-month coverage period.

FAMILY CHANGES

Family change notification, such as birth or adoption of a child or marriage, must be submitted in writing, within 30 days of the event. This notification must be submitted directly to the SIMON portal or email mit@nclm.org. Notification of divorce or legal separation, or a child's loss of dependent status, must be submitted within 60 days of the event and this notification must be sent directly to your former employer.

MEDICARE ENTITLEMENT

If you become entitled to Medicare while employed and later lose group health coverage due to loss of employment, you are not eligible for COBRA coverage. However, your covered dependents may continue COBRA coverage for up to 36 months from the date you initially became entitled to Medicare.

If you elect COBRA for yourself and your covered dependents and you become entitled to Medicare while on COBRA, your COBRA coverage must terminate. Your dependent(s) can remain on COBRA for a total of 36 months from the original COBRA effective date.

CERTIFICATES OF CREDITABLE COVERAGE

Proof of creditable coverage is usually submitted in the form of a Certificate of Creditable Coverage from the prior health insurance carrier. A participant

should contact their prior carrier to obtain the Certificate if one has not been furnished to them. HIPAA laws require employers or the health insurance carrier to provide the Certificate to the participant immediately upon termination of coverage and then again upon termination of COBRA coverage.

If a participant is unable to provide proof of prior coverage in the form of a Certificate of Creditable Coverage, the participant may furnish other documentation as proof. Examples of other documentation include EOBs, premium statements, canceled checks, medical records, enrollment information and telephone verification by the HBT prior to coverage.

RETIREMENT

Heath Benefits Trust makes available retiree coverage to those governmental units electing to offer this coverage to retired employees. Each governmental unit is responsible for establishing its own retiree criteria and providing HBT with a copy of its personnel policy or resolution. A group change card is required to enroll an individual on the retiree plan. Each governmental unit determines premium payment responsibility. Retiree premiums will be included on the monthly invoice notice.

Important Criteria that should be included in retiree resolutions:

- Age when employee qualifies
- Number of years of service
- NC Retirement System eligibility
- Premium payment – employer or employee paid benefit or percentage of both
- Payment due date
- When coverage ends (i.e., age 65, when employee becomes covered elsewhere, death)
- Medicare Supplement eligibility, if offered by your governmental unit

If a governmental unit chooses to offer retiree coverage to elected officials, this coverage may be made available only if the elected official has 20 years of service as an elected official. In addition, the elected official must have been participating in the governmental unit's group health plan for the last six years in office.

The minimum eligibility requirements for governmental units that pass a resolution to offer retiree coverage to their employees are as follows:

- Age when employee qualifies
- Retiree must have 10 years with the Local Government Retirement System;
- Retiree must have five years' tenure with your governmental unit;
- Retiree must select retiree coverage within 30 days of retirement; and
- Dependents must be covered for one year or longer as a dependent of the retiree.

This criterion only applies if your governmental unit did not have a retiree

policy or resolution in place by July 1, 2004. All governmental units with a retiree policy already in place and on file with the HBT have been grandfathered into the HBT retiree plan and this criterion will not apply.

MEDICARE SUPPLEMENT

All retirees and their dependents who are Medicare eligible (including disability) must be covered by the Medicare Supplement Plan if offered by your governmental unit.

A group change card, along with a copy of the retiree's Medicare Card, must be submitted in order to enroll them in the Medicare Supplement Plan. MIT will pay only those benefits that would have been paid if both Part A and Part B of Medicare were in effect. For detailed information on Medicare Supplement coverage, see your employee benefit plan book.

The HBT Department sends an annual letter to all retirees instructing all pre-65 retirees to notify their previous employer of their Medicare eligibility. Any Medicare-eligible retiree should be switched to our Medicare Supplement Plan if offered by the employer or terminated. This needs to happen on the first of the month in which the retiree becomes eligible for Medicare. The governmental unit will be charged for any overpayments made by the HBT on behalf of the retiree and refunds will be requested on all medical claims in the event the change is not made when Medicare becomes effective. No exceptions will be made.

For active employees who are Medicare eligible (over 65 years old), make sure they are enrolled in Medicare Parts A and B prior to or at retirement.

If the retiree becomes Medicare eligible, and the spouse is not Medicare eligible, the retiree would enroll in the Medicare Supplement Plan, while the spouse would continue under the regular retiree plan. A group change card is required to make this change.

If the retiree is not yet Medicare eligible, and the spouse becomes Medicare eligible, the retiree would continue under the regular retiree plan, while the spouse would enroll in the Medicare Supplement Plan. A group change card is required to make this change.

If retirement is due to a disability, it is necessary to change the retiree's plan to Medicare Supplement upon becoming entitled to Medicare, regardless of the age of the retiree.

Always direct retirees to contact their local Social Security office for information regarding Medicare eligibility.

*Special Note: It is especially important for the governmental unit offering a Medicare Supplement Policy to inform retirees of their obligation to enroll in Medicare Parts A and B. Failure to comply with Medicare enrollment procedures in a timely manner may result in reduced benefits.

MONTHLY INVOICE

Vimly processes, prepares and sends notice of our monthly billing invoices electronically to the appropriate personnel for payment.

Invoices are processed on or around the 15th of the month prior to the next billing cycle. For example: Invoices for November are processed on or around October 15th.

Your invoice is processed at a specific date and may not include all enrollment or eligibility changes; be assured it will be captured on the next billing cycle. This is a result of bill timing and will not change the effective date of your employee's coverage.

PAYMENT DUE DATE

Payment is due the first business day of the billing period stated on the invoice. Although your invoice may not reflect the most recent enrollment additions, terminations or eligibility changes, due to the timing of the submission of those changes and the billing cycle, please pay the total as billed on the invoice. Enrollment changes will be captured on a future invoice. Failure to pay the full amount of your invoice will result in finance charges (1.5% per month) on the outstanding balance.

PAYMENT METHODS

Your monthly invoice can be paid via various methods:

Check -- If paying by check, please make the check payable to Municipal Insurance Trust and mail to the following address (this address is shown on your invoice also):

Municipal Insurance Trust

P.O. Box 751485

Charlotte, NC 28275-1485

ACH -- If you prefer for us to collect your premium via an ACH withdrawal each month from your bank account, please complete the ACH authorization form provided in this manual and forward it to accountsreceivablerms@nclm.org. Monthly ACH payments are drafted on or around the 5th business day of the month following the invoice due date.

EFT -- Please contact accountsreceivablerms@nclm.org if you wish to process your payment via wire or electronic funds transfer.

INVOICE BALANCE INQUIRIES

Contact HBT if you have any questions about any outstanding invoices or balances. We are not able to answer questions regarding specific employee billing issues and request you contact the Health Benefits Trust department directly for those inquiries at mit@nclm.org or (919)715-4000 press 7.

WHO TO CALL

NCLM HEALTH BENEFITS

Working as one. Advancing all.

WHO TO CALL - FOR HR REPRESENTATIVES*

If you are an HR representative with questions about Enrollment, Billing and Coverage related to Medical, Dental, Vision, Pharmacy, Life and Disability, use the SIMON portal or the contact list below. *These contacts are not intended to be shared with employees or their dependents. Please direct them to the customer service lines instead.

MEDICAL

aetna®

General Questions
Aetna Concierge
(855) 221-1536

Pharmacy
For questions regarding prescription coverage
(888) 792- 3862

VISION

vsp®

www.vsp.com | (800) 877-7195

DENTAL

DELTA DENTAL®

www.deltadentalnc.com/hbt

Customer Service
800-662-8856

Escalated Questions
Dedra Tindall
Group Dental Client Specialist
dtindall@deltadentalnc.com
(919) 424-1038

Sherry Burchett
Strategic Client Consultant
(919) 863-5573
sburchett@deltadentalnc.com

LIFE AND DISABILITY

unum®

www.unum.com

Contact your Unum Benefit Specialist (name on the letter claimant received) or use online portal at www.unum.com for faster claim filing.

NCLM HEALTH BENEFITS

The League's Health Benefits Trust staff and administrative partners are available to answer any questions you have regarding coverage options, claims, policy details, and more. Use the following contact list to determine the best fit for your question.

