Aetna Standard Open Choice PPO 2 (Only available in IN, IL and in other states outside of managed choice operational areas)

Aetna Preferred Provider Organization (PPO)

With PPO plans, you may choose to obtain care from in-network or out-of-network physicians, but you will usually pay more for out-of-network care due to higher co-insurance amounts and provider rates not pre-agreed to by the carrier. Referrals for specialists are not necessary, but may help you manage your costs.

*Enrollment in this plan includes a $10,000 group life insurance benefit/AD&D coverage for the worksite employee. Benefits are subject to an age-based reduction starting at age 65. Basic life and AD&D policies are not included with COBRA medical plan continuation coverage.
Prescription Coverage

All of the Aetna medical plans in this book include prescription coverage. Most major pharmaceutical chains participate in the Aetna National Network. Additional cost savings may be available if you order your prescriptions through Aetna Rx Home Delivery®.

What can I expect to pay?
The amount you will pay depends on the tier associated with the medication that your doctor prescribes. A tier is a level of coverage. You will either pay a flat fee or a percentage of the total cost of the prescription.

The Aetna plans TriNet offers classify medications in one of four tiers:

- **Tier 1:** Preferred generic medications – You typically pay the lowest cost for medications in this level. Some plans may provide certain Tier 1 medications at an even lower cost to you - these are considered Value Medications/Tier 1a and include generics and some over-the-counter brands. Value Medications/Tier 1a are available at the lowest cost share indicated in your plan materials.

- **Tier 2:** Preferred brand name medications – You generally pay a slightly higher cost for medications in this level.

- **Tier 3:** Non-preferred generics and brand name medications not on the formulary list* – You typically pay the highest cost for medications in this level.

- **Tier 4:** All specialty medications – You generally pay a higher cost for specialty medications in this level. Specialty medications may be injected, infused or taken orally.

*A formulary is a list of prescription medications that are covered by a benefit plan. You may access current formulary information for the Aetna plans on aetna.com:

1. Select **Individuals & Families > Find a Medication**
2. Scroll down to complete a public search and select **Yes** to indicate that the pharmacy coverage is through an employer
3. Choose **2017** for the plan year, and **Value Plans** under the plan drop down, then click **Continue**
4. Refer to the **2017 Four Tier Open Plans**

You may also call the number on the back of your member ID card or refer to the numbers provided in the Carrier Contact Information.

In addition, the following limitations apply to certain prescriptions:

<table>
<thead>
<tr>
<th><strong>Mandatory generic medications</strong></th>
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<tbody>
<tr>
<td>Generic medications will be substituted for all prescriptions whenever they are available unless the doctor specifies “dispense as written” on the prescription (DAW Override). If you prefer the brand-name medication and your doctor does not specify “dispense as written” on your prescription, you will pay the difference in cost between the generic and brand-name medication in addition to the applicable co-payment.</td>
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<table>
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<tr>
<th><strong>Precertification</strong></th>
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<tbody>
<tr>
<td>Precertification means that you or your doctor need to get approval from Aetna before certain medications will be covered.</td>
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<tr>
<th><strong>Quantity limits</strong></th>
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<tbody>
<tr>
<td>These limits help your doctor and pharmacist make sure that the medication is used correctly and safely. Aetna uses medical guidelines and FDA-approved recommendations to set the limits. Your doctor can ask for an exception if it is medically necessary to prescribe a higher medication quantity.</td>
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<tr>
<th><strong>Step therapy</strong></th>
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<tr>
<td>Some medications require step therapy. This means that you must try one or more other medications before a step therapy medication is covered. The medications required before step therapy medications can be approved, are equally effective, have FDA approval, may cost less and treat the same condition. If you don’t try the other medication first, you may need to pay full cost for the step therapy medication.</td>
</tr>
</tbody>
</table>

Please refer to the Certificate of Coverage for more information. As soon as administratively possible, Carrier Certificates of Coverage will be posted on trinetsoi.com.
Affordable Care Act

All TriNet medical plans meet the Minimum Essential Coverage (MEC) requirements for the Affordable Care Act (ACA) individual mandate. This means that you will not have to pay the individual mandate penalty during any period you and your eligible dependents are enrolled in TriNet medical coverage.

Important Information

In accordance with the ACA, a Summary of Benefits and Coverage (SBC) has been prepared for your review. SBCs are intended to provide clear, consistent and comparable information about health plans and benefits coverage. The SBCs can be accessed by logging into trinetsoi.com. Visit the Resources tab, click Forms from the menu options, and then select SOI Health Plan SBC Docs folder. You may also request a copy by contacting the TriNet Solution Center at 800.572.2412, Monday–Friday, 4:30 a.m.–9 p.m. PT.

A uniform glossary of health coverage and medical terms is provided by the Department of Labor (DOL) to help you understand the terms used in the SBCs. The uniform glossary is available online at dol.gov/ebsa/pdf/SBCUniformGlossary.pdf.

The TriNet Benefits Guidebook and Summary Plan Description (SPD) include important information such as the HIPAA Privacy Notice, Medicare Part D Creditable Coverage, the Notice of Mandated Benefits, information about the Children’s Health Insurance Program (CHIP) and more. To access the Benefits Guidebook and SPD, visit trinetsoi.com or call the TriNet Solution Center at 800.572.2412, Monday–Friday, 4:30 a.m.–9 p.m. PT to request a copy.

