The following is a brief description of the benefit changes effective January 1, 2017. These changes were previously communicated during the 2017 Open Enrollment period. As a retiree, some of the changes described in this summary may not be applicable to you.

For additional information regarding these changes, please refer to the Summaries of Benefits & Coverage (SBCs) and non-medical plan summaries located on the AmWINS website.

- The medical insurance plan administrator has changed from Aetna to UnitedHealthcare (UHC).
- The dental insurance plan administrator has changed from Aetna to UHC.

- ID Cards
  - UHC Medical Plan
    - If you enroll in a UHC medical plan, you will receive a UHC medical plan ID card. This card will not include any dental plan information.
  - UHC Dental Plan
    - If you enroll in the UHC dental plan, you will receive a UHC dental plan ID card.
The following is a list of benefit providers and their contact information. Not all benefit providers listed may apply to you.

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Toll-Free Number</th>
<th>Website</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Medical Plans</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>UnitedHealthcare</td>
<td>(844) 634-1235</td>
<td><a href="http://www.myuhc.com">www.myuhc.com</a> (Network: Choice Plus)</td>
</tr>
<tr>
<td><strong>Prescription Coverage</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Express Scripts</td>
<td>(800) 294-5060</td>
<td><a href="http://www.express-scripts.com">www.express-scripts.com</a></td>
</tr>
<tr>
<td><strong>Dental Plan</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Vision Plan</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>VSP</td>
<td>(800) 877-7195</td>
<td><a href="http://www.vsp.com">www.vsp.com</a></td>
</tr>
<tr>
<td><strong>Retiree Life Insurance Plan</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Valero Retiree Administration</td>
<td>(800) 333-3377 extension 2933</td>
<td></td>
</tr>
<tr>
<td><strong>Retiree Health Care Plan Administration</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>AmWINS</td>
<td>(877) 422-4170</td>
<td>valero.amwins.com</td>
</tr>
<tr>
<td><strong>COBRA Administration &amp; Health Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>(401) 921-3514</td>
<td></td>
</tr>
</tbody>
</table>
2016 RETIREE HEALTH AND WELFARE BENEFITS HANDBOOK
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PROTON PUMP INHIBITORS (PPI)

HOW TO USE THE PRESCRIPTION BENEFITS

PREFERRED DRUGS

ACCREDO SPECIALTY PROGRAM

WHAT THE PRESCRIPTION BENEFIT DOES NOT COVER

SUMMARY OF BENEFITS AND COVERAGE (SBC)

WHEN MEDICAL (INCLUDES PRESCRIPTION DRUG COVERAGE) COVERAGE BEGINS AND ENDS

VALERO SPONSORED MEDICARE SUPPLEMENT PLANS

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INTRODUCTION

This Valero Retiree Health and Welfare Benefits Handbook (handbook), which is considered the Summary Plan Description (SPD), is a guide to Valero’s retiree benefits. This handbook provides a condensed, simplified explanation of the complete official governing document(s) and insurance contracts.

The benefits and policies stated in this handbook are subject to change at Valero's sole discretion. Valero Energy Corporation (the “Plan Sponsor” or “Company”), as the Plan Sponsor, reserves the right to modify or terminate benefits at any time. While this handbook includes summaries of the health and welfare benefit plans, the contents of this handbook may not address all benefits in detail.

With respect to fully insured benefits, this handbook does not replace the official plan documents or insurance contracts/policies that may govern the plans’ provisions. In the event of a discrepancy, the terms of the official plan documents will prevail. With respect to self-insured benefits, this handbook is the master plan document. The following table contains a list of contacts that may be used for additional assistance.

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Toll-Free Number</th>
<th>Website</th>
</tr>
</thead>
</table>
| Medical Plans                    | (800) 414-0768   | www.aetna.com
(Aetna Choice POSII (Open Access))|
<p>| Aetna                            |                  |                                      |
| Prescription Coverage            | (800) 294-5060   | <a href="http://www.express-scripts.com">www.express-scripts.com</a>              |
| Express Scripts                  |                  |                                      |</p>
<table>
<thead>
<tr>
<th>Benefit</th>
<th>Toll-Free Number</th>
<th>Website</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Dental Plan</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aetna</td>
<td>(800) 843-3661</td>
<td><a href="http://www.aetna.com">www.aetna.com</a> (Network: Dental PPO/PDN with PPOII Network)</td>
</tr>
<tr>
<td><strong>Vision Plan</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>VSP</td>
<td>(800) 877-7195</td>
<td><a href="http://www.vsp.com">www.vsp.com</a></td>
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<tr>
<td>Valero Retiree Administration</td>
<td>(800) 333-3377 extension 2933</td>
<td></td>
</tr>
<tr>
<td><strong>AmWINS (Retiree Health Care Plan Administration)</strong></td>
<td>(877) 422-4170</td>
<td><a href="http://www.valero.amwins.com">www.valero.amwins.com</a> (certain employees hired prior to January 1, 2010)</td>
</tr>
<tr>
<td><strong>COBRA Administration &amp; Health Services</strong></td>
<td>(401) 921-3514</td>
<td></td>
</tr>
</tbody>
</table>
PLAN ADMINISTRATION

Upon retirement, the Company may offer medical (which includes prescription drug coverage), dental and vision coverage to certain retirees and their eligible dependents. Retirees may also be provided with a company paid life insurance benefit.

Daily administration of the retiree medical, dental, and vision benefits is administered by AmWINS. However, Valero sponsors the retiree health care plans and the Valero Retiree Administration Department administers the retiree life insurance plans.

The cost of the coverage is dependent on the group or classification at retirement and the Medicare eligibility of the participant and any eligible dependents.

ELIGIBILITY

In order to be eligible for retiree health care coverage, you must:

- Be at least 55 years old and
- Have five years of service at the time of retirement.

ELIGIBLE DEPENDENTS

Retirees may elect coverage for eligible dependents under the Valero Retiree Health Care Plan. Eligible dependents include the following:

**Spouse** – A certificate of marriage is required.

**Common Law Spouse** – A notarized Affidavit of Common Law Marriage and supporting documentation is required. A common law spouse may only be added upon retirement or during the Annual Open Enrollment period. To be eligible for coverage, the retiree and the Common Law Spouse (CLS) must certify that they:

- Are at least 18 years of age and mentally competent to consent to a contract,
- Live together in the same residence in an exclusive, committed domestic relationship, have done so for a minimum of six months, and intend to do so indefinitely (documentation must reflect cohabitation for six months prior to the date coverage is requested),
- Share joint responsibility for one another’s common and financial welfare,
- Are not in the relationship solely for the purpose of obtaining coverage, and
- Are not married to anyone or not the common law spouse of anyone else.
Retirees who wish to cover their CLS under the plan must submit:

1. A notarized Affidavit of Common Law Marriage signed by the retiree and the
   retirees CLS,

2. A Health Care Agent Agreement or Health Care Power of Attorney, and

3. Two forms of documentation from the following list:
   - Common ownership of real property (joint deed or mortgage agreement) or a
     common leasehold interest in property,
   - Common ownership of a motor vehicle,
   - Driver’s license listing a common address,
   - Proof of joint bank and credit accounts, and/or
   - Proof of designation as a primary beneficiary for life insurance or retirement
     benefits, or a primary beneficiary designation under a common law spouse’s
     will.

If the retiree resides in a state that recognizes common law marriage and the state or
locality issues a form of certification of common law marriage, the retiree must obtain
and provide:

- A copy of the certification issued by the state or locality,
- A copy of the notarized Affidavit of Common Law Marriage, and
- A copy of at least one of the documents listed from #3 above as supporting a
  common law marriage.

To drop a CLS from the plan upon termination of the common law marriage, the plan
terms that govern the treatment of a retiree and spouse upon divorce apply if the retiree
resides in a state that recognizes common law marriage. If, however, the common law
marriage is not recognized under applicable state law, the retiree must submit a
notarized Affidavit of Dissolution of Common Law Marriage acknowledging the
relationship has ended.

For more information about the Company’s Policy for Common Law Marriage or to
obtain a copy of either the policy or affidavit, please contact the Valero Retiree
Administration Department.
**Domestic Partner/Same-Sex Partner** – A notarized Affidavit of Domestic Partner Relationship and supporting documentation are required. Opposite sex domestic partners must be common law spouses to be considered eligible for coverage. If residing in a state that recognizes Domestic Partner Relationship, a copy of the state issued certificate is required.

**Dependent Children** – Retirees may enroll dependent children in their Retiree Health Care Plan if the dependent child is younger than age 26. Dependent children are eligible for coverage up to the end of the month in which they turn 26. Eligible children include:

- Children who are the retiree’s natural children, stepchildren or legally adopted by the retiree. A birth certificate, Qualified Medical Child Support Order (QMCSO), or proof of adoption or legal guardianship (court appointed) is required.

- Foster children or other children residing with the retiree in a legal guardian relationship (court appointed) and relying on the retiree for support. Proof of foster care or legal guardianship is required.

- Foster children or other children where support and coverage are required by a court order. A copy of the court order is required.

- Children up to any age who were permanently, physically or mentally disabled before age 26 and who have been continuously eligible for coverage under the Retiree Health Care Plan, or for whom coverage is requested at Annual Open Enrollment. The dependent must be unable to support themselves, reside with the retiree and depend on the retiree for more than half their support. Proof of permanent disability is required and will be reviewed by the carrier.

**Newborn children** – will have coverage retroactive to the date of birth upon proof of birth and timely enrollment in a Valero Retiree Health Care Plan.

**ELECTIONS AND ENROLLMENT PERIODS**

**Initial Enrollment Period**

Upon notification of retirement, the benefits department will provide a binder containing information about an employee’s pension benefit, Thrift 401(k) balances, COBRA continuation of health care plan coverage, and basic information about retiree health care administration and life insurance.

AmWINS will be notified immediately so that they can prepare and mail the retiree a health care enrollment kit. The enrollment kit should be returned directly to AmWINS in the envelope they provide. Retirees wishing to enroll in health care benefits under the
plan must complete and return the Retiree Enrollment/Direct Payment Authorization Form within 30 days from the date of the enrollment kit from AmWINS. If a retiree does not enroll within this period, they waive all rights to benefits under the plan and are not eligible to enroll at any later date. Participation in the active employee plans will terminate on the last day of the month in which the employee retires. Retiree coverage is effective the first of the month following retirement from Valero.

When making plan elections, retirees must choose one plan for all covered members, except in the case of a split household with retirees who are both Medicare eligible and non-Medicare eligible. For more information, refer to the section in this handbook titled Split Households.

**Annual Open Enrollment**

The Company's retiree health care plans are kept on a calendar year basis from January 1 through December 31. In the fall of each year, during the Annual Open Enrollment period, participants will receive notification of any plan changes or premiums changes for the upcoming plan year.

Information about retiree health care premiums will be provided during every Annual Open Enrollment period. Current premium information is also available by calling AmWINS at (877) 422-4170 or visit the AmWINS website at www.valero.amwins.com.

**Election Period for Qualified Change Events**

A retiree may be eligible to add coverage upon experiencing a Qualified Status Change (QSC), or upon receiving a judgment, decree or order (other than a divorce decree), during a special enrollment period. To qualify for a change in coverage, the change must directly affect benefits. An example would be the need to elect retiree and spouse coverage upon marriage. A retiree may reduce or drop coverage at any time. For detailed information about notification and documentation requirements, refer to the section of this handbook titled Qualified Change Events.

**HEALTH CARE PREMIUMS**

Retiree health care premiums will be electronically debited from a designated personal bank account on a monthly basis through Automated Clearing House (ACH). Retirees will need to complete the Direct Payment Authorization Form. This form will be distributed in the initial enrollment packet. A new form will not be required each year. Retirees should only submit a new form if there has been a change to their banking information. For questions about ACH, or to request a form, contact AmWINS at (877) 422-4170 or visit the AmWINS website at www.valero.amwins.com.
ID CARDS

Retirees should present their ID cards to their health care providers when seeking medical, dental or prescription drug services.

Medical and Dental

Non-Medicare Eligible Participants – Aetna Retiree Medical and Dental

Aetna ID cards will be issued upon enrollment in the plan(s). Participants enrolled in both an Aetna medical plan and the Aetna dental plan with the same coverage level will receive a combined medical and dental ID card (i.e., retiree only; retiree and spouse; retiree and child; retiree and family). If the elected coverage levels for the plans are different, ID cards for each plan will be issued.

Participants will receive up to two cards per household. If needed, participants may request additional or replacement cards from the carrier.

Medicare Eligible Participants

Medicare eligible participants will receive new ID cards upon their initial enrollment in a Medicare supplement plan. If needed, participants may request additional or replacement cards from AmWINS.

Prescription

Non-Medicare Eligible Participants

If a participant is Non Medicare eligible, they will receive a new ESI prescription drug ID cards. If needed, participants may request additional or replacement cards from the carrier.

Medicare Eligible Participants

Medicare eligible participants will receive new United American prescription drug ID cards upon their initial enrollment in a Medicare supplement plan. If needed, participants may request additional or replacement cards from the AmWINS.

Vision

While VSP members are not required to have an ID card to access services, members may visit www.vsp.com to register and print an ID card that includes their name, group number and plan design information.
### WHEN HEALTH CARE COVERAGE ENDS

<table>
<thead>
<tr>
<th>A Retiree’s Coverage Ends When/On:</th>
<th>A Retiree’s Covered Dependent(s) Coverage Ends When/On:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• The date the retiree voluntarily drops coverage under the retiree health care plan(s)</td>
<td>• The date the retiree voluntarily drops coverage under the retiree health care plan(s)</td>
</tr>
<tr>
<td>• The last day of the month for which premiums were paid for, if payment is not received within 30 days from the due date</td>
<td>• The last day of the month for which premiums were last paid for retiree benefits, if payment is not received within 30 days from the due date</td>
</tr>
<tr>
<td>• The date a fraudulent claim is made by the retiree or on behalf of the retiree with their knowledge</td>
<td>• The date a fraudulent claim is made by or on behalf of the dependent with the retirees knowledge</td>
</tr>
<tr>
<td>• The plan(s) is terminated</td>
<td>• The plan(s) is terminated</td>
</tr>
<tr>
<td>• The date of the retiree’s death (for exception, see the section titled Continuing Coverage After the Death of a Retiree)</td>
<td>• The date of the dependent’s death</td>
</tr>
<tr>
<td></td>
<td>• The date the retiree’s dependent(s) no longer meets the eligibility requirements of the plan(s)</td>
</tr>
</tbody>
</table>

### CONTINUING COVERAGE AFTER THE DEATH OF A RETIREE

In the event of the retiree's death, eligible dependents who wish to continue health care coverage must contact AmWINS. Spouses, Common Law Spouses and Domestic Partners may continue their coverage as a surviving spouse, for the plan(s) under which they were covered immediately prior to the retiree’s death.

Eligible dependent children may continue coverage for the plan(s) under which they were covered immediately prior to the retiree’s death under:

- A surviving spouse’s coverage, if applicable, or
- As a primary insured participant in accordance with the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).
QUALIFIED CHANGE EVENTS

A retiree may be eligible to add or drop coverage upon experiencing a QSC or upon receiving a judgment, decree or order (other than a divorce decree). These types of events are considered qualified change events. It is the retiree’s responsibility to notify AmWins within 30 days of the change event including the ineligibility of a dependent.

Qualified change events include, but are not limited to the following:

- Marriage (refer to the section of this handbook titled Eligible Dependents for more information on when spouses, common law spouses or same-sex domestic partners can be added),
- Birth, adoption or placement for adoption of a dependent child, placement in foster care or legal guardianship,
- Divorce, legal separation or annulment, dissolution of a Common Law Marriage or Domestic Partner Relationship,
- Death of a dependent,
- Change in the dependent’s employment status resulting in a loss or gain of coverage, or
- A QMCSO (or similar judgment or decree that affects the health care coverage of the retiree, the retirees spouse or the retirees dependent).

To qualify for a change in coverage level to existing health care plans, the change must directly affect benefits. Required documentation for a qualified change event is as follows:

- Marriage – marriage certificate
- Birth – birth certificate or courtesy hospital copy
- Adoption or Legal Guardianship – official court documentation of adoption or guardianship
- Divorce or Annulment –
  - First and last page of final divorce decree signed by the judge,
  - Affidavit of Dissolution of Common Law Marriage, or
  - Affidavit of Dissolution of Domestic Partner Relationship.
• Death – death certificate

• Change in dependent’s employment status resulting in a loss or gain of other coverage – A document from the employer indicating the effective date of the gain or loss of other coverage

• QMCSO (or similar judgment or decree that affects the health care coverage of the retiree, the retirees spouse or the retirees dependent) – court decree

A retiree may also wish to consider a change of beneficiary in the event of a qualified change event.

**To Add a Dependent**

When a qualified change event results in a dependent becoming eligible for coverage under the Valero Retiree Health Care Plan, a written request and supporting documentation, as stated in this section, are required within 30 days of the qualifying change event. Requests to add new or previously ineligible dependents 30 days after a qualified change event will not be granted. In such cases, the participant must wait until the Annual Open Enrollment period to add the new dependent(s). To add a new dependent(s), participant should contact AmWINS at (877) 422-4170 or visit the AmWINS website at www.valero.amwins.com.

**To Drop a Dependent**

When a qualified change event results in a dependent losing coverage under the Valero Retiree Health Care Plan, certain dependents may be eligible to continue health care coverage in accordance with the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). For more information, refer to the section of this handbook titled Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). To remove a dependent(s), retirees should contact AmWINS at (877) 422-4170 or visit the AmWINS website at www.valero.amwins.com.

**CHANGE IN ADDRESS**

Address changes must be submitted in writing. The written communication should include the effective date of the address change to ensure that correspondence is mailed to the correct address. The address change form may be obtained by calling AmWINS at (877) 422-4170.

**BENEFICIARY INFORMATION**

A beneficiary is a person named to receive benefits in the event of a participant’s death. To name a beneficiary, a Valero Energy Corporation Beneficiary Designation Form (Beneficiary Designation Form) must be completed. The Beneficiary Designation Form must be on file with the Company before a participant’s death to ensure that benefits
are paid to the beneficiary of the participant’s choice. Beneficiary Designation Forms completed during active employment remain in force during the participant’s lifetime unless an updated form is submitted. To obtain a Beneficiary Designation Form, participants should contact Valero Retiree Administration Department (800) 333-3377 extension 4000.

In the absence of a Beneficiary Designation Form, survivor benefits will be paid as outlined in the plan documents.

A retiree may change beneficiary designations at any time. If a retiree beneficiary dies within 30 days of the retiree’s death, benefits are paid to a contingent beneficiary (or beneficiaries). A contingent beneficiary is explained on the Beneficiary Designation Form.

MEDICARE ELIGIBILITY AND THE VALERO RETIREE HEALTH CARE PLANS

The Valero Retiree Health Care Plans require that retirees who are Medicare eligible due to age or disability be enrolled in Medicare Part A and Part B. Retirees enrolling in a Medicare supplement plan through AmWINS will be automatically enrolled in the Valero sponsored Medicare Part D Prescription Drug Program. When making plan elections, retirees must choose one plan for all covered members, except in the case of a split Medicare eligible and non-Medicare eligible household. For more information, please refer to the section in this handbook titled Split Households.

Retirees must have an address within the domestic United States to be eligible for the Medicare supplement plans offered through AmWINS.

For additional information, please contact AmWINS at (877) 422-4170 or visit the AmWINS website at www.valero.amwins.com.

Medicare Eligible at Retirement

Retirees and their covered dependents who will be Medicare eligible on their retirement date should enroll in Medicare Part A and Part B on the first of the month after their retirement date. To enroll in Medicare, eligible participants should contact the Social Security Administration Office at (800) 772-1213.

Becoming Medicare Eligible during Retirement

Retirees who are no longer eligible for the Non-Medicare Valero sponsored plans will be disenrolled the last day of the month prior to their Medicare eligibility. If other members of the household are currently enrolled in a non-Medicare plan, they will remain enrolled as long as they are not Medicare eligible and pay applicable premiums.
If a retiree or a covered dependent becomes Medicare eligible due to a disability, they must notify AmWINS immediately and enroll in Medicare Part A and Part B. AmWINS will then send an enrollment kit containing information about the Valero sponsored Medicare supplement plans. Retirees enrolling in a Medicare supplement plan will be automatically enrolled in the Valero sponsored Medicare Part D Prescription Drug Program.

Retirees and their covered dependents who become Medicare eligible due to age will be notified by AmWINS up to three months prior to turning age 65. Retirees will receive an enrollment kit containing information about the Valero sponsored Medicare supplement plans. Retirees enrolling in a Medicare supplement plan will be automatically enrolled in the Valero sponsored Medicare Part D Prescription Drug Program.

**Split Households**

A split household contains both non-Medicare and Medicare eligible participants. A split household will be sent one enrollment kit for a plan election for all non-Medicare eligible participants and one enrollment kit for a plan election for all Medicare eligible participants.

**QUALIFIED MEDICAL CHILD SUPPORT ORDERS (QMCSOs)**

All medical, dental and vision plans are required by law to administer benefits in accordance with a QMCSO. For more information regarding QMCSOs, refer to the section titled *Qualified Change Events*. 
Participants and their dependents, which are not eligible for Medicare, are offered an option of either the Aetna Retiree Medical $1,000 Deductible Plan (Deductible Plan) or the Aetna Retiree PPO Plan (PPO Plan). The following benefits apply to retirees and their eligible dependents that have elected coverage through either the Deductible Plan or the PPO Plan.

The Aetna Medical $1,000 Deductible Plan (Deductible Plan) and Aetna PPO Plan (PPO Plan) help pay medical expenses for the treatment of non work-related illness or injury, as well as certain preventive care services. All medically necessary services are subject to plan provisions in effect at the time services are rendered. The Aetna medical benefit plans described in the handbook are a benefit of Valero. These benefits are not insured with Aetna or any of its affiliates, but will be paid from Valero’s fund.

This section of the Retiree Health and Welfare Benefits Handbook provides a highlight of benefits, and is not all inclusive of plan benefits, services, limitations or exclusions. For information about covered services and supplies, refer to the section of this summary titled What is Covered Under the Deductible, PPO and OOA Plan. For detailed information on what this plan covers, contact Aetna at (800) 414-0768. For Network provider information, refer to www.aetna.com (network: Aetna Choice POS II Open Access).
## PLAN HIGHLIGHTS

<table>
<thead>
<tr>
<th>Plan Highlights</th>
<th>Deductible Plan What You Pay</th>
<th>PPO Plan What You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Annual Deductibles</strong> <em>(must be paid prior to all services - except preventive services)</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Individual</strong></td>
<td>Combined $1,000 In-network &amp; Out-of-network</td>
<td>In-network $500 Out-of-network $1,000</td>
</tr>
<tr>
<td><strong>Family</strong></td>
<td>None</td>
<td>In-network $1,000 Out-of-network $2,000</td>
</tr>
</tbody>
</table>

| **Annual Out-of-Pocket Maximums** *(copayments, coinsurances and deductibles)* | | |
| **Individual** | In-network $2,500 | In-network $2,500 |
| | Out-of-network $5,000 | Out-of-network $5,000 |
| **Family** | In-network $5,000 | In-network $5,000 |
| | Out-of-network $10,000 | Out-of-network $10,000 |

| **Preventive Services** | | |
| **In-network** | No Charge | No Charge |
| **Out-of-network** | 30% | 40% |

| **All Other Medically Necessary Services** | | |
| **In-network** | 10% (after individual deductible) | $25 copayment for doctor visit  
$35 copayment for specialist visit  
20% all other medically necessary services (after individual deductible)  
$200 copayment for emergency room  
$100 copayment for urgent care services  
20% for inpatient admission (after individual deductible) |
| **Out-of-network** | 30% (after deductible) | 40% for doctor visit (after individual deductible)  
40% for specialist visit (after individual deductible)  
40% all other medically necessary services (after individual deductible)  
$200 copayment for emergency room  
40% for urgent care (after individual deductible)  
40% for inpatient admission (after individual deductible) |
HOW THE DEDUCTIBLE AND PPO PLANS WORK

The Deductible and PPO Plans have contracted with network providers and have agreed upon negotiated charges for certain services and supplies. Payment in the Deductible and PPO Plans will not be considered until treatment is rendered. The following provisions apply to the Deductible Plan and PPO Plan expenses.

Deductibles

The deductible is the amount a participant pays for covered expenses each year before the plan begins to pay. Amounts paid toward network or out-of-network expenses will be applied to the individual network and out-of-network calendar year deductibles.

- **Deductible at Year End** – If a covered participant is confined in a covered hospital or facility for a period of time extending past January 1 of any calendar year, a new individual calendar year deductible amount will be required of such individual for the charges incurred in the new calendar year during that confinement.

- **Deductible for Newborns** – Under the Deductible Plan only, the deductible is waived for the inpatient facility nursery expenses for covered newborns. This deductible waiver applies to the facility charges only. The newborn will be charged the applicable deductible for any individual physician's or ancillary charges incurred while the newborn is inpatient. For more information, refer to the section of this handbook titled Elections and Enrollment Periods.

- **Deductible for Preventive Care Services and Immunizations** – No deductible is required for preventive care services and immunizations (including routine and travel immunizations and flu shots).

Payment Percentage

The payment percentage is the percentage of covered expenses the plan pays and the percentage of covered expenses the participant will pay. Once applicable deductibles have been met, the plan will pay a percentage of the covered expenses, and the participant will be responsible for the remainder of the costs. For participants who are subject to network and out-of-network benefit provisions, the payment percentage may vary by type of expense and whether or not the participant uses a network or out-of-network provider. Participants should refer to the Summary of Benefits and Coverage (SBC) at the end of this handbook for a detailed listing of payment percentage amounts for each covered benefit.
Out-of-Pocket Maximums

- **Individual Out-of-Pocket Maximum** – The individual network or out-of-network out-of-pocket maximum is the largest amount of out-of-pocket expenses a participant would pay in one calendar year for network or out-of-network expenses. It includes the annual individual calendar year deductible and the covered participant’s coinsurance share of covered medical network or out-of-network expenses. Once the network and/or out-of-network individual out-of-pocket maximum is reached, the plan pays 100% of the covered network expenses for the remainder of that calendar year.

- **Family Out-of-Pocket Maximum** – A family network or out-of-network out-of-pocket maximum applies if a participant covers themselves and their child (ren), or themselves and family (spouse and child (ren)). Once a participant and family have reached the family network and/or out-of-network out-of-pocket maximum, the plan pays 100% of the covered network expenses for all covered individuals for the remainder of that calendar year.

*Exclusions*

Certain expenses do not apply toward the network, out-of-network or out-of-pocket maximum. These include, but are not limited to:

- Charges over the recognized charge,
- Non-covered expenses,
- Expenses from non-emergency use of the emergency room, or
- Penalties or denials for out-of-network expenses that required precertification, but where precertification was not obtained from Aetna.

*Lifetime Maximum Benefit*

The lifetime maximum benefit is the most the plan will pay for covered expenses incurred by any one covered participant during their lifetime. The lifetime maximum benefit for participants is $2,000,000 and applies to network and out-of-network expenses combined.

If a participant has met their lifetime maximum benefit, there is an automatic yearly restoration benefit at the beginning of each new benefit period. This restoration will restore expenses paid by the plan up to a maximum of $20,000 per year without action on the participant’s part. Evidence of good health will not be required. However, the participant’s coverage must be in force in order for restoration of benefits to apply.
Networks

The plans provide access to covered benefits through a network of health care providers and facilities. These network providers have contracted with Aetna, an affiliate or third party vendor, to provide health care services and supplies to Aetna plan members at a reduced fee called the negotiated charge. The network utilized for the plans is called the Aetna Choice POS II (Open Access) network. The Aetna Choice POS II (Open Access) network is designed to lower out-of-pocket costs when participants use network providers for covered expenses. Deductibles and coinsurance will generally be lower when using participating network providers and facilities. Refer to www.aetna.com for network provider information.