Health Benefits Trust Department:
(919) 715-4000 press 7

Youssou Fall, Director of Strategic Health Operations
(919) 715-9782
yfall@nclm.org

Shelly Linker, Business Manager
(919) 715-0979
slinker@nclm.org

Lisa Ervin, Health and Benefit Consultant
(919) 715-7973
lervin@nclm.org

Lisa Marzoli, Health and Benefit Consultant
(919) 715-3914
lmarzoli@nclm.org

Tisha Robinson, Health and Wellness Coordinator
(919) 715-4328
trobinson@nclm.org

HOW TO JOIN HBT

If your municipality is interested in joining the Health Benefits Trust, it first must be eligible for and enroll in membership with the League. Speak to your business service consultant for information on how to complete NCLM membership.

After joining the NCLM, complete the following steps:

- If your group is completely new to the Health Benefits Trust, a team member will reach out to schedule an Implementation call.
- If your group is adding a plan or changing a plan, HBT will send out a Proposal Acceptance Form (PAF) through an e-signature platform.
- Your municipality's governing board must adopt and have an authorized individual sign a resolution to join HBT.
- Your municipality must review and have an authorized individual sign all Interlocal Agreements (keep a copy for your file).
- Email Interlocal Agreement to MIT@nclm.org.
- Employee Meetings then need to be scheduled with NCLM HBT staff. Please call HBT at (919) 715-4000 press 7.
- Enrollment information needs to be collected and received by SIMON at least 30 days prior to starting benefits for medical cards to be delivered on time. Typically, this information is collected during employee meetings.

Feel free to call the Health Benefits Trust staff at 919-715-4000 press 7 any time.

HOW TO FILE A CLAIM

MEDICAL CLAIM

The Health Benefits Trust contracts with Aetna to process medical claims. Generally, providers submit claims electronically directly to Aetna. Covered individuals can view their claims/explanation of benefits (EOB) online in their Aetna account. You will need your HBT medical ID card to set up your online account. Unless you elect to go paperless, you will receive an Explanation of Benefits from Aetna in the mail.

Should you need to pay charges upfront and get reimbursed for a claim, you can find Aetna claim forms online at www.Aetna.com or call Aetna customer service at (855) 221-1536.

VISION CLAIM

VSP processes HBT Vision claims. In-network providers typically submit charges electronically to VSP. Covered individuals can view their claims/explanation of benefits (EOB) online in their VSP account. You will need your social security number to set up your online account.

Should you need to pay charges upfront and get reimbursed for a claim, you can find Vision claim forms online at www.vsp.com under Benefits - Submit a Claim. Or call VSP customer service at (800) 877-7195 for assistance.

Submit an Out-of-Network Vision Claim

If you've received eye care services from an out-of-network provider, you may need to submit a claim to request reimbursement.

Your benefits will always go further when you see an in-network doctor. However, if you'd like to submit an out-of-network claim, be sure to answer all the questions and attach any receipts related to your claim.

To submit a claim request, you'll need the following:

- Copies of the itemized receipts or statements that include:
- Doctor name or office name
- Name of Patient
- Date of Service
- Each service received and the amount paid
- Just a few minutes to complete the claim form

After completing the claim form, you may attach your receipt(s) OR print and mail copies of your claim form and receipt(s) to:

Vision Service Plan Attention: Claims Services
P.O. Box 385018
Birmingham, AL 35238-5018

Tip: Missing information and receipts can delay your reimbursement. Fill out the form completely and if you're filling it out online, snap a picture of your receipt and attach it to your claim to get your reimbursement faster. If you have receipts for other claims you must complete a separate claim form.

You typically have 12 months from the date of service to submit for reimbursement. Failure to submit your out-of-network claim within 12 months of the date of service may cause your claim request to be denied. Please allow up to 10 business days (plus mailing time to and from VSP) for us to process your reimbursement.

Questions? View Claims & Reimbursement FAQs at www.vsp.com/claims/submit-oon- claim.

LIFE OR DISABILITY CLAIM, ONLINE

As of October 2020, Members can file a Short Term and/or Long Term Disability online.

The League's Health Benefits Trust has partnered with Unum to deliver quick, easy and convenient service regarding our life and disability coverages.

No more long, arduous processes. Now, both employers and employees will be able to file and manage claims through an easy-to-use online portal.

For Employers

Set Up Account -- A secure account has been created for each municipality with life policies. Only the HBT contact for each city or town has an account, not every individual is covered.

To activate the account, follow the steps below:

- Go to Unum's Employer website: https://services.unum.com

- Log in
- Your user ID is your e-mail address

Temporary passwords were emailed separately to each HBT contact by Unum. If you did not receive this information, please contact Unum at 877-225-2712 or e-mail at iservices@unum.com.

Click on "Begin Account Activation." This will bring you to the User Agreement page. At the bottom, click "Agree and then Continue."

Manage Employee Claims. The easy-to-use Claims Management page will allow employers to upload employee documentation, file employee claims, manage open claims, and more.

For Employees

Digitally file all types of claims, 24/7/365.

- Disability
- Leaves of absence
- Life
- Accident, Critical Illness, and Hospital Insurance

And, if you're not sure what type of claim to file, no problem! Just answer a few questions on the website, and Unum will guide you in the right direction.

Set up an Account -- Getting started with Unum is easy. For your first time filing a claim, follow the below steps:

- Go to unum.com/claims
- Register for an account
- After registering online, claims can be filed either on that website or on the mobile Unum Customer App.

If you need help, customer service professionals are available to assist you Monday through Friday from 8:00 a.m. to 6:00 p.m. EST. You can reach them by phone at 1-877- 225-2712 or e-mail at iservices@unum.com.

You can also contact the League for assistance at MIT@nclm.org.

The Online claim form has three sections that need to be completed; the employee section, the employer section and the attending physician.

Steps:

1. Have employee complete their section through their account;
2. Complete the employer section through their admin account;
3. Have the employee give the form to their doctor to complete the attending physician section.

Once all sections of the form are completed, Unum will contact the employee about their benefits. Contact HBT staff at (919) 715-4000 press 7 for assistance.

LIFE OR DISABILITY CLAIM, PAPER FORMAT

Disability

The claim form has three sections that need to be completed; the employee section, the employer section and the attending physician.

1. Have employee complete their section;
2. Complete the employer section;
3. Have the employee give the form to their doctor to complete the attending physician section.

Once all sections of the form are completed, scan/email to HBT staff at MIT@nclm.org. Contact HBT staff at 919-715-4000 for assistance or submit directly to Unum.

Life

We encourage you to notify HBT staff of the claim as soon as possible.

A claim form is available from Health Benefits Trust staff. The Policy Number and Division Number are on the employer's life book listed as Identification No.

Policy Number: 468877 (HBT number)

Division Number: Xxx (should be a three-digit number after the Policy number; this number is specific to each member group).

A 50% accelerated life benefit can be obtained by the covered individual while alive if a doctor has diagnosed with terminal illness with 12 months or less to live. The life benefit will be reduced to 50 at the time of death.

The claim form must be completed and submitted by the employer.

1. Employer completes life claim form;
2. Beneficiary signs claim form;
3. Employee retains a copy of the completed & signed claim form for their personnel records.
4. Employee submits completed claim form to HBT staff at MIT@nclm.org along with the following documents:

Death Certificate

If accidental death,

- Copy of police report or newspaper article;
- Copy of Original enrollment form;
- Copy of Beneficiary Statement housed with the municipality's HR.

NCLM/HBT Staff will log in claim and forward to UNUM for processing. Contact HBT staff at (919) 715-4000 for assistance.

