Dear Valued Employees:

We are happy to provide you with this Benefits-At-A-Glance which summarizes your employee benefits for the 2017-2018 plan year. **Wycliffe Associates** recognizes that benefits are an important part of your total compensation package. Our benefit program provides competitive and valuable benefits for you and your dependents.

This document is not just an enrollment guide. It is a resource for you and your family to use throughout the year. In this guide you will find a summary of each of the benefit plans offered to eligible employees and their dependents. Our benefits program is designed to allow you to choose what works best for your needs and your budget, and this information will allow you to make informed decisions regarding the selection and continued management of the services and benefits provided to you as a **Wycliffe Associates employee**.

### IMPORTANT NOTICE TO EMPLOYEES:

This Benefits-at-a-Glance provides a general description of the various benefits available to you through the Wycliffe Associates Employee Benefits Program. The details of these plans and policies are contained in the official plan and policy documents. This guide is meant only to cover the major points of each plan or policy, for illustrative purposes only. It does not contain all of the facts regarding coverage, limitations, or exclusions that are contained in the policy documents. In the event of a conflict between the information in this guide and the formal policy documents, the formal documents will govern.

The rates and payroll deductions provided in this illustration are meant for illustrative purposes only and may not reflect final underwriting adjustments. Please refer back to your employer for confirmation of your premium responsibilities.
Employee Eligibility and Enrollment
All full time employees working an average of 30 hours per week are eligible to enroll in benefits. For specific details, please refer to the plan documents. New full time employees’ benefits for all lines of coverage will begin on the 1st of the month following your date of hire.

Dependent Eligibility – Medical Plans
New legislation has changed some of the eligibility requirements for dependent coverage on Medical insurance plans. It is important for everyone to understand what constitutes eligibility and what the implications could be for not following the eligibility guidelines.

Examples of Eligible dependents include:
- Spouse
- Dependent children
- Stepchildren

Healthcare reform legislation restricts a plan or issuer from denying coverage for a child under age 26 based on any of the following factors:
- Financial dependence on the employee
- Residency with the employee
- Student status
- Marital status
- Employment status

The adult child’s spouse and children are not subject to coverage. For adult children age 26 and older, the State of Florida has adopted legislation allowing for extended coverage up to age 30, but under more limited conditions such as the child must reside in Florida or be a part time or full time student and must be unmarried with no dependent child(ren) of his/her own. In addition, they cannot be covered under another group or franchise plan, student or individual plan, or be Medicare eligible.

Independent Verification of Eligibility
When you first enroll, and/or if you change coverage mid-year due to a qualifying event, you will be asked to provide the applicable documents from the following list:
- Spouse Verification Documentation: Marriage Certificate
- Child Verification Documentation: Birth Certificate, court document awarding custody or requiring coverage

Mid-Year Enrollment Changes – Section 125 Cafeteria Plan
Employees may take advantage of, at no cost to them, the tax benefits of a 125 Cafeteria Plan. This plan allows you to pay for your employee benefits on a pre-tax basis to be deducted from your paycheck. When you elect to pay for these authorized benefits pre-tax, you save because you are paying less in taxes...you do not pay Federal income or Social Security taxes on these designated benefit dollars. Therefore, you lower your taxable income. This will allow you to take home more of your paycheck, decreasing the net cost of the benefit you are purchasing.

Sample of Savings using pre-tax Deductions:

<table>
<thead>
<tr>
<th></th>
<th>Pre-Tax Contributions</th>
<th>Post Tax Contributions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee Gross Pay</td>
<td>$35,000</td>
<td>$35,000</td>
</tr>
<tr>
<td>Pre-Tax Premium</td>
<td>$417</td>
<td></td>
</tr>
<tr>
<td>Taxable Income</td>
<td>$34,583</td>
<td>$35,000</td>
</tr>
<tr>
<td>Assumed Tax Rate 1</td>
<td>25.65%</td>
<td>25.65%</td>
</tr>
<tr>
<td>Net Pay</td>
<td>$25,712</td>
<td>$26,023</td>
</tr>
<tr>
<td>After Tax Premium</td>
<td>-</td>
<td>$417</td>
</tr>
<tr>
<td>Take Home Pay</td>
<td>$25,712</td>
<td>$25,605</td>
</tr>
</tbody>
</table>

1Assumed Tax Rate of 18% Federal Income Tax and 7.65% FICA (Social Security and Medicare)

Current IRS regulations state that benefit choices cannot be changed in the middle of a plan year unless you experience a qualifying life event. Changes must be reported within 30 days of the actual event. Some common qualifying events may include:
- Marriage, divorce, or legal separation.
- Birth, adoption, or change in custody of a child.
- Change in employment status of either you or your spouse which affects benefits.

Please Note: the IRS does not consider financial hardship a qualifying event to drop coverage.

Notice of Special Enrollment Rights
If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents other coverage). However, you must request enrollment within 30 days after your or your dependents other coverage ends.

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the qualifying event.

If you or your dependents lose eligibility for coverage under Medicaid or the Children’s Health Insurance Program (CHIP) or become eligible for a premium assistance subsidy under Medicaid or CHIP, you may be able to enroll yourself and your dependents. You must request enrollment within 60 days of the loss of Medicaid or CHIP coverage or the determination of eligibility for a premium assistance subsidy.

To request special enrollment or obtain more information, please contact Human Resources.

Family Medical Leave Act (FMLA)
Employees eligible for continuation of benefits while on an approved qualifying leave are still responsible to pay the same portion of premiums paid prior to leave. You may pay your portion of premiums due before starting your leave or you may pay monthly during leave. Payment is due on the first of the month. Failure to make payments in a timely manner will result in the termination of your coverage. You should contact Human Resources to make payment arrangements prior to your leave.

Uniformed Services Employment and Reemployment Rights Act (USERRA)
In addition to protecting the job rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service USERRA also provides protections regarding health insurance coverage.
- If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents for up to 24 months while in the military.
- Even if you don’t elect to continue coverage during your military service, you have the right to be reinstated in your employer’s health plan when you are reemployed, generally without any waiting periods or exclusions (such as pre-existing condition limitations) except for service connected illnesses or injuries.