Participants also have the choice to access licensed providers, hospitals and facilities outside the network for covered benefits. Out-of-pocket costs (deductibles and coinsurance) will generally be higher when participants utilize out-of-network providers. Out-of-network providers have not agreed to accept the negotiated charge and may balance bill the participant for charges over the recognized charges. The recognized charge is the maximum amount Aetna will pay for a covered expense from an out-of-network provider.

Out-of-pocket costs may vary between network and out-of-network benefits. Participants should refer to the SBC at the end of this handbook to understand the cost sharing charges.

Availability of Providers

Aetna cannot guarantee the availability or continued participation of a particular network provider. Either Aetna or any network provider may terminate the provider contract or limit the number of patients accepted in a practice.

Pre-existing Conditions

The plans do not contain a pre-existing condition clause. In the event a participant becomes eligible for another plan that does contain pre-existing condition exclusions, federal law limits the circumstances under which coverage may be excluded for medical conditions present before enrolling.

Precertification

Precertification is a process that helps the participant and the participant’s physician determine whether the services being recommended are covered expenses under the Deductible Plan and PPO Plan. It also allows Aetna to help the participant’s provider coordinate transition from an inpatient setting to an outpatient setting (discharge planning), and to register for specialized programs or case management when appropriate.
To precertify an admission or one of the following outpatient services, participants should call Aetna at (800) 414-0768. Providers should call Aetna at (888) 632-3862 and select option 3.

Precertification is required for the following types of medical inpatient and outpatient care expenses:

- Stays in a hospital;
- Stays in a skilled nursing facility;
- Stays in a rehabilitation facility;
- Stays in a hospice facility;
- Outpatient hospice care;
- Stays in a Residential Treatment Facility for treatment of mental disorders and substance abuse;
- Partial Hospitalization Programs for mental disorders and substance abuse;
- Home health care;
- Private duty nursing care;
- Intensive Outpatient Programs for mental disorders and substance abuse;
- Amytal interview;
- Biofeedback;
- Electroconvulsive therapy;
- Neuropsychological testing;
- Outpatient detoxification;
- Psychiatric home care services; and
- Psychological testing.

Aetna will provide a written notification to the participant and the participant’s physician of the precertification decision. If the precertified expenses are approved, the approval remains valid for 60 days as long as the participant remains enrolled in the plan.
• **In-Network Admissions or Services**

A participant does not need to precertify services when provided by a network provider. Network providers are responsible for obtaining the necessary precertification. Since precertification is the provider’s responsibility, there is no additional out-of-pocket cost to the participant as a result of a network provider’s failure to precertify services.

If after a precertified admission, a participant’s physician recommends the stay be extended, additional days must be certified.

• **Out-of-Network Admissions or Services**

When a participant goes to an out-of-network provider, it is the participant’s responsibility to obtain precertification from Aetna for any services or supplies on the precertification list below. A participant’s provider may precertify the participant’s treatment; however, the participant should verify with Aetna, prior to the procedure, that the provider has obtained precertification from Aetna. If the service or supply is not precertified by the participant or the participant’s provider, the participant’s benefits may be significantly reduced or expenses may not be covered by the plan.

If after an initial precertified admission, a participant’s physician recommends the stay be extended, additional days must be certified.

The participant or a member of the participant’s family, a hospital staff member or the attending physician must contact Aetna to precertify the following out-of-network admissions or services within the following timelines:

<table>
<thead>
<tr>
<th>Out-of-Network Admission or Service</th>
<th>Precertification Timeline</th>
</tr>
</thead>
<tbody>
<tr>
<td>• For non-emergency admissions</td>
<td>• Precertification requests must be submitted at least 14 days before the scheduled admission date</td>
</tr>
<tr>
<td>(including hospitalizations, skilled nursing facilities, hospice, home health care, ambulatory surgical facilities and rehabilitation facilities, residential treatment facilities, and intensive outpatient programs)</td>
<td></td>
</tr>
<tr>
<td>• For an emergency admission</td>
<td>• Precertification requests must be submitted within 48 hours or as soon as reasonably possible after the participant has been admitted</td>
</tr>
<tr>
<td>• For an urgent admission - An urgent admission is a hospital admission by a physician due to the onset of or change in an illness; the diagnosis of an illness; or an injury</td>
<td>• Precertification requests must be submitted before the participant is scheduled to be admitted</td>
</tr>
</tbody>
</table>
• **Precertification Denial Decision**

If precertification determines the stay, or services and supplies are not covered expenses, the notification will explain why and how Aetna’s decision can be appealed. The participant and/or the participant’s provider may request a review of the precertification decision according to the section of this handbook titled *Aetna Claims and Appeals*.

• **How Failure to Precertify Services May Effect Benefits**

  o A precertification benefit reduction will be applied to the benefits paid if a participant fails to obtain required precertification prior to incurring medical expenses. This means Aetna will reduce the amount paid towards coverage or expenses may not be covered.

  o A $200 benefit reduction will be applied separately to certain designated procedures covered under the outpatient precertification program for failure to precertify.

  o The participant will be responsible for any unpaid balance of medical expenses.

The chart below illustrates the effect on benefits if necessary precertification for outpatient or inpatient services, procedures and treatments is not obtained.

<table>
<thead>
<tr>
<th>If Precertification is:</th>
<th>Then the Expenses are:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Requested and denied</td>
<td>• Not covered, and may be appealed</td>
</tr>
<tr>
<td>• Not requested, but would have been covered if requested</td>
<td>• Covered after a precertification benefit reduction is applied</td>
</tr>
<tr>
<td>• Not requested, and would not have been covered if requested</td>
<td>• Not covered, and may be appealed</td>
</tr>
</tbody>
</table>

It is important to remember that any additional out-of-pocket expenses incurred because the participant’s precertification requirement was not met will not count toward the participant’s deductible, payment percentage or maximum out-of-pocket limit.

**Emergency and Urgent Care**

Emergency and urgent care coverage is available 24 hours a day, seven days a week, anywhere inside or outside the plan’s service area for:

• An emergency medical condition, or

• An urgent condition.
In Case of a Medical Emergency

An emergency medical condition is a recent and severe condition, sickness or injury, including (but not limited to) severe pain, which would lead a prudent layperson (including the parent or guardian of a minor child or the guardian of a disabled individual) possessing an average knowledge of medicine and health to believe that failure to get immediate medical care could result in:

- Placing a participant’s health in serious jeopardy,
- Serious impairment to a bodily function(s),
- Serious dysfunction to a body part(s) or organ(s), or
- In the case of a pregnant woman, serious jeopardy to the health of the woman and/or her unborn child.

When emergency care is necessary, participants should follow the guidelines below:

- Seek the nearest emergency room, or dial 911 or a local emergency response service for medical and ambulatory assistance. If possible, call the participant’s physician provided a delay would not be detrimental to the participant's health.
- After assessing and stabilizing the participant’s condition, the emergency room should contact the participant’s physician to obtain the participant’s medical history to assist the emergency physician in the participant’s treatment.
- If the participant is admitted to an inpatient facility, notify the participant’s physician as soon as reasonably possible.
- If a participant seeks care in an emergency room for a non-emergency condition (one that does not meet the criteria above), the plan will not cover any incurred expenses.

In Case of an Urgent Condition

An urgent condition is a sudden illness, injury or condition that:

- Requires prompt medical attention to avoid serious deterioration of the participant’s health,
- Cannot be adequately managed without urgent care or treatment,
- Does not require the level of care provided in a hospital emergency room, and
• Requires immediate outpatient medical care that cannot wait for the participant’s physician to become available.

A participant’s physician should be contacted if urgent care is needed. Physicians usually provide coverage 24 hours a day, including weekends and holidays for urgent care. The participant may contact any physician or urgent care provider for an urgent care condition if the participant cannot reach their physician.

If it is not feasible to contact their physician, the participant should do so as soon as possible after urgent care is provided. If the participant needs help finding an urgent care provider, they may call Aetna or access Aetna’s online provider directory at www.aetna.com.

Follow-up care after treatment of an emergency or urgent medical condition is not considered an emergency or urgent condition, and is not covered as part of any emergency or urgent care visit. Once the participant has been treated and discharged, the participant should contact their physician for any necessary follow-up care. Follow-up care includes (but is not limited to) suture removal, cast removal and radiological tests such as x-rays. For coverage purposes, follow-up care is treated as any other expense for illness or injury. If the participant accesses a hospital emergency room for follow-up care, the participant’s expenses will not be covered and the participant will be responsible for the entire cost of treatment. To keep out-of-pocket costs lower, follow-up care should be provided by a physician within an office setting.

For participants who are subject to network and out-of-network benefit provisions, a participant may use an out-of-network provider for follow-up care. The participant will be subject to the deductible and coinsurance that apply to out-of-network expenses, which may result in higher out-of-pocket costs.

**Prescription Drug Coverage**

Prescription drug coverage is included in the Aetna Medical Plans and is administered by Express Scripts. For information on prescription coverage, refer to the section of this handbook titled [Express Scripts Prescription Drug Coverage](#).

**HOW MEDICAL EXPENSES ARE PAID THROUGH THE DEDUCTIBLE AND PPO PLANS**

In most cases, the physician or health care provider will file a claim on the participant’s behalf. Providers are encouraged to file claims electronically. Providers should call Aetna for coverage inquiries prior to services being rendered.

At times, it may be necessary for a participant to file a claim for medical benefits, particularly for participants who use out-of-network providers. Claim forms are available at [www.aetna.com](http://www.aetna.com) and should be completed and sent directly to the address shown on
the back of the Aetna ID card. Separate claim forms should be filed for each family member. Copies of claims and all bills submitted should be retained for the participant’s records.

All claims should be filed promptly. The claim filing deadline for the Aetna Medical Plans is 24 months from the date of service.

After a claim has been processed an Explanation of Benefits (EOB) is sent to the participant, the physician and any other provider of care. If the claim is denied, the participant has the right to appeal. For complete information on filing and appealing claims, refer to the section of this handbook titled Aetna Claims and Appeals.

Covered participants who have medical expenses incurred as a result of an accident and paid by the plan but reimbursed by a third party insurance are required to refund the plan up to the amount the plan paid on the accident. For more information on subrogation and reimbursement, refer to the section of this handbook titled The Right of Subrogation and Reimbursement.

**Summary of Benefits and Coverage (SBC)**

Please refer to Exhibit A at the end of this handbook for a copy of the Deductible Plan SBC.

Please refer to Exhibit B at the end of this handbook for a copy of the PPO Plan SBC.
AETNA OUT-OF-AREA PLAN

The Aetna Out-of-Area Plan (OOA Plan) helps pay medical expenses for the treatment of non work-related illness or injury, as well as certain preventive care services. All medically necessary services are subject to plan provisions in effect at the time services are rendered. These benefits are not insured with Aetna or any of its affiliates, but will be paid from Valero’s funds.

This section of the Retiree Health and Welfare Benefits Handbook provides a highlight of benefits, and is not all inclusive of plan benefits, services, limitations or exclusions. For more information about covered services and supplies refer to the section of this handbook titled What is Covered under the Deductible, PPO and OOA Plans. For detailed information on what this plan covers, contact Aetna at (800) 414-0768.

PLAN HIGHLIGHTS

<table>
<thead>
<tr>
<th>Plan Highlights</th>
<th>What You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Annual Deductibles</strong> <em>(must be paid prior to all services – except preventive services)</em></td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>$500</td>
</tr>
<tr>
<td>Family</td>
<td>$1,000</td>
</tr>
<tr>
<td><strong>Annual Out-of-Pocket maximums</strong> <em>(copayments, coinsurances and deductibles)</em></td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>$2,500</td>
</tr>
<tr>
<td>Family</td>
<td>$5,000</td>
</tr>
<tr>
<td><strong>Preventive &amp; All Other Medically Necessary Services</strong></td>
<td></td>
</tr>
<tr>
<td>Preventive</td>
<td>No charge</td>
</tr>
<tr>
<td>All other services</td>
<td>20% (after deductible)</td>
</tr>
</tbody>
</table>

HOW THE OOA PLAN WORKS

The OOA Plan is designed to provide medical coverage for participants and their covered dependents that are not eligible to enroll in the Deductible Plan or PPO Plan because they reside out of the Aetna network service area. Payment in the OOA Plan will not be considered until treatment is rendered. The following provisions apply to the OOP Plan expenses.

Deductibles

The deductible is the amount a participant pays for covered expenses each year before the plan begins to pay.
• **Deductible at Year End** – If a covered participant is confined in a covered hospital or facility for a period of time extending past January 1 any calendar year, a new individual calendar year deductible amount will be required of such individual for the charges incurred in the new calendar year during that confinement.

• **Deductible for Preventive Care Services and Immunizations** – No deductible is required for preventive care services or immunizations (including routine and travel immunizations and flu shots).

**Payment Percentage**

The payment percentage is the percentage of covered expenses the plan pays and the percentage of covered expenses the participant will pay. Once applicable deductibles have been met, the plan will pay a percentage of the covered expenses, and the participant will be responsible for the remainder of the costs. For participants who are subject to network and out-of-network benefit provisions, the payment percentage may vary by type of expense and whether or not the participant uses a network or out-of-network provider. Participants should refer to the SBC at the end of this handbook for a detailed listing of payment percentage amounts for each covered benefit.

**Out-of-Pocket Maximums**

The out-of-pocket maximum limits the amount a participant pays toward covered medical expenses each year. The OOA Plan pays 100% of covered medical expenses after a participant meets the out-of-pocket maximums.

**Availability of Providers**

The OOA Plan does not utilize a network of providers. Participants who are enrolled in the OOA Plan will not utilize the Aetna Choice POS II (Open Access) network.

When receiving covered medical services, each participant:

• Pays a deductible for out-of-area services,

• Pays any required coinsurance amount, and

• Will file a claim form to be reimbursed for out-of-area services.

**Pre-existing Conditions**

The plan does not contain a pre-existing condition clause. In the event a participant becomes eligible for another plan that does contain pre-existing condition exclusions, federal law limits the circumstances under which coverage may be excluded for medical conditions present before enrolling.
Precertification

Precertification is a process that helps the participant and the participant’s physician determine whether the services being recommended are covered expenses under the OOA Plan. It also allows Aetna to help the participant’s provider coordinate transition from an inpatient setting to an outpatient setting (discharge planning), and to register for specialized programs or case management when appropriate.

To precertify an admission or one of the following outpatient services, participants should call Aetna at (800) 414-0768. Providers should call Aetna at (888) 632-3862 and select option 3.

Precertification is required for the following types of medical inpatient and outpatient care expenses:

- Stays in a hospital;
- Stays in a skilled nursing facility;
- Stays in a rehabilitation facility;
- Stays in a hospice facility;
- Outpatient hospice care;
- Stays in a Residential Treatment Facility for treatment of mental disorders and substance abuse;
- Partial Hospitalization Programs for mental disorders and substance abuse;
- Home health care;
- Private duty nursing care;
- Intensive Outpatient Programs for mental disorders and substance abuse;
- Amytal interview;
- Biofeedback;
- Electroconvulsive therapy;
- Neuropsychological testing;
- Outpatient detoxification
• Psychiatric home care services; and
• Psychological testing.

The Precertification Process for Admissions or Services

It is the participant’s responsibility to obtain precertification from Aetna for any services or supplies on the precertification list below. A participant’s provider may precertify the participant’s treatment; however, the participant should verify with Aetna, prior to the procedure, that the provider has obtained precertification from Aetna.

Aetna will provide a written notification to the participant and the participant’s physician of the precertification decision. If the precertified expenses are approved, the approval remains valid for 60 days as long as the participant remains enrolled in the plan.

If after a precertified admission, a participant’s physician recommends the stay be extended, additional days must be certified.

The participant or a member of the participant’s family, a hospital staff member or the attending physician must contact Aetna to precertify the following admissions or services within the following timelines:

<table>
<thead>
<tr>
<th>Admission or Service</th>
<th>Precertification Timeline</th>
</tr>
</thead>
<tbody>
<tr>
<td>• For non-emergency admissions (including hospitalizations, skilled nursing facilities, hospice, home health care, ambulatory surgical facilities and rehabilitation facilities, residential treatment facilities, and intensive outpatient programs)</td>
<td>• Precertification requests must be submitted at least 14 days before the scheduled admission date</td>
</tr>
<tr>
<td>• For an emergency admission</td>
<td>• Precertification requests must be submitted within 48 hours or as soon as reasonably possible after the participant has been admitted</td>
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<tr>
<td>• For an urgent admission - An urgent admission is a hospital admission by a physician due to the onset of or change in an illness; the diagnosis of an illness; or an injury</td>
<td>• Precertification requests must be submitted before the participant is scheduled to be admitted</td>
</tr>
</tbody>
</table>
• **Precertification Denial Decision**

If precertification determines the stay, or services and supplies are not covered expenses, the participant and the participant’s physician will be notified. The notification will explain why and how Aetna’s decision may be appealed. The participant and/or the participant’s provider may request a review of the precertification decision according to the section of this handbook titled *Aetna Claims and Appeals*.

• **How Failure to Precertify Services May Effect Benefits**

Failure to precertify a service or supply by either the participant or the participant’s provider may result in the following:

- A precertification benefit reduction will be applied to the benefits paid if a participant fails to obtain required precertification prior to incurring medical expenses. This means Aetna will reduce the amount paid towards coverage or expenses may not be covered.

- A 20% benefit reduction will be applied separately to certain designated procedures covered under the outpatient precertification program for failure to precertify.

- The participant will be responsible for the unpaid balance of the bills.

Additional out-of-pocket expenses incurred because the participant’s precertification requirement was not met will not count toward the participant’s deductible, payment percentage or maximum out-of-pocket limit.

The chart below illustrates the effect on benefits if necessary precertification for outpatient or inpatient services, procedures and treatments is not obtained.

<table>
<thead>
<tr>
<th>If Precertification is:</th>
<th>Then the Expenses are:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Requested and approved by Aetna</td>
<td>Covered</td>
</tr>
<tr>
<td>Requested and denied</td>
<td>Not covered, may be appealed</td>
</tr>
<tr>
<td>Not requested, but would have been covered if requested</td>
<td>Covered after a precertification benefit reduction is applied</td>
</tr>
<tr>
<td>Not requested, would not have been covered if requested</td>
<td>Not covered, may be appealed</td>
</tr>
</tbody>
</table>

**Emergency and Urgent Care**

Emergency and urgent care coverage is available 24 hours a day, seven days a week, anywhere inside or outside the plan’s service area for:

- An emergency medical condition, or
• An urgent condition.

In Case of a Medical Emergency

An emergency medical condition is a recent and severe condition, sickness or injury, including (but not limited to) severe pain, which would lead a prudent layperson (including the parent or guardian of a minor child or the guardian of a disabled individual) possessing an average knowledge of medicine and health to believe that failure to get immediate medical care could result in:

• Placing a participant’s health in serious jeopardy,
• Serious impairment to a bodily function(s),
• Serious dysfunction to a body part(s) or organ(s), or
• In the case of a pregnant woman, serious jeopardy to the health of the woman and/or her unborn child.

When emergency care is necessary, participants should follow the guidelines below:

• Seek the nearest emergency room, or dial 911 or a local emergency response service for medical and ambulatory assistance. If possible, call the participant’s physician provided a delay would not be detrimental to the participant’s health.

• After assessing and stabilizing the participant’s condition, the emergency room should contact the participant’s physician to obtain the participant’s medical history to assist the emergency physician in the participant’s treatment.

• If the participant is admitted to an inpatient facility, notify the participant’s physician as soon as reasonably possible.

• If a participant seeks care in an emergency room for a non-emergency condition (one that does not meet the criteria above), the plan will not cover any incurred expenses.

In Case of an Urgent Condition

An urgent condition is a sudden illness, injury or condition that:

• Requires prompt medical attention to avoid serious deterioration of the participant’s health,
• Cannot be adequately managed without urgent care or treatment,
• Does not require the level of care provided in a hospital emergency room, and

• Requires immediate outpatient medical care that cannot wait for the participant’s physician to become available.

A participant’s physician should be contacted if urgent care is needed. Physicians usually provide coverage 24 hours a day, including weekends and holidays for urgent care. The participant may contact any physician or urgent care provider for an urgent care condition if the participant cannot reach their physician.

If it is not feasible to contact their physician, the participant should do so as soon as possible after urgent care is provided. If the participant needs help finding an urgent care provider, they may call Aetna or access Aetna’s online provider directory at www.aetna.com.

Follow-up care after treatment of an emergency or urgent medical condition is not considered an emergency or urgent condition, and is not covered as part of any emergency or urgent care visit. Once the participant has been treated and discharged, they should contact their physician for any necessary follow-up care. Follow-up care includes (but is not limited to) suture removal, cast removal and radiological tests such as x-rays. For coverage purposes, follow-up care is treated as any other expense for illness or injury. If the participant accesses a hospital emergency room for follow-up care, the participant’s expenses will not be covered and the participant will be responsible for the entire cost of treatment. To keep out-of-pocket costs lower, follow-up care should be provided by a physician within an office setting.

For participants who are subject to network and out-of-network benefit provisions, a participant may use an out-of-network provider for follow-up care. The participant will be subject to the deductible and coinsurance that apply to out-of-network expenses, which may result in higher out-of-pocket costs.

Prescription Drug Coverage

Prescription drug coverage is included in the Aetna Medical Plans and is administered by Express Scripts. For information on prescription coverage, refer to the section of this handbook titled Express Scripts Prescription Drug Coverage.

HOW MEDICAL EXPENSES ARE PAID THROUGH THE OOA PLAN

In most cases, the physician or health care provider will file a claim on the participant’s behalf. Providers may submit claims electronically. Providers should call Aetna at (888) 632-3862 for coverage inquiries prior to services being rendered.

At times, it may be necessary for a participant to file a claim for medical benefits. Claim forms are available at www.aetna.com and should be completed and sent directly to the address shown on the back of the Aetna ID card. Separate claim forms should be filed
for each family member. Copies of claims and all bills submitted should be retained for the participant’s records.

All claims should be filed promptly. The claim filing deadline for the Aetna Medical Plans is 24 months from the date of service.

After a claim has been processed an EOB is sent to the participant, the physician and any other provider of care. If the claim is denied, the participant has the right to appeal. For complete information on filing and appealing claims, refer to the section of this handbook titled Aetna Claims and Appeals.

Covered participants who have medical expenses incurred as a result of an accident and paid by the plan but reimbursed by a third party insurance are required to refund the plan up to the amount the plan paid on the accident. For more information on subrogation and reimbursement, refer to the section of this handbook titled The Right of Subrogation and Reimbursement.

**Summary of Benefits and Coverage (SBC)**

Please refer to Exhibit C at the end of this handbook for a copy of the OOA Plan SBC.
WHAT IS COVERED UNDER THE DEDUCTIBLE, PPO AND OOA PLANS

Adoption

Recognized medical expenses (including newborn expenses) for the individual child being adopted are considered the same as any other recognized medical expense, once the adopted child has been added to the plan. The medical expenses for the birth mother or any adoption fees are not covered.

Alcoholism and Substance Abuse

Covered expenses include charges made for the treatment of alcoholism and substance abuse by behavioral health providers. In addition to meeting all other conditions for coverage, the treatment must meet the following criteria:

- There is a program of therapy prescribed and supervised by a behavioral health provider, and
- The program of therapy includes either:
  - A follow-up program directed by a behavioral health provider on at least a monthly basis, or
  - Meetings at least twice a month with an organization devoted to the treatment of alcoholism or substance abuse.

Inpatient Treatment for Alcoholism and Substance Abuse

The plan covers room and board at the semi-private room rate, and other services and supplies provided during a stay in a psychiatric hospital or residential treatment facility appropriately licensed by the State Department of Health or its equivalent.

Coverage includes:

- Treatment in a hospital for the medical complications of alcoholism or substance abuse (Medical complications include detoxification, electrolyte imbalances, malnutrition, cirrhosis of the liver, delirium tremens and hepatitis), and
- Treatment in a hospital when the hospital does not have a separate treatment facility section.

Outpatient Treatment for Alcoholism and Substance Abuse

The plan covers outpatient treatment of alcoholism or substance abuse.
The plan covers partial hospitalization services (more than four hours, but less than 24 hours per day) provided in a facility or program for the intermediate, short-term or medically-directed intensive treatment of alcoholism or substance abuse. The partial hospitalization will only be covered if inpatient care is needed and if the participant is not admitted to an inpatient facility.

**Partial Confinement Treatment for Alcoholism and Substance Abuse**

Covered expenses include charges made for partial confinement treatment provided in a facility or program for the intermediate, short-term or medically-directed intensive treatment of alcoholism or substance abuse.

The partial confinement treatment will only be covered if a hospital stay is needed and if the participant is not admitted to an inpatient facility.

Inpatient care must be precertified by Aetna.

**Chiropractic Care**

A chiropractor is defined as someone who is legally licensed to provide medically necessary services within the scope of his or her license or certificate.

Under the Deductible Plan, chiropractic care is limited to 20 visits per calendar year and is combined for both network and out-of-network care.

Under the PPO and OOA Plans, chiropractic care is limited to 26 visits per calendar year and is combined for both network and out-of-network care.

**Clinical Trials**

**Clinical Trial Therapies (Experimental or Investigational)**

Covered expenses include charges made for experimental or investigational drugs, devices, treatments or procedures “under an approved clinical trial” only in the case of cancer or a terminal illness and all of the following conditions are met:

- Standard therapies have not been effective or are inappropriate;
- Aetna determines, based on published peer-reviewed scientific evidence that the participant may benefit from the treatment; and
- The participant is enrolled in an approved clinical trial that meets these criteria.

An “approved clinical trial” is a clinical trial that meets these criteria:
• The FDA has approved the drug, device, treatment or procedure to be investigated or has granted it investigational new drug (IND) or group c/treatment IND status. This requirement does not apply to procedures and treatments that do not require FDA approval.

• The clinical trial has been approved by an Institutional Review Board that will oversee the investigation.

• The clinical trial is sponsored by the National Cancer Institute (NCI) or similar federal organization.

• The trial conforms to standards of the NCI or other, applicable federal organization.

• The clinical trial takes place at an NCI-designated cancer center or takes place at more than one institution.

• The participant is treated in accordance with the protocols of that study.

Routine Patient Costs

• Covered expenses include charges made by a provider for “routine patient costs” furnished in connection with participation in an “approved clinical trial” for cancer or other life-threatening disease or condition, as those terms are defined in the federal Public Health Service Act, Section 2709.

Diagnostic and Preoperative Testing

• This plan covers diagnostic complex imaging expenses made on an outpatient basis by a physician, hospital or a licensed imaging or radiological facility for complex imaging services to diagnose an illness or injury, including:
  - Computed Axial Tomography (CAT) scans,
  - Magnetic Resonance Imaging (MRI), and
  - Positron Emission Tomography (PET) scans.

• This plan covers outpatient diagnostic lab work and radiological services and expenses including charges for radiological services (other than diagnostic complex imaging), lab services, and pathology and other tests provided to diagnose an illness or injury. The participant must have definite symptoms that start, maintain or change a plan of treatment prescribed by a physician. The charges must be made by a physician, hospital or licensed radiological facility or lab.
• This plan covers outpatient preoperative testing prior to a scheduled covered surgery. Covered expenses include charges made for tests performed by a hospital, surgery center, physician or licensed diagnostic laboratory provided the charges for the surgery are covered expenses and the tests are:

  • Related to the participant’s surgery, and the surgery takes place in a hospital or surgery center,
  • Completed within 14 days before the participant’s surgery,
  • Performed on an outpatient basis,
  • Performed while the participant was inpatient in a hospital, and
  • Not repeated in or by the hospital or surgery center where the surgery will be performed.

• Test results should appear in the participant’s medical record kept by the hospital or surgery center where the surgery is performed. If the participant’s tests indicate surgery should not be performed because of a physical condition, the plan will pay for the tests; however, surgery will not be covered.

**Durable Medical and Surgical Equipment (DME)**

Covered expenses include charges by a DME supplier for the rental of equipment or, in lieu of rental.