HBT CONTACT RESPONSIBILITIES

Setup SIMON Administrative Account online

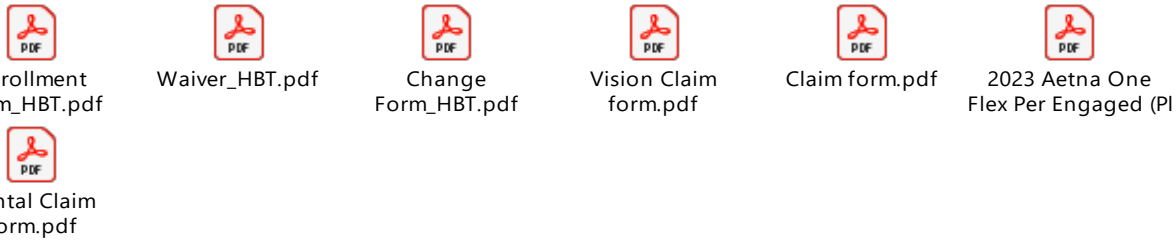
Updating/uploading enrollment information in a timely manner to SIMON including:

- Adding/changing/terminating individuals as applicable
- Updating individual's mailing addresses and phone numbers
- Updating covered individuals' beneficiary information
- Updating covered individuals' salary
- Retrieving monthly invoices in SIMON administrative account
- Verifying monthly invoices have accurate information

If enrollment information is found to be outdated, HBT is only responsible of issuing a maximum of three months credit.

APPENDIX FORMS:

Digital Download



NCLM HEALTH BENEFITS

Three ways to make these eligibility changes:

- Please submit all changes on SIMON
- Email MIT@nclm.org
- Call (919) 715-4000 press 7

ENROLLMENT FORM

EMPLOYEE INFORMATION							
Company Name			Group Number				
Employees Last Name			Employees First Name				
Employee Date of Birth			Sex		M ☐		F ☐
Employee Address							
Employee Email							
Actively Working ☐	Hours worked per week		Position/Job Title				
Employee Social Security Number			Main Phone Number for Employee				
Date of Full Time Employment			Date of Hire		Annual Income:		
COVERAGE ELECTIONS							
Effective Date of Coverage							
Medical	Myself ☐		Dependents ☐		Plan Options		
Dental	Myself ☐		Dependents ☐		Plan Options		
Vision	Myself ☐		Dependents ☐		Plan Options		
Life	Myself ☐		Dependents ☐		Plan Options		
Supplemental Life							
STD	Myself						
LTD	Myself						
OTHER HEALTH INSURANCE COVERAGE							
Do you or your dependents have other health insurance coverage, including Cobra, Medicare, or Medicaid?					☐ Yes		☐ No
Name of Insurance Company			Name of Policy Holder				
Relationship to Employee			Plan/Policy Number				

Comment:

NCLM HEALTH BENEFITS

Dependent Information									
First/Middle/Last	Birthdate	SSN	Sex	Relationship	Medical	Vision	Dental	Life	Disabled
					☐	☐	☐	☐	☐
					☐	☐	☐	☐	☐
					☐	☐	☐	☐	☐
					☐	☐	☐	☐	☐
					☐	☐	☐	☐	☐

I agree that to the best of my knowledge and belief, all statements and answers to the questions in this application are complete and true and agree that they will be the basis of the issuance of any coverage by any underwriter or carrier. Subject to the approval of this application the benefits applied for shall become effective in accordance with the summary plan description of your employer's health care plan.

_____ _____

Instructions for Employer

- Please keep the original signed form in the employee's personnel records.
- Please make the enrollments in the Benefits Enrollment platform SIMON
- If enrollment is late, all past due premiums must be paid in full within thirty (30) days before employee can be placed on insurance plan.

If you have any questions, please call the Health Benefits Trust team at (919) 715-4000 press 7

Three ways to make these eligibility changes:

- Please submit all changes on SIMON
- Email MIT@nclm.org
- Call (919) 715-4000 press 7

WAIVER FORM

NCLM LIFE & HEALTH INSURANCE

Employer Name		Division/Location
Employee Last Name	First Name	Middle Initial
Social Security Number	Date of Full Time Employment (mm/dd/yyyy)	Email Address

REASON FOR WAIVING COVERAGE

☐ I am waiving coverage for myself

☐ I am waiving coverage for my spouse

Name of Spouse_____

☐ I am waiving coverage for my Dependent(s)

Dependent Name (First / Middle / Last)	Relationship

DECLINE TO PARTICIPATE

I certify that I have been given the opportunity to participate in the health care plan offered by my employer and have declined to participate. I have declined to participate for the following reason (check one).

☐ Another plan offered by employer

☐ My spouse's group coverage

☐ An individual plan

☐ A government plan (type) _____

☐ COBRA or State Continuation

☐ I and/or my dependents are currently not covered by any other health care plan

☐ Other (please explain) _____

I understand that if I elect to apply for coverage for myself, my spouse, and/or my dependent children through this health care plan at a later time, the application will be subject to the Summary Plan Description of my employer's Health Care Plan.

_____ _____

Employee Signature Date

NCLM HEALTH BENEFITS

Three ways to make these eligibility changes:

- Please submit all changes on SIMON
- Email MIT@nclm.org
- Call (919) 715-4000 press 7

CHANGE FORM

Employee Information			
Company Name		Group Number	
Employees Last Name		Employees First Name	
Employee Date of Birth		Sex	M ☐ F ☐
Employee Social Security Number		Main Phone Number for Employee	
Employee Email			

Change Reasons			
Effective Date of Changes:			
Qualifying Event			

Benefits you would like to add					
Medical	Myself ☐		Dependents ☐		Plan Options
Dental	Myself ☐		Dependents ☐		Plan Options
Vision	Myself ☐		Dependents ☐		Plan Options
Life	Myself ☐		Dependents ☐		Plan Options
Supplemental Life	Myself ☐				
STD	Myself ☐				
LTD	Myself ☐				

Cancelation Reason					
Select Benefits you wish to cancel					
Effective Date of Changes:					
Medical	Myself ☐		Dependents ☐		Plan Options
Dental	Myself ☐		Dependents ☐		Plan Options
Vision	Myself ☐		Dependents ☐		Plan Options
Life	Myself ☐		Dependents ☐		Plan Options
STD	Myself ☐				
LTD	Myself ☐				

Comment:

FORM INSTRUCTIONS

The form must be filled out by the member. All fields flagged with an asterisk (*) are required. The form is fillable, so you do not have to hand write. Fill it out on a computer, print it, and mail it in. If you decide to hand write, use blue or black ink.

Patient section:

1. Select the patient's relation to the member. Choose only one.
2. Enter the patient's date of birth in the following format: Month/Day/Four-Digit Year
3. Select a gender. Choose only one.
4. Enter the patient's last name and first name.
5. Enter the address, city, state and ZIP code.
6. The patient's middle initial and ZIP+4 are optional.

Member section:

1. Enter the Last 4 Digits of the member's SSN.
2. If the patient is the member, select "Member information below is the same as Patient."
3. Otherwise, enter the member's information:
    a. Enter the member's date of birth in the following format: Month/Day/Four-Digit Year
    b. Select a gender. Choose only one.
    c. Enter the member's last name and first name.
    d. Enter the first address line, city, state, and ZIP code.
    e. The member's middle initial, second address line, and ZIP+4 are optional.

Claim section:

1. Enter the Date of Service in the following format: Month/Day/4-Digit Year.
2. Enter the amount charged for each applicable line item. Ensure they match the receipts.
3. Select a Lens Type.
4. If another insurance company is involved, check the box and attach a copy of the statement showing payment.

Provider section:

1. If the provider's name is known, enter the provider's last name and first name.
2. If the office name is known, enter the provider's office name.
3. Step #1 or #2 or both must contain a value.
4. Enter the first address line, city, state, and ZIP code.
5. The second address line and ZIP+4 are optional.

Print and Sign section:

1. Review the completed form for accuracy.
2. Read the acknowledgement paragraph.
3. Print the form.
4. Sign the form.
5. Date the form in the following format: Month/Day/Four-Digit Year.
6. Only the form on the next page needs to be mailed in. All other pages are for reference.

VSP MEMBER REIMBURSEMENT FORM

To request reimbursement, complete and print this form, enclose a legible copy of your itemized receipt(s), and send them to the following address. Be sure to keep a copy for your records.