Carrier Contact Information

Carrier Contact Information: For pre-enrollment questions, contact Aetna at 800.704.7287 with Group Number 326371. For post-enrollment questions, contact the number on the back of your ID card. For general questions, contact Aetna at 800.704.7287.

Participating doctors, hospitals, pharmacies, and other providers are listed in Aetna’s online directory, DocFind. You can access DocFind by clicking on Find a Doctor at aetna.com.
For More Information About TriNet SOI Medical Benefits: Contact the TriNet SOI Solution Center at 800.572.2412.

Please refer to your insurance carrier’s Certificate of Coverage and ID Cards for more information. As soon as administratively possible, Carrier Certificates of Coverage will be posted on trinetsoi.com. You will receive an ID card from the carrier approximately two weeks after your initial enrollment has been processed by TriNet. If you need additional card(s) please contact the carrier.

**Frequently Asked Questions (FAQs)**

**How do I enroll for benefits?** You have two options for enrolling for benefits – online or by submitting a paper form. If you enroll online, you will only see the plans available to you and the TriNet Online Benefits Enrollment tool will walk you through an easy step-by-step process to make your elections. To enroll online, log in to trinetsoi.com, click **Benefits**, then **Benefits Enrollment**. To enroll by paper form, contact the TriNet Solution Center at 800.572.2412, Monday–Friday, 4:30 a.m.–9 p.m. PT to request a copy of the Benefits Election form.

**When will deductions for coverage begin?** Deductions will begin on the first paycheck of the month in which your coverage begins or, if you are newly eligible for TriNet benefits, the first paycheck after the date your benefit elections are processed. If a benefits election form is submitted after your initial effective date (and prior to the enrollment deadline), your coverage will be set-up retroactively and any missed payments will be deducted from your next paycheck in a lump sum.

**When can I elect to make changes to my coverage?** The rules under Section 125 of the Internal Revenue Code require that the benefit elections you make when you are initially eligible or during Open Enrollment be irrevocable and remain in effect until the end of the benefits plan year. Aside from your contributions to an HSA, no changes may be made to any benefit elections during the benefits plan year, regardless whether such benefits are paid on a pre-tax or taxable basis, unless you experience a life status change event. Changes to your benefit elections may be made if the life status change event is reported in a timely manner to TriNet and the benefit changes you request are consistent with the event and are allowed under the TriNet plan and carrier contracts. For more information, refer to the TriNet Benefits Guidebook, or contact the TriNet Solution Center at 800.572.2412, Monday-Friday, 4:30 a.m.–9 p.m. PT.
How do I know if my dependents are eligible for benefits? Eligible dependents include:

- Your spouse. Your spouse is your legally married husband or wife, as defined by applicable state law.
- Your (same-sex or opposite-sex) domestic partner who meets the criteria set forth in the TriNet Declaration of Domestic Partnership form.
- Your, your spouse’s, or your domestic partner’s natural child, stepchild, adopted child, child placed for adoption, or child for whom you or your spouse, or domestic partner have been appointed legal guardianship, who is less than age 26 (medical coverage may extend past the age of 26 as mandated by applicable state law); a disabled child (insurance carrier approval required); the child of a dependent (this may include grandchildren and great grandchildren if the dependents coverage is mandated by state law and the coverage is permitted by the applicable insurance carrier), or a child named in a Qualified Medical Child Support Order (QMCSO).

If you elect coverage for a dependent with a different last name than yours, TriNet may request additional documentation to verify eligibility.

What if I am in an active course of treatment with an out-of-network doctor when I enroll in an Aetna plan? Members who are in an active course of treatment with an out-of-network provider may apply for Aetna’s transition of coverage program. To apply, the prospective member and his/her physician must complete a Transition Coverage Request form and submit it to Aetna. The Aetna Transition Coverage Request form can be found on the Aetna website at aetna.com.

When will my active TriNet Health Plan coverage end? Active coverage in the TriNet Health Plan will terminate on the date that your active employment or eligibility for the health plan ends (for example, the date you move from full-time to part-time employment).

Do I have other options to see a doctor instead of going to the Emergency Room or urgent care for a non-emergency or while I’m traveling? Aetna plans offer access to a physician virtually through Teladoc at a much lower copay. Doctors are available 24/7/365 to resolve many non-emergency medical issues through phone or video consults. Contact Teladoc online at https://member.teladoc.com/aetna or call 800.835.2362 to request a consult.

Is Aetna required to pre-certify any services? Precertification is required for certain services. Please refer to your insurance carrier’s Certificate of Coverage for more information.

When can I contact the TriNet Solution Center? Contact the TriNet Solution Center for assistance at 800.572.2412, Monday–Friday, 4:30 a.m.–9 p.m. PT. (Hay representantes de habla hispana disponibles por teléfono.)

COBRA Continuation Coverage Rights
If you or your covered dependents are no longer eligible for health care coverage through the TriNet Benefits Plan, under certain circumstances you and they may be eligible to continue coverage under the Federal Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985. When you are initially covered under the Plan, TriNet will send a notice that explains COBRA coverage, when it may become available to you and your covered dependents, and what you need to do to protect your right to elect COBRA coverage. For more information about your COBRA rights and obligations under the Plan and under federal law, you should review the TriNet Benefits Guidebook and Summary Plan Description, or contact the TriNet Solution Center at 800.572.2412, Monday–Friday, 4:30 a.m.–9 p.m. PT.