The initial purchase of DME is covered if:

• Long-term care is planned, and
• The equipment cannot be rented or is likely to cost less to purchase than to rent.

Maintenance and repairs of purchased equipment needed due to misuse or abuse are not covered.

Replacement of purchased equipment is covered if:

• The replacement is needed because of a change in the participant’s physical condition, and
• It is likely to cost less to replace the item than to repair the existing item or rent a similar item.

The plan limits coverage to one item of equipment for the same or similar purpose and the accessories needed to operate the item. The participant is responsible for the entire
cost of any additional pieces of the same or similar equipment purchased or rented for personal convenience or mobility.

Covered DME includes those items covered by Medicare unless noted in the medical plan exclusions found in this section. Aetna reserves the right to limit the payment of charges up to the most cost efficient and least restrictive level of service or item which can be safely and effectively provided. The decision to rent or purchase is at the discretion of the plan.

**Emergency Room Services**

An emergency medical condition is defined as one manifesting itself by acute symptoms of sufficient severity such that a prudent layperson, who possesses average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in serious jeopardy to the individual’s health, or with respect to a pregnant woman, the health of the woman and/or her unborn child.

When a participant has an emergency, they should contact their personal physician, if possible. In the event of an emergency, participants in the Deductible or PPO Plans should go to the nearest emergency room, regardless of whether the hospital is in the network. Participants in the OOA Plan should go to the nearest emergency room. The participant, or a representative of the participant, must contact Aetna within 48 hours of admission to the hospital.

By following these procedures, use of the outpatient emergency care facility for covered emergency services or medically necessary emergent treatment is covered if the condition qualifies as an emergency. X-ray, lab and other professional fees that are billed separate from the emergency care facility fee(s) will be paid at the percentage listed in the SBC.

If a patient goes to an emergency facility and the condition is not considered a medical emergency, no benefits will be payable.

For information on precertification, refer to the section of this handbook titled **How the Deductible and PPO Plans Work**.

**Hearing Benefit – PPO Plan Only**

Hearing services are included in the PPO Plan. Hearing exams obtained through a network provider are covered at 100% after a $35 office visit copayment. Hearing aids (hardware) are eligible for a maximum annual benefit of $150.

A participant must submit a medical claim form and supporting receipt(s) to Aetna for reimbursement of hardware expenses (and an exam expense from an out-of-network provider). Claims should be mailed to:
Participants may obtain a claim form on the Aetna website at www.aetna.com.

**Home Health Care**

Covered expenses include charges made by a home health care agency for home health care if the care:

- Is given under a home health care plan, and
- Is given to the participant in the participant’s home while homebound.

Home health care expenses include charges for:

- Part-time or intermittent care by an R.N. or by an L.P.N., if an R.N. is not available;

- Part-time or intermittent home health aide services provided in conjunction with, and in direct support of, care by an R.N. or an L.P.N.;

- Part-time or intermittent medical social services by a social worker when provided in conjunction with, and in direct support of care, by an R.N. or an L.P.N.; and

- Medical supplies and lab services by or for a home health care agency to the extent they would have been covered under this plan if the participant had continued the participant’s hospital stay.

Benefits for home health care visits are payable up to the home health care maximum. Each visit by a nurse or therapist is one visit. A visit is defined as up to four hours.

The maximum will not apply to care given by an R.N. or L.P.N. when:

- Care is provided within 10 days of discharge from a hospital or skilled nursing facility as a full-time inpatient, and

- Care is needed to transition from the hospital or skilled nursing facility to home care.

When the above criteria are not met, covered expenses include up to 12 hours of continuous care by an R.N. or L.P.N. per day.
Covered home health care services are not determined by the availability of caregivers to perform them. The absence of an individual to perform a non-skilled or custodial care services does not cause the service to become covered. If the covered participant is a minor or an adult who is dependent upon others for non-skilled care (e.g. bathing, eating, toileting), coverage for home health services will only be provided during times when there is a family member or caregiver present in the home to meet the participant’s non-skilled needs.

Home health care must be precertified for participants who are subject to network, out-of-network or OOA benefit provisions.

**Hospice Care**

*Facility Expenses*

These include charges made by a hospital, hospice or skilled nursing facility for:

- Room and board and other services and supplies furnished during a stay for pain control and other acute and chronic symptom management, and
- Services and supplies furnished to the participant on an outpatient basis.

*Outpatient Hospice Expenses*

Covered expenses include charges made on an outpatient basis by a hospice care agency for:

- Part-time or intermittent nursing care by an R.N. or L.P.N. for up to eight hours a day,
- Part-time or intermittent home health aide services to care for the participant up to eight hours a day,
- Medical social services under the direction of a physician. These include but are not limited to:
  - Assessment of the participant’s social, emotional and medical needs, and the participant’s home and family situation,
  - Identification of available community resources,
  - Assistance provided to the participant to obtain resources to meet the participant’s assessed needs,
  - Physical and occupational therapy,
• Consultation or case management services by a physician,
• Medical supplies,
• Prescription drugs,
• Dietary counseling, and
• Psychological counseling.

Charges made by the providers below are covered if the provider is not an employee of a hospice care agency, and such agency retains responsibility for the participant’s care:

• A physician for a consultation or case management,
• A physical or occupational therapist, or
• A home health care agency for:
  • Physical and occupational therapy,
  • Part-time or intermittent home health care aide services for the participant’s care up to eight hours a day,
  • Medical supplies,
  • Prescription drugs,
  • Psychological counseling, and
  • Dietary counseling.

Inpatient hospice care and home health care must be precertified by Aetna for participants who are subject to network, out-of-network or OOA benefit provisions.

**Hospital Expenses**

Covered medical expenses include charges made by a hospital for services and supplies furnished to the participant in connection with the participant’s stay, such as:

• Ambulance services,
• Physicians and surgeons,
• Operating and recovery rooms,
• Intensive or special care facilities,
• Administration of blood and blood products, but not the cost of the blood or blood product,
• Radiation therapy,
• Speech therapy, physical therapy and occupational therapy,
• Oxygen and oxygen therapy,
• Radiological services, laboratory testing and diagnostic services,
• Medications,
• Intravenous (IV) preparations, and
• Discharge planning.

Room and Board

Private room charges that exceed the hospital's semi-private room rate are not covered unless a private room is required because of a contagious illness or immune system problem.

Outpatient Hospital Expenses

Covered expenses include hospital charges made for covered services and supplies provided by the outpatient department of a hospital.

Emergency Medical Conditions

Covered expenses include charges made by a hospital or a physician for services provided in an emergency room to evaluate and treat an emergency medical condition. The emergency care benefit covers:

• Use of emergency room facilities,
• Emergency room physicians services,
• Hospital nursing staff services, and
• Radiologists and pathologists services.
Urgent Conditions

Covered expenses include charges made by an urgent care provider to evaluate and treat an urgent condition. The urgent conditions coverage includes:

- Use of urgent care facilities,
- Physicians services,
- Nursing staff services, and
- Radiologists and pathologists services.

Outpatient Surgery

If the surgery can be performed adequately and safely only in a surgery center or hospital, then covered expenses include charges for services and supplies furnished in connection with outpatient surgery made by:

- A surgery center, or
- The outpatient department of a hospital.

Birthing Center

Covered expenses include charges made by a birthing center for services and supplies related to care received in a birthing center for:

- Prenatal care,
- Delivery, and
- Postpartum care within 48 hours after a vaginal delivery and 96 hours after a cesarean delivery.

Hospital Services

Hospital admissions must be precertified to receive full benefits. For more information about precertification requirements, refer to the sections of this handbook titled How the Deductible and PPO Plans Work or How the OOA Plan Works.

The plan covers hospital expenses including:

- A semi-private hospital room,
- Intensive care or coronary care unit,
• Hospital services and supplies (except personal items),
• Anesthesia and oxygen, and
• Blood and plasma.

Infertility

Basic, comprehensive and Advanced Reproductive Technology (ART) infertility expenses are covered up to a lifetime maximum of $25,000. Covered expenses include charges made by a physician to diagnose and surgically treat the underlying medical cause of infertility.

Comprehensive Infertility Expenses

To be an eligible female covered for benefits, the participant must be covered under the plan as a retiree or be a covered dependent who is the retiree’s spouse.

Even though not incurred for treatment of an illness or injury, covered expenses will include expenses incurred by an eligible covered female for infertility if all of the following tests are met:

• It has been documented in the participant’s medical records that the participant’s gynecologist or an infertility specialist (or a network infertility specialist for participants who are subject to network, out-of-network or OOA benefit provisions) has diagnosed the participant as infertile due to a condition that is a demonstrated cause of infertility and that is recognized by the gynecologist or infertility specialist (or a network infertility specialist for participants who are subject to network, out-of-network or OOA benefit provisions),

• The procedures are done while not confined in a hospital or any other facility as an inpatient,

• FSH levels are less than 19 mIU on day three of the menstrual cycle,

• The infertility is not caused by voluntary sterilization of either one of the partners (with or without surgical reversal) or a hysterectomy, and

• A successful pregnancy cannot be attained through less costly treatment for which coverage is available under the Deductible, PPO or OOA Plan.

If the covered participant meets the eligibility requirements above, the following comprehensive infertility services are payable when provided by an infertility specialist, subject to all the exclusions and limitations outlined in this section:
• Ovulation induction with menotropins is subject to the maximum benefit, if any, and has a maximum of six cycles per lifetime, and

• Intrauterine insemination is subject to the maximum benefit, if any, and has a maximum of six cycles per lifetime.

**ART Benefits**

ART is defined as:

- In Vitro Fertilization (IVF)
- Zygote Intra-Fallopian Transfer (ZIFT)
- Gamete Intra-Fallopian Transfer (GIFT)
- Cryopreserved embryo transfers
- Intra-Cytoplasmic Sperm Injection (ICSI), or ovum microsurgery

To be eligible for ART benefits, participants must meet certain medical requirements and:

- First exhaust the comprehensive infertility services benefits. Coverage for ART services is available only if comprehensive infertility services do not result in a pregnancy in which a fetal heartbeat is detected, and
- Be referred by the participant’s physician to Aetna’s infertility case management unit.

The following charges are covered benefits for eligible covered females when all of the above conditions are met subject to the exclusions outlined in this section:

- Up to three cycles and subject to the maximum benefit, of any combination of the following ART services per lifetime which only include: IVF, GIFT, ZIFT or cryopreserved embryo transfers.
- IVF, ICSI, ovum microsurgery, GIFT, ZIFT or cryopreserved embryo transfers subject to the maximum benefit while covered under the plan.
- Payment for charges associated with the care of an eligible covered participant under this plan, who is participating in a donor IVF program, including fertilization and culture.
- Charges associated with obtaining the spouse’s sperm for ART when the spouse
is also covered under the plan.

Maternity

Group health plans may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth, for the mother or newborn child, to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending physician from discharging the mother or her newborn child earlier than 48 hours (or 96 hours, as applicable). In any case, group health plans may not, under federal law, require that a provider obtain authorization from the plan for prescribing a length of stay not in excess of 48 hours (or 96 hours).

The plan may require pre-authorizations for stays longer than 48 hours (or 96 hours). Deductibles and other conditions of coverage, including coinsurance requirements, apply to hospital stays in connection with childbirth on the same terms as with other benefits provided under the plan.

Health Care Expenses for a Dependent Child’s Newborn Child

Expenses resulting from the birth of a child to a dependent child covered under the plan will NOT automatically be paid for the first 30 days following the newborn's date of birth. To be eligible for coverage from the newborn's date of birth, the participant must provide documentation of adoption, legal guardianship or legal custody of the newborn and must request coverage within 30 days of the legal acquisition. For more information, refer to the section of this handbook titled Elections and Enrollment Periods.

Obesity Treatment

Covered expenses include charges made by a physician, licensed or certified dietician, nutritionist or hospital for the non-surgical treatment of obesity for the following outpatient weight management services:

- An initial medical history and physical exam,
- Diagnostic tests given or ordered during the first exam, and
- Prescription drugs as outlined in the section of this handbook titled Express Scripts Prescription Drug Coverage.

Covered expenses include both inpatient and outpatient morbid obesity surgical procedures.

Limitations

Unless specified above, not covered under this benefit are charges incurred for:
• Weight control services including medical treatments, weight control/loss programs, dietary regimens and supplements, food or food supplements, appetite suppressants and other medications; exercise programs, exercise or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity. For details regarding obesity non-surgical treatment, surgical treatment and or plan limitations, contact Aetna.

Mental Disorders Treatment

Covered expenses include charges made for the treatment of mental disorders by behavioral health providers.

Oral and Maxillofacial Treatment (Mouth, Jaws and Teeth)

Covered expenses include charges made by a physician, dentist and hospital for:

• Non-surgical treatment of infections or diseases of the mouth, jaw joints or supporting tissues.

• Services and supplies for treatment of, or related conditions of the teeth, mouth, jaws, jaw joints or supporting tissues (this includes bones, muscles and nerves); for surgery needed to:
  • Treat a fracture, dislocation or wound,
  • Cut out cysts, tumors or other diseased tissues,
  • Cut into gums and tissues of the mouth. This is only covered when not done in connection with the removal, replacement or repair of teeth, or
  • Alter the jaw, jaw joints or bite relationships by a cutting procedure when appliance therapy alone cannot result in functional improvement.

• Hospital services and supplies received for a stay required because of a medical condition.

• Dental work, surgery and orthodontic treatment due to an accident or injury, and needed to remove, repair, restore or reposition:
  • Natural teeth damaged, lost or removed, or
  • Other body tissues of the mouth fractured or cut.
  • Any such teeth must have been free from decay or in good repair, and are firmly attached to the jaw bone at the time of the injury.
• The treatment must be completed in the calendar year or in the next calendar year of the accident.

• If crowns, dentures, bridges or in-mouth appliances are installed due to injury, covered expenses only include charges for:
  • The first denture or fixed bridgework to replace lost teeth,
  • The first crown needed to repair each damaged tooth, and
  • An in-mouth appliance used in the first course of orthodontic treatment after the injury.

• Covered expenses include charges made for limited services and supplies related to the treatment of teeth, gums, jaws and their supporting structures, muscles and nerves as follows:
  • Accidental injuries and other trauma. The plan covers oral surgery and related dental services to return sound natural teeth to their pre-trauma functional state, but only if the services take place no later than 24 months after the injury.
  • Sound natural teeth are teeth that were stable, functional, and free from decay and advanced periodontal disease at the time of the trauma.
  • If a child needs oral surgery as the result of accidental injury or trauma, surgery may be postponed until a certain level of growth has been achieved.
  • Trauma which occurs as a result of biting or chewing is not considered accidental injury, even if it is unplanned or unexpected.

Pathology

The plan covers removal of tumors and cysts requiring pathological examination.

Radiation Treatment

The plan covers fluoride treatment, removal of teeth and hyperbaric oxygen therapy in connection with covered radiation therapy.

Anatomical Defects

The plan covers oral surgery and related dental services to correct a gross anatomical
defect present at birth which results in significant functional impairment of a body part, if
the services or supplies will improve function. Related dental services are limited to:

- The first placement of a permanent crown or cap to repair a broken tooth,
- The first placement of dentures or bridgework to replace lost teeth, and
- Orthodontic therapy to preposition teeth.

**Physician Services**

To receive network benefits under the plan, participants who are subject to network or
out-of-network benefits provisions must select a physician participating in the Aetna
Choice POS II (Open Access) network.

Participants who are subject to network or out-of-network benefits provisions may use
an out-of-network physician and receive benefits at the lower out-of-network benefit
level.

A physician is defined as someone who is legally licensed to provide medical services
which are within the scope of his or her license or certificate.

**Physician Visits**

Covered medical expenses include charges made by a physician during a visit to treat
an illness or injury. The visit may be at the physician’s office, in the participant’s home,
in a hospital or other facility during a stay or in an outpatient facility. Covered expenses
also include:

- Immunizations for infectious disease,
- Allergy testing and allergy injections, and
- Charges made by the physician for supplies, radiological services, x-rays and
tests provided by the physician.

**Surgery**

Covered expenses include charges made by a physician for:

- Performing the participant’s surgical procedure,
- Pre-operative and post-operative visits, and
- Consultation with another physician to obtain a second opinion prior to the
surgery.

Anesthetics

Covered expenses include charges for the administration of anesthetics and oxygen by a physician, other than the operating physician, or Certified Registered Nurse Anesthetist (C.R.N.A.) in connection with a covered procedure.

Pregnancy Related Expenses

Covered expenses for eligible participants include charges made by a physician for pregnancy and childbirth services, and supplies at the same level as any illness or injury. This includes prenatal visits, delivery and postnatal visits.

For inpatient care of the mother and newborn child, covered expenses include charges made by a hospital for a minimum of:

- 48 hours after a vaginal delivery,
- 96 hours after a cesarean section, or
- A shorter stay if the attending physician, with the consent of the mother, discharges the mother or newborn earlier.

Covered expenses also include charges made by a birthing center.

Covered expenses also include services and supplies provided for circumcision of the newborn during the stay.

Preventive Care Services

Under the preventive care benefit, the deductible does not apply, however preventive care services may be subject to age, family history and frequency limitations. Charges submitted with a medical diagnosis cannot be considered as preventive. For more information on all preventive care benefits, preventive care visit maximums and limitations, contact Aetna.

Routine Physical Exams

Covered expenses include charges made by a participant’s primary care physician (PCP) for routine physical exams. This includes routine vision and hearing screenings given as part of the routine physical exam. A routine exam is a medical exam given by a physician for a reason other than to diagnose or treat a suspected or identified illness or injury, and also includes:

- Evidence-based items that have in effect a rating of A or B in the current
recommendations of the United States Preventive Services Task Force (USPSTF).

- Screening and counseling services for covered females, as provided for in the comprehensive guidelines recommended by the Health Resources and Services Administration (HRSA). These services may include but are not limited to:
  - Interpersonal and domestic violence,
  - Sexually transmitted diseases,
  - Human Immune Deficiency Virus (HIV) infections,
  - Screening for gestational diabetes, and
  - High risk Human Papillomavirus (HPV) DNA testing for women age 30 and older.

- X-rays, lab and other tests given in connection with the exam.

- For covered newborns, an initial exam in the hospital.

*Preventive Care Immunizations*

Covered expenses include charges made by a participant’s physician or a facility for:

- Immunizations as recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention; and

- The materials for administration of immunizations.

Not covered under this Preventive Care benefit are charges incurred for immunizations that are not considered Preventive Care, such as those required due to employment or travel.

*Well Woman Preventive Visits*

Covered expenses include charges made by a participant’s physician for a routine well woman preventive exam office visit, including Pap smears, in accordance with the recommendations by the HRSA. A routine well woman preventive exam is a medical exam given by a physician for a reason other than to diagnose or treat a suspected or identified illness or injury.

*Routine Cancer Screenings*

Covered expenses include, but are not limited to, charges incurred for routine cancer
screening as follows:

- Mammograms;
- Fecal occult blood tests;
- Digital rectal exams;
- Prostate specific antigen (PSA) tests;
- Sigmoidoscopies;
- Double contrast barium enemas (DCBE); and
- Colonoscopies (removal of polyps performed during a screening procedure is a covered expense); and
- Lung cancer screening, age 55 and above.

These benefits will be subject to age; family history; and frequency guidelines that are:

- Evidence-based items or services that have in effect a rating of A or B in the recommendations of the United States Preventive Services Task Force; and
- Evidence-informed items or services provided in the comprehensive guidelines supported by the HRSA.

For more information regarding plan guidelines and limitations, contact Aetna.

**Comprehensive Lactation Support and Counseling Services**

Covered expenses include comprehensive lactation support (assistance and training in breast feeding) and counseling services provided to females during pregnancy and in the post partum period by a certified lactation support provider. The "post partum period" means the one-year period directly following the child's date of birth. Covered expenses incurred during the post partum period also include the rental or purchase of breast feeding equipment as described in this handbook.

Lactation support and lactation counseling services are covered expenses when provided in either a group or individual setting. Benefits for lactation counseling services are subject to the visit maximums. For more information, contact Aetna.
Breast Feeding Durable Medical Equipment

Coverage includes the rental or purchase of breast feeding durable medical equipment for the purpose of lactation support (pumping and storage of breast milk) as follows.

- Breast Pump. Covered expenses include the following:
  
  - The rental of a hospital-grade electric pump for a newborn child when the newborn child is confined in a hospital.
  
  - The purchase of:
    
    - An electric breast pump (non-hospital grade), if requested within 60 days from the date of the birth of the child. A purchase will be covered once every three years following the date of the birth; or
    
    - A manual breast pump, if requested within 12 months from the date of the birth of the child. A purchase will be covered once every three years following the date of the birth.

If an electric breast pump was purchased within the previous three year period, the purchase of an electric or manual breast pump will not be covered until a three year period has elapsed from the last purchase of an electric pump.

- Breast Pump Supplies

  Coverage is limited to only one purchase per pregnancy in any year where a covered female would not qualify for the purchase of a new pump.

  Coverage for the purchase of breast pump equipment is limited to one item of equipment, for the same or similar purpose, and the accessories and supplies needed to operate the item. You are responsible for the entire cost of any additional pieces of the same or similar equipment you purchase or rent for personal convenience or mobility.

Aetna reserves the right to limit the payment of charges up to the most cost efficient and least restrictive level of service or item which can be safely and effectively provided. The decision to rent or purchase is at the discretion of Aetna.

If a participant needs a breast pump service or supply that is covered under this plan, but is not available from a network provider in the participant’s area, the participant should contact Aetna.
Screening and Counseling Services

Benefits for the screening and counseling services below are subject to visit maximums, each session of up to 60 minutes is equal to one visit. For more information, contact Aetna. Covered expenses include charges made by a primary care physician in an individual or group setting for the following:

- **Obesity** - Screening and counseling services to aid in weight reduction due to obesity. Coverage includes:
  - Preventive counseling visits and/or risk factor reduction intervention;
  - Medical nutrition therapy;
  - Nutrition counseling; and
  - Healthy diet counseling visits provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease.

- **Misuse of Alcohol and Drugs** - Screening and counseling services to aid in the prevention or reduction of the use of an alcohol agent or controlled substance. Coverage includes:
  - Preventive counseling visits,
  - Risk factor reduction intervention, and a
  - Structured assessment.

- **Use of Tobacco Products** - Screening and counseling services to aid in the cessation of the use of tobacco products. Tobacco product means a substance containing tobacco or nicotine including: cigarettes; cigars; smoking tobacco; snuff; smokeless tobacco and candy-like products that contain tobacco. The following screening and counseling service visits are covered:
  - Preventive counseling visits;
  - Treatment visits; and
  - Class visits.
Prenatal Care

Prenatal care will be covered as Preventive Care for services received by a covered pregnant female in a physician's, obstetricians, or gynecologist's office but only to the extent described below.

Coverage for prenatal care under this Preventive Care benefit is limited to pregnancy-related physician office visits including the initial and subsequent history and physical exams of the pregnant woman (maternal weight, blood pressure and fetal heart rate check). Pregnancy expenses (other than prenatal care as described) are not covered under the Preventive Care benefit.

Family Planning Services - Female Contraceptives

For females with reproductive capacity, covered expenses include those charges incurred for services and supplies that are provided to prevent pregnancy. All contraceptive methods, services and supplies covered under this Preventive Care benefit must be approved by the U.S. Food and Drug Administration (FDA).

Coverage includes counseling services on contraceptive methods provided by a physician, obstetrician or gynecologist. Such counseling services are covered expenses when provided in either a group or individual setting. They are subject to the contraceptive counseling services visit maximum. For more information, contact Aetna.

The following contraceptive methods are covered expenses under this Preventive Care benefit:

- Female voluntary sterilization procedures and related services and supplies including, but not limited to, tubal ligation and sterilization implants except where the voluntary sterilization procedure was not billed separately by the provider or because it was not the primary purpose of a confinement.

- Female contraceptive devices including the related services and supplies needed to administer the device.

When contraceptive devices are obtained at a pharmacy, prescriptions must be submitted to the pharmacist for processing. For information on oral contraceptives, refer to the section of this handbook titled Express Scripts Prescription Drug Coverage.

Not covered under this Preventive Care benefit are charges for:

- Any contraceptive methods that are only "reviewed" by the FDA and not "approved" by the FDA;

- **Male** contraceptive methods, sterilization procedures or devices; and
• The reversal of voluntary sterilization procedures, including any related follow-up care.

Family Planning Services - Other

Covered expenses include charges for certain family planning services, even though not provided to treat an illness or injury, such as:

• Voluntary sterilization for males.

Expenses not covered are:

• Voluntary termination of pregnancy, except if the life of the mother is endangered or complications arise.

• Reversal of voluntary sterilization procedures, including related follow-up care; and

• Charges incurred for family planning services while confined as an inpatient in a hospital or other facility for medical care.

Private Duty Nursing

Covered expenses include private duty nursing provided by an R.N. or L.P.N. if the participant’s condition requires skilled nursing care and visiting nursing care is not adequate. However, covered expenses will not include private duty nursing for any shifts during a calendar year in excess of the private duty nursing care maximum shifts. Each period of private duty nursing of up to eight hours will be deemed to be one private duty nursing shift.

The plan also covers skilled observation for up to one four-hour period per day, for up to 10 consecutive days following:

• A change in medication,

• Treatment of an urgent or emergency medical condition by a physician,

• The onset of symptoms indicating a need for emergency treatment,

• Surgery, and

• An inpatient stay.

Prosthetic Devices

Covered expenses include charges made for internal and external prosthetic devices
and special appliances, if the device or appliance improves or restores body part function that has been lost or damaged by illness, injury or congenital defect. Covered expenses also include instruction and incidental supplies needed to use a covered prosthetic device.

The plan covers the first prosthesis the participant needs that temporarily or permanently replaces all or part of a body part lost or impaired as a result of disease or injury or congenital defects as described in the list of covered devices below for an:

- Internal body part or organ, or
- External body part.

Covered expenses also include replacement of a prosthetic device if the replacement is needed because:

- A change in the participant's physical condition,
- Normal growth or wear and tear,
- It is likely to cost less to buy a new one than to repair the existing one, or
- The existing one cannot be made serviceable.

The list of covered devices includes but is not limited to:

- An artificial arm, leg, hip, knee or eye,
- Eye lens,
- An external breast prosthesis and the first bra made solely for use with it after a mastectomy,
- A breast implant after a mastectomy,
- Ostomy supplies, urinary catheters and external urinary collection devices,
- Speech generating device,
- A cardiac pacemaker and pacemaker defibrillators, and
- A durable brace that is custom made for and fitted for the participant.
Reconstructive or Cosmetic Surgery and Supplies

Covered expenses include charges made by a physician, hospital or surgery center for reconstructive services and supplies, including:

- Surgery needed to improve a significant functional impairment of a body part.

- Surgery to correct the result of an accidental injury, including subsequent related or staged surgery, provided the surgery occurs no more than 24 months after the original injury. For a covered child, the time period for coverage may be extended through age 18.

- Surgery to correct the result of an injury that occurred during a covered surgical procedure provided the reconstructive surgery occurs no more than 24 months after the original injury.

Note: Injuries that occur as a result of a medical (i.e., non-surgical) treatment are not considered accidental injuries, even if unplanned or unexpected.

- Surgery to correct a gross anatomical defect present at birth or appearing after birth (but not the result of an illness or injury) when:
  - The defect results in severe facial disfigurement, or
  - The defect results in significant functional impairment and the surgery is needed to improve function.

Reconstructive Breast Surgery

As required by the Women’s Health and Cancer Rights Act of 1998 (WHCRA), this plan provides coverage for:

- All stages of reconstruction of the breast on which the mastectomy has been performed,

- Surgery and reconstruction of the other breast to produce a symmetrical appearance, and

- Prostheses and physical complications of mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the patient. Such coverage may be subject to annual deductibles and coinsurance provisions as may be deemed appropriate and are consistent with those established for other benefits under the plan or coverage.
Short-term Rehabilitation Therapy Services

Covered expenses include charges for short-term therapy services when prescribed by a physician, as described below, up to the benefit maximums. For more information on the benefit maximums, participants should contact Aetna.