VSP
PO Box 385018
Birmingham, AL 35238-5018

PATIENT

Relation to Member*: *(choose one)*
○ Member ○ Domestic Partner ○ Dependent Parent ○ Disabled Dependent
○ Spouse ○ Child ○ Full-Time Student ○ Other

Date of Birth*: *(mm/dd/yyyy)* | Gender*: ○ Male ○ Female

Last Name*: | First Name*: | MI:

Address*:

City*: | State*: | ZIP Code*: | ZIP+4:

MEMBER

Last 4 Digits of SSN*:

☐ Member information below is the same as Patient

Date of Birth*: *(mm/dd/yyyy)* | Gender*: ○ Male ○ Female

Last Name*: | First Name*: | MI:

Address 1*: | Address 2:

City*: | State*: | ZIP Code*: | ZIP+4:

CLAIM

Date of Service*: *(mm/dd/yyyy)*

☐ Another insurance company made payments to you, another insurer, or the doctor's office. If so, attach a copy of the statement showing payment.

Exam	$
Frame	$
Lens	$
Lens tints or coatings	$
Contact Lens Exam / Fitting Evaluation	$
Contacts	$

Lens Type*: *(choose one)*
○ Single ○ Progressive
○ Bi-focal ○ Lenticular
○ Tri-focal

PROVIDER

Last Name: | First Name:

Office Name:

Address 1*: | Address 2:

City*: | State*: | ZIP Code*: | ZIP+4:

PRINT & SIGN

I acknowledge that the above-named provider is not a VSP Preferred Provider and that VSP cannot guarantee eye care and/or eyewear satisfaction. By signing this claim form, I certify that I have read the applicable claim fraud warnings included with this form, and that all the information I have provided above is complete and accurate.

Claimant Signature: _____ Date: _____

FRAUD WARNINGS

Alabama, Arkansas, District of Columbia, Louisiana, Massachusetts, Minnesota, New Mexico, Ohio, Rhode Island and West Virginia: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Alaska: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete or misleading information may be prosecuted under state law.

Arizona: For your protection, Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

California: For your protection, California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado: It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly presents false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Delaware, Idaho, Indiana and Oklahoma: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive an insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Florida: A person who knowingly and with intent to injure, defraud or deceive any insurance company files a statement of claim or an application containing false, incomplete or misleading information is guilty of a felony of the third degree.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files a 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.

Maine, Tennessee, Virginia and Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Maryland: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

New Hampshire: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud as provided in RSA 638:20.

New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New York: 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Oregon: Any person who knowingly presents a materially false statement of claim may be guilty of a criminal offense and may be subject to penalties under state law.

Puerto Rico: Any person who knowingly and with the intention to defraud includes false information in an application for insurance or files, assists or abets in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony and if found guilty shall be punished for each violation with a fine of no less than five thousand dollars ($5,000), not to exceed ten thousand dollars ($10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years.

Texas: Any person who knowingly presents a false or fraudulent claim for penalty of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Vermont: Any person who knowingly presents a false statement of claim for insurance may be guilty of a criminal offense and subject to penalties under state law.

Pennsylvania and all other states: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a 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.

Language Assistance Services Available

English: ATTENTION: If you speak another language, language assistance services, free of charge, are available to you. Call 1-800-877-7195 (TTY: 1-800-428-4833).

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-877-7195 (TTY: 1-800-428-4833).

Chinese: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電1-800-877-7195 (TTY: 1-800-428-4833).

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-877-7195 (TTY: 1-800-428-4833).

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-877-7195 (TTY: 1-800-428-4833))번으로 전화해 주십시오.

Tagalog –Filipino: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-877-7195 (TTY:1-800-428-4833).

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-877-7195 (телетайп: 1-800-428-4833).

Armenian: ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք 1-800-877-7195 (TTY (հեռատիպ)՝ 1-800-428-4833).

French: ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-877-7195 (ATS : 1-800-428-4833).

Japanese: 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。
1-800-877-7195 (TTY: 1-800-428-4833)まで、お電話にてご連絡ください。

Tongan: FAKATOKANGA'I: Kapau 'oku ke Lea-Fakatonga, ko e kau tokoni fakatonu lea 'oku nau fai atu ha tokoni ta'etotongi, pea teke lava 'o ma'u ia. Telefoni mai 1-800-877-7195 (TTY: 1-800-428-4833).

Serbo-Croatian: OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-800-877-7195 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 1-800-428-4833).

Cambodian: ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយឥតគិតថ្លៃ ភាសា ហើយមិនគិតថ្លៃ គឺអាចមានសំរាប់បំ រើអ្នក។ ចូរ ទូរស័ព្ទ 1-800-877-7195 (TTY: 1-800-428-4833)។

Punjabi: ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-800-877-7195 (TTY: 1-800-428-4833) 'ਤੇ ਕਾਲ ਕਰੋ।

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-877-7195 (TTY: 1-800-428-4833).

Amharic: ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጅተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-800-877-7195 (መስማት ለተሳናቸው: 1-800-428-4833).

Ukrainian: УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-800-877-7195 (телетайп: 1-800-428-4833).

Nepali: ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-800-877-7195 (टिटिवाइ: 1-800-428-4833)।

Romanian: ATENŢIE: Dacă vorbiţi limba română, vă stau la dispoziţie servicii de asistenţă lingvistică, gratuit. Sunaţi la 1-800-877-7195 (TTY: 1-800-428-4833).

Sudan (Fulfulde): MAANDO: To a waawi [Adamawa], e woodi ballooji-ma to ekkitaaki wolde caahu. Noddu 1-800-877-7195 (TTY: 1-800-428-4833).

Thai: เรียน: ถาคุณพูดภาษาไทยคุณสามารถใชบรการชวยเหลอทางภาษาไดฟร โทร 1-800-877-7195 (TTY: 1-800-428-4833).

Laotian: ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບລການຊວຍເຫລອດ້ານພາສາ, ໂດຍບເສຽຄ່າ, ແມ່ນພ້ອມໃຫ້ທ່ານ. ໂທ 1-800-877-7195 (TTY: 1-800-428-4833).

Cushite/Oromo: XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-800-877-7195 (TTY: 1-800-428-4833).

Persian (Farsi):

هجوت: اگر ب زبان پارسی گفتگو یم کنید، تسهلات زبانی بصورت رایگان برای شما فراهم یم باشد. با 1-800-877-7195 تماس بگیرید (TTY: 800-428-4833-1).

Arabic:

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية متوفرة لك بالمجان. اتصل برقم 7195-877-800-1(رقم الهاتف الصم والبكم: 1-800-428-4833-1).

Navajo

Díí baa akó nínízin: Díí saad bee yáníłti'go **Diné Bizaad**, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, koji' hódíílnih 1-800-877-7195 (TTY: 1-800-428-4833.)

हिंदी (Hindi)

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-800-877-7195 (TTY: 1-800-428-4833) पर कॉल करें।

aetna® Medical Benefits – Claim Instructions

Any person who knowingly and with intent to injure, defraud or deceive 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.

Attention Alabama Residents: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof. **Attention Arkansas, District of Columbia, Rhode Island and West Virginia Residents:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. **Attention California Residents: For your protection California law requires notice of the following to appear on this form:** Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison. **Attention Colorado Residents:** It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies. **Attention Florida Residents:** Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree. **Attention Kansas Residents:** Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person submits an enrollment form 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 Kentucky Residents:** Any person who knowingly and with intent to **defraud** any insurance company or other person files a 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**. **Attention Louisiana Residents:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application is guilty of a crime and may be subject to fines and confinement in prison. **Attention Maine and Tennessee Residents:** It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, or denial of insurance benefits. **Attention Maryland Residents:** Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. **Attention Missouri Residents:** It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, denial of insurance and civil damages, as determined by a court of law. Any person who knowingly and with intent to injure, defraud or deceive an insurance company may be guilty of fraud as determined by a court of law. **Attention New Jersey Residents:** Any person who includes any false or misleading information on an application for an insurance policy or knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties. **Attention New York 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 shall be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation. **Attention North Carolina Residents:** Any person who knowingly and with intent to injure, defraud or deceive 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 may be a crime and subjects such person to criminal and civil penalties. **Attention Ohio Residents:** Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud. **Attention Oklahoma Residents:** WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Attention Oregon Residents: Any person who with intent to injure, defraud, or deceive any insurance company or other person submits an enrollment form 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 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. **Attention Puerto Rico Residents:** Any person who knowingly and with the intention to defraud includes false information in an application for insurance or file, assist or abet in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony and if found guilty shall be punished for each violation with a fine of no less than five thousand dollars ($5,000), not to exceed ten thousand dollars ($10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years. **Attention Texas Residents:** Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any intentional misrepresentation of material fact or conceals, for the purpose of misleading, information concerning any fact material thereto may commit a fraudulent insurance act, which may be a crime and may subject such person to criminal and civil penalties. **Attention Vermont Residents:** Any person who knowingly and with intent to injure, defraud or deceive 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 may be a crime and may subject such person to criminal and civil penalties. **Attention Virginia Residents:** Any person who knowingly and with intent to injure, defraud or deceive 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 act, which is a crime and subjects such person to criminal and civil penalties. **Attention Washington Residents:** It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

NOTE: INCOMPLETE CLAIM FORMS WILL BE RETURNED TO YOU FOR MISSING INFORMATION. THIS WILL DELAY THE PROCESSING OF THE CLAIM. FOR FASTER, EASIER SUBMISSION OF CLAIMS, THE PROVIDER MAY CONTACT THE AETNA CLAIM PROCESSING CENTER FOR INFORMATION REGARDING ELECTRONIC CLAIM SUBMISSIONS.