Health Insurance Marketplace
The healthcare reform law creates a new Marketplace for purchasing health insurance coverage, also called an exchange. Federal subsidies for eligible individuals will be available through the Marketplace. Eligibility is determined based on many factors, including income as well as access to other coverage. You will not be eligible for subsidies if you are offered coverage through your employer that is deemed “affordable” and provides “minimum value” in accordance with regulations. To ensure that taxpayers receive the right amount of subsidies, Marketplaces report certain information to the IRS. At the end of the year, the subsidy amount will be recalculated using the taxpayer’s household income as reported on his or her tax return, and any
difference in the amounts will be reconciled. If the taxpayer’s income has increased from the amount that he or she reported to the Marketplace, and as a result received a larger subsidy than he or she was entitled to, that individual may have to repay part of their subsidy.

The Marketplace open enrollment period may or may not correspond with your employer’s open enrollment period. Purchasing coverage through the Marketplace may or may not be a qualifying event to change or drop your coverage through your employer. Please check with Human Resources for further details.

Certain events may allow you to enroll in the Marketplace after the open enrollment period. These events include but are not limited to: loss of minimum essential coverage, marriage, birth, or placement for adoption, employer coverage is non-qualifying, gaining citizenship or qualifying immigration status.

More information on the health care reform law and the Marketplaces is available at www.healthcare.gov.

**Individual Shared Responsibility**
Under healthcare reform, individuals without minimum essential health coverage could be assessed a penalty starting in 2014 unless an exemption is applicable. Employer sponsored coverage is generally minimum essential coverage.

**Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rights**
Federal law requires that health plan protect the confidentiality of your private health information. A complete description of your rights under HIPAA can be found in the Plan’s privacy notice, which is available to you from the Human Resources Department.


### Medical Insurance

#### Aetna International

<table>
<thead>
<tr>
<th>In Network Benefits</th>
<th>Outside the U.S.</th>
<th>Aetna OAMC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductible (Individual / Family)</td>
<td>None</td>
<td>$1000 / $2000</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>None</td>
<td>20%</td>
</tr>
<tr>
<td>Out of Pocket Maximum - (Individual / Family)</td>
<td>None</td>
<td>$2000 / $2000</td>
</tr>
<tr>
<td>Prescription Drugs</td>
<td>No charge</td>
<td>$0 copay</td>
</tr>
<tr>
<td>Mail Order Drugs (Up to 90 Day Supply)</td>
<td>N/A</td>
<td>$0 copay</td>
</tr>
</tbody>
</table>

#### Physician Office Visits

<table>
<thead>
<tr>
<th></th>
<th>U.S. - Deductible + Coinsurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office Visit</td>
<td>No charge</td>
</tr>
<tr>
<td>Specialist Office Visit</td>
<td>No charge</td>
</tr>
<tr>
<td>Referral Needed for Specialist</td>
<td>No</td>
</tr>
</tbody>
</table>

#### Preventative Care

<table>
<thead>
<tr>
<th>Routine Adult Physical Exams, Well Woman Exams, Mammograms, Well Child Exams</th>
<th>Covered 100%</th>
</tr>
</thead>
</table>

#### Diagnostic / Laboratory

<table>
<thead>
<tr>
<th>Independent Clinical Lab - (Blood Work)</th>
<th>U.S. - Deductible + Coinsurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnostic Testing Facility - (X-Rays)</td>
<td>U.S. - Deductible + Coinsurance</td>
</tr>
<tr>
<td>Advanced Imaging (MRI, CT-Scan, PET Scan, Nuclear Medicine)</td>
<td>U.S. - Deductible + Coinsurance</td>
</tr>
</tbody>
</table>

#### Hospitalization & Outpatient Services

<table>
<thead>
<tr>
<th>Inpatient Hospitalization (Facility)</th>
<th>U.S. - Deductible + Coinsurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient Surgical Care (Hospital Facility)</td>
<td>U.S. - Deductible + Coinsurance</td>
</tr>
<tr>
<td>Ambulatory Surgical Center</td>
<td>U.S. - Deductible + Coinsurance</td>
</tr>
<tr>
<td>Emergency Room</td>
<td>U.S. - Deductible + Coinsurance (Non emergent use = Deductible + 50% Coinsurance)</td>
</tr>
<tr>
<td>Urgent Care</td>
<td>U.S. - Deductible + Coinsurance (Non urgent use = Deductible + 50% Coinsurance)</td>
</tr>
</tbody>
</table>

#### Out of Network Benefits

<table>
<thead>
<tr>
<th>Deductible (Individual / Family)</th>
<th>N/A</th>
<th>$3000 / $6000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coinsurance</td>
<td>N/A</td>
<td>50%</td>
</tr>
<tr>
<td>Out of Pocket Maximum (Individual / Family)</td>
<td>N/A</td>
<td>$6000 / $6000</td>
</tr>
</tbody>
</table>

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**Also included is access to an International Employee Assistance Program (EAP)**

Includes up to 5 counseling sessions per issue per year per enrolled member. Access benefits by calling the member service number on ID card: 800-231-7729 or collect 813-775-0190. Services include: Cultural adjustment assistance, Marital/Family Stress, Child care and behavioral concerns, Social adaptation needs, Alcohol/Substance Abuse, Work/Life Balance and Depression.

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This information summarizes the Wycliffe Associates Medical benefits plans and is for illustrative purpose only.
KNOW YOUR OPTIONS
-Time saving and cost effective methods for getting the right kind of immediate medical care when your doctor is not available.

**Convenience Care Clinics**
In situations where you may not be able to get in to see your primary care doctor and your condition is not urgent or an emergency, you may want to consider a **Convenience Care Clinic**. Convenience Care Clinics are conveniently located in malls or some retail stores, such as CVS Caremark, Walgreens, Wal-mart and Target, and offer services without the need to schedule an appointment. These services are often provided at a lower out of pocket cost than at urgent care clinics and emergency room visits. Services at these types of clinics are usually available to patients 18 months of age or older.

**Urgent Care Centers**
In situations where you need medical care fast, but a trip to the emergency room is not necessarily required you may want to consider an **Urgent Care Center**. At urgent care centers you can be treated for many minor medical issues, usually at a lower cost and on quicker turn around than an emergency room.

**Emergency Rooms**
In situations where you think that you or a covered dependent may be experiencing a true medical emergency you should go to the nearest **Emergency Room** or call 911. An emergent medical condition usually results in serious jeopardy to your health, impairment of bodily functions, or serious dysfunction of organs.

Where should I go?