Coverage for services is subject to medical necessity and medical review. Generally, medical review is not needed for these services if the course of treatment does not exceed 25 visits. However, please note that this review may occur prior to the 25th visit, even if the services are provided by a participating provider. Physical therapy shall be expected to result in significant improvement of the patient's condition within 60 days from the date therapy begins. The short-term rehabilitation therapy services have to be performed by:

- A licensed or certified physical, occupational or speech therapist,
- A hospital, skilled nursing facility or hospice facility,
- A home health care agency, or
- A physician.

Charges for the following Short-term rehabilitation expenses are covered:

Cardiac and Pulmonary Rehabilitation Benefits

- Cardiac rehabilitation benefits are available as part of an inpatient hospital stay. A limited course of outpatient cardiac rehabilitation is covered when following angioplasty, cardiovascular surgery, congestive heart failure or myocardial infarction. The plan will cover charges in accordance with a treatment plan as determined by risk level when recommended by a physician. This course of treatment is limited to a maximum of 36 sessions in a 12-week period.

- Pulmonary rehabilitation benefits are available as part of an inpatient hospital stay. A limited course of outpatient pulmonary rehabilitation is covered for the treatment of reversible pulmonary disease states. This course of treatment is limited to a maximum of 36 hours or a six-week period.

Outpatient Cognitive Therapy, Physical Therapy, Occupational Therapy and Speech Therapy Rehabilitation Benefits

Inpatient rehabilitation benefits for the services listed will be paid as part of the participant’s inpatient hospital and skilled nursing facility benefits provision of the plan.

- Physical therapy is covered for non-chronic conditions, and acute illnesses and injuries, provided the therapy expects to significantly improve, develop or restore
physical functions lost or impaired as a result of an acute illness, injury or surgical procedure. Physical therapy does not include educational training or services designed to develop physical function.

- Occupational therapy (except for vocational rehabilitation or employment counseling) is covered for non-chronic conditions, and acute illnesses and injuries, provided the therapy expects to significantly improve, develop or restore physical functions lost or impaired as a result of an acute illness, injury or surgical procedure, or to relearn skills to significantly improve independence in the activities of daily living. Occupational therapy does not include educational training or services designed to develop physical function.

- Speech therapy is covered for non-chronic conditions, and acute illnesses and injuries and expected to restore the speech function or correct a speech impairment resulting from illness or injury or for delays in speech function development as a result of a gross anatomical defect present at birth. Speech function is the ability to express thoughts, speak words and form sentences. Speech impairment is difficulty with expressing thoughts with spoken words.

- Cognitive therapy associated with physical rehabilitation is covered when the cognitive deficits have been acquired as a result of neurologic impairment due to trauma, stroke or encephalopathy, and when the therapy is part of a treatment plan intended to restore previous cognitive function.

- For a diagnosis of pervasive developmental disorders or autism, the combined maximum number of visits per calendar year is 60 visits for physical and occupational therapy, and 30 visits for speech therapy.

A visit consists of no more than one hour of therapy. Covered expenses include charges for two therapy visits of no more than one hour in a 24-hour period.

The therapy should follow a specific treatment plan that:

- Details the treatment, and specifies frequency and duration,

- Provides for ongoing reviews and is renewed only if continued therapy is appropriate, and

- Allows therapy services provided in the participant’s home, if homebound.

**Skilled Nursing Facility**

Covered expenses include charges made by a skilled nursing facility during the participant’s stay for the following services and supplies:

- Room and board, up to the semi-private room rate. The plan will cover up to the
private room rate if it is needed due to an infectious illness or a weak or compromised immune system,

- Use of special treatment rooms,
- Radiological services and lab work,
- Physical, occupational or speech therapy,
- Oxygen and other gas therapy,
- Other medical services and general nursing services usually given by a skilled nursing facility (this does not include charges made for private or special nursing, or physician’s services), and
- Medical supplies.

Specialized Care

Chemotherapy

Covered expenses include charges for chemotherapy treatment. Coverage levels depend on where treatment is received. In most cases, chemotherapy is covered as outpatient care. Inpatient hospitalization for chemotherapy is limited to the initial dose while hospitalized for the diagnosis of cancer and when a hospital stay is otherwise medically necessary based on the participant’s health status.

Radiation Therapy Benefits

Covered expenses include charges for the treatment of illness by x-ray, gamma ray, accelerated particles, mesons, neutrons, radium or radioactive isotopes.

Outpatient Infusion Therapy Benefits

Covered expenses include charges made on an outpatient basis for infusion therapy by:

- A free-standing facility,
- The outpatient department of a hospital, or
- A physician in their office or in the participant’s home.

Infusion therapy is the intravenous or continuous administration of medications or solutions that are a part of the course of treatment. Charges for the following outpatient infusion therapy services and supplies are covered expenses:
• The pharmaceutical, when administered in connection with infusion therapy and any medical supplies, equipment and nursing services required to support the infusion therapy,

• Professional services,

• Total Parenteral Nutrition (TPN),

• Chemotherapy,

• Drug therapy (includes antibiotic and antivirals),

• Pain management (narcotics), and

• Hydration therapy (includes fluids, electrolytes and other additives).

Coverage for inpatient infusion therapy is provided under the inpatient hospital and skilled nursing facility benefits of the plan. Benefits payable for infusion therapy will not count toward any applicable home health care maximums.

Transplant Services

Any facility that is not specified as an Institutes of Excellence network facility is considered non-participating or out-of-network for transplant-related services, even if they are considered participating network for other types of services.

Aetna requires pre-authorization at the time of evaluation for transplant services. Contact Aetna Member Services at the toll-free number show on the Aetna ID card to begin the process.

Treatment of Mental Disorders

Covered expenses include charges made for the treatment of other mental disorders by behavioral health providers.

Benefits are payable for charges incurred in a hospital, psychiatric hospital, residential treatment facility or behavioral health provider's office for the treatment of mental disorders as follows:

Inpatient Treatment

Covered expenses include charges for room and board at the semi-private room rate, and other services and supplies provided during a stay in a hospital, psychiatric hospital or residential treatment facility. Inpatient benefits are payable only if the condition requires services that are only available in an inpatient setting.
Partial Confinement Treatment

Covered expenses include charges made for partial confinement treatment provided in a facility or program for the intermediate, Short-term or medically-directed intensive treatment of a mental disorder. Such benefits are payable if the condition requires services that are only available in a partial confinement treatment setting.

Outpatient Treatment

Covered expenses include charges for treatment received while not confined as a full-time inpatient in a hospital, psychiatric hospital or residential treatment facility.

The plan covers partial hospitalization services (more than four hours, but less than 24 hours per day) provided in a facility or program for the intermediate, Short-term or medically-directed intensive treatment. The partial hospitalization will only be covered if inpatient care is needed and if the participant is not admitted to an inpatient facility.

Inpatient care must be precertified by Aetna for participants who are subject to network, out-of-network or OOA benefit provisions.

Walk-in Clinic Visits

Covered expenses include charges made by walk-in clinics for:

- Unscheduled, non-emergency illnesses and injuries,
- The administration of certain immunizations administered within the scope of the clinic’s license, and
- Certain screening and counseling services.

Other Medical Benefits

Even when hospitalization is not necessary, the Deductible, PPO and OOA Plans include coverage up to the recognized charge for the following medically necessary services, treatments and supplies:

Acupuncture

The plan covers charges made for acupuncture services provided by a physician, if the service is performed within the scope of their license and is administered for treatment of illness or injury that is covered under the plan, or as a form of anesthesia in connection with a surgery that is covered under the plan.
Ambulance Service

Covered expenses made by a professional ambulance as follows:

- Ground ambulance covered expenses include charges for transportation:
  - To the first hospital where treatment is given in a medical emergency.
  - From one hospital to another hospital in a medical emergency when the first hospital does not have the required services or facilities to treat the participant’s condition.
  - From hospital to home or to another facility when other means of transportation would be considered unsafe due to the participant’s medical condition.
  - From home to hospital for covered inpatient or outpatient treatment when other means of transportation would be considered unsafe due to the participant’s medical condition. Transport is limited to 100 miles.
  - When during a covered inpatient stay at a hospital, skilled nursing facility or acute rehabilitation hospital, an ambulance is required to safely and adequately transport the participant to or from inpatient or outpatient medically necessary treatment.

Air or Water Ambulance

Covered expenses include charges for transportation to a hospital by air or water ambulance when:

- Ground ambulance transportation is not available, and
- The participant’s condition is unstable, and requires medical supervision and rapid transport, and
- In a medical emergency, transportation from one hospital to another hospital; when the first hospital does not have the required services or facilities to treat the condition and the participant’s need to be transported to another hospital; and the two conditions above are met.

Ambulance services not covered under this benefit are charges incurred to transport the participant:

- If an ambulance service is not required by the participant’s physical condition, or
- If the type of ambulance service provided is not required for the participant’s
physical condition, or

- By any form of transportation other than a professional ambulance service.

Other Supplies and Services

- Covered services by an assistant surgeon are reimbursed based on the surgeon’s fee

- Blepharoplasty will be reviewed on a case-by-case basis to determine medical necessity.

- Blood glucose monitors for medical conditions such as diabetes. A prescription from a physician is required.

- Circumcision of an infant.

- Parenteral (i.e., by intravenous administration) and enteral feedings (i.e., by feeding tube) are covered based on certain medical criteria and necessity, where the patient has either (a) a permanent non-function or disease of the structures that normally permit food to reach the small bowel; or (b) disease of the small bowel which impairs digestion and absorption of an oral diet, either of which requires enteral or parenteral feedings to provide sufficient nutrients to maintain weight and strength commensurate with the member’s overall health status.

- Medical supply items, subject to medical necessity. Covered DME includes, but is not necessarily limited to, the following items:
  - Pressure reducing support surfaces (i.e., pads and mattresses), when prescribed by a physician for a participant having or being susceptible to decubitus ulcers and who meet certain medical criteria,
  - Portable bath paraffin units, when medically necessary and prescribed by a physician who expects that the participant’s condition will be relieved by use of this treatment,
  - Bed pan,
  - Bed side rails,
  - Brace,
  - Breast prosthesis, form or insert/surgical bra – the initial limit is two for each breast. The plan allows two to four surgical bras for either single or double mastectomy every 12 months. Later acceptance of reasonable replacement is permitted, subject to physician’s recommendation and
medical necessity,

- Canes, crutches or walkers, if the participant’s condition impairs ambulating,

- Certain equipment (such as bedside commode and transfer boards) are considered on a case-by-case basis and must have a physician’s statement of medical necessity,

- Cervical traction devices,

- Cervical collar or roll,

- Chair, child care orthokinetic such as cerebral palsy, mental retardation, multiple handicapped,

- Dialysis machine due to chronic renal failure,

- Diabetic shoes prescribed by a physician and reviewed for medical necessity,

- Hospital bed, manual – rental only,

- Hospital bed, electric – individual consideration is given in cases of paralysis diagnoses (i.e., muscular dystrophy, etc.),

- Needleless injector for administration of insulin,

- Nebulizers,

- Orthotic inserts or shoes must be prescribed by a physician and reviewed for medical necessity,

- Postural drainage board/table, if the participant has a chronic pulmonary condition,

- Respirators,

- Standing frame for quadriplegic/paraplegic,

- Stimulators (electrical nerve, TENS Unit) prescribed by a physician and reviewed for medical necessity,

- Synthesized voice instrument,
• Wheelchair, manual – rental only,

• Wheelchair, electric – individual consideration is given in cases of paralysis diagnoses (i.e., muscular dystrophy, etc.),

• Orthopedic devices are considered on a case-by-case basis and must have a physician’s statement of medical necessity,

• Psychological testing by a licensed clinical psychologist, psychiatrist, licensed professional counselor or licensed master social worker when recommended by a licensed physician,

• Surgical stockings or support (pre-authorization is required) if prescribed as medically necessary, which require purchase through a medical supply company, are limited to two pairs initially, with later acceptance of replacements subject to medical necessity. Commercial type support stockings are not covered, as they are not a medical supply item, or

• X-ray and lab exams.
WHAT IS NOT COVERED UNDER THE DEDUCTIBLE, PPO AND OOA PLANS

Not every medical service or supply is covered by the plan, even if prescribed, recommended or approved by the participant’s physician or dentist. The plan covers only those services and supplies that are medically necessary and outlined in the section of this handbook titled What is Covered Under the Deductible, PPO and OOA Plans. The plan will not pay for charges resulting from any of the following:

- Services that are not medically necessary, including but not limited to those treatments, services, prescription drugs and supplies which are not medically necessary, as determined by Aetna, for the diagnosis and treatment of illness, injury, restoration of physiological functions or covered preventive care services. This applies even if they are prescribed, recommended or approved by a physician or dentist.

- Charges for care, treatment, services or supplies that are not prescribed, recommended or approved by the individual’s attending physician or dentist,

- Charges for or in connection with services or supplies that are, as determined by Aetna, to be experimental or investigational. A drug, a device, a procedure or treatment will be determined to be experimental or investigational if:
  
  - There are insufficient outcomes data available from controlled clinical trials published in the peer reviewed literature to substantiate its safety and effectiveness for the disease or injury involved,
  
  - If required by the FDA, approval has not been granted for marketing,
  
  - A recognized national medical or dental society or regulatory agency has determined, in writing, that it is experimental, investigational or for research purposes, or
  
  - The written protocol or protocols used by the treating facility or any other facility studying substantially the same drug, device, procedure or treatment, or the written informed consent used by the treating facility or by another facility studying the same drug, device, procedure or treatment states that it is experimental, investigational or for research purposes.

- Services and supplies related to data collection and record-keeping are solely needed due to the clinical trial (i.e. protocol-induced costs);

- Services and supplies are provided by the trial sponsor without charge to the participant, or
• The experimental intervention itself is not covered (except medically necessary Category B investigational devices and promising experimental or investigational inventions for terminal illnesses in certain clinical trials in accordance with Aetna’s claim policies).

This exclusion will not apply with respect to services or supplies (other than drugs) received in connection with a disease if Aetna determines that:

• The disease can be expected to cause death within one year in the absence of effective treatment, and

• The care or treatment is effective for that disease or shows promise of being effective for that disease as demonstrated by scientific data. In making this determination Aetna will take into account the results of a review by a panel of independent medical professionals selected by Aetna. This panel will include professionals who treat the type of disease involved.

Also, this exclusion will not apply with respect to drugs that:

• Have been granted treatment for IND or group treatment/IND status, or

• Are being studied at the phase III level in a national clinical trial sponsored by the NCI if Aetna determines that available scientific evidence demonstrates that the drug is effective or shows promise of being effective for the disease.

• Charges for or related to services, treatment, education testing, or training related to learning disabilities or developmental delays,

• Charges for care furnished mainly to provide a surrounding free from exposure that can worsen the participant’s disease or injury,

• Charges for or related to the following types of treatment: primal therapy, rolfing, psychodrama, megavitamin therapy, bioenergetic therapy, vision perception training or carbon dioxide therapy,

• Charges for treatment by covered health care providers who specialize in the mental health care field and who receive treatment as a part of their training in that field,

• Charges for services of a resident physician or intern rendered in that capacity,

• Charges for services and supplies:

  • Furnished, paid for or for which benefits are provided or required by reason of the past or present service of any individual in the armed forces of a government, or
• Furnished, paid for or for which benefits are provided or required under any law of a government.

• Charges for or related to any eye surgery mainly to correct refractive errors,

• Charges for therapy, supplies or counseling for sexual dysfunctions or inadequacies that do not have a physiological or organic basis,

• Charges for or related to artificial insemination, in vitro fertilization or embryo transfer procedures, except to the extent coverage for such procedures is specifically provided by the plan,

• Charges for routine physical exams, routine vision exams, routine dental exams, routine hearing exams, routine foot care, immunizations or other preventive care services and supplies, except to the extent coverage for such exams, immunizations, services or supplies is specifically provided by the plan,

• Charges for services and/or treatment for or in connection with marriage, family, child, career, social adjustment, pastoral or financial counseling,

• Charges for plastic surgery, reconstructive surgery, cosmetic surgery or other services and supplies which improve, alter or enhance appearance, whether or not for psychological or emotional reasons; except to the extent needed:

  • To improve the function of a part of the body that:

    • Is not a tooth or structure that supports the teeth, and

    • Is malformed as a result of a severe birth defect; including harelip, webbed fingers or toes

  • As a direct result of:

    • Disease, or

    • Surgery performed to treat a disease or injury

• Surgery must be performed in the calendar year of the accident which causes the injury or in the next calendar year,

• Any charges in excess of the benefit, dollar, day, visit or supply limits stated in the plan or as determined by Aetna.

• Charges for the reversal of a voluntary sterilization procedure,
• Charges for a service or supply furnished by a preferred care provider in excess of such provider’s negotiated charge for that service or supply. This exclusion will not apply to any service or supply for which a benefit is provided under Medicare before the benefits of the group contract are paid,

• Specific non-standard allergy services and supplies, including but not limited to, skin titration (wrinkle method), cytotoxicity testing (Bryan’s Test), treatment of non-specific candida sensitivity and urine autoinjections.

• Applied behavioral analysis, the LEAP, TEACCH, Denver and Rutgers programs.

• Behavioral health services, except when provided as part of a covered service:
  • Treatment by a covered health care provider who specializes in the mental health care field and who receives treatment as a part of their training in that field.
  
  • Treatment of impulse control disorders such as pathological gambling, kleptomania, pedophilia, caffeine or nicotine use.

  • Treatment of antisocial personality disorder.

  • Treatment in wilderness programs or other similar programs.

  • Treatment of mental retardation, defects, and deficiencies. This exclusion does not apply to mental health services or to medical treatment of mentally retarded in accordance with the benefits provided in the section of this handbook titled What is Covered Under the Deductible, PPO and OOA Plans.

• Blood, blood plasma, synthetic blood, blood products or substitutes, including but not limited to, the provision of blood, other than blood derived clotting factors. Any related services including processing, storage or replacement costs, and the services of blood donors, apheresis or plasmapheresis are not covered. For autologous blood donations, only administration and processing costs are covered.

• Services rendered outside the U.S. and its territories that are not medically necessary.

• Charges submitted for services that are not rendered, or rendered to an individual not eligible for coverage under the plan.

• Charges submitted for services by an unlicensed hospital, physician or other provider or not within the scope of the provider’s license.
• Contraceptive supplies, except for those devices that are prescribed by a physician and administered in a doctor’s office.

• Over the counter contraceptive supplies including but not limited to condoms, contraceptive foams, jellies and ointments.

• Certain prescription drugs. For more information refer to the section of this handbook titled Express Scripts Prescription Drug Coverage.

• Services associated with the prescribing, monitoring and/or administration of contraceptives.

• Cosmetic services and plastic surgery. Any treatment, surgery (cosmetic or plastic), service or supply to alter, improve or enhance the shape or appearance of the body whether or not for psychological or emotional reasons including:
  
  • Face lifts, body lifts, tummy tucks, liposuctions, removal of excess skin, removal or reduction of non-malignant moles, blemishes, varicose veins, cosmetic eyelid surgery and other surgical procedures,
  
  • Procedures to remove healthy cartilage or bone from the nose (even if the surgery may enhance breathing) or other part of the body,
  
  • Chemical peels, dermabrasion, laser or light treatments, bleaching, creams, ointments or other treatments or supplies to alter the appearance or texture of the skin,
  
  • Insertion or removal of any implant that alters the appearance of the body (such as breast or chin implants), except removal of an implant will be covered when medically necessary,
  
  • Removal of tattoos (except for tattoos applied to assist in covered medical treatments, such as markers for radiation therapy),
  
  • Repair of piercings and other voluntary body modifications, including removal of injected or implanted substances or devices,
  
  • Surgery to correct gynecomastia,
  
  • Breast augmentation, and
  
  • Otoplasty.

• Court ordered services including those required as a condition of parole or release.
Charges as determined by Aetna to be for custodial care, including, but not limited to: services and supplies that are primarily intended to help the participant meet personal needs. Custodial care can be prescribed by a physician or given by trained medical personnel. It may involve artificial methods such as feeding tubes, ventilators or catheters. Examples of custodial care include:

- Routine patient care such as changing dressings, periodic turning and positioning in bed and administering medications,
- Care of a stable tracheostomy (including intermittent suctioning),
- Care of a stable colostomy/ileostomy,
- Care of stable gastrostomy/jejunostomy/nasogastric tube (intermittent or continuous) feedings,
- Care of a stable indwelling bladder catheter (including emptying/changing containers and clamping tubing),
- Watching or protecting the participant,
- Respite care, adult (or child) day care or convalescent care,
- Institutional care, including room and board for rest cures, adult day care and convalescent care,
- Help with the daily living activities, such as walking, grooming, bathing, dressing, getting in or out of bed, toileting, eating or preparing foods,
- Any services that an individual without medical or paramedical training could be trained to perform, and
- Any service that can be performed by an individual without any medical or paramedical training.

Dental services: any treatments, services or supplies related to the care, filling, removal or replacement of teeth and the treatment of injuries and diseases of the teeth, gums and other structures supporting the teeth. This includes but is not limited to:

- Services of dentists, oral surgeons, dental hygienists and orthodontists including apicoectomy (dental root resection), root canal treatment, soft tissue impactions, removal of bony impacted teeth, treatment of periodontal disease, alveolectomy, augmentation and vestibuloplasty, and application of fluoride and other substances to protect, clean or alter the appearance
of teeth,

- Dental implants, false teeth, prosthetic restoration of dental implants, plates, dentures, braces, mouth guards and other devices to protect, replace or reposition teeth, and

- Non-surgical treatments to alter bite or the alignment or operation of the jaw, including treatment of malocclusion or devices to alter bite or alignment.

- Disposable outpatient supplies: any outpatient disposable supply or device, including sheaths, bags, elastic garments, support hose, bandages, bedpans, syringes, blood or urine testing supplies, and other home test kits; and splints, neck braces, compresses and other devices not intended for reuse by another patient.

- Educational services: any services or supplies related to education, training, retraining services or testing, including:
  - Special education, remedial education, job training and job hardening programs,
  - Evaluation or treatment of learning disabilities, minimal brain dysfunction, developmental, learning and communication disorders, behavioral disorders, (including pervasive developmental disorders) training or cognitive rehabilitation, regardless of the underlying cause, and
  - Services, treatment, and educational testing and training related to behavioral (conduct) problems, learning disabilities and delays in developing skills.

- Any health examinations:
  - Required by a third party, including examinations and treatments required to obtain or maintain employment, or which an employer is required to provide under a labor agreement,
  - Required by any law of a government, securing insurance or school admissions, or professional or other licenses,
  - Required to travel, attend a school, camp, sporting event, or participate in a sport or other recreational activity, and
  - Any special medical reports not directly related to treatment except when provided as part of a covered service.
• Food items: any food item, including infant formulas, nutritional supplements, vitamins, including prescription vitamins and prenatal vitamins, and medical foods and other nutritional items, even if it is the sole source of nutrition.

• Foot care for any services, supplies or devices to improve appearance of toes, feet or ankles (unless specifically covered for diabetics), including but not limited to:
  • Treatment of calluses, bunions, toenails, hammer-toes, subluxations, fallen arches, weak feet, chronic foot pain or conditions caused by routine activities such as walking, running, working or wearing shoes, and
  • Arch supports, guards, protectors, creams, ointments and other equipment, devices and supplies.

• Any treatment, device, drug, service or supply (including surgical procedures, devices to stimulate growth and growth hormones), solely to increase or decrease height or alter the rate of growth.

• Any hearing service or supply that:
  • Does not meet professionally accepted standards,
  • Are provided during a stay in a hospital or other facility, and
  • Are for the improvement of hearing (including hearing aids and amplifiers), or to enhance other forms of communication to compensate for hearing loss or devices that simulate speech. (For exception, refer to the section titled Hearing Benefit – PPO Plan Only.)

• Any addition or alteration to a home, workplace or other environment, or vehicle and any related equipment or device, such as:
  • Purchase or rental of exercise equipment, air purifiers, central or unit air conditioners, water purifiers, waterbeds and swimming pools,
  • Exercise and training devices, whirlpools, portable whirlpool pumps, sauna baths or massage devices,
  • Equipment or supplies to aid sleeping or sitting, including non-hospital electric and air beds, water beds, pillows, sheets, blankets, warming or cooling devices, bed tables and reclining chairs,
  • Equipment installed in the participant’s home, workplace or other environment, including stair-glides, elevators, wheelchair ramps, or equipment to alter air quality, humidity or temperature,
• Other additions or alterations to the participant’s home, workplace or other environment, including room additions, changes in cabinets, countertops, doorways, lighting, wiring, furniture, communication aids, wireless alert systems or home monitoring.

• Services and supplies furnished mainly to provide a surrounding free from exposure that can worsen the participant’s illness or injury.

• Removal from the participant’s home, worksite or other environment of carpeting, hypo-allergenic pillows, mattresses, paint, mold, asbestos, fiberglass, dust, pet dander, pests or other potential sources of allergies or illness, and

• Transportation devices, including stair-climbing wheelchairs, personal transporters, bicycles, automobiles, vans or trucks, or alterations to any vehicle or transportation device.

• Any services and supplies related to births occurring in the home or in a place not licensed to perform deliveries.

• Home uterine activity monitoring.

• The following infertility charges will not be payable:

  • ART services for a female attempting to become pregnant who has not had at least one year or more of timed, unprotected coitus, 12 cycles of artificial insemination (for covered persons under 35 years of age), six months or more of timed, unprotected coitus, or six cycles of artificial insemination (for covered persons 35 years of age or older) prior to enrolling in the infertility program,

  • Infertility services for females with FSH levels 19 or greater mIU/ml on day three of the menstrual cycle,

  • Charges for treatment that exceeds the lifetime maximum,

  • ART services for couples in which one of the partners has had a previous sterilization procedure, with or without surgical reversal,

  • Reversal surgery,

  • The purchase of donor sperm and any charges for the storage of sperm,

  • The purchase of donor eggs and any charges associated with care of the donor required for donor egg retrievals or transfers or gestational carriers
(or surrogacy),

- Injectable infertility medications, including but not limited to, menotropins, hCG, GnRH agonists and IVIG,

- All charges associated with a gestational carrier program for the covered participant or the gestational carrier,

- Charges associated with cryopreservation or storage of cryopreserved eggs and embryos,

- Home ovulation prediction kits, and

- Drugs related to the treatment of non-covered benefits.

- Treatment of infertility must be pre-authorized by Aetna. Treatment received without pre-authorization will not be covered. Participants who do not pre-authorize treatment for infertility will be responsible for full payment of services.

- Services and supplies that are furnished mainly to maintain, rather than to improve, a level of physical or mental function.

- Payment for that portion of the charge for which Medicare or another party is the primary payer.

- Miscellaneous charges for services or supplies including:
  
  - Annual or other charges to be in a physician’s practice,
  
  - Charges to have preferred access to a physician’s services such as boutique or concierge physician practices,
  
  - Cancelled or missed appointment charges
  
  - Charges the recipient has no legal obligation to pay or the charges would not be made if the recipient did not have coverage (to the extent exclusion is permitted by law) including:
    
    - Care in charitable institutions,
    
    - Care for conditions related to current or previous military service,
    
    - Care while in the custody of a governmental authority,
    
    - Any care a public hospital or other facility is required to provide, or
• Any care in a hospital or other facility owned or operated by any federal, state or other governmental entity, except to the extent coverage is required by applicable laws.

• Nursing and home health aide services provided outside of the home (such as in conjunction with school, vacation, work or recreational activities).

• Any service or supply primarily for convenience and personal comfort or that of a third party, including: telephone, television, internet, barber or beauty service, or other guest services; housekeeping, cooking, cleaning, shopping, monitoring, security or other home services; and travel, transportation, living expenses, rest cures, recreational or diversional therapy.