TO THE EMPLOYEE

1. Complete items one (1) through nineteen (19) in full.
2. Complete items twenty (20) through twenty-four (24) only if other medical coverage exists.
3. Be certain to sign the authorization to release information in block twenty-five (25).
4. If you wish to have your benefits for this claim paid directly to your physician or supplier, sign block twenty-six (26).
5. If you have submitted a request for benefits to another plan, including Medicare, attach a copy of the bills you submitted to the other plan and the explanation of benefits you received from the other plan.
6. Attach itemized bills or ask your health care provider to complete the applicable section on the reverse side. The bills must include:
   - patient's name
   - condition being treated
   - type of service(s) rendered
   - date(s) of service(s)
   - relationship to employee

   If this information is missing, write it on the bill and sign your name.
7. If prescription drugs are covered under your plan, submit receipts or a Prescription Drug Record form. Receipt must contain:
   - drug name
   - purchase date
   - prescription number
   - pharmacy name/address
   - dose per/day
   - nature of illness or injury
   - quantity
   - charge
   - strength
   - physician's name

   This information can be copied from the prescription bottle or box.
8. Retain copies of your bills for your record.
9. **Refer to the back of your ID card for claim mailing address.**

TO THE PHYSICIAN OR SUPPLIER

1. Complete items twenty-seven (27) through forty-six (46) in full.
2. If the employee indicates that benefits should be paid directly to the physician or supplier, then these benefits will be sent directly to you with an information copy of the transactions to the employee.

aetna®

Medical Benefits Request

Refer to the back of your ID card for claim mailing address

TO BE COMPLETED BY EMPLOYEE

1. Employer's Name
2. Policy/Group Number
3. Employee's Aetna ID Number
4. Employee's Name
5. Employee's Birthdate *(MM/DD/YYYY)*
6. ☐ Active ☐ Retired Date of Retirement
7. Employee's Address (include ZIP Code) ☐ Address is new
8. Employee's Daytime Telephone Number ( )
9. Patient's Name
10. Patient's Aetna ID Number
11. Patient's Birthdate *(MM/DD/YYYY)*
12. Patient's Relationship to Employee ☐ Self ☐ Spouse ☐ Child ☐ Other
13. Patient's Address (if different from employee)
14. Patient's Gender ☐ Male ☐ Female
15. Patient's Marital Status ☐ Married ☐ Single
16. Is patient employed? ☐ No ☐ Yes
17. Name & Address of Employer
18. Is claim related to an accident? ☐ No ☐ Yes If Yes, date _____ time _____ ☐ am ☐ pm
19. Is claim related to employment? ☐ No ☐ Yes
20. Are any family members expenses covered by another group health plan, group pre-payment plan (Blue Cross- Blue Shield, etc.), no fault auto insurance, Medicare or any federal, state or local government plan? ☐ No ☐ Yes
21. If Yes, list policy or contract holder, policy or contract number(s) and name/address of insurance company or administrator:
22. Member's ID Number
23. Member's Name
24. Member's Birthdate *(MM/DD/YYYY)*
25. To all providers of health care:
You are authorized to provide Aetna Life Insurance Company or one of its affiliated companies ("Aetna"), and any independent claim administrators and consulting health professionals and utilization review organizations with whom Aetna has contracted, information concerning health care advice, treatment or supplies provided the patient (including that relating to mental illness and/or AIDS/ARC/HIV). This information will be used to evaluate claims for benefits. Aetna may provide the employer named above with any benefit calculation used in payment of this claim for the purpose of reviewing the experience and operation of the policy or contract. This authorization is valid for the term of the policy or contract under which a claim has been submitted. I know that I have a right to receive a copy of this authorization upon request and agree that a photographic copy of this authorization is as valid as the original.
Patient's or Authorized Person's Signature _____ Date _____
26. I authorize payment of medical benefits to the physician or supplier of service.
Patient's or Authorized Person's Signature _____ Date _____

TO BE COMPLETED BY PHYSICIAN OR SUPPLIER

27. Date of Illness (first symptom) or injury (accident) or pregnancy (LMP)
28. Date first consulted you for this condition
29. If patient has had similar illness or injury, give dates
30. If an emergency check here ☐ emergency
31. Date patient able to return to work
32. Date of total disability from through
33. Date of partial disability from through
34. Name of referring physician (e.g., Public Health Agency)
35. For services related to hospitalization give hospitalization dates admitted discharged
36. Name & address of facility where services rendered (if other than home or office)
37. Diagnosis or nature of illness or injury (please indicate primary and secondary)
1.
2.
3.
4.

38. Procedures, Medical Services, Supplies Furnished

Date of Service	Place of Service*	Procedure Code Identify**	Description of Service	Type of Service †	Charges	Days or Units	Diagnosis Code ††

39. Physician's Name & Address (include ZIP Code)
40. Telephone Number ( )
41. Enter the taxpayer identifying number to be used for 1099 reporting purposes. You are required under authority of law to furnish your taxpayer identifying number.
42. Patient Account Number
43. Total charge $ _____ Amount paid $ _____ Balance due $ _____
44. Physician's or Supplier's Signature
45. National Provider Identifier
46. Date

*** Place of Service Codes:**

1 - (IH)	- Inpatient Hospital	8 - (SNF)	- Skilled Nursing Facility
2 - (OH)	- Outpatient Hospital	9 -	- Ambulance
3 - (O)	- Office Visit	0 - (OL)	- Other Location
4 - (H)	- Patient Home	A - (IL)	- Independent Laboratory
5 -	- Day Care Facility (PSY)	B -	- Other Medical Surgical Facility
6 -	- Night Care Facility (PSY)	C - (RTC)	- Residential Treatment Center
7 - (NH)	- Nursing Home	D - (STF)	- Specialized Treatment Facility

** Please Use Current Procedural Terminology Codes For Surgery

†Type of Service Codes:

1 - Medical Care	8 - Assistance at Surgery
2 - Surgery	9 - Other Medical Service
3 - Consultation	0 - Blood or Packed Red Cells
4 - Diagnostic X-Ray	A - Used DME
5 - Diagnostic Laboratory	M - Alternate Payment for Maintenance Dialysis
6 - Radiation Therapy	Y - Second Opinion on Elective Surgery
7 - Anesthesia	Z - Third Opinion on Elective Surgery

††Please Use ICD Code For Discharge Diagnosis

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

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

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 Civil Rights Coordinator.

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 (Aetna).