<table>
<thead>
<tr>
<th>Minor Health Issues</th>
<th>Moderate Health Issues</th>
<th>Life Threatening Emergencies</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Common infections (Sore or strep throat, Urinary tract and bladder infections, Earaches and ear infections, pink eye)</td>
<td>• Migraines</td>
<td>• Loss of consciousness</td>
</tr>
<tr>
<td>• Minor fevers</td>
<td>• Severe back pain</td>
<td>• Chest pain</td>
</tr>
<tr>
<td>• Cough, colds, and flu</td>
<td>• Vomiting and diarrhea</td>
<td>• Severe trouble breathing</td>
</tr>
<tr>
<td>• Nasal Congestion</td>
<td>• Minor broken bones</td>
<td>• Sudden loss of vision, numbness or difficulty speaking</td>
</tr>
<tr>
<td>• Allergy Symptoms</td>
<td>• Fevers</td>
<td>• Severe abdominal pain</td>
</tr>
<tr>
<td>• Skin issues (rashes, ringworm, and chicken pox)</td>
<td>• Asthma attacks</td>
<td>• Coughing or vomiting blood</td>
</tr>
<tr>
<td>• Head Lice</td>
<td>• Severe cough</td>
<td>• Severe bleeding</td>
</tr>
<tr>
<td>• Insect bites</td>
<td>• Eye irritations</td>
<td>• Severe burns</td>
</tr>
<tr>
<td>• Minor burns, cuts, and scrapes</td>
<td>• Animal bites</td>
<td>• Head trauma</td>
</tr>
<tr>
<td>• Sprains and Strains</td>
<td>• Wounds requiring stitches</td>
<td>• Major broken bones</td>
</tr>
</tbody>
</table>

*The information provided in this material should not be viewed as medical advice from Wycliffe Associates or Insurance Office of America. If you have questions concerning your medical conditions, drugs, treatment plans or symptoms consult your healthcare provider.*
# Dental Insurance

## Aetna

<table>
<thead>
<tr>
<th>Summary of Benefits</th>
<th>Outside the U.S.</th>
<th>Aetna PPO Dental</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calendar Year Deductible (Individual/Family)</td>
<td>$0 / $0</td>
<td>$0 / $0</td>
</tr>
<tr>
<td>Calendar Year Maximum</td>
<td>$2000</td>
<td>$2000</td>
</tr>
<tr>
<td>Orthodontia Lifetime Maximum (children only)</td>
<td>$2,000</td>
<td></td>
</tr>
<tr>
<td>Preventive Services</td>
<td>100%, deductible waived</td>
<td></td>
</tr>
<tr>
<td>Basic Services</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td>Major Services</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td>Orthodontia Coverage</td>
<td>50%</td>
<td>50%</td>
</tr>
</tbody>
</table>

**TOTAL MONTHLY PREMIUM**

<table>
<thead>
<tr>
<th>Total Monthly Premium 2017-2018</th>
<th>Medical</th>
<th>Dental</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee Only</td>
<td>$511.72</td>
<td>$50.83</td>
</tr>
<tr>
<td>Employee + Spouse</td>
<td>$1221.37</td>
<td>$103.45</td>
</tr>
<tr>
<td>Employee + Child(ren)</td>
<td>$1066.71</td>
<td>$123.55</td>
</tr>
<tr>
<td>Employee + Family</td>
<td>$1740.01</td>
<td>$176.16</td>
</tr>
</tbody>
</table>

This page summarizes the Wycliffe Associates Dental & Vision benefits plans and is for illustrative purpose only.
Take comfort in a partner you can trust

Security assistance as a standard for individuals and groups

We’re more than just health insurance. We help protect our members by providing security advice and assistance to keep them safe from political unrest and natural disasters. To do this, we partner with global crisis management experts red24 to make sure members have help — should their safety ever be threatened.

AdviceLine
Valuable information and resources

- Expert safety advice and assistance that’s just a phone call away
  – A team of multilingual representatives, political risk analysts, and crisis support specialists are available 24/7 to provide safety advice and assistance.
- Country intelligence and security advice on countries and cities around the world
  – Traveling employees and operational staff get access to security and safety information on more than 230 countries and more than 160 cities.
- Personalized travel reports and safety briefings
  – The service provides a range of personalized reports in order to give a thorough analysis of a members’ travel itinerary. This includes a phone briefing to allow members to ask specific questions.
- Email and text alerts for up-to-the-minute information on civil unrest, natural disasters and travel disruptions
  – Traveling and operational staff can sign up to receive travel and security alerts by email or text on everything from major transport disruptions to terrorism.
- A daily summary of worldwide security news
  – A daily newsletter provides a summary of significant security incidents along with analysis and advice to help clients keep pace with world events and prepare for potential obstacles.

ActionResponse
Personal support and assistance

- On-the-ground crisis management to protect personal safety
  – A worldwide network of crisis support specialists are trained to handle a range of scenarios including civil unrest, adverse weather conditions and terrorism.
- Specialized evacuation services to remove members from potentially life-threatening situations
  – A team of crisis support specialists, analysts, and customer service staff work together to seamlessly coordinate evacuation from high-risk situations.

To register for these services, members can visit www.red24.com/aetnaus and enter “US” followed by their Aetna policy number. Example: “US123456”

From there, members can complete their registration by creating a login username and password. Or they can contact red24’s crisis management experts at +1-646-513-4232

Meet every member’s most valuable travel companion.

Choice
Comfort
Care
Control
Convenience

Plans are available in a number of currencies.

If coverage provided by any insurance policy violates or will violate any US, UN, EU or other applicable economic or trade sanctions, the coverage is immediately considered invalid. For example, Aetna companies cannot make payments or reimburse for health care or other claims or services if it violates a financial sanction regulation. This includes sanctions related to a blocked person or entity, or a country under sanction by the United States, unless permitted under a valid written Office of Foreign Asset Control (OFAC) license. For more information on OFAC, visit www.treasury.gov/resource-center/sanctions/Pages/default.aspx

Aetna® is a trademark of Aetna Inc. and is protected throughout the world by trademark registrations and treaties. Program is underwritten and administered by Aetna Life & Casualty (Bermuda) Ltd.

Aetna does not provide care or guarantee access to health services. Not all health services are covered. Health information programs provide general health information and are not a substitute for diagnosis or treatment by a health care professional. See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Information is believed to be accurate as of the production date; however, it is subject to change. For more information, refer to www.aetnainternational.com.

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Welcome to Aetna International
Faith-Based & Non-Profit
It’s time to put your benefits to work.
We’re here to help make it easy.