• Private duty nursing during a stay in a hospital and outpatient private duty nursing services, except as otherwise provided for by the plan. For more information, participants should contact Aetna.

• Any treatment, drug, service or supply related to changing sex or sexual characteristics, including:
  • Surgical procedures to alter the appearance or function of the body,
  • Hormones and hormone therapy,
  • Prosthetic devices, and
  • Medical or psychological counseling.

• Services provided by a spouse, domestic partner, parent, child, step-child, brother, sister, in-law or any household member.

• Services provided where there is no evidence of pathology, dysfunction or disease except as specifically provided in connection with covered routine care and cancer screenings.

• Any treatment, drug, service or supply to treat sexual dysfunction, enhance sexual performance or increase sexual desire, including:
  • Surgery, drugs, implants, devices or preparations to correct or enhance erectile function, enhance sensitivity, or alter the shape or appearance of a sex organ, and
  • Sex therapy, sex counseling, marriage counseling or other counseling or advisory services.
• Any treatment, drug, service or supply to stop or reduce smoking or the use of other tobacco products or to treat or reduce nicotine addiction, dependence or cravings, including counseling, hypnosis and other therapies, medications, nicotine patches and gum, except what is covered under the prescription benefit.

• Services, including those related to pregnancy, rendered before the effective date or after the termination of coverage, unless coverage is continued under the section of this handbook titled Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

• Services and supplies provided in connection with treatment or care that is not covered under the plan.

• Speech therapy for treatment of delays in speech development, except as provided for by the plan. For more information, participants should contact Aetna.

• Spinal disorder, including care in connection with the detection and correction by manual or mechanical means of structural imbalance, distortion or dislocation in the human body or other physical treatment of any condition caused by or related to biomechanical or nerve conduction disorders of the spine including manipulation of the spine treatment, except as specifically provided for by the plan. For more information, participants should contact Aetna.

• Services, devices and supplies to enhance strength, physical condition, endurance or physical performance, including:
  
  • Exercise equipment, memberships in health or fitness clubs, training, advice or coaching,
  
  • Drugs or preparations to enhance strength, performance or endurance, and
  
  • Treatments, services and supplies to treat illnesses, injuries or disabilities related to the use of performance-enhancing drugs or preparations.

• Any of the following therapies, test treatments or procedures, unless medically necessary:
  
  • Aromatherapy,
  
  • Bio-feedback therapy,
  
  • Chelation therapy (except for heavy metal poisoning),
  
  • Computer-aided tomography (CAT) scanning of the entire body,
• Educational therapy,
• Gastric irrigation,
• Hair analysis,
• Hyperbaric therapy, except for the treatment of decompression or to promote healing of wounds,
• Hypnosis and hypnotherapy, except when performed by a physician as a form of anesthesia in connection with covered surgery,
• Lovaas therapy,
• Massage therapy,
• Purging,
• Recreational therapy,
• Sensory or auditory integration therapy,
• Sleep therapy,
• Thermograms and thermography.

• The transplant coverage does not include charges for:
  • Outpatient drugs including bio-medicals and immunosuppressant’s not expressly related to an outpatient transplant occurrence,
  • Services and supplies furnished to a donor when the recipient is not a covered participant,
  • Harvesting and/or storage of organs, without the expectation of immediate transplantation for an existing illness,
  • Harvesting and/or storage of bone marrow, tissue or stem cells without the expectation of transplantation within 12 months for an existing illness, or
  • Cornea (corneal graft with amniotic membrane) or cartilage (autologous chondrocyte or autologous osteochondral mosaicplasty) transplants, unless otherwise precertified by Aetna.

• Transportation costs, including ambulance services for routine transportation to
receive outpatient or inpatient services except as described in section of this handbook titled What is Covered Under the Deductible, PPO and OOA Plan.

- Unauthorized services, including any service obtained by or on behalf of a covered participant without precertification by Aetna when required. This exclusion does not apply in a medical emergency or in an urgent care situation.

- Weight: drug service or supply intended to decrease or increase body weight, control weight or treat obesity, including morbid obesity, regardless of the existence of comorbid conditions, including but not limited to:
  - Liposuction, surgical procedures, medical treatments, weight control/loss programs and other services and supplies that are primarily intended to treat or are related to the treatment of obesity, including morbid obesity,
  - Drugs, stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food or food supplements, appetite suppressants and other medications,
  - Counseling, coaching, training, hypnosis or other forms of therapy, and
  - Exercise programs, exercise equipment, membership to health or fitness clubs, recreational therapy, or other forms of activity or activity enhancement.

- Any illness or injury related to employment or self-employment including any illness or injury that arises out of (or in the course of) any work for pay or profit, unless no other source of coverage or reimbursement is available to the participant for the services or supplies. Sources of coverage or reimbursement may include the participant's employer, the Company, WC, or an occupational illness or similar program under local state or federal law. A source of coverage or reimbursement will be considered available to the participant even if the participant waived the right to payment from that source. If the participant is also covered under a WC law or similar law, and submits proof that the participant is not covered for a particular illness or injury under such law, that illness or injury will be considered non-occupational regardless of cause.

- Charges for an administration fee or the completion of claim forms or the filing of claims.

- Charges for services, supplies or treatment with respect to which benefits are provided under any other plan, except as described under the sections of this handbook titled Coordination of Benefits for the Aetna Retiree Medical Plans.

- Charges from care or treatment received as a result of injury or sickness caused by or contributed to by actions determined in the discretion of the BPAC (Benefit
Plans Administrative Committee) to constitute the commission or attempt to commit an illegal act or an assault, participation in a riot or public disturbance, or any other form of illegal behavior, whether or not the actions in question resulted in a criminal conviction.

- Claims which are not received within 24 months of the date services were incurred.
- Charges that have been previously billed and considered by the plan.
- Charges made by a surgeon for admission and complete history on the same day surgery is performed will not be paid as separate charges.
- Certain medical supply items:
  - Bathroom safety equipment, including rails and grab bars,
  - Car seats,
  - Chairs or recliners,
  - Environmental control equipment – all types, including air cleaners, air filters, air conditioner, dehumidifier, humidifier, puritron air freshener and portable room heaters,
  - Escalator,
  - Exercise equipment – including bikes and exercycles,
  - Food liquidizer/blender,
  - Ice bags,
  - Language master – Bell & Howell,
  - Niagara vibrator,
  - Non-prescription drugs,
  - Portable whirlpool pump, Jacuzzi whirlpool equipment,
  - Posture support chairs,
  - Professional medical equipment – including blood pressure kits and stethoscopes,
• Bathroom scale,
• Stair lift,
• Support stockings, all commercial types,
• Thermometers,
• Treadmill,
• Walking cane with seat, and
• Water bed.

• Any services for which no charge would have been made in the absence of a medical benefit plan.

• Charges for services, supplies or treatment not prescribed as necessary by:
  • A duly qualified physician or
  • Any other provider of service.

• Services paid under any plan that this plan modifies or replaces.

• Charges in excess of the applicable plan maximums.

• Charges for non-acute care in a residential treatment facility.

• Separate charges for stat fees.

• Charges for standby or on-call services by a physician.

• Charges incurred for a surrogate mother.

• Charges for travel, whether or not prescribed by a physician.

• Charges for individual procedures performed as part of a total procedure but charged separately (example: separate charges for removal of tubes and ovaries when performed as part of a total hysterectomy).

• Expenses incurred as a result of war.
- Specialty drugs (considered only through Express Scripts prescription coverage).

- Elective termination of a pregnancy, including related services, unless it is medically necessary.

Any reference with respect to drugs noted above applies only to drugs administered during an inpatient stay and approved by Aetna. The plans do not cover outpatient prescription drugs. Refer to the section of this handbook titled Express Scripts Prescription Drug Coverage for information on prescription coverage for participants enrolled in an Aetna medical plan.

Any exclusion above will not apply to the extent that coverage of the charges is required under any law that applies to the coverage. These excluded charges will not be used when figuring benefits.

The law of the jurisdiction where an individual lives when a claim occurs may prohibit some benefits. If so, they will not be paid.

For questions regarding whether or not a service is covered, participants should contact Aetna.
AETNA DEFINITIONS

The following definitions apply to benefits provided under the Deductible Plan, PPO Plan, the OOA Plan and the Aetna Dental Deductible Plans:

**Accident** – This means a sudden; unexpected; and unforeseen; identifiable occurrence or event producing, at the time, objective symptoms of a bodily injury. The accident must occur while the individual is covered under this contract. The occurrence or event must be definite as to time and place. It must not be due to, or contributed by, an illness or disease of any kind.

**Advanced Reproductive Technology Specialist** – A specialist physician who has entered into a contractual agreement with Aetna for the provision of covered ART services.

**Aetna** – Aetna Life Insurance Company.

**Ambulance** – A vehicle that is staffed with medical personnel and equipped to transport an ill or injured individual.

**Annual Maximum** – This is the most the plan will pay for covered expenses incurred by any one covered participant during the calendar year.

**Behavioral Health Provider/Practitioner** – A licensed organization or professional providing diagnostic, therapeutic or psychological services for behavioral health conditions.

**Birthing Center** – A freestanding facility that meets all of the following requirements:

- Meets licensing standards,
- Is set up, equipped and run to provide prenatal care, delivery and immediate postpartum care,
- Charges for its services,
- Is directed by at least one physician who is a specialist in obstetrics and gynecology,
- Has a physician or certified nurse midwife present at all births and during the immediate postpartum period,
- Extends staff privileges to physicians who practice obstetrics and gynecology in an area hospital,
- Has at least two beds or two birthing rooms for use by patients while in labor and
during delivery,

- Provides, during labor, delivery and the immediate postpartum period, full-time skilled nursing services directed by an R.N. or certified nurse midwife,

- Provides or arranges with a facility in the area for diagnostic x-ray and lab services for the mother and child,

- Has the capacity to administer a local anesthetic and to perform minor surgery. This includes episiotomy and repair of perineal tear,

- Is equipped and has trained staff to handle emergency medical conditions and provide immediate support measures to sustain life if:
  - Complications arise during labor, or
  - A child is born with an abnormality which impairs function or threatens life, and

- Accepts only patients with low-risk pregnancies,

- Has a written agreement with a hospital in the area for emergency transfer of a patient or a child. Written procedures for such a transfer must be displayed and the staff must be aware of them,

- Provides an ongoing quality assurance program. This includes reviews by physicians who do not own or direct the facility, and

- Keeps a medical record on each patient and child.

**Comprehensive Orthodontic Treatment of Adolescent Dentition** – Treatment involves procedures that reduce or eliminate an existing malocclusion with mixed (transitional) dentition. Treatment involves full banded braces. The down payment will be calculated based on 25% of the provider’s contracted fee or 25% of the out of network provider’s total case fee, paid at 50%. The remaining balance is divided into the months of treatment paid monthly at 50%.

**Comprehensive Orthodontic Treatment of Adult Dentition** – Treatment involves procedures that reduce or eliminate an existing malocclusion with permanent dentition. Treatment involves full banded braces. The down payment will be calculated based on 25% of the provider’s contracted fee or 25% of the out of network provider’s total case fee, paid at 50%. The remaining balance is divided into the months of treatment paid monthly at 50%.

**Cosmetic** – Services or supplies that alter, improve or enhance appearance.
Covered Expenses – Medical, dental, or hearing services and supplies shown as covered in this handbook.

Custodial Care – Services and supplies that are primarily intended to help a participant meet personal needs. Custodial care can be prescribed by a physician or given by trained medical personnel. It may involve artificial methods such as feeding tubes, ventilators or catheters. Examples of custodial care include:

- Routine patient care such as changing dressings, periodic turning and positioning in bed, and administering medications,
- Care of a stable tracheostomy (including intermittent suctioning),
- Care of a stable colostomy/ileostomy,
- Care of stable gastrostomy/jejunostomy/nasogastric tube (intermittent or continuous) feedings,
- Care of a stable indwelling bladder catheter (including emptying/changing containers and clamping tubing),
- Watching or protecting a participant,
- Respite care, adult (or child) day care, or convalescent care,
- Institutional care, including room and board for rest cures, adult day care and convalescent care,
- Help with the daily living activities, such as walking, grooming, bathing, dressing, getting in or out of bed, toileting, eating or preparing foods,
- Any services that an individual without medical or paramedical training could be trained to perform, and
- Any service that can be performed by an individual without any medical or paramedical training.

Deductible – The part of covered expenses a participant pays before the plan starts to pay benefits.

Dentist – A legally qualified dentist or physician licensed to do the dental work they perform.

Detoxification – The process by which an alcohol-intoxicated or drug-intoxicated, or an alcohol-dependent or drug-dependent individual is medically managed through the period of time necessary to eliminate, by metabolic or other means, the:
• Intoxicating alcohol or drug,
• Alcohol or drug-dependent factors, or
• Alcohol in combination with drugs,

as determined by a physician. The process must keep the physiological risk to the patient at a minimum, and take place in a facility that meets any applicable licensing standards established by the jurisdiction in which it is located.

**Directory** – A listing of all network providers serving covered participants. Network provider information is also available through Aetna’s online provider directory, DocFind®.

**DME** – The equipment and the accessories needed to operate it that is:

• Made to withstand prolonged use,
• Made for and mainly used in the treatment of a illness or injury,
• Suited for use in the home,
• Not normally of use to people who do not have a illness or injury,
• Not for use in altering air quality or temperature, and
• Not for exercise or training.

**Emergency Care** – This means the treatment given in a hospital's emergency room to evaluate and treat an emergency medical condition.

**Emergency Medical Condition** – A recent and severe medical condition, including (but not limited to) severe pain, which would lead a prudent layperson possessing an average knowledge of medicine and health, to believe that his or her condition, illness, or injury is of such a nature that failure to get immediate medical care could result in:

• Placing a participant’s health in serious jeopardy,
• Serious impairment to bodily function,
• Serious dysfunction of a body part or organ, or
• In the case of a pregnant woman, serious jeopardy to the health of the fetus.
Experimental or Investigational – A drug, a device, a procedure or treatment will be determined to be experimental or investigational if:

- There is insufficient outcome data available from controlled clinical trials published in the peer-reviewed literature to substantiate its safety and effectiveness for the illness or injury involved,
- Approval required by the FDA has not been granted for marketing,
- A recognized national medical or dental society or regulatory agency has determined, in writing, that it is experimental or investigational, or for research purposes,
- It is a type of drug, device or treatment that is the subject of a phase I or phase II clinical trial or the experimental or research arm of a phase III clinical trial, using the definition of phases indicated in regulations and other official actions and publications of the FDA and Department of Health and Human Services, or
- The written protocol or protocols used by the treating facility, or the protocol or protocols of any other facility studying substantially the same drug, device, procedure, or treatment, or the written informed consent used by the treating facility or by another facility studying the same drug, device, procedure or treatment states that it is experimental or investigational, or for research purposes.

Homebound – This means that the participant is confined to a place of residence:

- Due to an illness or injury which makes leaving the home medically contraindicated, or
- Because the act of transport would be a serious risk to life or health.

Home Health Care Agency – An agency that meets all of the following requirements:

- Mainly provides skilled nursing and other therapeutic services,
- Is associated with a professional group (of at least one physician and one R.N.) which makes policy,
- Has full-time supervision by a physician or an R.N.,
- Keeps complete medical records on each individual,
- Has an administrator, and
- Meets licensing standards.
Home Health Care Plan – This is a plan that provides for continued care and treatment of an illness or injury. The care and treatment must be:

- Prescribed in writing by the attending physician, and
- An alternative to a hospital or skilled nursing facility stay.

Hospice Care (Hospice) – This is care given to a terminally ill individual by or under arrangements with a hospice care agency. The care must be part of a hospice care program.

Hospice Care Agency – An agency or organization that meets all of the following requirements:

- Has hospice care available 24 hours a day,
- Meets any licensing or certification standards established by the jurisdiction where it is located,
- Provides:
  - Skilled nursing services,
  - Medical social services,
  - Psychological and dietary counseling, and
- Provides or arranges for, other services which include:
  - Physician services,
  - Physical and occupational therapy,
  - Part-time home health aide services which mainly consist of caring for terminally ill people, and
  - Inpatient care in a facility when needed for pain control and acute and chronic symptom management, and
- Has at least the following personnel:
  - One physician,
  - One R.N., and
• One licensed or certified social worker employed by the agency, and
• Establishes policies about how hospice care is provided,
• Assesses the patient's medical and social needs,
• Develops a hospice care program to meet those needs,
• Provides an ongoing quality assurance program. This includes reviews by physicians, other than those who own or direct the agency,
• Permits all area medical personnel to utilize its services for their patients,
• Keeps a medical record on each patient,
• Uses volunteers trained in providing services for non-medical needs, and
• Has a full-time administrator.

Hospice Care Program – This is a written plan of hospice care, which:
• Is established, and reviewed from time to time, by a physician attending the individual, and appropriate personnel of a hospice care agency,
• Is designed to provide palliative and supportive care to terminally ill individuals and supportive care to their families, and
• Includes an assessment of the participant’s medical and social needs, and a description of the care to be given to meet those needs.

Hospice Facility – A facility, or distinct part of one, that meets all of the following requirements:
• Mainly provides inpatient hospice care to terminally ill individuals,
• Charges patients for its services,
• Meets any licensing or certification standards established by the jurisdiction where it is located,
• Keeps a medical record on each patient,
• Provides an ongoing quality assurance program including reviews by physicians other than those who own or direct the facility,
• Is run by a staff of physicians. At least one staff physician must be on call at all times,

• Provides 24-hour-a-day nursing services under the direction of an R.N., and

• Has a full-time administrator.

**Hospital** – An institution that:

• Is primarily engaged in providing, on its premises, inpatient medical, surgical and diagnostic services,

• Is supervised by a staff of physicians,

• Provides 24 hour-a-day R.N. service,

• Charges patients for its services,

• Is operating in accordance with the laws of the jurisdiction in which it is located, and

• Does not meet all of the requirements above, but does meet the requirements of the jurisdiction in which it operates for licensing as a hospital and is accredited as a hospital by the Joint Commission on the Accreditation of Healthcare Organizations.

**Hospitalization** – Is necessary and continuous confinement as an inpatient in a hospital is required and a charge for room and board is made.

**Illness** – A pathological condition of the body that presents a group of clinical signs and symptoms and laboratory findings peculiar to it and that sets the condition apart as an abnormal entity differing from other normal or pathological body states.

**Infertile or Infertility** – The condition of a presumably healthy covered participant who is unable to conceive or produce conception after:

• For a woman who is under 35 years of age, one year or more of timed, unprotected coitus, or 12 cycles of artificial insemination, or

• For a woman who is 35 years of age or older, six months or more of timed, unprotected coitus, or six cycles of artificial insemination.

**Injury** – An accidental bodily injury that is the sole and direct result of:

• An unexpected or reasonably unforeseen occurrence or event, or
• The reasonable unforeseeable consequences of a voluntary act by the individual.

• An act or event must be definite as to time and place.

**Interceptive/Limited Orthodontic Treatment** – This is a limited objective treatment, which may not involve the entire dentition (the development and cutting of teeth). Treatment may include head-gear, a retainer or partial brackets. Treatment is payable at 50% in one lump sum.

**Jaw Joint Disorder** – This is:

• A Temporomandibular Joint (TMJ) dysfunction or any similar disorder of the jaw joint,

• A Myofacial Pain Dysfunction (MPD), or

• Any similar disorder in the relationship between the jaw joint and the related muscles and nerves.

**L.P.N.** – A licensed practical or vocational nurse.

**Maintenance Care** – Care made up of services and supplies that:

• Are furnished mainly to maintain, rather than to improve, a level of physical or mental function, and

• Provide a surrounding free from exposures that can worsen the participant’s physical or mental condition.

**Maximum Out-of-Pocket Limit** – The plan has a separate maximum out-of-pocket limits for network and out-of-network expenses. The network or out-of-network deductibles, payment percentage, copayments and other eligible out-of-pocket expense apply to the separate maximum out-of-pocket limits. Once the network and/or out-of-network out-of-pocket maximum is reached, the plan pays 100% of the covered network expenses for the remainder of that calendar year.

**Medically Necessary or Medical Necessity** – Health care or dental services, and supplies or prescription drugs that a physician, other health care provider or dental provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that provision of the service, supply or prescription drug is:

• In accordance with generally accepted standards of medical or dental practice,

• Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient’s illness, injury or disease,
• Not primarily for the convenience of the patient, physician, other health care or dental provider, and

• Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury, or disease.

For these purposes “generally accepted standards of medical or dental practice” means standards that are based on credible scientific evidence published in peer-reviewed literature generally recognized by the relevant medical or dental community, or otherwise consistent with physician or dental specialty society recommendations and the views of physicians or dentists practicing in relevant clinical areas and any other relevant factors.

**Morbid Obesity** – This means a body mass index that is: greater than 40 kilograms per meter squared, or equal to or greater than 35 kilograms per meter squared with a comorbid medical condition, including hypertension, a cardiopulmonary condition, sleep apnea or diabetes.

**Negotiated Charge** – The maximum charge a network provider has agreed to make as to any service or supply for the purpose of the benefits under this plan.

**Network Provider (Network)** – A health care provider who has contracted to furnish services or supplies for a negotiated charge, but only if the provider is, with Aetna's consent, included in the directory as a network provider for:

• The service or supply involved, and

• Eligible plan participants.

**Network Service(s) or Supply(ies)** – Health care service or supply that is:

• Furnished by a network provider, or

• Furnished or arranged by a Primary Care Physician (PCP).

**Non-Occupational Illness** – A non-occupational illness is an illness that does not:

• Arise out of (or in the course of) any work for pay or profit, or

• Result in any way from an illness that does.

An illness will be deemed to be non-occupational regardless of cause if proof is furnished that the individual:
• Is covered under any type of WC law, and
• Is not covered for that illness under such law.

**Non-Occupational Injury** – A non-occupational injury is an accidental bodily injury that does not:

• Arise out of (or in the course of) any work for pay or profit, or
• Result in any way from an injury which does.

**Non-Specialist** – A physician who is not a specialist.

**Non-Urgent Admission** – An inpatient admission that is not an emergency admission or an urgent admission.

**Occupational Injury or Occupational Illness** – An injury or illness that:

• Arises out of (or in the course of) any activity in connection with employment or self-employment whether or not on a full time basis, or
• Results in any way from an injury or illness that does.

**Occurrence** – This means a period of disease or injury. An occurrence ends when 60 consecutive days have passed during which the covered participant:

• Receives no medical treatment, services or supplies, for a disease or injury, and
• Neither takes any medication, nor has any medication prescribed for a disease or injury.

**Orthodontic Treatment** – This is any:

• Medical service or supply, or
• Dental service or supply,

furnished to prevent, diagnose or correct a misalignment:

• Of the teeth,
• Of the bite, or
• Of the jaws or jaw joint relationship,

whether or not for the purpose of relieving pain.
The following are not considered orthodontic treatment:

- The installation of a space maintainer, or
- A surgical procedure to correct malocclusion.

**Out-of-Network Service(s) and Supply(ies)/Out-of-Network** – Health care service or supply that is:

- Furnished by an out-of-network provider, or
- Not furnished or arranged by a PCP.

**Out-of-Network Provider** – A health care provider who has not contracted with Aetna to furnish services or supplies at a negotiated charge.

**Partial Confinement Treatment** – A plan of medical, psychiatric, nursing, counseling or therapeutic services to treat alcoholism, substance abuse or mental disorders. The plan must meet these tests:

- It is carried out in a hospital, psychiatric hospital or residential treatment facility on less than a full-time inpatient basis,
- It is in accord with accepted medical practice for the condition of the individual,
- It does not require full-time confinement,
- It is supervised by a psychiatric physician who weekly reviews and evaluates its effect, and
- Day care treatment and night care treatment are considered partial confinement treatment.

**Payment Percentage** – Payment percentage is both the percentage of covered expenses the plan pays, and the percentage of covered expenses a participant pays. The percentage the plan pays is referred to as the plan payment percentage, and varies by the type of expense.

**Pharmacy** – An establishment where prescription drugs are legally dispensed. Pharmacy includes a retail pharmacy, mail-order pharmacy and specialty pharmacy.

**Physician** – A duly licensed member of a medical profession who:

- Has an M.D. or D.O. degree,
• Is properly licensed or certified to provide medical care under the laws of the jurisdiction where the individual practices, and

• Provides medical services which are within the scope of their license or certificate.

This also includes a health professional who:

• Is properly licensed or certified to provide medical care under the laws of the jurisdiction where they practice,

• Provides medical services which are within the scope of their license or certificate,

• Under applicable insurance law is considered a physician for purposes of this coverage,

• Has the medical training and clinical expertise suitable to treat a condition,

• Specializes in psychiatry, if an illness or injury is caused, to any extent, by alcohol abuse, substance abuse or a mental disorder, and

• Is not the participant or related to the participant.

Post Treatment Stabilization (Retainer) – Considered all inclusive with the full treatment plan when using a contracted provider (not payable separately). If billed separately by out-of-network providers, may be payable at 50% under orthodontia.

Precertification or Precertify – A process where Aetna is contacted before certain services are provided, such as hospitalization or outpatient surgery, or prescription drugs are prescribed to determine whether the services being recommended or the drugs prescribed are considered covered expenses under the plan. It is not a guarantee that benefits will be payable.

Prescription – An order for the dispensing of a prescription drug by a prescriber. If it is an oral order, it must be promptly put in writing by the pharmacy.

Prescription Drug – A drug, biological or compounded prescription which, by state and federal law, may be dispensed only by prescription and which is required to be labeled "caution: federal law prohibits dispensing without prescription." This includes:

• An injectable drug prescribed to be self-administered or administered by any other individual except one who is acting within the capacity of a paid health care professional. Covered injectable drugs include injectable insulin.
Primary Care Physician – This is the network provider who:

- Is selected by a participant from the list of primary care physicians in the directory,
- Supervises, coordinates and provides initial care and basic medical services to an individual as a general or family care practitioner, or in some cases, as an internist or a pediatrician,
- Initiates referrals for specialist care and maintains continuity of patient care, and
- Is shown on Aetna's records as the participant's PCP.

Psychiatric Hospital – This is an institution that meets all of the following requirements:

- Mainly provides a program for the diagnosis, evaluation and treatment of alcoholism, substance abuse or mental disorders,
- Is not mainly a school or a custodial, recreational or training institution,
- Provides infirmary-level medical services. Also, it provides or arranges with a hospital in the area for any other medical service that may be required,
- Is supervised full-time by a psychiatric physician who is responsible for patient care and is there regularly,
- Is staffed by psychiatric physicians involved in care and treatment,
- Has a psychiatric physician present during the whole treatment day,
- Provides, at all times, psychiatric social work and nursing services,
- Provides, at all times, skilled nursing services by licensed nurses who are supervised by a full-time R.N,
- Prepares and maintains a written plan of treatment for each patient based on medical, psychological and social needs. The plan must be supervised by a psychiatric physician,
- Makes charges, and
- Meets licensing standards.
Psychiatric Physician – This is a physician who:

- Specializes in psychiatry, or
- Has the training or experience to do the required evaluation and treatment of alcoholism, substance abuse or mental disorders.

Recognized Charge – Only that part of a charge which is less than or equal to the recognized charge benefit. The recognized charge for a service or supply is the lowest of:

- The provider's usual charge for furnishing said service or supply, and
- The charge Aetna determines to be appropriate, based on factors such as the cost of providing the same or a similar service or supply and the manner in which charges for the service or supply are made, billed or coded, or the charge Aetna determines to be the prevailing charge level made for it in the geographic area where it is furnished.

In determining the recognized charge for a service or supply that is:

- Unusual, or
- Not often provided in the geographic area, or
- Provided by only a small number of providers in the geographic area,

Aetna may take into account factors, such as:

- The complexity,
- The degree of skill needed,
- The type of specialty of the provider,
- The range of services or supplies provided by a facility, and
- The recognized charge in other geographic areas.