TTY: 711

For language assistance in your language call the number listed on your ID card at no cost. (English)

Para obtener asistencia lingüística en español, llame sin cargo al número que figura en su tarjeta de identificación. (Spanish)

欲取得繁體中文語言協助，請撥打您 ID 卡上所列的號碼，無需付費。(Chinese)

Pour une assistance linguistique en français appeler le numéro indiqué sur votre carte d'identité sans frais. (French)

Para sa tulong sa wika na nasa Tagalog, tawagan ang nakalistang numero sa iyong ID card nang walang bayad. (Tagalog)

T'áá shí shizaad k'ehjí bee shíká a'doowoł nínízingo Diné k'ehjí naaltsoos bee atah nílíjigo nanitinígíí béésh bee hane'é bikáá' áajį' t'áá jíík'e hólne'. (Navajo)

Benötigen Sie Hilfe oder Informationen auf Deutsch? Rufen Sie kostenlos die auf Ihrer Versicherungskarte aufgeführte Nummer an. (German)

Për asistencë në gjuhën shqipe telefononi falas në numrin e regjistruar në kartën tuaj të identitetit (ID). (Albanian)

ለአማርኛ ቋንቋ እገዛ በመታወቅያዎ ላይ በተጠቀሰው ቁጥር በነጻ ይደውሉ (Amharic)

للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني المذكور في بطاقتك التعريفية. (Arabic)

Լեզվի ցուցաբերած աջակցության (հայերեն) Ձանգահարեք թիվը նշված է ձեր ID քարտի առանց գնով: (Armenian)

Niba urondera uwugufasha mu Kirundi, twakure ku busa ku inomero iri ku ikarata karangamuntu yawe. (Bantu-Kirundi)

Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawga ang numero nga gilista sa imong kard sa kailhanan nga walay bayad. (Bisayan-Visayan)

বাংলায় ভাষা সহায়তার জন্য আপনার আইডি কার্ডে যে নম্বরটি তালিকাভুক্ত রয়েছে বিনামূল্যে তাতে কল করুন। (Bengali-Bangala)

ငွေကုန်ကျခံစရာမလိုဘဲ (မြန်မာဘာသာစကား) ဖြင့် ဘာသာစကားအကူအညီရယူရန် သင့်အိုင်ဒီကတ်ပေါ်တွင် ပေးထားသည့်ဖုန်းနံပါတ်ကိုခေါ်ဆိုပါ။ (Burmese)

Per rebre assistència en (català), truqui al número de telèfon gratuït que apareix a la seva targeta d'identificació. (Catalan)

Para ayuda gi fino' (Chamoru), ågang I numiru ni mangaige gi iyo-mu 'ID card', sin gåstu.. (Chamorro)

ᎾᏍᎩᎾ ᏕᏫᏂᏡᏍᏗ ᏗᏂᏍᏕᎵᏍᎩ ᎾᏓᎢ (ᏣᎳᎩ) ᏎᏏᎳᏛᎢᏕ ᎾᏍᎩ ᏗᏎᏍᏗ ᏚᏕᏍᏛ ᎣᎾᎢ ᏣᏤᎵ ᏕᎪᏣᏍᏗ ᏆᎾᏲᏍᏗ ᎣᎾᎢ Ꮭ ᎪᎱᏍᏗ ᏧᎬᏩᎶᏗ ᏂᎨᏒᎾ. (Cherokee)

(Chahta) anumpa y<u>a</u> apela a chi bvnna hokmvt ch<u>i</u> holisso kallo iskitini ma holhtena yvt takanli. Na aivlli keyu h<u>o</u> ish <u>I</u> p<u>a</u>ya hinla. (Choctaw)

Tajaajila afaan Oromiffa argachuuf lakkoofsota bilbilaa waraqaa eenyummaa keessan irra jiran irratti bilisaan bilbilaa. (Cushite)

Bel voor tolk- en vertaaldiensten in het Nederlands gratis naar het nummer dat op uw identiteitskaart vermeld staat. (Dutch)

Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo a yo endike nan kat idantifikasyon ou gratis. (French Creole)

Για γλωσσική βοήθεια στα Ελληνικά καλέστε χωρίς χρέωση τον αριθμό που αναγράφεται στην κάρτα αναγνώρισης. (Greek)

(Gujarati) ગુજરાતીમાં ભાષા સહાય માટે તમારા આઈડી કાર્ડ પર લખેલ નંબર પર કોઈ ખર્ચ વગર કૉલ કરો.

No ke kōkua ma ka ʻōlelo Hawaiʻi e kahea aku i ka helu kelepona ma kāu kaleka ID, kāki ʻole ʻia kēia kōkua nei. (Hawaiian)

(Hindi) **हिन्दी में भाषा सहायता के लिए, अपने आईडी कार्ड पर दिये गये नम्बर पर मुफ्त कॉल करें।**

Yog xav tau kev pab txhais lus Hmoob hu dawb tau rau tus xov tooj ntawm koj daim npav. (Hmong)

Maka enyemaka asụsụ na Igbo kpọọnọmba edepụtara na kaadị ID gị na akwụghị ụgwọ ọ bụla. (Ibo)

Para iti tulong ti pagsasao iti pagsasao tawagan ti numero a nakalista iti ID card yo nga awan ti bayadan yo. (Ilocano)

Untuk bantuan dalam bahasa Indonesia, silakan hubungi nomor yang tercantum di kartu ID Anda tanpa dikenakan biaya. (Indonesian)

Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente il numero riportato sulla Sua scheda identificativa. (Italian)

日本語で援助をご希望の方は、IDカードに記載されている番号まで無料でお電話ください。 (Japanese)

လၢတၢ်မၤစၢၤဃာ်ကတိၤကျိာ်အဂီၢ် ကျိာ် ကိးနီၣ်ဂံၢ်တၢ်ကွဲးလီၤဃာ်လၢနလံာ်အုၣ်ထံး အၣ်ဒိၣ်ကး အလီၤ လၢတအိၣ်ဒီးတၢ်လၢာ်ဘူၣ်လၢာ်စ့ၤဘၣ် (Karen)

한국어로 언어 지원을 받고 싶으시면 보험 ID 카드에 수록된 무료 통화번호로 전화해 주십시오. (Korean)

Bé m̀ ké gbo-kpá-kpá dyé ɖé Bǎsɔ́ɔ̀ wùɖùǔn wɛ̃ɛ, ɖá nɔ̀bà bé ɔ céèà bó nì dyí-dyoìn-bɛ̃̀ɔ̃̀ kɔ̃ɛ bó pídyi. (Kru-Bassa)

(Kurdish) بۆ وەرگرتنی ڕێنوینی پێوەندیدار بە زمان بە زمان بە ژمارەی خۆڕایی نووسراو لە کارتی پێناسی خۆتاندا پەیوەندی بکەن.

ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ,
ກະລຸນາໂທຫາໝາຍເລກທີ່ລະບຸໃນບັດປະຈຳຕົວຂອງທ່ານໂດຍບໍ່ເສຍຄ່າໂທ. (Laotian)

तील भाषा (मराठी) सहाय्यासाठी तुमच्या आयडी कार्डवर सूचिबद्ध करण्यात आलेल्या क्रमांकावर कोणत्याही खर्चाशिवाय कॉल करा. (Marathi)

Ñan bōk jipañ ilo Kajin Majol kwon kallok nōmba eo ej walok ilo kaat in ID eo aṃ ejjelok wōnān. (Marshallese)

Ohng palien sawas en soun kawewe ni omw lokaia Ponape koahl nempe me sansal pohn noumw ID koard ni sohte isais. (Micronesian-Pohnpeian)

សម្រាប់ជំនួយភាសាជា ភាសាខ្មែរ
សូមទូរស័ព្ទតាមលេខដែលមាននៅលើប័ណ្ណសម្គាល់សមាជិករបស់អ្នកដោយឥតគិតថ្លៃ។ (Mon-Khmer, Cambodian)

(नेपाली) मा निःशुल्क भाषा सहायता पाउनका लागि तपाईंको परिचय-पत्रमा उल्लेख गरिएको नम्बरमा फोन गर्नुहोस् । (Nepali)

Tën kuɔɔny ë thok ë Thuɔŋjäŋ cɔl akuën cï reec ë kaaddu kɔ̈u kecïn ayöc.(Nilotic-Dinka)

For språkassistanse på norsk, ring nummeret på ID-kortet ditt kostnadsfritt. (Norwegian)

Fer Helfe in Deitsch, ruf die Fonnummer aa die uff dei ID Kaarde iss. Es Aaruf koschtet nix. (Pennsylvania Dutch)

برای راهنمایی به زبان فارسی، بدون هیچ هزینه ای با شماره ای که بر روی کارت شناسایی شما آمده است تماس بگیرید. انگلیسی (Persian)

Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer podany na karcie ID. (Polish)

Para obter assistência linguística em português ligue para o número grátis listado no seu cartão de identificação. (Portuguese)

(Punjabi) ਪੰਜਾਬੀ ਵਿੱਚ ਭਾਸ਼ਾਈ ਸਹਾਇਤਾ ਲਈ ਆਪਣੇ ਆਈਡੀ ਕਾਰਡ ਤੇ ਦਿੱਤੇ ਨੰਬਰ ਤੇ ਕਾਲ ਕਰੋ।

Pentru asistenţă lingvistică în româneşte telefonaţi la numărul gratuit indicat pe cardul dvs. de membru de la Aetna. (Romanian)

Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру, указанному в вашей ID-карте удостоверения личности. (Russian)

Mo fesoasoani tau gagana I le Gagana Samoa vala'au le numera o lo'o lisiina I luga o lau pepa ID e aunoa ma se totogi. (Samoan)

Za jezičnu pomoć na hrvatskom jeziku pozovite besplatan broj naveden na poleđini Vaše identifikacijske kartice. (Serbo-Croatian)

Fii yo on heɓu balal e ko yowitii e haala Pular noddee e dii numero ji lintaadi ka kaydi dantite mon. Njodi woo fawaaki on. (Sudanic-Fulfulde)

Ukihitaji usaidizi katika lugha ya Kiswahili piga simu kwa nambari iliyoorodheshwa kwenye Kitambulisho chako bila malipo. (Swahili)

ܐܢ ܒܥܐ ܐܢܬ ܡܬܘܪܓܡܢܘܬܐ ܒܠܫܢܐ ܣܘܪܝܝܐ ܗܐ ܐܝܬ ܠܟ ܕܡܨܐ

ܕܡܠܝܫܘܢ ܕܡܚܒܪ ܥܠܠ ܡܢܝܢܐ ܕܟܬܝܒܐ ܥܠ ܟܪܬܐ ܕܗܘܝܬܐ.(Syriac-Assyrian)

భాషతో సాయం కొరకు ఎలాంటి ఖర్చు లేకుండా మీ ఐడి కార్డు మీద ఉన్న నెంబరుకు కాల్ చేయండి (తెలుగు) (Telugu)

สำหรับความช่วยเหลือทางด้านภาษาเป็น (ภาษาไทย) โทรหมายเลขที่แสดงไว้บนบัตรประจำตัวของท่าน ฟรีไม่มีค่าใช้จ่าย (Thai)

Kapau 'oku fiema'u hā tōkoni 'i he lea faka-Tonga telefoni ki he fika 'oku lisi 'i ho'o kaati ID 'o 'ikai hā tōtōngi (Tongan)

Ren áninnisin chiakú ren (Kapasen Chuuk) kopwe kékkééri ena nampaan tengewa aa makketiw wóón noumw ena chéén taropween ID nge esapw kamé ngonuk. (Trukese)

(Dilde) dil yardım için sayı hiçbir ücret ödemeden kimlik kartı listelenen diyoruz. (Turkish)

Щоб отримати допомогу перекладача української мови, зателефонуйте за безкоштовним номером, наданим у вашій ID-картці посвідчення особи. (Ukrainian)

اُردو میں لسانی معاونت کے لیے اپنے ID کارڈ پر درج نمبر پر مفت کال کریں۔ (Urdu)

Để được hỗ trợ ngôn ngữ bằng (ngôn ngữ), hãy gọi miễn phí đến số được ghi trên thẻ ID của quý vị. (Vietnamese)

פאר שפראך הילף אין אידיש רופט דעם נומער וואס שטייט אויף אייער אידענטיטעט קארטל פריי פון אפצאל. (Yiddish)

Fún ìrànlọwọ nípa èdè (Yorùbá) pe nọmbà tí a kọ sórí káàdì idánimọ rẹ lái san owó kankan rárá. (Yoruba)

DELTA DENTAL

DENTAL CLAIM STATEMENT

TYPE OF TRANSACTION

1. ☐ STATEMENT OF ACTUAL SERVICES ☐ PRE-TREATMENT ESTIMATE

MAIL CLAIMS TO: DELTA DENTAL
PO BOX 9085
FARMINGTON HILLS, MI 48333-9085

OTHER COVERAGE

2. OTHER DENTAL OR MEDICAL COVERAGE? ☐ NO IF NO, SKIP TO #11 ☐ YES
3. AMOUNT OF PRIMARY PAYMENT $
4. SUBSCRIBER NAME (LAST, FIRST, MIDDLE INITIAL), ADDRESS, CITY, STATE, ZIP

SUBSCRIBER INFORMATION

11. SUBSCRIBER NAME (LAST, FIRST, MIDDLE INITIAL), ADDRESS, CITY, STATE, ZIP
12. DATE OF BIRTH
13. GENDER M F
14. SUBSCRIBER ID (SSN OR ID#)
15. PLAN/GROUP NUMBER
16. EMPLOYER NAME

PATIENT INFORMATION

5. DATE OF BIRTH
6. GENDER ☐ M ☐ F
7. SUBSCRIBER/POLICYHOLDER ID (SSN OR ID#)
8. PLAN/GROUP NUMBER
9. RELATIONSHIP TO PATIENT ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER
10. OTHER INSURANCE COMPANY/DENTAL BENEFIT PLAN NAME
17. PATIENT NAME (LAST, FIRST, MIDDLE INITIAL)
18. RELATIONSHIP TO SUBSCRIBER ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER
19. DATE OF BIRTH
20. GENDER ☐ M ☐ F
21. IF PATIENT IS A DEPENDENT OVER AGE 19, PLEASE INDICATE STATUS ☐ FULL TIME STUDENT ☐ TOTALLY & PERM DISABLED ☐ IRS DEPENDENT ☐ SPONSORED DEPENDENT

DENTAL SERVICES

	22. DATE OF SERVICE MM/DD/CCYY	23. AREA OF ORAL CAVITY	24. TOOTH NO. OR LETTER	25. TOOTH SURFACE	26. CURRENT CDT PROCEDURE CODE	27. DESCRIPTION	28. FEE
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							

MISSING TEETH	PERMANENT															PRIMARY										29. TOTAL FEE CHARGED
30. PLACE X ON MISSING TOOTH NUMBERS	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	A	B	C	D	E	F	G	H	I	J	
	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	T	S	R	Q	P	O	N	M	L	K	

REMARKS

31.

AUTHORIZATIONS

32. AS PERMITTED UNDER LAW, I CONSENT TO THE USE AND DISCLOSURE OF MY PROTECTED HEALTH INFORMATION FOR PURPOSES OF PAYMENT OF THIS CLAIM.

PATIENT/GUARDIAN SIGNATURE DATE

33. IF PERMITTED, I HEREBY ASSIGN AND AUTHORIZE PAYMENT OF THE DENTAL BENEFITS OTHERWISE PAYABLE TO ME TO THE TREATING DENTIST.

SUBSCRIBER SIGNATURE DATE

ADDITIONAL CLAIM INFORMATION

34. PLACE OF TREATMENT ☐ DENTAL OFFICE ☐ HOSPITAL ☐ ECF ☐ OTHER
35. NUMBER OF ENCLOSURES RADIOGRAPHS _____ DIGITAL IMAGES _____ MODELS _____
36. IS TREATMENT RELATED TO ORTHODONTICS? ☐ NO ☐ YES DATE APPLIANCE PLACED _____ MONTHS OF TREATMENT REMAINING _____
37. TREATMENT RESULTING FROM: ☐ OCCUPATIONAL ILLNESS/INJURY ☐ AUTO ACCIDENT ☐ OTHER ACCIDENT
38. REPLACEMENT OF PROSTHESIS? ☐ YES DATE PRIOR PLACEMENT _____ ☐ NO

BILLING DENTIST/DENTAL ENTITY (#40- #43: USE FOR GROUP PRACTICE/MULTIPLE LOCATIONS)

39. NAME, ADDRESS, CITY, STATE, ZIP
40. NPI
41. LICENSE NUMBER
42. TIN
43. PHONE NUMBER ( )

TREATING DENTIST AND LOCATION

44. I HEREBY CERTIFY THAT I HAVE PERFORMED THE PROCEDURES AS INDICATED BY DATE AND/OR WISH TO OBTAIN A PRE-TREATMENT ESTIMATE FOR THE PROCEDURES WHICH ARE NOT DATED. THE PROCEDURES WERE/ARE NECESSARY IN MY PROFESSIONAL JUDGMENT.