What to do right now .................................................. 3
Help for your health needs ........................................... 4
How to see a doctor ..................................................... 5
How to submit a claim .................................................. 6
Online and mobile tools ............................................... 7
Discount programs .................................................... 9
Common insurance terms ........................................... 10
What to do right now

The most important first step is to register for your Secure Member Website. The site gives you the tools you’ll need to manage your health benefits. You can register in just a few steps by visiting www.aetnainternational.com and clicking “Start Here” under the “Secure login” section. You’ll need to select your plan type, enter your name, date of birth and the number on your Member ID Card.

There are important documents on your secure member website that will help you understand your plan better. To view these documents, log in to your member website and click “Your Account, Your Policy” then “Policy Documents.” The documents located here will provide even more details of your coverage.

You can use the website to:

Submit and track claims
Find nearby doctors and hospitals
Browse a library of health topics
View your plan documents

If you have a smartphone, now is also a good time to download helpful apps, such as our International Mobile Assistant App, which makes it easy to manage your benefits on the go. You can search “Aetna International” in the iTunes or Google Play store to get started. You can also read more about our apps on page 7 of this handbook.

YOUR MEMBER ID CARD

The Member ID Card is your key to quality health care. Make sure to keep the card in a safe place — you'll be asked to present it whenever you receive care. You may also need to have it handy when registering for the website or calling the Member Service Center.
If you have questions about your health care, you can call the International Health Advisory Team (IHAT) to get answers. This team of clinicians is available 24/7/365 to support you pre-trip, post trip, and anytime in between.

Here are a few of the things you can get help with:

- Pre-trip planning
- Coordinating routine and urgent medical care worldwide
- Locating providers and specialists
- Getting medical devices or prescription medications
- Coordinating and supervising medical evacuations

If you or a family member is managing a chronic health condition, or if you’re pregnant, it’s a good idea to talk with an IHAT clinician. They’ll be able to help make sure you get the care and medication you need no matter where you are in the world. You can get in touch with IHAT by calling the number on the back of your Member ID Card.

IHAT offers 24/7/365 support on everything from helping to get a prescription filled to coordinating urgent medical care.
Get ready for your next doctor visit

Save money and time by accessing care through our direct settlement provider network

You have access to our direct settlement network for easier admissions and payment. This network includes leading hospitals and clinics throughout the world. And it helps cut your out-of-pocket costs at the point of service since we’ll pay all or part of the provider’s fee directly.

Here’s what direct settlement means for you:

• Easier claim submissions
• Additional reimbursement and prepayment choices
• Lower out-of-pocket costs at the point of service
• Letter of Authorization (LOA) documents sent directly to the treatment facility

If you need non-emergency medical attention and want to ensure a smooth direct settlement process, it’s a good idea to contact us at least five business days before your scheduled visit to request a Letter of Authorization (LOA). This document helps ensure that the expected procedure(s) will be covered and your provider will directly settle the charges with us. Please remember to bring a copy of the LOA and your Member ID Card at the time of visit.

In the event of an emergency, please seek the care you need first and then submit the direct-settlement request as soon as you are able.

How to find a provider

We have made it easy to find care when and where you need it.

You can search our list of our direct settlement providers online by logging in to your Secure Member Website.

You can also download our apps to find providers right from your smartphone or tablet. The Aetna International Mobile Assistant and Mobile Provider Director apps are available in the iTunes and Google Play stores.

You can call us any time to get help finding a provider. You can find our number on the back of your Member ID Card.
How to submit a claim

If you choose a provider in our direct settlement network, you can access care without needing to submit a claim. If you choose to go outside of the network for care, you’ll have to pay for the charges and submit the claim.

Here are some tips to help the claim process go smoothly:

• All claims must be submitted within 180 days of the treatment date
• Make sure to provide all necessary supporting documents including original receipts, certificates and x-rays
• Keep your original receipts on file in case they are needed for verification purposes
• Include your Member ID number on each document submitted with your claim form
• Make sure to indicate the country and currency you would like to be reimbursed in
• Provide complete details on the description of service and the reason for the visit

How to submit a claim

Once you are ready to submit your claim, just log in to your secure member website from your computer, smartphone or tablet.

1. Click “Claims center” > “Start a new claim”
2. Please fill out all required fields of the online claim form. We’ll fill in as many details as we know based on your profile
3. Scan and upload your receipts
4. Submit your claim
5. Retain your claim “reference tracking number” for tracking purposes

After a claim is submitted you can find your claim below the online submission history section of the claim center for future reference.

It’s easy to submit another claim for the same provider. The “modify” feature uses your previous claim information to submit a new claim.

You can also submit a claim by traditional mail or secure fax. It’s important to keep in mind that submitting your claim online, by e-mail or from your smartphone means we’ll be able to start working on it quicker.

Convenient reimbursement options

We offer a variety of payment methods and currencies so that you can decide the most convenient way to receive your reimbursements. We are able to reimburse your covered health expenses via check, wire or electronic funds transfer (EFT) — it’s your choice. We can even wire the money directly to your bank account and we’ll cover any applicable fees. To select your method of reimbursement and preferred currency, simply complete the “Summary of Reimbursement” and, if applicable, “Banking” section(s) on your claim form.

* Aetna does not charge a fee for wire transfers (“direct deposits”); however, your financial institution may charge a processing fee to receive the wire transfer. You should verify any applicable fees with your financial institution.

Setting up your automatic payment method

You can set-up your Payment Autopilot with multiple reimbursement methods. Select any previously saved payment method when completing and submitting your claims online to ensure your payment is sent to the most convenient place for you.

Here’s how:
1. Login at www.aetnainternational.com
2. Click on the “Claims Center” tab at the top of the page
3. Scroll down to the “Questions” section and click “Put your payment method on autopilot”
4. Click “Submit new request”
5. Make sure you fill out all of the details in the form
6. Click “Submit” to save this Autopilot payment method for future use
The edge you need to make the most of your plan

We believe in the power of technology to help you play a greater, more informed role in your health. **That’s why we provide tools that give you relevant information when, where and how you need it.**

Secure member website

You have access to a world of personalized tools and resources to help you manage your health care online. You can register in just a few steps by visiting **www.aetnainternational.com** and clicking “Member” under the “Secure login” section.