In some circumstances, Aetna may have an agreement with a provider (either directly or indirectly through a third party) which sets the rate that Aetna will pay for a service or supply. In these instances, in spite of the methodology described above, the recognized charge is the rate established in such agreement.
Rehabilitation Facility – A facility, or a distinct part of a facility which provides rehabilitative services, meets any licensing or certification standards established by the jurisdiction where it is located, and makes charges for its services.

Rehabilitative Services – The combined and coordinated use of medical, social, educational and vocational measures for training or retraining if a participant is disabled by illness or injury.

Residential Treatment Facility (Alcoholism and Substance Abuse) – This is an institution that meets all of the following requirements:

- On-site licensed behavioral health provider 24 hours per day/seven days a week,
- Provides a comprehensive patient assessment (preferably before admission, but at least upon admission),
- Is admitted by a physician,
- Has access to necessary medical services 24 hours per day/seven days a week,
- If the member requires detoxification services, must have the availability of on-site medical treatment 24 hours per day/seven days a week, which must be actively supervised by an attending physician,
- Provides living arrangements that foster community living and peer interaction that are consistent with developmental needs,
- Offers group therapy sessions with at least an RN or Masters-Level Health Professional,
- Has the ability to involve family/support systems in therapy (required for children and adolescents, encouraged for adults),
- Provides access to at least weekly sessions with a psychiatrist or psychologist for individual psychotherapy,
- Has peer oriented activities,
- Services are managed by a licensed behavioral health provider who, while not needing to be individually contracted, needs to meet the Aetna credentialing criteria as an individual practitioner, and function under the direction/supervision of a licensed psychiatrist (medical director),
- Has individualized active treatment plan directed toward the alleviation of the impairment that caused the admission,
• Provides a level of skilled intervention consistent with patient risk,

• Meets any and all applicable licensing standards established by the jurisdiction in which it is located,

• Is not a wilderness treatment program or any such related or similar program, school and/or education service,

• Ability to assess and recognize withdrawal complications that threaten life or bodily functions and to obtain needed services either on site or externally,

• 24 hours per day/seven days a week supervision by a physician with evidence of close and frequent observation, and

• On-site, licensed behavioral health provider, medical or substance abuse professionals 24 hours per day/seven days a week.

Residential Treatment Facility (Mental Disorders) – This is an institution that meets all of the following requirements:

• On-site licensed behavioral health provider 24 hours per day/seven days a week,

• Provides a comprehensive patient assessment (preferably before admission, but at least upon admission),

• Is admitted by a physician,

• Has access to necessary medical services 24 hours per day/seven days a week,

• Provides living arrangements that foster community living and peer interaction that are consistent with developmental needs,

• Offers group therapy sessions with at least an RN or Masters-Level Health Professional,

• Has the ability to involve family/support systems in therapy (required for children and adolescents, encouraged for adults),

• Provides access to at least weekly sessions with a psychiatrist or psychologist for individual psychotherapy,

• Has peer oriented activities,

• Services are managed by a licensed behavioral health provider who, while not needing to be individually contracted, needs to meet the Aetna credentialing criteria as an individual practitioner, and function under the direction/supervision
of a licensed psychiatrist (medical director),

- Has individualized active treatment plan directed toward the alleviation of the impairment that caused the admission,

- Provides a level of skilled intervention consistent with patient risk,

- Meets any and all applicable licensing standards established by the jurisdiction in which it is located, and

- Is not a wilderness treatment program or any such related or similar program, school and/or education service.

R.N. – A registered nurse.

**Room and Board** – Charges made by an institution for room and board and other medically necessary services and supplies. The charges must be regularly made at a daily or weekly rate.

**Semi-Private Room Rate** – The room and board charge that an institution applies to the most beds in its semi-private rooms with two or more beds. If there are no such rooms, Aetna will calculate the rate based on the rate most commonly charged by similar institutions in the same geographic area.

**Service Area** – This is the geographic area, as determined by Aetna, in which network providers for this plan are located.

**Serious Mental Disorder** – This means the following serious mental disorders as defined in the most recent edition of the American Psychiatric Association’s "Diagnostic and Statistical Manual of Mental Disorders":

- Bipolar disorder,

- Major depressive disorder,

- Obsessive-compulsive disorder,

- Panic disorder,

- Paranoia and other psychotic disorders,

- Pervasive developmental disorder (autism),

- Schizoaffective disorder, and/or

- Schizophrenia.
Treatment is generally provided by, or under the direction of, a behavioral health provider such as a psychiatric physician, a psychologist or a psychiatric social worker.

**Skilled Nursing Facility** – An institution that meets all of the following requirements:

- It is licensed to provide, and does provide, the following on an inpatient basis for individuals convalescing from illness or injury:
  - Professional nursing care by an R.N., or by a L.P.N. directed by a full-time R.N., and
  - Physical restoration services to help patients to meet a goal of self-care in daily living activities, and
- Provides 24-hour a day nursing care by licensed nurses directed by a full-time R.N.,
- Is supervised full-time by a physician or an R.N.,
- Keeps a complete medical record on each patient,
- Has a utilization review plan,
- Is not mainly a place for rest, for the aged, for drug addicts, for alcoholics, for mental retardates, for custodial or educational care, or for care of mental disorders,
- Charges patients for its services,
- An institution or a distinct part of an institution that meets all of the following requirements:
  - It is licensed or approved under state or local law.
  - Is primarily engaged in providing skilled nursing care and related services for residents who require medical or nursing care, or rehabilitation services for the rehabilitation of injured, disabled or sick individuals, and
- Qualifies as a skilled nursing facility under Medicare or as an institution accredited by:
  - The Joint Commission on Accreditation of Health Care Organizations,
  - The Bureau of Hospitals of the American Osteopathic Association, or
• The Commission on the Accreditation of Rehabilitative Facilities.

Skilled nursing facilities also include rehabilitation hospitals (all levels of care, e.g. acute) and portions of a hospital designated for skilled or rehabilitation services.

**Skilled Nursing Services** – Services that meet all of the following requirements:

- The services require medical or paramedical training,
- The services are rendered by an R.N. or L.P.N. within the scope of their license, and
- The services are not custodial.

**Specialist** – A physician who practices in any generally accepted medical or surgical sub-specialty.

**Specialty Care** – Health care services or supplies that require the services of a specialist.

**Stay** – A full-time inpatient confinement for which a room and board charge is made.

**Substance Abuse** – This is a physical or psychological dependency, or both, on a controlled substance or alcohol agent (These are defined on axis I in the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association which is current as of the date services are rendered to the participant or their insured dependents). This term does not include conditions not attributable to a mental disorder that are a focus of attention or treatment (the V codes on axis I of DSM), an addiction to nicotine products, food or caffeine intoxication.

**Surgery Center** – A freestanding ambulatory surgical facility that meets all of the following requirements:

- Meets licensing standards,
- Is set up, equipped and run to provide general surgery,
- Charges for its services,
- Is directed by a staff of physicians. At least one of them must be on the premises when surgery is performed and during the recovery period,
- Has at least one certified anesthesiologist at the site when surgery requiring general or spinal anesthesia is performed and during the recovery period,
- Extends surgical staff privileges to:
• Physicians who practice surgery in an area hospital, and

• Dentists who perform oral surgery, and

• Has at least two operating rooms and one recovery room,

• Provides or arranges with a medical facility in the area for diagnostic x-ray and lab services needed in connection with surgery,

• Does not have a place for patients to stay overnight,

• Provides, in the operating and recovery rooms, full-time skilled nursing services directed by an R.N., and

• Is equipped and has trained staff to handle emergency medical conditions.

Must have all of the following:

• A physician trained in cardiopulmonary resuscitation,

• A defibrillator,

• A tracheotomy set,

• A blood volume expander,

• Has a written agreement with a hospital in the area for immediate emergency transfer of patients,

• Written procedures for such a transfer must be displayed and the staff must be aware of them,

• Physicians who do not own or direct the facility, and

• Keep a medical record on each patient.

**Terminally Ill** – Hospice Terminally Ill means a medical prognosis of six months or less to live.

**Urgent Admission** – A hospital admission by a physician due to:

• The onset of or change in a illness,

• The diagnosis of a illness, or
• An injury.

• The condition, while not needing an emergency admission, is severe enough to require confinement as an inpatient in a hospital within two weeks from the date the need for the confinement becomes apparent.

**Urgent Care Provider** – A freestanding medical facility that meets all of the following requirements:

• Provides unscheduled medical services to treat an urgent condition if the participant's physician is not reasonably available,

• Routinely provides ongoing unscheduled medical services for more than eight consecutive hours,

• Makes charges,

• Is licensed and certified as required by any state or federal law or regulation,

• Keeps a medical record on each patient,

• Provides an ongoing quality assurance program. This includes reviews by physicians other than those who own or direct the facility,

• Is run by a staff of physicians. At least one physician must be on call at all times,

• Has a full-time administrator who is a licensed physician, and

• A physician's office, but only one that:
  
  • Has contracted with Aetna to provide urgent care,

  • Is, with Aetna's consent, included in the directory as a network urgent care provider, and

  • Is not the emergency room or outpatient department of a hospital.

**Urgent Condition** – This means a sudden illness, injury or condition that:

• Is severe enough to require prompt medical attention to avoid serious deterioration of health,

• Includes a condition which would subject the participant to severe pain that could not be adequately managed without urgent care or treatment,
• Does not require the level of care provided in the emergency room of a hospital, and

• Requires immediate outpatient medical care that cannot be postponed until the participant’s physician becomes reasonably available.

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

**CLAIMS AND APPEALS DEFINITIONS**

**Adverse Benefit Determination** – A denial, reduction, termination of, or failure to provide or make payment (in whole or in part) for a service, supply or benefit.

Such adverse benefit determination may be based on:

• The claimant’s eligibility for coverage,

• The results of any utilization review activities,

• A determination that the service or supply is experimental or investigational, or

• A determination that the service or supply is not medically necessary.

**Appeal** – A written request to Aetna to reconsider an adverse benefit determination.

**Complaint** – Any written expression of dissatisfaction about quality of care or the operation of the plan.

**Concurrent Care Claim Extension** – A request to extend a previously approved course of treatment.

**Concurrent Care Claim Reduction or Termination** – A decision to reduce or terminate a previously approved course of treatment.

**Pre-Service Claim** – Any claim for medical care or treatment that requires approval before the medical care or treatment is received.

**Post-Service Claim** – Any claim that is not a pre-service claim.

**Urgent Care Claim** – Any claim for medical care or treatment in which a delay in treatment could:
• Jeopardize the claimant’s life,

• Jeopardize the claimant’s ability to regain maximum function,

• Cause the claimant to suffer severe pain that cannot be adequately managed without the requested medical care or treatment, or

• In the case of a pregnant woman, cause serious jeopardy to the health of the fetus.
COORDINATION OF BENEFITS FOR THE AETNA RETIREE MEDICAL PLANS

If a Deductible, PPO or OOA Plan (Aetna medical plan(s)) participant or a covered family member has other health coverage in addition to the coverage under an Aetna medical plan, benefits from the other plan may be taken into account when calculating the benefit amount payable from the Aetna medical plan.

- If Aetna is the primary carrier for the participant or covered family members, Aetna will pay claims as primary carrier.

- If the other health care coverage plan is primary over the Aetna plan, a reduction in benefits may occur. Under the coordination of benefits provision of the Aetna medical plans, the amount normally reimbursed under the medical plan is reduced to take into account payments made by other plans. The combined benefits of the Aetna plan and the other health care coverage plan will not be more than the expenses recognized under these Aetna plans.

Other plans include, but are not limited to:

- Group insurance,

- Any other type of coverage for individuals in a group. This includes plans that are insured and those that are not (i.e., state or local governmental programs, etc.), or

- No-fault auto insurance required by law and provided on other than a group basis. Only the level of benefits required by law will be counted.

When a participant has coverage under another medical plan, the order in which the other plan(s) will pay benefits must be determined. This will be done as follows using the first rule that applies:

1. A plan with no rules for coordination with other benefits will be deemed to pay its benefits before a plan which contains such rules.

2. A plan which covers an individual other than as a dependent will be deemed to pay its benefits before a plan which covers the individual as a dependent.

3. In the case of a dependent child of a married couple, common law married couple or a domestic partner union, the plan of the parent whose birthday is earlier in the calendar year will be primary. If both parents have the same birthday, the plan which covered one parent longer will be primary. If the other plan does not have the rule described in this provision (3), but instead has a rule based on the gender of the parent and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.
4. In the case of a dependent child whose parents are divorced or separated:

- If there is a court decree which states the parents shall share joint custody of a dependent child, without stating that one of the parents is responsible for the health care expenses of the child, the order in which the plan pays would be based on the rules specified in (3) above.

- If there is a court decree which makes one parent financially responsible for the medical, dental or other health care expenses of such dependent child, the benefits of the plan which covers the child as a dependent of such parent will pay first before the benefits of any other plan which covers the dependent child.

If there is not a court decree:

- And the parent with custody of the child has not remarried; the benefits of the parent’s plan with custody which covers the dependent child will pay first before the benefits of a parent’s plan without custody that covers the dependent child.

- And the parent with custody of the child has remarried; the benefits of the parent’s plan with custody which covers the dependent child will pay before the benefits of the stepparent’s plan which covers that dependent child. The benefits of the stepparent’s plan which covers that dependent child will be considered before the benefits of the parent’s plan without custody that covers that dependent child.

5. In the case of a dependent child that is eligible for coverage under the parent’s plan and is also married and covered under their spouse’s plan, the Longer/Shorter Rule applies. This means, whichever plan has covered the dependent for the longest amount of time will be considered the primary carrier.

6. If (1), (2), (3), (4) and (5) above do not establish an order of payment, the plan that has covered the dependent child the longest will be deemed to pay its benefits first; except that:

The benefits of a plan which covers the individual on whose expenses claim is based as:

- a laid-off or retired employee, or

- the dependent of such individual.

Shall be determined after the benefits of any other plan which covers the individual as:

- An employee who is not laid-off or retired, or
• The dependent of such individual.

If the other plan does not have a provision:

• regarding laid-off or retired employees, and

• as a result, each plan determines its benefits after the other,

then the above paragraph will not apply.

The benefits of a plan which covers the individual on whose expenses claim is based under a right of continuation pursuant to federal or state law shall be determined after the benefits of any other plan which covers the individual other than under such right of continuation.

If the other plan does not have a provision:

• regarding right of continuation pursuant to federal or state law, and

• as a result, each plan determines its benefits after the other,

then the above paragraph will not apply.

The general rule is that the benefits otherwise payable under an Aetna medical plan for all expenses processed during a single processed claim transaction will be reduced by the total benefits payable under all other plans for the same expenses. An exception to this rule is that when the coordination of benefits rules of the Aetna medical plan and any other plan both agree the Aetna medical plan is primary, the benefits of the other plan will be ignored in applying this rule. In this paragraph, a processed claim transaction is defined as a group of actual or prospective charges submitted to Aetna for consideration, that have been grouped together for administrative purposes as a claim transaction in accordance with Aetna's then current rules.

Certain facts about health care coverage and services are required to apply coordination of benefits rules to determine benefits under the Aetna medical plans and other plans. Aetna has the right to obtain or release any information, and make or recover any payments it considers necessary, in order to administer this provision.
AETNA CLAIMS AND APPEALS

The information in this section applies to the claims and appeals process under the Deductible Plan, PPO Plan, the OOA Plan and the Aetna Dental Plans.

Urgent Care Claims

Aetna will make notification of an urgent care claim determination as soon as possible but not more than 72 hours after the claim is made.

If more information is needed to make an urgent claim determination, Aetna will notify the claimant within 24 hours of receipt of the claim. The claimant has 48 hours after receiving such notice to provide Aetna with the additional information. Aetna will notify the claimant within 48 hours of the earlier of the receipt of the additional information or the end of the 48 hour period given the physician to provide Aetna with the information.

If the claimant fails to follow plan procedures for filing a claim, Aetna will notify the claimant within 24 hours following the failure to comply.

Pre-Service Claims

Aetna will make notification of a claim determination as soon as possible but not later than 15 calendar days after the pre-service claim is made. Aetna may determine that due to matters beyond its control an extension of this 15 calendar days claim determination period is required. Such an extension, of not longer than 15 additional calendar days, will be allowed if Aetna notifies participants within the first 15 calendar day period. If this extension is needed because Aetna needs additional information to make a claim determination, the notice of the extension shall specifically describe the required information. Participants will have 45 calendar days, from the date of the notice, to provide Aetna with the required information.

Post-Service Claims

Aetna will make notification of a claim determination as soon as possible but not later than 30 calendar days after the post-service claim is made. Aetna may determine that due to matters beyond its control an extension of this 30 calendar day claim determination period is required. Such an extension, of not longer than 15 additional calendar days, will be allowed if Aetna notifies the participant within the first 30 calendar day period. If this extension is needed because Aetna needs additional information to make a claim determination, the notice of the extension shall specifically describe the required information. The patient will have 45 calendar days, from the date of the notice, to provide Aetna with the required information.

Concurrent Care Claim Extension

Following a request for a concurrent care claim extension, Aetna will make notification
of a claim determination for emergency or urgent care as soon as possible but not later than 24 hours, with respect to emergency or urgent care provided the request is received at least 24 hours prior to the expiration of the approved course of treatment, and 15 calendar days with respect to all other care, following a request for a concurrent care claim extension.

**Concurrent Care Claim Reduction or Termination**

Aetna will make notification of a claim determination to reduce or terminate a previously approved course of treatment with enough time for the claimant to file an appeal.

**Complaints**

If the participant is dissatisfied with the service they receive from the plan or wants to issue a complaint about a provider they must write Aetna Customer Service within 30 calendar days of the incident. They must include a detailed description of the matter and include copies of any records or documents they think are relevant to the matter. Aetna will review the information and provide the participant with a written response within 30 calendar days of the receipt of the complaint, unless additional information is needed and it cannot be obtained within this period. The notice of the decision will tell the participant what they need to do to seek an additional review.

**Appeals of Adverse Benefit Determinations**

Claimants may submit an appeal if Aetna gives notice of an adverse benefit determination. This plan provides for two levels of appeal. It will also provide an option to request an external review of the adverse benefit determination.

Claimants have 180 calendar days following the receipt of notice of an adverse benefit determination to request a level one appeal. The appeal may be submitted verbally or in writing and should include the following:

- The participant’s name,
- Name of the policyholder, Valero Energy Corporation,
- A copy of Aetna’s notice of an adverse benefit determination,
- The participant’s reasons for making the appeal, and
- Any other information the participant would like to have considered.

The notice of an adverse benefit determination will include the address where the appeal can be sent. If the appeal is of an urgent nature, the claimant may call Aetna.
Claimants may also choose to have another individual (an authorized representative) make the appeal on their behalf by providing verbal or written consent to Aetna.

**GROUP HEALTH CLAIMS**

**Level One Appeal**

A level one appeal of an adverse benefit determination shall be provided by Aetna personnel not involved in making the adverse benefit determination.

**Urgent Care Claims**

Aetna shall issue a decision within 36 hours of receipt of the request for an appeal that may include concurrent care claim reduction or termination.

**Pre-Service Claims**

Aetna shall issue a decision within 15 calendar days of receipt of the request for an appeal that may include concurrent care claim reduction or termination.

**Post-Service Claims**

Aetna shall issue a decision within 30 calendar days of receipt of the request for an appeal.

Claimants may submit written comments, documents, records and other information relating to the claim, whether or not the comments, documents, records or other information were submitted in connection with the initial claim.

A copy of the specific rule, guideline or protocol relied upon in the adverse benefit determination will be provided free of charge upon request by the claimant or their authorized representative. Claimants may also request the plan provide, free of charge, copies of all documents, records and other information relevant to the claim.

**Level Two Appeal**

If Aetna upholds an adverse benefit determination at the first level of appeal, the claimant or their authorized representative has the right to file a level two appeal. The appeal must be submitted within 60 calendar days following the receipt of notice of a level one appeal.

A level two appeal of an adverse benefit determination of an urgent care claim, a pre-service claim or a post-service claim shall be provided by Aetna personnel not involved in making an adverse benefit determination.
Urgent Care Claims

Aetna shall issue a decision within 36 hours of receipt of the request for a level two appeal that may include concurrent care claim reduction or termination.

Pre-Service Claims

Aetna shall issue a decision within 15 calendar days of receipt of the request for a level two appeal that may include concurrent care claim reduction or termination.

Post-Service Claims

Aetna shall issue a decision within 30 calendar days of receipt of the request for a level two appeal. If the claimant does not agree with the final determination on review, they have the right to bring a civil action, if applicable.

Exhaustion of Process

Claimants must exhaust the applicable level one and level two processes of the appeal procedure before establishing any:

- Litigation,
- Arbitration or
- Administrative proceeding

regarding an alleged breach of the policy terms by Aetna Life Insurance Company or any matter within the scope of the appeals procedure.

How to File a Claim

The claim filing deadline for the Deductible Plan, PPO Plan, OOA Plan and the Aetna Dental Plans is 24 months from the date of service.

Claims should be mailed to the following address:

Aetna
Attn: Member Claims
P.O. Box 981106
El Paso, TX 79998-1106
Appeals should be mailed to the following address:

Aetna
Attn: National Account CRT
P.O. Box 14463
Lexington, KY 40512

Please keep a copy of the information for your records. For additional information you may contact Aetna.

**USE AND DISCLOSURE OF HEALTH INFORMATION**

This plan is permitted in some circumstances to disclose information relating to a participant’s health or coverage. Federal law limits the uses and disclosures the Aetna plans may make of a participant’s Protected Health Information (PHI). Refer to the section of this handbook titled [HIPAA Privacy Notice](#) for more details.

**AMENDMENT AND TERMINATION**

The Company reserves the right to amend in whole or in part any provision of this plan, including the right to terminate the plan altogether, at any time and for any reason, without regard to whether expenses have already been incurred by a participant or whether a course of treatment has been initiated. Participants should remember that any such amendment or termination of the plan could affect their future benefits and expectations from the Deductible, PPO and OOA Plan. If the plan should end, benefits will be paid for eligible charges incurred before the termination.
EXPRESS SCRIPTS PRESCRIPTION DRUG COVERAGE

HIGHLIGHTS

Non-Medicare eligible participant and their covered dependents enrolled in an Aetna retiree medical plan have prescription drug coverage through Express Scripts, Inc. (ESI).

The pharmacist will fill the prescription with a generic substitute unless the physician indicates otherwise. If a physician does not indicate that a brand name drug is required and the participant requests the brand name drug, the participant will pay the difference between the cost of the brand name and the generic, in addition to the copayment and/or deductible.


PRESCRIPTION DEDUCTIBLE

Participants will pay a $50 individual calendar year deductible for retail and/or Home Delivery preferred brand-name and non-preferred brand-name drugs each calendar year. The $50 individual calendar year deductible will be waived for all generic drugs filled at a retail location or through Home Delivery. There is an additional $50 deductible for Accredo specialty drugs.

OUT-OF-POCKET MAXIMUM

The prescription drug program has an annual individual out-of-pocket maximum of $4,100 and an annual family out-of-pocket maximum of $8,200, which includes any specialty medication out-of-pocket maximum. After you reach your annual out-of-pocket maximum, you will no longer be responsible for additional copayments for medications during that plan year.

RETAIL PHARMACY PRESCRIPTIONS

Participants pay the pharmacy a retail copayment of $7 for generic drugs, a $20 for preferred brand-name drugs and a $35 for non-preferred brand-name drugs for a maximum 30-day supply. ESI will bill the Company for the balance. Completion of claim forms is necessary when prescriptions are filled at a non-participating pharmacy or when a participant pays out-of-pocket at a participating pharmacy. Claims filed by the participant will be paid by ESI according to the contracted rate, minus the appropriate copayment and/or deductible.
RETAIL90 MAINTENANCE DRUG PROGRAM (MDP)

The Retail90 MDP allows participants to fill the first two 30-day prescriptions of maintenance medication through a retail pharmacy at the normal copayment before requiring the participant to either submit their maintenance medication through the Home Delivery program or through a participating Retail90 MDP pharmacy. Beginning with the third prescription fill, Retail90 MDP requires the prescription for maintenance medications to be between an 84 to 90-day supply. The Retail90 MDP allows participants to fill an 84 to 90-day supply of maintenance medication for a $15 copayment for generic drugs, a $40 copayment for preferred brand-name drugs and a $70 copayment for non-preferred brand-name drugs. To find a Retail90 MDP participating pharmacy go online to www.express-scripts.com.

HOME DELIVERY

The Home Delivery program allows participants to fill up to a 90-day supply of maintenance medication for a $15 copayment for generic drugs, a $40 copayment for preferred brand-name drugs and a $70 copayment for non-preferred brand-name drugs. Home Delivery does not apply to Accredo specialty drugs. Specialty drug prescriptions for a 90-day supply will be rejected. For additional information regarding Accredo specialty drug copayments, refer to the section of this handbook titled Accredo Specialty Program.

PRESCRIPTION PREVENTIVE MEDICATION

Under the Patient Protection and Affordable Care Act (ACA) guidelines, plan sponsors are now required to cover certain preventive drugs at no charge to plan participants. The preventive drugs or categories of drugs that are offered at no charge to participants in the Valero sponsored medical plans are listed below. Please note, coverage associated with ACA may be subject to change throughout the year.

- Aspirin
- Fluoride
- Folic Acid
- Immunizations
- Iron
- Smoking Cessation Agents
- Vitamin D
- Bowel Preps
• Contraceptives
• Certain breast cancer medications

**STEP THERAPY**

Step Therapy is a program for people who take prescription drugs regularly to treat an ongoing medical condition. Only new prescriptions under the Step Therapy drug classes will be affected by these guidelines. The list of drugs subject to the Step Therapy program may be found online at [www.express-scripts.com](http://www.express-scripts.com) or obtained from ESI by calling (800) 294-5060.

Within all Step Therapy programs, all brand drugs that have a generic equivalent are non-formulary. The program makes prescription drugs more affordable for most participants and helps the Company control the rising cost of drugs. In Step Therapy, the covered drugs are organized in a series of steps with a physician approving and writing the prescriptions. The first step is generic drugs. Generic drugs covered by the program have been tested and approved by the United States Food and Drug Administration and have been proven to be effective in treating many medical conditions. The first step allows participants to receive treatment with safe, effective prescription drugs that are also affordable. The participant must have tried one or two first step medication within the past 130 days before a second step medication will be covered (unless otherwise indicated). The second step is a more expensive brand-name drug. The participant’s physician is consulted, approving and writing prescriptions based on the list of Step Therapy drugs covered by the program. The participant’s physician must write a new prescription when changing to a drug covered under a different step in the program.

**GLUCOSE MONITORS**

The Blood Glucose Monitoring program encourages diabetes management by offering one free meter to plan participants. Glucose monitors are limited to the brand(s) listed on the Express Scripts National Formulary. For information on how to obtain a free glucose monitor, participants should contact ESI at (800) 294-5060.

**PRIOR AUTHORIZATION**

The Prior Authorization program monitors certain prescription drugs and their costs so the participant can get the right drug at the right cost. For example, a medicine may be in the program because it treats a serious skin condition, but it could also be used for cosmetic purposes, such as reducing wrinkles. To make sure the medicine is used to treat a medical condition and not for general health and wellness, the plan may cover it only when a physician prescribes it for a medical condition. A Prior Authorization is required for these types of drugs.
PROTON PUMP INHIBITORS (PPI)

The quantity limit for Proton Pump Inhibitors allows a maximum fill of two pills per day for the 10mg and 20mg pills and one pill per day for the 30mg and 40mg pills for a 30-day supply. The participant will pay the out-of-pocket cost for additional pills per day.

HOW TO USE THE PRESCRIPTION BENEFITS

Retail Pharmacy or a Retail90 MDP for Maintenance Medications

1. Participants should visit a participating ESI pharmacy.

   Participating pharmacies are available nationwide and include most national chains and independent pharmacies. To determine if a pharmacy is part of the ESI network, the participant should ask the pharmacist, go online to [www.express-scripts.com](http://www.express-scripts.com), or contact ESI at (800) 294-5060.