X _____
SIGNED (TREATING DENTIST) DATE

45. NPI
46. LICENSE NUMBER
47. TIN
48. ADDRESS, CITY, STATE, ZIP (IF DIFFERENT THAN #39)
49. PHONE NUMBER ( )
50. ADDITIONAL DENTIST ID
51. SPECIALTY CODE

For the fastest processing, submit claims electronically through our **Dental Office Toolkit**!
It's free, easy, and available to all dentists. Check our Web sites for more information.

INSTRUCTIONS FOR COMPLETING THE SCANNABLE CLAIM

Optical scanning of paper claims can decrease total processing time by two to three days over those claims that must be manually keyed.

FOR CLAIMS TO BE OPTICALLY SCANNED:

- **Clearly type, hand write, or use a computer printer to enter information.**
- **Use all upper-case (capital) letters, if possible.**
- **Write, type, or print in black or blue pen/ink—do not use red or green ink or any color of highlighter.**
- **Keep information within the correct field.**
- **Make sure the typewriter or printer ribbon is dark and the print can be easily read.**
- **Cover mistakes with line tape and print or type over—do not use liquid correction fluid.**
- **Use paperclips to hold attachments whenever possible. Place stapled items only at the lower edge of the form.**

FIELDS 2 THROUGH 21—PATIENT/SUBSCRIBER INFORMATION:

- **If the patient has dental coverage through another carrier(s), complete the other coverage section, fields #2 through #10 (if not, leave them blank). Fill in the amount of primary payment (#3) ONLY when the claim is billing for secondary benefits. Do not enter $0 unless the primary carrier's determination of payment was $0. DO NOT ATTACH the primary carrier's voucher.**
- **Enter the patient's and subscriber's names in this order: last, first, middle initial. Do not use titles, such as Mrs. or Dr.**

FIELDS 22 THROUGH 31—DENTAL SERVICES AND REMARKS:

- **Hand or machine print**
- **When machine printing, double-space lines and enter information in between the correct column guidelines. Dates may be entered without separators (/).**
- **Use current ADA CDT procedure codes.**
- **Use the REMARKS section (#31) for information necessary to process the claim, such as non-standard COB, miscellaneous codes, codes for which Delta Dental requires a report, or supporting documentation that will assist in accurately processing the claim. Keep documentation within the designated field. Unnecessary documentation delays processing.**

FIELDS 39 THROUGH 51—BILLING DENTIST AND TREATING DENTIST:

- **The dentist's name or business name entered in field #39 must match the name on file with Delta Dental.**
- **Enter the license number and Tax Identification number (TIN) of the treating dentist in fields #46 and #47. Enter his/her National Provider Identifier (NPI) in field #45.**
- **Fields #40 through #43 are optional for group practices or practices with more than one location who have more than one NPI, license number and/or TIN.**

NOTICE TO ALL PARTIES COMPLETING THIS FORM:

Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

MAIL CLAIMS TO:	MAIL INQUIRIES TO:	TELEPHONE FOR ELIGIBILITY AND BENEFIT INFO
Delta Dental P.O. Box 9085 Farmington Hills, MI 48333-9085	Delta Dental Attn: Customer Service P.O. Box 9089 Farmington Hills, MI 48333-9089	800-524-0149 (GROUP) 800-971-4108 (INDIVIDUAL)

Delta Dental of Michigan	Delta Dental of Ohio	Delta Dental of Indiana	Delta Dental of North Carolina
www.deltadentalmi.com	www.deltadentaloh.com	www.deltadentalin.com	www.deltadentalnc.com

FRAUD WARNINGS

Please read the warning statement for the state where you reside and for the state where your policy was issued.

Alabama: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

Alaska: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

Arizona: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

Arkansas: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

California: For your protection California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

Delaware: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

District of Columbia: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.

Florida: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Idaho: Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.

Indiana: A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

Kansas: NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files a 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.

Louisiana: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance {Footnote 1} is guilty of a crime and may be subject to fines and confinement in prison.

Maine: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Maryland: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Massachusetts: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Minnesota: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

New Hampshire: Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in R.S.A. 638:20.

New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New Mexico: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

New York: 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 shall also be subject to a civil penalty not to exceed $5000 and the stated value of the claim for each such violation.

Ohio: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Oklahoma: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive and insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Oregon: Any person who knowingly presents a false statement of claim for insurance may be guilty of a criminal offense and subject to penalties under state law.

Pennsylvania: 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.

Rhode Island: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Tennessee: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Texas: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Vermont: No person shall, with intent to defraud, present or cause to be presented a claim for payment or benefit, pursuant to any insurance policy, that contains false representations as to any material fact or which conceals a material fact. Any person who knowingly presents a false statement of claim for insurance may be guilty of a criminal offense and subject to penalties under state law.

Virginia: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Washington: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

West Virginia: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

A step above

Aetna One® Flex care management

Better health, better cost management

Our care management model takes a holistic approach to physical and emotional well-being. There's one-on-one support for acute and chronic condition care through a single nurse. And our transgender advocates support all necessary procedures and services.

And our Aetna Advice™ program uses advanced artificial intelligence (AI), exclusive member data and progressive analytics. Working together, they create a predictive, custom engagement. Our clinical data comes from an analysis of social determinants of health to help close equity gaps in care. All of which leads to better health outcomes and lower medical costs.

Three core strengths

Caring
Personalized outreach

Connected data create insights for a more personal touch, giving employees more reasons to engage and take the right health actions. Features single-nurse care for the family for acute and chronic condition support.

Connected
Digital tools

A simpler, more connected approach delivers a better experience, focusing on whole health. Features the Aetna Health℠ app, text and emails.

Closer to home
Local support

You can reach more employees in more ways, at more times, than ever before. Features MinuteClinic®, CVS® HealthHUB™ and CVS Pharmacy® staff member support.

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aetna®

Aetna One® Flex care management

Simply put, our solution provides a higher clinical touch with greater engagement, expanded staff and monetary reward incentives that encourage members to make better health decisions.*

What's included

- ✓ One-on-one support for clinical concerns both acute and chronic conditions
- ✓ Your employees will receive a behavioral health assessment and medication review
- ✓ Personalized care plan and information specific to your health needs
- ✓ Aetna® Healing Better™ full program and care team support
- ✓ Referral to other programs (internal and external)
- ✓ Readmission prevention visits at MinuteClinic® at select CVS Pharmacy® and Target® locations
- ✓ Pharmacist Panel,** which boosts member reach through in-store and telephonic communication
- ✓ Personalized nurse communication
- ✓ 24-Hour Nurse Line***
- ✓ Aetna Compassionate Care℠ program
- ✓ Digital coaching and well-being tools
- ✓ Expanded interdisciplinary care team that is trained in gender diversity, suicide prevention and cultural sensitivity. Dietitian, pharmacist and transgender advocate support

93%
of members reached
engaged in a clinical conversation[1]

2.5:1 **return on investment[2]**

Need more info about Aetna One Flex care management?

Just ask your Aetna® representative.

*Incentive reward program is an additional buy-up option.

**The Pharmacist Panel is available to self-insured customers who purchase the new Aetna One® Care Management portfolio with MedQuery® to ensure targeting inclusive of pharmacy claims. A similar product already exists for most fully insured plan sponsors. Existing plan sponsors on the Aetna One Care Management model will automatically receive this benefit as of January 1, 2022, if they also have MedQuery.

***While only your doctor can diagnose, prescribe or give medical advice, the 24-Hour Nurse Line can provide information on a variety of health topics.

[1] Average number of conversations and average length of call per engaged member in Aetna In Touch Care℠ Solutions (most similar current model to Aetna One Flex) in 2018.

[2] Customer savings can vary based on a number of factors (e.g., number of members, demographics, pharmacy integration). Although not guaranteed, many customers achieve a 2.5:1 return on investment (ROI).

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