**You can use the website to:**

- Submit claims and track claim status
- Access your policy information
- View and Print temporary ID cards or request a replacement
- Search for direct-settlement hospitals and doctors around the world
- View CityHealth™ profiles to learn about health risks, required vaccinations, local health systems, emergency contact and currency information
- Translate drug names and medical phrases
- Find travel safety and security information including travel tips, country assessments, news and more

The site also gives you access to the Virtual Benefits Assistant tool to help you learn how to use your benefits.
The International Mobile Assistant app takes the important features of the secure member website and packages them in an easy-to-use mobile format.

You can use the website to:
• Submit claims
• Check claims status
• Search for providers and get turn-by-turn directions

The app is free to download and is available for both iPhones and Android phones.

You can use these apps without Internet access to find providers while in remote locations. They make it easy for you to find nearby doctors, specialists, hospitals, clinics, pharmacies and other health care providers. You can also get directions on how to get there and schedule the appointment in your calendar. There’s one for every region, so you are covered no matter where you are.
If you are traveling or living in the United States, you can take advantage of health and wellness discounts that come built into your plan. There are no referrals, no claims forms and no limits on how many times you can save.

**Aetna Natural Products and Services™ Discount Program**
The ChooseHealthy® program provides reduced rates on massage therapy, acupuncture, chiropractic care and dietetic counseling. You can also get discounts on over-the-counter vitamins, yoga equipment, homeopathic remedies and more. The program also provides savings through the Vital Health Network, a network of medical doctors who provide online consultations and alternative remedies for a variety of conditions.

**Aetna Fitness™ Discount Program**
The GlobalFit® program gives you access to preferred membership rates at over 10,000** gyms in the United States and Canada, as well as discounts on home fitness options. You can try out an at-home weight-loss program and get one-on-one health coaching*** to help you quit smoking, lower stress, lose weight and more.

**Aetna Hearing™ Discount Program**
We offer two programs to meet your hearing needs, including Hearing Care Solutions and HearPO®. These programs offer discounts on hearing aids, as well as batteries, maintenance and replacements and/or exams.

**Aetna Vision™ Discount Program**
This program offers you valuable savings on eye exams, contact lenses and prescription and non-prescription eyeglasses at participating locations throughout the United States. Through the EyeMed network, you can save at JCPenney® Optical, LensCrafters®, Target Optical®, Sears Optical® and Pearle Vision®, plus many doctors in private practice. You can also save on LASIK surgery. You’ll receive education, an initial complementary screening and follow-up care — all wrapped into the discounted price.

**More healthy savings**
You can enhance your healthy lifestyle with the additional savings listed below.
- Sonic toothbrushes and water-jet flossers from Waterpik®
- Gum, toothpastes and mouth rinses from Epic dental
- An automatic Home Blood Pressure Monitor
- ZAGAT.com memberships
- Books and other items from the American Cancer Society and MayoClinic.com bookstores
- Yoga DVDs, books and online videos through Pranamaya

**How to save**

1. Log in to the secure member website at www.aetna.com
2. Choose Health Programs, then Get Discounts
3. Follow the steps for each program you want to use

Discount programs provide access to discounted prices and are NOT insured benefits. The member is responsible for the full cost of the discounted services. Aetna may receive a percentage of the fee you pay to the discount vendor.

* The ChooseHealthy program is made available through American Specialty Health Networks, Inc. (ASH Networks) and Healthyroads, Inc., subsidiaries of American Specialty Health Incorporated (ASH). ChooseHealthy is a federally registered trademark of ASH and used with permission herein.

*** Offered by WellCall, Inc., through GlobalFit.
**Common insurance terms**

**Coinsurance**
This refers to the percentage of a covered medical expense for which the insurer (Aetna) and the member (you) will each pay. For example, in an 80 percent coinsurance plan, the insurer pays 80 percent of covered expenses and the member pays 20 percent. Refer to your plan documents to determine the coinsurance rate for your plan.

**Deductible**
A deductible is the amount that you must pay for covered services before the plan will begin to pay. For example, if a covered expense of $500 is submitted under a plan with a $200 deductible, you must pay the first $200 before Aetna will pay the remaining $300. The deductible must be paid only once each calendar year. Please refer to your plan documents to determine the deductible for your plan.

**Copayment**
This refers to a fixed dollar amount that you are responsible to pay when you receive care. Refer to your plan documents to determine if a copayment is part of your plan.

**Direct-settlement**
A direct-settlement arrangement is an agreement that we have established with leading hospitals and clinics throughout the world. If you visit a provider in our direct-settlement network, you will benefit from easier claim submission and lower out-of-pocket expenses.
Health insurance plans and programs are offered, underwritten or administered by Aetna Life & Casualty (Bermuda) Ltd. or Aetna Life Insurance Company (Aetna).

Providers are independent contractors and are not agents of Aetna. Provider participation may change without notice. Aetna does not provide care or guarantee access to health services. Not all health services are covered. See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Plan features are subject to change. Information subject to change. For more information about Aetna International plans, refer to www.aetnainternational.com.

www.aetnainternational.com

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46.02.153.1 (4/16)
Basic Life and AD&D Insurance
Aetna

This benefit is paid by Wycliffe Associates.

<table>
<thead>
<tr>
<th>Benefit Summary</th>
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<tr>
<td><strong>Life Benefit Amount</strong></td>
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<tr>
<td><strong>AD&amp;D Benefit Amount</strong></td>
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<tr>
<td><strong>Reduction in Coverage</strong></td>
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<tr>
<td><strong>Eligibility</strong></td>
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Voluntary Life and AD&D Insurance
Aetna

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<th>Benefit Summary</th>
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<td><strong>Eligibility</strong></td>
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<td><strong>Employee</strong></td>
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<td><strong>Spouse</strong></td>
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<td><strong>Children</strong></td>
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<tr>
<th>Monthly Cost for Each $1,000 of Coverage</th>
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<tr>
<td><strong>Age</strong></td>
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<tr>
<td><strong>Cost</strong></td>
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<tr>
<td><strong>Note</strong></td>
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How to Calculate your Voluntary Life Premium:

Premium is based on coverage units of $1,000.

Formula: **Benefit Volume x Rate)/1000 = Monthly Premium**

Example: 40 year old employee elects $200,000 in coverage

Monthly premium = ($200,000 x .162) / 1000 = $32.40

Payroll Deduction = ($32.40 x 12) / 24 = $16.20 per paycheck.

This page summarizes the Wycliffe Associates Basic/Voluntary Life and AD&D benefits plans and is for illustrative purpose
The Wycliffe Associates 403(b) Retirement Savings Plan offers a convenient way to save for your future through payroll deductions.