2. Present the ESI card and your prescription to the retail pharmacy or the Retail90 MDP pharmacist.

   The pharmacist may ask the participant to verify certain information. The pharmacist may also contact ESI’s Pharmacy Help Desk at (800) 922-1557 for claim assistance or additional information.

3. Pay the required copayment and/or deductible.

Home Delivery Service

1. Participants should have a prescription for up to a 90-day supply with three refills.

   If a medication is needed immediately, the participant should ask the physician to issue two prescriptions: one for an immediate supply to be taken to a local participating pharmacy and a second for an extended supply to be mailed to ESI’s Home Delivery service.

2. Participants should complete all sections of the Home Delivery information form for the first Home Delivery order.

   Forms are available in the ESI packet that is sent with the ID cards. To update a participant’s personal profile, they should complete section 1 of the ESI Home Delivery form and mail the form to ESI.

3. Refill a prescription online or by completing a Home Delivery form.

4. To file an original prescription, the Home Delivery form must be completed and mailed with the copayment to:
Participants should include the appropriate payment, or provide credit card information with the order. Participants should allow 10 to 14 days from the date that the participant mails the prescription order for delivery.

5. Order refills by phone or online:
   - To order refills by phone, participants should call patient services at (800) 294-5060.
   - Prescriptions may also be refilled online to www.express-scripts.com.

6. Transferring current prescriptions from retail to Home Delivery.

Participants interested in transferring current prescriptions from retail to Home Delivery may call ESI at (800) 294-5060 or go online to www.express-scripts.com and request to convert the current retail script to home delivery. ESI will contact the physician to obtain a new 90-day prescription. Once the prescription is received, ESI will fill the medication for standard home delivery at no extra shipping charge. The cost of overnight shipping is $21 (does not include processing time).

**PREFERRED DRUGS**

The Express Scripts National Preferred Formulary list may be subject to change and may be viewed at www.express-scripts.com. It is an abbreviated version of the drug list (formulary) that is at the core of the pharmacy benefit plan. The list is not all-inclusive and does not guarantee coverage. Not all drugs listed are covered by all pharmacy benefit programs. For specific information regarding drugs not listed on the Express Scripts Formulary, participants should contact ESI at (800) 294-5060.

**ACCREDO SPECIALTY PROGRAM**

The ESI prescription program includes a delivery service for specialty drugs through Accredo pharmacy. There is an additional $50 deductible for specialty drugs. The participant also pays a 20% coinsurance, with a maximum out-of-pocket of $250 per script. There is also an individual maximum out-of-pocket maximum of $1,000 per year. After a participant reaches the $1,000 maximum, the plan pays 100% of covered specialty drugs. Routine drugs such as insulin and allergy serum are not considered specialty drugs. After one fill at any network pharmacy, specialty drugs are covered only through the Accredo program.
Under the Accredo program, participants will receive additional benefits of:

- Program enrollment with just one phone call to Accredo. Accredo will then call the participant’s physician for a prescription, and call the participant to schedule delivery.

- Convenient overnight delivery to the participant’s home, work or physician’s office within 48 hours of ordering,

- Free administration supplies. Participants are not charged for needles, syringes, bandages, sharps containers or any supplies needed for the injection program,

- Consultation with a pharmacist or nurse experienced in specialty drugs is available 24 hours a day,

- Contact by the Accredo team initiating delivery arrangements and refill reminders each month, and

- Dedicated customer service representatives trained to handle Accredo calls.

Participants should contact ESI at (800) 294-5060 for information concerning specific prescription drug coverage. Other drugs covered under the program are available through the retail or Home Delivery service program. For more information or to begin using Accredo call ESI at (800) 278-0980.

**WHAT THE PRESCRIPTION BENEFIT DOES NOT COVER**

Certain services and supplies may be excluded or limited. Some of the expenses not covered are listed below:

- Drugs used for the purpose of weight loss or weight management,

- Anti-wrinkle agents, depigmentation products or any drugs prescribed for cosmetic purposes,

- Hair growth stimulants,

- Dietary supplements,

- Non-prescription drugs,

- Over the counter drugs or prescription drugs with equivalent products available over the counter,

- Lifestyle enhancing drugs and devices,
• Therapeutic devices or appliances, including support garments and other non-medicinal substances,

• Charges for the administration or injection of any drug,

• Experimental or investigational drugs,

• DME, including peak flow meters and ostomy supplies,

• Legend homeopathic drugs,

• Medical foods, and

• Prescriptions that exceed the ESI quantity limit (i.e., PPIs).

Summary of Benefits and Coverage (SBC)

Summaries of the prescription plan coverage can be found in the Aetna SBCs. Please refer to Exhibit A at the end of this handbook for a copy of the Deductible Plan SBC.

Please refer to Exhibit B at the end of this handbook for a copy of the PPO Plan SBC.

Please refer to Exhibit C at the end of this handbook for a copy of the OOA Plan SBC.

WHEN MEDICAL (INCLUDES PRESCRIPTION DRUG COVERAGE) COVERAGE BEGINS AND ENDS

For information on when coverage begins and ends, refer to the section of this handbook titled Plan Administration.
The Valero sponsored Medicare supplement plans are offered through AmWINS and are fully insured plans with United American. United American is an A.M. Best rated “A+ Superior” insurance company.

There are three Medicare supplement plans available, so retirees may choose the plan that best meets their needs. Please be advised that all Medicare eligible members of one household must be enrolled in the same Medicare supplement plan. Therefore, if someone in your household is already enrolled in a Valero sponsored Medicare supplement plan, you must enroll in the same plan they have elected.

When you enroll in a Valero sponsored Medicare supplement plan, the plan becomes effective on the first day of the month you are Medicare eligible. Participants enrolling in a Medicare supplement plan will be automatically enrolled in the Valero sponsored Medicare Part D Prescription Drug Program.

Please refer to Exhibit D at the end of this handbook for a copy of the Medicare supplement plans and Medicare Part D Prescription Drug Program Benefits Summary.
AETNA RETIREE DENTAL $50 DEDUCTIBLE PLAN

The Aetna Retiree Dental Deductible Plan (Dental Plan), the Dental Plan helps pay for a wide range of dental expenses for the treatment of non work-related illness or injury. The Dental Plan provides coverage for preventive and diagnostic care, basic and major restorative care, and orthodontic dental services.

HIGHLIGHTS

Providers are encouraged to file claims electronically and should call Aetna at (800) 843-3661 for coverage inquiries prior to services being rendered.

Participants enrolled in the Dental Plan can visit the dental provider of their choice when dental care is needed. If a participant chooses a dental provider that is in the dental network, they may pay less out-of-pocket than when they choose an out-of-network provider.

Preventive and Diagnostic Care – The Dental Plan pays 100% of the negotiated charges for covered services and supplies. No deductible applies to preventive and diagnostic care. Covered services include sealants, two routine exams, two problem focused exams, two fluoride treatments and four cleanings per year. The Dental Plan also covers 100% of one set of bitewing x-rays and one panoramic film x-ray or one full mouth series x-ray per year.

Basic and Major Restorative Care – The Dental Plan pays 80% of the negotiated charges for covered services and supplies. Participants must pay a $50 individual calendar year deductible before the Dental Plan begins paying expenses. Basic care includes the extraction of impacted wisdom teeth, root canals, fillings, crowns, dentures, and necessary care as the result of an accidental injury and most other dental procedures. The calendar year maximum benefit for basic and major restorative care is $2,500 per individual.

Orthodontic Care – The Dental Plan pays 50% of the cost of orthodontic care, up to an orthodontic lifetime maximum benefit of $2,000 per individual payable over the comprehensive treatment period. Interceptive/limited treatment is payable in one lump sum. No deductible applies to orthodontic care expenses.

Networks

Participants should refer to www.aetna.com for network provider information. The Aetna network is the “Dental PPO/PDN with PPOII Network.”
HOW THE DENTAL PLAN WORKS

The Dental Plan is a Preferred Provider Organization (PPO) that covers a wide range of dental services and supplies. Participants enrolled in the Dental Plan can visit the dental provider of their choice when dental care is needed.

Participants will receive an EOB of what the Dental Plan has paid toward covered expenses. It will indicate any amounts owed towards the individual calendar year deductible, payment percentage or other non-covered expenses incurred. Participants may elect to receive this notification by email or through the mail.

Course of Dental Treatment

A course of dental treatment is a planned program of one or more services or supplies. The services or supplies are provided by one or more dentists to treat a dental condition that was diagnosed by the attending dentist as a result of an oral examination. A course of treatment starts on the date a participant’s dentist first renders a service to correct or treat the diagnosed dental condition.

Availability of Providers

Aetna cannot guarantee the availability or continued participation of a particular provider. Either Aetna or any network provider may terminate the provider contract or limit the number of patients accepted in a practice.

Using Network Providers

- Out-of-pocket expenses will be lower when care is provided by a network provider.
- The Dental Plan begins to pay benefits for basic and major restorative care after the individual calendar year deductible has been satisfied.
- Participants share the cost of covered services and supplies by paying a portion of certain expenses (the participant’s payment percentage). Network providers have agreed to provide covered services and supplies at a negotiated charge.
- The participant’s payment percentage is based on the negotiated charge. In no event will the participant have to pay any amounts above the negotiated charge for a covered service or supply. Participants have no further out-of-pocket expenses when the Dental Plan covers network services at 100%.
- Participants will not have to submit dental claims for treatment received from network providers. The network provider will take care of claim submission. Participants will be responsible for deductibles and payment percentage, if any.
Using Out-of-Network Providers

- Participants can obtain dental care from dental providers who are not in the network. The Dental Plan covers out-of-network services and supplies, but the participant’s expenses will generally be higher.

- Participants must satisfy a deductible before the plan begins to pay benefits and will share the cost of covered services and supplies by paying a portion of certain expenses (the participant’s payment percentage).

If an out-of-network provider charges more than the recognized charge, the participant will be responsible for any expenses incurred above the recognized charge. The recognized charge is the maximum amount Aetna will pay for a covered expense from an out-of-network provider.

Advance Claim Reviews

The purpose of the advance claim review is to determine, in advance, the benefits the plan will pay for proposed services. The pre-treatment review process is not a guarantee of benefit payment, but rather an estimate of the amount or scope of benefits to be paid. The advance claim review is voluntary. It is a service that provides the participant with information to consider before deciding on a course of treatment. It is not necessary for emergency treatment or routine care such as cleaning teeth or check-ups.

In determining the amount of benefits payable, Aetna will take into account alternate procedures, services or courses of treatment for the dental condition in question in order to accomplish the anticipated result. For information on alternate procedures, services or courses of treatment under the Dental Plan, refer to the subsection titled “Alternate Treatment Rule” under the section of this summary titled Rules and Limits.

When to Get an Advance Claim Review

An advance claim review is recommended whenever a course of dental treatment is likely to cost more than $500. Prior to beginning treatment, the participant should request that the dentist complete and mail to Aetna an Aetna claim form or an American Dental Association (ADA) approved claim form detailing a full description of the treatment needed. Aetna may request supporting x-rays and other diagnostic records. Once all of the information has been gathered, Aetna will review the proposed treatment plan and provide the participant and the dentist with a statement outlining the benefits payable by the Dental Plan.
WHAT THE DENTAL PLAN PAYS FOR

The Dental Plan will cover services and supplies that meet the following:

- Services and supplies must be medically necessary,
- Services and supplies must be covered by the Dental Plan, and
- The participant must be covered by the Dental Plan when an expense is incurred.

If a charge is made for an unlisted service given for the dental care of a specific condition, the charge will be considered to have been made for a service in the list that Aetna determines would have produced a professionally acceptable result if the list includes one or more services that, under standard practices, are separately suitable for the dental care of that condition.

Preventative and Diagnostic Care

The following are covered services and supplies under the diagnostic and preventative care provisions of the Dental Plan.

Visits and X-Rays

- Routine comprehensive examination (limited to two visits every calendar year),
- Problem-focused examination (limited to two visits every calendar year),
- Prophylaxis (cleaning) (limited to four treatments per calendar year),
- Topical application of fluoride (limited to two courses of treatment per calendar year),
- Sealants (per tooth for permanent molars only),
- Bitewing x-rays (limited to one set per calendar year),
- Complete x-ray series, including bitewings, if necessary, or panoramic film (limited to one set per calendar year).

Basic Restorative Care

The following are covered services and supplies under the basic restorative care provisions of the Dental Plan.
Visits and X-Rays

• Professional visit after hours (payment will be made on the basis of services rendered or visit, whichever is greater), or

• Emergency palliative treatment, per visit.

X-Ray and Pathology

• Periapical x-rays (up to 13 single films),
• Intra-oral, occlusal view, maxillary or mandibular,
• Upper or lower jaw, extra-oral,
• Vertical bitewing x-rays
• Biopsy and histopathologic examination of oral tissue, and
• Diagnostic casts.

Oral Surgery

• Extractions:
  • Erupted tooth or exposed root,
  • Coronal remnants,
  • Surgical removal of erupted tooth/root tip, and
  • Postoperative visit (sutures and complications) after multiple extractions and impaction.

• Impacted teeth:
  • Removal of tooth, and
  • Removal of soft tissue impactions.

• Alveolar of gingival reconstructions:
  • Alveolectomy (edentulous) per quadrant,
  • Alveolectomy (in addition to removal of teeth) per quadrant,
• Alveoplasty with ridge extension per arch,
• Removal of exostosis,
• Excision of hyperplastic tissue per arch, and
• Excision of pericoronal gingiva.

• Odontogenic cysts and neoplasms:
  • Incision and drainage of abscess, and
  • Removal of odontogenic cyst or tumor.

• Other surgical procedures:
  • Sialolithotomy (removal of salivary calculus),
  • Closure of salivary fistula,
  • Dilation of salivary duct,
  • Transplantation of tooth or tooth bud,
  • Removal of foreign body from bone (independent procedure),
  • Closure of oral fistula of maxillary sinus,
  • Sequestrectomy for osteomyelitis or bone abscess (superficial),
  • Crown exposure to aid eruption,
  • Removal of foreign body from soft tissue,
  • Frenectomy, and
  • Suture of soft tissue injury.

Periodontics

• Occlusal adjustment (other than with an appliance or by restoration),
• Root planning and scaling, per quadrant (limited to four separate quadrants per calendar year),
• Root planning and scaling - one to three teeth per quadrant (limited to once per site every calendar year),

• Gingivectomy - per quadrant,

• Gingivectomy - one to three teeth per quadrant,

• Gingival flap procedure, including root planning - per quadrant,

• Gingival flap procedure, including root planning - one to three teeth per quadrant,

• Periodontal maintenance procedures following active therapy, and

• Localized delivery of antimicrobial agents.

Endodontics

• Pulp capping,

• Pulpotomy,

• Apexification/recalcification,

• Apicoectomy, and

• Root canal therapy including necessary x-rays (anterior and bicuspid).

Restorative Dentistry

Restorative dentistry excludes inlays, crowns (other than prefabricated stainless steel or resin) and bridges. Multiple restorations in one surface will be considered as a single restoration.

• Amalgam restorations,

• Resin-based composite restorations (other than for molars),

• Sedative fillings,

• Pin retention - per tooth, in addition to amalgam or resin restoration,

• Crowns (when tooth cannot be restored with a filling material):

  • Prefabricated stainless steel, and
• Prefabricated resin crown (excluding temporary crowns).

• Recementation:
  • Inlay
  • Crown
  • Bridge

• Fixed (unilateral or bilateral)
• Removable (unilateral or bilateral)

**Space Maintainers**

Space maintainers are only approved when needed to preserve space resulting from premature loss of primary teeth (includes all adjustments within six months after installation).

**Major Restorative Care**

General Anesthesia and Intravenous Sedation are covered (only when medically necessary and only when provided in conjunction with a covered surgical procedure).

Inlays, onlays, labial veneers and crowns are covered only as treatment for decay or acute traumatic injury and only when teeth cannot be restored with a filling material or when the tooth is an abutment to a fixed bridge. Major restorative care is limited to one per tooth every five years. For more information on the major restorative care limits, refer to the section of this summary titled Rules and Limits. *It is recommended that a pre-treatment estimate be requested for any treatment costs $300 or higher.*

• Implants,
• Inlays/onlays,
• Labial veneers,
• Crowns,
• Full and partial denture repairs
  • Broken dentures (no teeth involved),
  • Repair cast framework,
• Replacing missing or broken teeth (each tooth),

• Post and core, and

• Repairs for crowns and bridges.

The following are covered services and supplies under the major restorative care provisions of the Dental Plan.

**Periodontics**

• Osseous surgery (including flap entry and closure) – one to three teeth per quadrant,

• Osseous surgery (including flap entry and closure) – per quadrant, and

• Soft tissue graft procedures.

**Endodontics**

• Molar root canal therapy including necessary x-rays.

**Prosthodontics**

First installation of dentures and bridges is covered only if needed to replace teeth previously extracted if extraction is not less than five years old. Replacement of existing bridges or dentures is limited to one every five years for any previously installed prosthetics and crowns.

• Bridge abutments (see inlays and crowns),

• Pontics,

• Removable bridge (unilateral),

• Dentures and partials (Fees for dentures and partial dentures include relines, rebases and adjustments within six months after installation. Fees for relines and rebases include adjustments within six months after installation. Specialized techniques and characterizations are not eligible),

• Complete upper denture,

• Complete lower denture,
• Partial upper or lower, resin base (including any conventional clasps, rests and teeth),

• Partial upper or lower, cast metal base with resin saddles (including any conventional clasps, rests and teeth),

• Stress breakers,

• Interim partial denture (stayplate), anterior only,

• Office reline,

• Laboratory reline,

• Special tissue conditioning per denture,

• Rebase per denture,

• Adjustment to denture more than six months after installation, and

• Adding teeth to existing partial – each tooth and each clasp.

**Oral Surgery**

• Impacted teeth:

  • Removal of partially bony/fully bony impactions.

**Miscellaneous Services**

• Occlusal guard (for bruxism only)

**Orthodontics Services**

Orthodontic services include the appliance necessary to straighten and reposition teeth, including examinations and the installation and adjustment of appliances.

Charges for orthodontic dental services shall be deemed incurred on the date the initial appliance is placed. Orthodontic claims will be paid in installments for comprehensive treatment or a lump sum for interceptive and limited treatment. The first down payment will be made at the time the appliance is placed based on 25% of the provider’s contracted fee or 25% of the out of network provider’s total case fee, payable at 50%. The remaining allowable of the total fee will be considered on a monthly basis based upon the treatment time indicated on the initial claim until the total allowed charge or the lifetime maximum has been paid. The initial itemized claim including the total treatment
plan must be filed with Aetna. Monthly visit fees will be processed automatically based upon the initial filing information.

Orthodontic services shall include, but are not limited to:

- Interceptive orthodontic treatment,
- Limited orthodontic treatment,
- Comprehensive orthodontic treatment of adolescent dentition,
- Comprehensive orthodontic treatment of adult dentition, and
- Post treatment stabilization uprising.

**Orthodontic Treatment Rule**

The Dental Plan does not cover the following orthodontic services and supplies:

- Replacement of broken appliances,
- Re-treatment of orthodontic cases,
- Changes in treatment necessitated by an accident,
- Maxillofacial surgery,
- Myofunctional therapy,
- Treatment of cleft palate,
- Treatment of micrognathia,
- Treatment of macroglossia,
- Lingually placed direct bonded appliances and arch wires (i.e., invisible braces),
- Removable acrylic aligners (i.e., invisible aligners),
- Removable inhibiting appliance to correct thumbsucking, or
- Fixed or cemented inhibiting appliance to correct thumbsucking.
RULES AND LIMITS

Several rules apply to the Dental Plan. Participants should observe these rules to avoid expenses that are not covered by the Dental Plan.

Replacement Rule

Crowns, inlays, onlays and veneers, complete dentures, removable partial dentures, fixed partial dentures (bridges) and other prosthetic services are subject to the Dental Plan’s replacement rule. That means certain replacements of, or additions to, existing crowns, inlays, onlays, veneers, dentures or bridges are covered only when the participant provides proof to Aetna that:

- While the participant was covered by the Dental Plan, the participant had a tooth (or teeth) extracted after the existing denture or bridge was installed. As a result, the participant needs to replace or add teeth to their denture or bridge.

- The present crown, inlay and onlay, veneer, complete denture, removable partial denture, fixed partial denture (bridge) or other prosthetic service was installed at least five years before its replacement and cannot be made serviceable.

- The participant had a tooth (or teeth) extracted while the participant was covered by the Dental Plan. The present denture is an immediate temporary one that replaces that tooth (or teeth). A permanent denture is needed, and the temporary denture cannot be used as a permanent denture. Replacement must occur within 12 months from the date that the temporary denture was installed.

Alternate Treatment Rule

Sometimes there are several ways to treat a dental problem, all of which provide acceptable results. When alternate services or supplies can be used, the Dental Plan's coverage will be limited to the cost of the least expensive service or supply that is:

- Customarily used nationwide for treatment, and

- Deemed by the dental profession to be appropriate for treatment of the condition in question. The service or supply must meet broadly accepted standards of dental practice, taking into account the participant’s current oral condition.

The participant should review the differences in the cost of alternate treatment with the dental provider. The participant and the dental provider can still choose the more costly treatment method, but the participant is responsible for any charges in excess of what the Dental Plan will cover.
Coverage for Dental Work Begun before a Participant is Covered by the Plan

The Dental Plan does not cover dental work that began before a participant is covered by the Dental Plan. This means that the following dental work is not covered:

- An appliance or modification of an appliance, if an impression for it was made before a participant is covered by the Dental Plan,
- A crown, bridge or cast or processed restoration, if a tooth was prepared for it before the participant is covered by the Dental Plan, or
- Root canal therapy, if the pulp chamber for it was opened before the participant is covered by the Dental Plan.

**WHAT THE DENTAL PLAN DOES NOT PAY FOR**

Although the Dental Plan covers most types of necessary dental services and supplies, it does not cover all dental expenses, even if prescribed, recommended or approved by the participant’s physician or dentist. The Dental Plan covers only those services and supplies that are medically necessary and included in the section of this handbook titled *What the Dental Plan Pays For*. The following describes expenses that are subject to specific limitations or expenses that are not covered by the Dental Plan:

- Any instruction for diet, plaque control and oral hygiene,
- Cosmetic services and supplies including plastic surgery, reconstructive surgery, cosmetic surgery, personalization or characterization of dentures or other services and supplies which improve alter or enhance appearance, augmentation and vestibuloplasty, and other substances to protect, clean, whiten, bleach or alter the appearance of teeth; whether or not for psychological or emotional reasons; except to the extent coverage is specifically provided in the section of this handbook titled *What the Dental Plan Pays For*. Facings on molar crowns and pontics will always be considered cosmetic,
- Crown, inlays and onlays, and veneers unless:
  - It is treatment for decay or traumatic injury and teeth cannot be restored with a filling material, or
  - The tooth is an abutment to a covered partial denture or fixed bridge.
- Mouth guards and other devices to protect teeth,
- Removal of implants,
- Dental services and supplies that are covered in whole or in part:
- Under any other part of this Dental Plan, or
- Under any other plan of group benefits provided by the contract holder.

- Dentures, crowns, inlays, onlays, bridges, or other appliances or services used for the purpose of splinting, to alter vertical dimension, to restore occlusion, or correcting attrition, abrasion, or erosion,

- Except as covered in the section of this handbook titled What the Dental Plan Pays For, treatment of any jaw joint disorder and treatments to alter bite or the alignment or operation of the jaw, including Temporomandibular Joint Disorder (TMJ) treatment, orthognathic surgery, and treatment of malocclusion or devices to alter bite or alignment,

- First installation of a denture or fixed bridge, and any inlay and crown that serves as an abutment to replace congenitally missing teeth or to replace teeth all of which were lost while the individual was not covered,

- General anesthesia and intravenous sedation, unless specifically covered and only when done in connection with another necessary covered service or supply,

- Orthodontic treatment except as covered in the section of this handbook titled What the Dental Plan Pays For,

- Pontics, crowns, cast or processed restorations made with high noble metals (gold or titanium),

- Prescribed drugs, pre-medication, or analgesia,

- Replacement of a device or appliance that is lost, missing or stolen, and for the replacement of appliances that have been damaged due to abuse, misuse or neglect and for an extra set of dentures,

- Services and supplies done where there is no evidence of pathology, dysfunction or disease other than covered preventive services,

- Services and supplies provided for personal comfort or convenience or the convenience of any other individual, including a provider,

- Services and supplies provided in connection with treatment or care that is not covered under the Dental Plan,

- Space maintainers except when needed to preserve space resulting from the premature loss of deciduous teeth,

- Surgical removal of impacted wisdom teeth only for orthodontic reasons, and
• Treatment by a provider other than a dentist. However, the Dental Plan will cover some services provided by a licensed dental hygienist under the supervision and guidance of a dentist. These are:
  • Scaling of teeth,
  • Cleaning of teeth, and
  • Topical application of fluoride.

Additional Items Not Covered By a Health Plan

Not every health service or supply is covered by an Aetna medical plan or the Dental Plan, even if prescribed, recommended or approved by a Physician or Dentist. The Dental Plan covers only those services and supplies that are medically necessary and included in the section of this handbook titled What the Dental Plan Pays For.

Charges made for the following are not covered except to the extent listed under the section of this handbook titled What the Dental Plan Pays For.

• Acupuncture, acupressure and acupuncture therapy,

• Any charges in excess of the plan’s benefit, dollar, day, visit or supply limits,

• Charges submitted for services by an unlicensed hospital, physician or other provider or not within the scope of the provider’s license,

• Charges submitted for services that are not rendered, or not rendered to an individual not eligible for coverage under the Plan,

• Court ordered services, including those required as a condition of parole or release,

• Any dental examinations:
  • Required by a third party, including examinations and treatments required to obtain or maintain employment or which an employer is required to provide under a labor agreement,
  • Required by any law of a government, securing insurance or school admissions, or professional or other licenses,
  • Required to travel, attend a school, camp, or sporting event or participate in a sport or other recreational activity, and
• Any special medical reports not directly related to treatment except when provided as part of a covered service.

• Experimental or investigational drugs, devices, treatments or procedures,

• Medicare payment for that portion of the charge for which Medicare or another party is the primary payer,

• Miscellaneous charges for services or supplies including:
  
  • Cancelled or missed appointment charges or charges to complete claim forms,
  
  • Charges the recipient has no legal obligation to pay; or the charges would not be made if the recipient did not have coverage (to the extent exclusion is permitted by law) including:
    
    • Care in charitable institutions,
    
    • Care for conditions related to current or previous military service, or
    
    • Care while in the custody of a governmental authority.
  
• Non-medically necessary services, including but not limited to, those treatments, services, prescription drugs and supplies which are not medically necessary, as determined by Aetna, for the diagnosis and treatment of illness, injury, restoration of physiological functions or covered preventive services. This applies even if they are prescribed, recommended or approved by a physician or dentist,

• Services rendered before the effective date or after the termination of coverage, unless coverage is continued under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) section of this handbook,

• Any illness or injury related to employment or self-employment including any injuries that arise out of (or in the course of) any work for pay or profit, unless no other source of coverage or reimbursement is available to the participant for the services or supplies. Sources of coverage or reimbursement may include an employer, WC, or an occupational illness or similar program under local, state or federal law. A source of coverage or reimbursement will be considered available to the participant even if they waived the right to payment from that source. If the participant is also covered under a WC law or similar law, and submit proof they are not covered for a particular illness or injury under such law, that illness or injury will be considered non-occupational regardless of cause.
COORDINATION OF BENEFITS

If a Dental Plan participant or a covered family member has dental coverage in addition to the coverage under the plan, benefits from the other plan will be taken into account when calculating the benefit amount payable from the Dental Plan, and a reduction in benefits may occur.

Under the coordination of benefits provision of the Dental Plan, the amount normally reimbursed under the Dental Plan is reduced to take into account payments made by other plans. The combined benefits will not be more than the expenses recognized under these plans.