**Eligibility**
You are eligible to participate in the plan as of the first day of the month following 90 days of service with Wycliffe Associates.

**Employee Contributions**
Contributions from your pay are made on a pre or post tax basis-up to the IRS annual limit. If you are 50 years of age or older, (or if you will reach age 50 by the end of the year), you may make a catch-up contribution in addition to the normal IRS annual limit.

**Vesting**
Vesting refers to your right of ownership to the money in your account. You are immediately vested in all contributions and earnings.

**For More Information**
For additional details about the 403(b) Retirement Savings Plan or to enroll or change your contribution rates or investment elections, please refer to Human Resources.
Glossary of Commonly Used Terms

ANNUAL ENROLLMENT: Designated period of time during which an employee may enroll in group health coverage. Also, designated period of time during the year when individuals without group coverage may enroll in health coverage without needing medical underwriting.

CARRIER: The insurance company.

CLAIM: The request for payment for benefits received in accordance with an insurance policy.

COPAY: A co-payment, or copay, is a capped contribution defined in the policy and paid by an insured person each time a medical service is accessed. It must be paid before any policy benefit is payable by an insurance company.

COINSURANCE: A payment made by the covered person in addition to the payment made by the health plan on covered charges, shared on a percentage basis. For example, the health plan may pay 80% of the allowable charge, with the covered person responsible for the remaining 20%. The 20% amount is then referred to as the coinsurance amount.

DEDUCTIBLE: A deductible is the amount you must pay each year before your carrier begins to pay for services. If you have a PPO plan, there is usually a separate higher deductible for using out of network providers.

EOB (Explanation of Benefits): EOB stands for Explanation of Benefits. This is a document produced by your medical insurance carrier that explains their response and action (whether it is payment, denial, or pending) to a medical claim processed on your be-half.

EVIDENCE OF INSURABILITY (EOI): This is the medical information you must provide that requires review and approval by the insurance company BEFORE coverage becomes effective. This may include medical records and a physical exam.

HMO: Health Maintenance Organization, this type of medical plan is Network exclusive. A participant must receive services from in-network providers except in a case of medical emergency.

IN NETWORK: Refers to the use of providers who participate in the health plan's provider network. Many benefit plans encourage members to use participating in-network providers to reduce out-of-pocket expenses.

MAIL ORDER PRESCRIPTIONS: Used for maintenance drugs, members can order and refill their prescriptions via postal mail, Internet, fax, or telephone. Once filled, the prescriptions are mailed directly to the member’s home.

MAINTENANCE DRUGS: A medication that is anticipated to be taken regularly for several months to treat a chronic condition such as diabetes, high blood pressure and asthma, this also includes birth control.

MAXIMUM OUT OF POCKET: The total amount a covered person must pay before his or her benefits are paid at 100%. Deductible, copayments, and coinsurance may apply towards the maximum out of pocket, depending on the plan.

OUT OF NETWORK: The use of health care providers who have not contracted with the health plan to provide services. HMO members are generally not covered for out-of-network services except in emergency situations. Members enrolled in Preferred Provider Organizations (PPO) and Point-of-Service (POS) coverage can go out-of-network, but will pay higher out-of-pocket costs.
PARTICIPATING PROVIDER: Individual physicians, hospitals and professional health care providers who have a contract to provide services to its members at a discounted rate and to be paid directly for covered services.

PCP (PRIMARY CARE PHYSICIAN): A physician selected by the member, who is part of the plan network, who provides routine care and coordinates other specialized care. The PCP should be selected from the network that corresponds to the plan in which you are a member. The physician you choose as your PCP may be a family or general practitioner, internist, gynecologist or pediatrician.

PPO: Benefits paid for both in and out of a network of doctors. Member makes choice with knowledge that better benefits are available in network. Plans feature office visit copays, deductibles at a variety of levels and then coinsurance to a maximum out of pocket expense. Usually includes copays for prescription drugs.

PREVENTIVE CARE: Care rendered by a physician to promote health and prevent future health problems for a member who does not exhibit any symptoms. Examples are routine physical examinations and immunizations.

REFERRAL: A written recommendation by a physician that a member may receive care from a specialty physician or facility.

SPECIALIST: A participating physician who provides non-routine care, such as a dermatologist or orthopedist.
Premium Assistance Under Medicaid and the Children’s Health Insurance Program (CHIP)

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2017. Contact your State for more information on eligibility –

<table>
<thead>
<tr>
<th>ALABAMA – Medicaid</th>
<th>FLORIDA – Medicaid</th>
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<tbody>
<tr>
<td>Phone: 1-855-692-5447</td>
<td>Phone: 1-877-357-3268</td>
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<tr>
<th>ALASKA – Medicaid</th>
<th>GEORGIA – Medicaid</th>
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<tr>
<td>Phone: 1-866-251-4861</td>
<td>- Clic on Health Insurance Premium Payment (HIPP)</td>
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<tr>
<td>Email: <a href="mailto:CustomerService@MyAKHIPP.com">CustomerService@MyAKHIPP.com</a></td>
<td>Phone: 404-656-4507</td>
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<tr>
<td>Medicaid Eligibility:</td>
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<tr>
<td><a href="http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx">http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx</a></td>
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<tr>
<th>ARKANSAS – Medicaid</th>
<th>INDIANA – Medicaid</th>
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<tr>
<td>Phone: 1-855-MyARHIP (855-692-7447)</td>
<td>Phone: 1-877-438-4479</td>
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<tr>
<td></td>
<td>All other Medicaid</td>
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<td></td>
<td>Website: <a href="http://www.indianamedicaid.com">http://www.indianamedicaid.com</a></td>
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<td>Phone 1-800-403-0864</td>
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<tr>
<th>COLORADO – Health First Colorado (Colorado’s Medicaid Program) &amp; Child Health Plan Plus (CHP+)</th>
<th>IOWA – Medicaid</th>
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<tbody>
<tr>
<td>Health First Colorado Website: <a href="https://www.healthfirstcolorado.com/">https://www.healthfirstcolorado.com/</a></td>
<td>Website: <a href="http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp">http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp</a></td>
</tr>
<tr>
<td>Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711</td>
<td>Phone: 1-888-346-9562</td>
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<tr>
<td>CHP+: Colorado.gov/HCPF/Child-Health-Plan-Plus</td>
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<tr>
<td>State</td>
<td>Medicaid/CHIP Information</td>
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</table>
| **KANSAS** – Medicaid | Website: [http://www.kdheks.gov/hcf/](http://www.kdheks.gov/hcf/)  
Phone: 1-785-296-3512 |
Phone: 603-271-5218 |
| **KENTUCKY** – Medicaid | Website: [http://chfs.ky.gov/dms/default.htm](http://chfs.ky.gov/dms/default.htm)  
Phone: 1-800-635-2570 |
| **NEW JERSEY** – Medicaid and CHIP | Medicaid Website: [http://www.state.nj.us/humanservices/dmahs/clients/medicaid/](http://www.state.nj.us/humanservices/dmahs/clients/medicaid/)  
Medicaid Phone: 609-631-2392  
CHIP Website: [http://www.njfamilycare.org/index.html](http://www.njfamilycare.org/index.html)  
CHIP Phone: 1-800-701-0710 |
| **LOUISIANA** – Medicaid | Website: [http://dhhh.louisiana.gov/index.cfm/subhome/1/n/331](http://dhhh.louisiana.gov/index.cfm/subhome/1/n/331)  
Phone: 1-888-695-2447 |
| **NEW YORK** – Medicaid | Website: [https://www.health.ny.gov/health_care/medicaid/](https://www.health.ny.gov/health_care/medicaid/)  
Phone: 1-800-541-2831 |
Phone: 1-800-442-6003  
TTY: Maine relay 711 |
| **NORTH CAROLINA** – Medicaid | Website: [https://dma.ncdhhs.gov/](https://dma.ncdhhs.gov/)  
Phone: 919-855-4100 |
| **MASSACHUSETTS** – Medicaid and CHIP | Website: [http://www.mass.gov/eohhs/gov/departments/masshealth/](http://www.mass.gov/eohhs/gov/departments/masshealth/)  
Phone: 1-800-462-1120 |
| **NORTH DAKOTA** – Medicaid | Website: [http://www.nd.gov/dhs/services/medicalserv/medicaid/](http://www.nd.gov/dhs/services/medicalserv/medicaid/)  
Phone: 1-844-854-4825 |
| **MINNESOTA** – Medicaid | Website: [http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp](http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp)  
Phone: 1-800-657-3739 |
| **OKLAHOMA** – Medicaid and CHIP | Website: [http://www.insureoklahoma.org](http://www.insureoklahoma.org)  
Phone: 1-888-365-3742 |
| **MISSOURI** – Medicaid | Website: [http://www.dss.mo.gov/mhd/participants/pages/hipp.htm](http://www.dss.mo.gov/mhd/participants/pages/hipp.htm)  
Phone: 573-751-2005 |
| **OREGON** – Medicaid | Website: [http://www.oregonhealthcare.gov/index-es.html](http://www.oregonhealthcare.gov/index-es.html)  
Phone: 1-800-699-9075 |
| **MONTANA** – Medicaid | Website: [http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP](http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP)  
Phone: 1-800-694-3084 |
| **PENNSYLVANIA** – Medicaid | Website: [http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancetippprogram/index.htm](http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancetippprogram/index.htm)  
Phone: 1-800-692-7462 |
| **NEBRASKA** – Medicaid | Website: [http://dhhs.ne.gov/Children_Family_Services/AccessNebraska/Pages/accessnebraska_index.aspx](http://dhhs.ne.gov/Children_Family_Services/AccessNebraska/Pages/accessnebraska_index.aspx)  
Phone: 1-855-632-7633 |
| **RHODE ISLAND** – Medicaid | Website: [http://www.eohhs.ri.gov/](http://www.eohhs.ri.gov/)  
Phone: 401-462-5300 |
| **NEVADA** – Medicaid | Medicaid Website: [https://dwss.nv.gov/](https://dwss.nv.gov/)  
Medicaid Phone: 1-800-992-0900 |
| **SOUTH CAROLINA** – Medicaid | Website: [https://www.scdhhs.gov](https://www.scdhhs.gov)  
Phone: 1-888-549-0820 |
To see if any other states have added a premium assistance program since January 31, 2017, or for more information on special enrollment rights, contact either:

**U.S. Department of Labor**
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

**U.S. Department of Health and Human Services**
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

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<table>
<thead>
<tr>
<th>SOUTH DAKOTA - Medicaid</th>
<th>WASHINGTON – Medicaid</th>
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<tr>
<td>Website: <a href="http://dss.sd.gov">http://dss.sd.gov</a></td>
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<tr>
<td>Phone: 1-888-828-0059</td>
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<tr>
<td>Website: <a href="http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program">http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program</a></td>
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<tr>
<td>Phone: 1-800-562-3022 ext. 15473</td>
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<tr>
<th>TEXAS – Medicaid</th>
<th>WEST VIRGINIA – Medicaid</th>
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<tr>
<td>Website: <a href="http://gethipptexas.com/">http://gethipptexas.com/</a></td>
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<tr>
<td>Phone: 1-800-440-0493</td>
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<tr>
<td>Website: <a href="http://www.dhhr.wv.gov/bms/Medicaid%20Expansion/Pages/default.aspx">http://www.dhhr.wv.gov/bms/Medicaid%20Expansion/Pages/default.aspx</a></td>
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<tr>
<td>Phone: 1-877-598-5820, HMS Third Party Liability</td>
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<tr>
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<th>WISCONSIN – Medicaid and CHIP</th>
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<tr>
<td>Medicaid Website: <a href="https://medicaid.uta.gov/">https://medicaid.uta.gov/</a></td>
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<td>CHIP Website: <a href="http://health.utah.gov/chip">http://health.utah.gov/chip</a></td>
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<tr>
<td>Phone: 1-877-543-7669</td>
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<tr>
<td>Website: <a href="https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf">https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf</a></td>
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<td>Phone: 1-800-362-3002</td>
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<th>VERMONT – Medicaid</th>
<th>WYOMING – Medicaid</th>
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<td>Website: <a href="http://www.greenmountaincare.org/">http://www.greenmountaincare.org/</a></td>
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<tr>
<td>Phone: 1-800-250-8427</td>
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<tr>
<td>Website: <a href="https://wyequalitycare.acs-inc.com/">https://wyequalitycare.acs-inc.com/</a></td>
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<td>Phone: 307-777-7531</td>
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<th>VIRGINIA – Medicaid and CHIP</th>
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<td>Medicaid Website: <a href="http://www.coverva.org/programs_premium_assistance.cfm">http://www.coverva.org/programs_premium_assistance.cfm</a></td>
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<tr>
<td>Medicaid Phone: 1-800-432-5924</td>
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<tr>
<td>CHIP Website: <a href="http://www.coverva.org/programs_premium_assistance.cfm">http://www.coverva.org/programs_premium_assistance.cfm</a></td>
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<td>CHIP Phone: 1-855-242-8282</td>
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**U.S. Department of Labor**

Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

**U.S. Department of Health and Human Services**

Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

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**Paperwork Reduction Act Statement**

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

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

OMB Control Number 1210-0137 (expires 12/31/2019)
Women's Health and Cancer Rights Act of 1998

The Women’s Health and Cancer Rights Act (WHCRA), signed into law on October 21, 1998, contains protections for patients who elect breast reconstruction in connection with a mastectomy. For plan participants and beneficiaries receiving benefits in connection with a mastectomy, plans offering coverage for a mastectomy must also cover reconstructive surgery and other benefits related to a mastectomy.

WHCRA:
- Applies to group health plans for plan years starting on or after October 21, 1998
- Applies to group health plans, health insurance companies or HMOs, if the plan or coverage provides medical and surgical benefits with respect to a mastectomy
- Requires coverage for reconstructive surgery in a manner determined in consultation with the attending physician and the patient

Under WHCRA, mastectomy benefits must include coverage for:
- Reconstruction of the breast on which the mastectomy was performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses and physical complications at all stages of mastectomy, including lymphedemas

Under WHCRA, mastectomy benefits may be subject to annual deductibles and coinsurance consistent with those established for other benefits under the plan or coverage.

The law also contains prohibitions against:
- Plans and issuers denying patients eligibility or continued eligibility to enroll or renew coverage under the plan to avoid the requirements of WHCRA
- Plans and issuers providing incentives to, or penalizing, physicians to induce them to provide care in a manner inconsistent with the WHCRA
- Group health plans, health insurance companies and HMOs covered by the law must notify individuals of the coverage required by WHCRA upon enrollment and annually thereafter.

Resources:
WHCRA is administered by the U.S. Departments of Labor and Health and Human Services.

Department of Labor
If you have questions regarding your WHCRA rights under an employer-sponsored group health plan, call the Department of Labor’s Employee Benefits Security Administration toll free at 1-866-444-EBSA (3272) or visit www.dol.gov/ebwa and click on Contact Us for the addresses of the 15 field offices that can assist you. You also can request a copy of Your Health Plan and HIPAA...Making the Law Work for You and a list of all publications from the Employee Benefits Security Administration.

Centers for Medicare and Medicaid Services
Go to http://www.cms.hhs.gov/HealthInsReformfor more information on WHCRA and HIPAA or call toll free at 1-877-267-2323, extension 61565.

National Association of Insurance Commissioners
Visit www.naic.org and click on States and Jurisdiction Map, then the state of your choice for the office in your state.

Statement of Rights under the Newborns’ and Mothers’ Health Protection Act

Under Federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g. your Physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under Federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under Federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. For information on precertification, contact your issuer.

Michelle’s Law
On January 1, 2010 an important new law became effective. The new law, known as “Michelle’s Law”, expands coverage and notice obligations for eligible college students.

What does the law require? All group health plans must allow a college student with a “serious illness or injury” to remain eligible for active dependent coverage for 12 months, even if he or she no longer qualifies as a full-time student. The specific requirements are:
- The Individual must be covered as a full time student, as defined in the plan, at a postsecondary educational institution immediately before any serious illness or injury.
- The student must experience a serious illness or injury that requires a medically necessary leave of absence or a medically necessary change in enrollment status from full-time to part-time.
- A physician must verify the illness or injury in writing and certify the leave or change in enrollment status as medically necessary.
- The Health Plan must allow the student to remain covered as an active participant/dependent for 12 months after the leave of absence begins. The regular premium will apply during these 12 months.
- The 12 months, however, does not extend coverage beyond another independent event that would end active/dependent status, such as the parent’s termination of employment or the student exceeding the plan’s age limit.
- COBRA coverage would not be offered until after the 12 month special period has expired, unless the student returns to full time status and remains eligible under other terms of the plan.
Important Notice: Medicare D Creditable Coverage Disclosure

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with your employer and about your options under Medicare’s prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare’s prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. Your employer has determined that the prescription drug coverage offered by the group plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current group coverage and don’t join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage...

Contact your Human Resources Employee Benefits Administrator for further information. NOTE: You’ll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage changes. You also may request a copy of this notice at any time.

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

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

For more information about Medicare prescription drug coverage:

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

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

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

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

If you decide to join a Medicare drug plan, your current group coverage may or may not be affected.

If you do decide to join a Medicare drug plan and drop your current group coverage, be aware that you and your dependents may or may not be able to get this coverage back.
<table>
<thead>
<tr>
<th>LINE OF COVERAGE</th>
<th>CARRIER</th>
<th>CUSTOMER SERVICE</th>
<th>WEBSITE/NETWORK/EMAIL</th>
<th>ID Cards</th>
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<td>Medical &amp; Dental</td>
<td>Aetna International</td>
<td>855-829-9558 Collect: 813-775-0449</td>
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<td>Basic Life &amp; AD&amp;D, Voluntary Life</td>
<td>Aetna</td>
<td>800-523-5065</td>
<td><a href="http://www.aetna.com">www.aetna.com</a></td>
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<td>Employee Assistance Program</td>
<td>Aetna International</td>
<td>800-231-7729 or Collect: 813-775-0190</td>
<td><a href="http://www.aetnainternational.com">www.aetnainternational.com</a></td>
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<td>Wycliffe Human Resources</td>
<td>Terri Mwangi</td>
<td>407-852-5364</td>
<td><a href="mailto:Terri_Mwangi@wycliffeassociates.com">Terri_Mwangi@wycliffeassociates.com</a></td>
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All enrollments and changes must be processed through the ADP system. If you have any questions please contact Human Resources.

**INSURANCE OFFICE OF AMERICA**

For assistance with benefits questions, membership card issues, claims, and billing issues please contact one of your IOA service team members per the contact information below:

**Heather Nolan**  
Account Manager  
Toll Free: 1-800-243-6899 x 15320  
Direct Line: 407-998-5320  
E-mail: heather.nolan@ioausa.com

**Russell J. Rizor**  
Consultant  
Toll Free: 1-800-243-6899 x 15415  
Direct Line: 407-998-5415  
E-mail: russ.rizor@ioausa.com