Other plans include but are not limited to:

- Group insurance,
- Any other type of coverage for individuals in a group. This includes plans that are insured and those that are not (i.e., Medicaid, any governmental program, etc.), or
- No-fault auto insurance required by law and provided on other than a group basis. Only the level of benefits required by law will be counted.

When a participant has coverage under another plan, the order in which the other plan(s) will pay benefits must be determined. This will be done as follows using the first rule that applies:

1. A plan with no rules for coordination with other benefits will be deemed to pay its benefits before a plan which contains such rules.

2. A plan which covers an individual other than as a dependent will be deemed to pay its benefits before a plan which covers the individual as a dependent.

   The benefits of a plan which covers the individual as a dependent will be determined before the benefits of a plan which:

   - Covers the individual as other than a dependent.

3. In the case of a dependent child of a married couple, common law married couple or a domestic partner union, the plan of the parent whose birthday is earlier in the calendar year will be primary. If both parents have the same birthday, the plan which covered one parent longer will be primary. If the other plan does not have the rule described in this provision (3), but instead has a rule based on the gender of the parent and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.
4. In the case of a dependent child whose parents are divorced or separated:

- If there is a court decree which states the parents shall share joint custody of a dependent child, without stating that one of the parents is responsible for the health care expenses of the child, the order in which the plan pays would be based on the rules specified in (3) above.

- If there is a court decree which makes one parent financially responsible for the medical, dental or other health care expenses of such dependent child, the benefits of the plan which covers the child as a dependent of such parent will pay first before the benefits of any other plan which covers the dependent child.

If there is not a court decree:

- And the parent with custody of the child has not remarried; the benefits of the parent's plan with custody which covers the dependent child will pay first before the benefits of a parent’s plan without custody that covers the dependent child.

- And the parent with custody of the child has remarried; the benefits of the parent's plan with custody which covers the dependent child will pay before the benefits of the stepparent’s plan which covers that dependent child. The benefits of the stepparent’s plan which covers that dependent child will be considered before the benefits of the parent’s plan without custody that covers that dependent child.

5. In the case of a dependent child that is eligible for coverage under the parent’s plan and is also married and covered under their spouse’s plan, the Longer/Shorter Rule applies. This means, whichever plan has covered the dependent for the longest amount of time will be considered the primary carrier.

6. If (1), (2), (3), (4) and (5) above do not establish an order of payment, the plan that has covered the dependent child the longest will be deemed to pay its benefits first; except that:

The benefits of a plan which covers the individual on whose expenses claim is based as a:

- Laid-off or retired employee, or

- The dependent of such individual.

Shall be determined after the benefits of any other plan which covers the individual as:

- An employee who is not laid-off or retired, or
• The dependent of such individual.

If the other plan does not have a provision:

• Regarding laid-off or retired employees, and

• As a result, each plan determines its benefits after the other,

then the above paragraph will not apply.

The benefits of a plan which covers the individual on whose expenses claim is based under a right of continuation pursuant to federal or state law shall be determined after the benefits of any other plan which covers the individual other than under such right of continuation.

If the other plan does not have a provision:

• Regarding right of continuation pursuant to federal or state law, and

• As a result, each plan determines its benefits after the other,

then the above paragraph will not apply.

The general rule is that the benefits otherwise payable under the Dental Plan for all expenses processed during a single processed claim transaction will be reduced by the total benefits payable under all other plans for the same expenses. An exception to this rule is that when the coordination of benefits rules of the Dental Plan and any other plan both agree the Dental Plan is primary, the benefits of the other plan will be ignored in applying this rule. In this paragraph, a processed claim transaction is defined as a group of actual or prospective charges submitted to Aetna for consideration, that have been grouped together for administrative purposes as a claim transaction in accordance with Aetna’s then current rules.

In order to administer this provision, Aetna can release or obtain data. Aetna can also make or recover payments.

SCHEDULE OF BENEFITS

Please refer to Exhibit E at the end of this handbook for a copy of the Aetna Dental Plan summary.

AETNA DEFINITIONS

The definitions set forth under the Aetna Definitions section of this handbook also apply to the Aetna Dental Plan.
CLAIMS AND APPEALS

The claims and appeals processes set forth under the Aetna Claims and Appeals section of this handbook also apply to the Aetna Dental Plan.
The Company offers the VSP Retiree Vision Plan (Vision Plan). VSP provides the following benefits.

- Exams
- Lenses
- Frames
- Necessary contact lenses
- Elective contact lenses

Participants may choose between prescription eyeglasses or contact lenses. If a participant chooses contact lenses, they will not be eligible to receive benefit coverage for eyeglasses (lenses and a frame) in the same benefit period.

Vision care services are available from VSP doctors, participating Retail Chains or out-of-network providers. When a participant obtains services from a VSP doctor or a participating Retail Chain, VSP covers the benefits described herein (examination, lenses and frames) at no expense to the participant, except for a $10 copayment. Any additional care, services, and/or materials above VSP limits may be arranged between the participant and the doctor and paid for by the participant.

When a participant obtains services from an out-of-network provider, the participant will be reimbursed up to a certain amount depending on the services provided.

**Cost of Coverage**

The participant pays the full cost for coverage. The annual cost of VSP depends on the coverage option chosen. Information about retiree health care premiums will be provided during every Annual Open Enrollment period.

**SCHEDULE OF BENEFITS**

Please refer to Exhibit F at the end of this handbook for a copy of the VSP Retiree Vision Plan Benefits Summary.
HOW VSP WORKS

VSP Doctors

To use the Vision Plan, a participant calls a participating VSP Doctor for an appointment and identifies themselves as a VSP participant. The participant is not required to complete any up-front paperwork or obtain a benefit form. For assistance in locating a VSP Doctor, participants may call VSP at (800) 877-7195 or go to www.vsp.com.

After a participant has scheduled an appointment, the provider will contact VSP to verify eligibility and plan coverage. The doctor will also obtain authorization for services and materials. If a participant is not eligible for benefits at that time, the doctor will notify the participant.

Network Benefits

Eye Examination – A complete vision analysis which includes an appropriate examination of visual functions is covered in full, after a $10 copayment.

Prescription Eyewear – Covered participants may choose between eyeglasses or contact lenses. If a covered participant chooses contact lenses, they will not be eligible to receive eyeglasses (lenses and frame) in the same benefit period.

Lenses – Single vision, lined bifocals or lined trifocals (more complex lenses) are covered in full. The VSP Doctor or participating Retail Chain will order the lenses and verify the accuracy of the finished lenses.

Frames – Frames are covered up to a $130 allowance. If a covered participant selects a frame that exceeds the vision plan’s allowance, they will be responsible for the difference. Also, when a covered participant purchases a pair of non-covered prescription eyeglasses (including prescription sunglasses) from the same VSP Doctor on the same day as the WellVision Exam, they will receive a 30% savings. If the covered participant purchases a pair of non-covered prescription eyeglasses (including prescription sunglasses) from any VSP Doctor within 12 months of their last WellVision Exam, they will receive a 20% savings. Participants may visit www.vsp.com or ask a VSP doctor for details.

Elective Contact Lenses – The contact lens exam (fitting and evaluation) and lenses are covered up to a $130 allowance. A 15% discount applies to a VSP Doctor’s usual and customary professional fees for the contact lens exam. The contact lens exam is performed in addition to the routine eye exam to check the eye for health risks associated with improper wearing or fitting of contact lenses. When this benefit is paid, no other materials benefit (eyeglasses (lenses and frame)) is payable for the benefit period.
**Medically Necessary Contact Lenses** – Contact lenses and necessary ophthalmic materials are covered in full under the vision plan when specific benefit criteria are satisfied. The following conditions may meet the criteria:

- As a result of cataract surgery,
- Extreme visual acuity problems that may not be corrected with spectacle lenses,
- Significant anisometropia, and
- Keratoconus.

**Diabetic Eye Care Program** – For services related to Diabetic Eye Disease (Type 1 and Type 2 Diabetes), glaucoma and age-related macular degeneration (AMD). Under this program, medical eye care examinations are covered in full, after a $20 copayment. In addition, this program provides coverage for limited vision-related medical services. The frequency at which these services may be provided is dependent on the specific service and the diagnosis associated with such service. A current list of these services is available from VSP upon request. Participants may visit [www.vsp.com](http://www.vsp.com) or call VSP at (800) 877-7195 for more information.

**Laser Vision Care** – VSP has contracted with many of the nation’s finest laser surgery facilities and doctors, offering discounts in PRK, LASIK and Custom LASIK surgeries available through these contracted surgery centers. Participants may visit [www.vsp.com](http://www.vsp.com) for more information.

For more information, refer to the sections of this summary titled Extra Cost and What VSP Does not Pay For.

**Open Access (Out-of-Network) Reimbursements**

Participants will be reimbursed directly according to the Open Access reimbursement schedule listed in the section of this summary titled Schedule of Benefits.

There is no assurance that the open access (out-of-network) reimbursement schedule will cover the entire cost of the examination or the lenses. VSP may not guarantee patient satisfaction when services are received from other providers.

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**EXTRA COST**

This plan is designed to cover visual needs rather than cosmetic. There may be extra costs involved if you select a frame above the plan allowance or purchase lens enhancements such as:

- Optional cosmetic processes
- Anti-reflective coating
- Color coating
- Mirror coating
- Scratch coating
- Blended lenses
- Cosmetic lenses
- Laminated lenses
- Oversize lenses
- Polycarbonate lenses
- Photochromic lenses, tinted lenses except Pink #1 and Pink #2
- Progressive multifocal lenses
- UV (ultraviolet) protected lenses
- Certain limitations on low vision care

**WHAT VSP DOES NOT PAY FOR**

There are no benefits for professional services or materials connected with:

- Orthoptics or vision training and any associated supplemental testing; plano lenses (less than a +50 diopter power); or two pairs of glasses instead of bifocals;

- Replacement of lenses and frames furnished under this Plan which are lost or broken, except at the normal intervals when services are otherwise available;

- Medical or surgical treatment of the eyes;

- Corrective vision treatment of an experimental nature;

- Costs for services and/or materials above Plan Benefit allowances;

- Services and/or materials not indicated as covered Plan Benefits.
CLAIMS AND APPEALS

How to File a Network Claim

If a participant uses a VSP Doctor or participating Retail Chain, the provider will handle the claims process.

How to File an Out-of-Network Claim

If a participant uses another Provider (out-of-network), the participant must pay the provider in full at the time of service.

To ensure a timely reimbursement, participants may access the Out-of-Network Reimbursement Form at www.vsp.com or send the following information to VSP:

- An itemized receipt listing the services received;
- The name, address and phone number of the out-of-network provider;
- The participant’s name, phone number, address and date of birth;
- The last four digits of the participant’s identification number (Social Security Number);
- Indicate “VSP coverage provided through Valero” on the receipt;
- The patient’s name, date of birth, phone number and address; and
- The patient’s relationship to the participant (such as self, spouse or child).

Please keep a copy of the information and mail the originals to the following address:

VSP
Attn: Out-of-Network Provider Claims
P.O. Box 385018
Birmingham, AL  35238-5018

Out-of-network claims must be submitted to VSP within 365 days of the date of service for reimbursement.

COMPLAINTS AND GRIEVANCES

If a participant ever has a question or problem, the participant’s first step is to call VSP’s Customer Service Department. The Customer Service Department will make every effort to answer the participant’s question and/or resolve the matter informally. If a matter is not initially resolved to the satisfaction of a participant, the participant may
communicate a complaint or grievance to VSP orally or in writing by using the complaint form that may be obtained upon request from the Customer Service Department. Complaints and grievances include disagreements regarding access to care, or the quality of care, treatment or service. Participants also have the right to submit written comments or supporting documentation concerning a complaint or grievance to assist in VSP’s review. VSP will resolve the complaint or grievance within 30 days after receipt, unless special circumstances require an extension of time. In that case, resolution shall be achieved as soon as possible, but no later than 120 days after VSP’s receipt of the complaint or grievance. If VSP determines that resolution cannot be achieved within 30 days, a letter will be sent to the participant to indicate VSP’s expected resolution date. Upon final resolution, the participant will be notified of the outcome in writing.

Claim Payments and Denials

Initial Determination

VSP will pay or deny claims within 30 calendar days of the receipt of the claim from the participant or the participant’s authorized representative. In the event that a claim cannot be resolved within the time indicated, VSP may, if necessary, extend the time for decision by no more than 15 calendar days.

Request for Appeals

If a participant’s claim for benefits is denied by VSP in whole or in part, VSP will notify the participant in writing of the reason or reasons for the denial. Within 180 days after receipt of such notice of denial of a claim, the participant may make a verbal or written request to VSP for a full review of such denial. The request should contain sufficient information to identify the participant for whom a claim for benefits was denied, including the name of the VSP Enrollee, Member Identification Number of the VSP Enrollee, the participant’s name and date of birth, the name of the provider of services and the claim number. The participant may state the reasons the participant believes that the claim denial was in error. The participant may also provide any pertinent documents to be reviewed. VSP will review the claim and give the participant the opportunity to review pertinent documents, submit any statements, documents, or written arguments in support of the claim, and appear personally to present materials or arguments. The participant or participant’s authorized representative should submit all requests for appeals to:

VSP
Member Appeals
3333 Quality Drive
Rancho Cordova, CA 95670
(800) 877-7195

VSP’s determination, including specific reasons for the decision, shall be provided and communicated to the participant within 30 calendar days after receipt of a request for
appeal from the participant or participant’s authorized representative.

If the participant disagrees with VSP’s determination, he/she may request a second level appeal within 60 calendar days from the date of the determination. VSP shall resolve any second level appeal within 30 calendar days.

When a participant has completed all appeals mandated by the Employee Retirement Income Security Act of 1974 (ERISA), additional voluntary alternative dispute resolution options may be available, including mediation and arbitration. The participant should contact the U. S. Department of Labor or the State insurance regulatory agency for details. Additionally, under ERISA (Section 502(a)(1)(B)) [29 U.S.C. 1132(a)(1)(B)], a participant has the right to bring a civil (court) action when all available levels of reviews of denied claims, including the appeal process, have been completed, the claims were not approved in whole or in part, and the participant disagrees with the outcome.

**WHEN VISION COVERAGE BEGINS AND ENDS**

For information on when coverage begins and ends, refer to the section of this handbook titled Plan Administration.

Participants may have the option to continue this coverage through COBRA. For more information, refer to the section of this handbook titled Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).
RETIREE LIFE INSURANCE

The retiree life insurance provides certain retirees the opportunity to protect survivors’ financial security in the event of the participant’s death. The company paid life insurance is administered by the Valero Retiree Administration Department. Should a participant or their beneficiary have questions regarding the company paid life insurance, they may contact the Valero Retiree Administration Department.

Cost of Coverage

Retiree life insurance is provided to retirees at no cost.

Coverage Amount

A retiree’s company paid life insurance coverage amount depends on the work location at the time of retirement and the date of retirement. For questions about retiree life insurance amounts, participants should contact the Valero Retiree Administration Department.

IMPUTED INCOME

If the life insurance coverage amount from the company paid life insurance is more than $50,000, a retiree will be required to pay income taxes based on the value of the coverage greater than $50,000. This amount will be reported to the IRS as taxable income. The amount of tax a retiree pays is based on the dollar value of the coverage assigned by the IRS. This is called imputed income. Retirees subject to imputed income will receive a 1099 from the Company.

LIFE INSURANCE CLAIMS

Valero’s group life insurance benefits are provided under insurance policies issued by Metropolitan Life Insurance Company (MetLife).

Upon notification of a loss, the Valero Retiree Administration Department will attempt to contact the beneficiaries and provide the proper claim forms. However, if the Valero Retiree Administration Department is unable to contact the beneficiaries, it is the responsibility of the beneficiaries to make certain a claim has been filed. The Valero Retiree Administration Department is available to provide assistance in completing and filing the claim if necessary.

Claim Submission

In submitting claims for life insurance benefits, the claimant must complete the appropriate claim form and submit the required proof as described in the claimant packet. Claim forms must be submitted in accordance with the instructions on the claim form.
Initial Determination

After MetLife receives a claim for benefits, MetLife will review the claim and notify the beneficiary(ies) of its decision to approve or deny the claim.

Such notification is provided to the claimant within a reasonable period, not to exceed 90 days from the date MetLife receives the claim, unless MetLife notifies the claimant within that period that there are special circumstances requiring and extension of time of up to 90 additional days.

If MetLife denies a claim in whole or in part, the notification of the claims decision will state the reason why the claim was denied and reference the specific plan provision(s) on which the denial is based. If the claim is denied because MetLife did not receive sufficient information, the claims decision will describe the additional information needed and explain why such information is needed. The notification will also include a description of the plan review procedures and time limits, including a statement of the claimant’s rights to bring a civil action if the claim is denied after an appeal.

If the beneficiary does not receive a written decision on the claim within 90 days after the claim is received. The beneficiary has an immediate right to request a review under the review procedures as if the claim had been denied.

Investigation of the Claim

MetLife has the right to conduct an independent investigation of any claim for benefits under the group policy. No benefits will be paid until MetLife has had a reasonable time to conduct an investigation.

Denial Claim Appeal Procedures

The beneficiary(ies) has a right to appeal any denial by MetLife of all or any part of the claim. To obtain an appeal, the beneficiary(ies) should send a written request for appeal to MetLife within 60 days after the beneficiary(ies) receives notice of the denial. No special form is required.

As a part of the beneficiary’s request for appeal, they may submit issues and comments in writing and provide additional documentation in support of the claim. The beneficiary(ies) may review pertinent documents related to the beneficiary’s request for appeal.

MetLife will review the claim promptly after receiving the beneficiary’s request for appeal. The beneficiary(ies) will receive written notice of MetLife’s decision within 60 days after the request for appeal is received, or within 120 days if special circumstances require an extension. The written decision the beneficiary(ies) receives will include the reasons for the decision and reference to the provisions of the group policy on which the
decision is based. The insured participant may authorize another individual to act on their behalf under this appeal procedure.
INFORMATION APPLICABLE TO ALL PLANS

The items in this section provide information relating to all of the Company’s retiree health care plans, unless otherwise stated. This information should be read in conjunction with the individual descriptions of the Company’s retiree health care plans provided in this handbook.

HOW TO FILE A CLAIM

For information on claims and appeals, refer to the section of this handbook applicable to the plan in question.

RIGHTS UNDER ERISA

The following paragraphs describe certain rights and protections that participants have under certain Valero retiree health care plans. These rights and protections are provided for plans covered by ERISA. ERISA provides that all plan participants must be entitled to certain rights.

- Participants have the right to receive information about plans and benefits.
- Participants have the right to continue group health care plan coverage.
- Participants have the right to prudent actions by plan fiduciaries.
- Participants have the right to enforce their rights.
- Participants have the right to receive assistance with questions.

THE RIGHT TO RECEIVE INFORMATION ABOUT PLANS AND BENEFITS

The following are rights to receive information about plans and benefits.

- Participants have the right to examine, without charge, at the plan administrator’s office and at other specified locations, such as work sites and union halls, all documents governing the plans, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the public disclosure room of the Employee Benefits Security Administration.
- Participants have the right to obtain, upon written request to the plan administrator, copies of documents governing the operation of the plans.
including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated handbook. The administrator may charge a reasonable amount for the copies.

- Participants have the right to receive a summary of the plans’ annual financial report. The plan administrator is required by law to furnish each participant with a copy of the summary annual report.

THE RIGHT TO CONTINUE GROUP HEALTH CARE PLAN COVERAGE

The following are rights to continue group health care plan coverage.

- If there is a loss of coverage under the plans as a result of a qualifying event, as defined by COBRA, a participant and/or their covered dependents may have the right to continue health care coverage under the health care benefit plans in which they were participating at the time. A participant and their covered dependents may have to pay for the continued coverage. Review the benefits summary and the documents governing the plans on the rules governing COBRA continuation coverage rights. For more information, refer to the section in this handbook titled *Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)*.

- If there is creditable coverage from another plan, a participant has the right to reduce or eliminate exclusionary periods of coverage for pre-existing conditions under their group health plan. A participant should be provided a certificate of creditable coverage, free of charge, from their group health plan or health insurance issuer when a participant loses coverage under the plans, when a participant becomes entitled to elect COBRA continuation coverage, when COBRA continuation coverage ceases, if a participant requests it before losing coverage, or up to 24 months after losing coverage. Without evidence of creditable coverage, a participant may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after the coverage enrollment date.

THE RIGHT TO PRUDENT ACTIONS BY PLAN FIDUCIARIES

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the retiree health care plan. The people who operate the plans, called fiduciaries, have a duty to do so prudently and in the interest of plan participants and beneficiaries. No one, including an employer, union or any other person, may fire a participant or otherwise discriminate against a participant in any way to prevent the retiree from obtaining a (pension or welfare) benefit or exercising his rights under ERISA.
THE RIGHT TO ENFORCE ERISA RIGHTS

If a participant’s claim for a benefit is denied or ignored, in whole or in part, the participant has a right to know why it occurred, to obtain copies of documents relating to the decision without charge, and to appeal any denial (all within certain time schedules).

Under ERISA, there are steps a participant can take to enforce the above rights. For instance, if a participant requests a copy of plan documents or the latest annual report from the plan and does not receive them within 30 days, they may pursue their rights through the BPAC (Benefit Plans Administrative Committee) and ultimately in federal court. In such a case, the court may require the plan administrator to provide the materials and pay the participant up to $110 a day until they receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator.

If a participant has a claim for their benefits which is denied or ignored, in whole or in part, the participant may pursue their rights through the BPAC and ultimately in federal court. In addition, if a participant disagrees with the plan’s decision, or lack thereof, concerning a medical child support order, the participant may pursue his rights through the BPAC and ultimately in federal court.

If fiduciaries misuse the plan’s money, or if a participant is discriminated against for asserting their rights, the participant may seek assistance from the U.S. Department of Labor, or pursue their rights through the BPAC and ultimately in federal court. The court will decide who should pay costs and legal fees. If the participant is successful, the court may order the party the participant has sued to pay these costs and fees. If the participant is unsuccessful, the court may order the party to pay these costs and fees, for example, if it finds the participant’s claim to be frivolous.

THE RIGHT TO RECEIVE ASSISTANCE WITH QUESTIONS

The participant should contact the plan administrator if they have any questions about their plans. If a participant has any questions about the statement, rights under ERISA, or needs assistance obtaining documents from the plan administrator, the participant should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, or the Division of Technical Assistance and Inquiries.

   Employee Benefits Security Administration  
   U.S. Department of Labor  
   200 Constitution Avenue NW  
   Washington, D.C. 20210

A participant may also obtain certain publications about rights and responsibilities under ERISA by calling the publication hotline of the Employee Benefits Security Administration.
GENERAL INFORMATION

The following is plan administrator and employer information relating to all of the Company’s health care plans:

**Plan Administrator:**
Valero
P.O. Box 696000
San Antonio, Texas 78269-6000
(210) 345-2000

**Plan Employer:**
Valero Energy Corporation
P.O. Box 696000
San Antonio, Texas 78269-6000
(210) 345-2000

**Human Resources:**
Valero
P.O. Box 696000
San Antonio, Texas 78269-6000
(210) 345-2000

**Employer Identification Number of Valero Energy Corporation:**
74-1828067

For insured plans, the plan administrator is provided under the terms of the insurance contract. Plan administrators for insured plans are listed in the section of this handbook titled Plan Administration and Funding.

Legal Process

The following is the agent for service of legal process relating to the Company’s retiree health care plans:

- The Corporation Trust Company
  1209 Orange Street
  Wilmington, Delaware 19801

Legal process may also be served on the plan administrator and trustee.

Plan Year

Records for all of the Company’s retiree health care plans are kept on a plan year basis from January 1 through December 31.

Administration

All of the Company’s retiree health care plans are administered by the BPAC, which is selected by the Board of Directors of the Company. The BPAC is responsible for the proper administration of the plans and has full power and authority to interpret the provisions of the plans.
In particular, the BPAC and any other designees (including the Claims Administrators) each have all such powers, authority and discretion as may be necessary to implement and carry out the provisions of the plan and to interpret and construe all of the terms, provisions and limitations of the plan. Such power, authority and discretion include, but are not limited to, the power, authority and discretion to: (a) determine all questions regarding eligibility to participate in the plan, as well as all questions regarding the status of particular retirees, dependents and others in relation to the plan; (b) determine all questions regarding eligibility to receive benefits under the plan, the date of commencement and termination of the payment of benefits and the amount of benefits; (c) interpret and construe all terms, provisions and limitations of the plan, including without limitation, any and all doubtful, disputed or ambiguous provisions; (d) evaluate the compliance by participants and dependents of their respective obligations and responsibilities under the plan; and (e) promulgate binding rules for the administration and implementation of the plan. Its interpretations are final, conclusive, and binding on the Company, the participants, and all other parties of interest.

**THE RIGHT TO RELEASE OR OBTAIN INFORMATION**

Any participant in any of the plans offered in the Retiree benefits program authorizes the Company to obtain or release any information required to determine benefits payable. Federal law prohibits the Company from using or disclosing protected health information for purposes other than health care treatment, payment, plan operations or for certain other purposes without an authorization from the participant. For further details, refer to the section of this handbook titled HIPAA Privacy Notice.
CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1985 (COBRA)

This notice is intended to inform the covered dependents of retirees, in a summary fashion, of the potential future options and obligations under the health care coverage continuation provisions of the COBRA law. At such time when a qualifying event occurs, additional information and the appropriate election notice will be sent by the plan administrator.

Valero has contracted with COBRA Administration & Health Services to serve as plan administrator. COBRA administration & Health Services will process all COBRA enrollments, premium payments, collections and maintain the plan’s compliance with legal requirements.

For additional information regarding COBRA, please contact the Valero Retiree Administration Department.

COBRA GENERAL INFORMATION

COBRA continuation coverage for retirees is only offered in the time of retirement.

Federal law states that most group health care plans (including this Valero sponsored health care plan) is required to offer temporary health care coverage continuation to covered dependents of retirees when coverage under a group health plan would otherwise end due to certain qualifying events.

Continuation coverage is the same coverage that the plan gives to other participants or beneficiaries under the plan who are not receiving continuation coverage. Each qualified beneficiary who elects continuation coverage will have the same rights under the plan as other participants or beneficiaries covered under the plan, including open enrollment and special enrollment rights.

Notification of Separate Address or Address Change

In order to protect your and your family’s rights, you should keep the Plan Administrator informed of any changes in your address and the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

COBRA QUALIFYING EVENTS

The following events have been identified as COBRA qualifying events that would allow a covered dependent the right to elect temporary health care coverage continuation at the current group rate.

Qualifying events for covered spouses are:
The death of the retiree,

Divorce, or

The retiree becomes entitled to Medicare.

Qualifying events for a covered dependent child are:

The death of the retiree,

Parent’s divorce or legally separate,

A dependent child ceases to be a dependent under the terms of the health plan, or

The retiree becomes entitled to Medicare.

OBLIGATION TO NOTIFY THE COBRA ADMINISTRATOR OF A QUALIFIED CHANGE EVENT

Retirees and their covered dependents have the responsibility to provide written notice to COBRA Administration & Health Services of all other qualified change events. This notification must be made within 30 days from the qualified change event date. For information on required documentation for a qualified change event, refer to the section of this handbook Qualified Change Events.

If this notification is not completed according to the above procedures and submitted within the required 30-day notification period and the 60-day COBRA election period, then rights to continuation coverage will be forfeited.

ELECTION PERIOD

Once COBRA Administration & Health Services is notified that a qualifying event has occurred, covered individuals (also known as qualified beneficiaries) will be notified about their COBRA rights within 14 days.

If a qualifying event affects more than one qualified beneficiary, each person has an independent right to COBRA within a 60-day election period. The 60-day election period is measured from the later of the date the health care coverage is lost due to the event or the date of COBRA notification. This is the maximum period allowed to elect COBRA as the group health plans do not provide an extension of the election period beyond what is required by law. If a qualified beneficiary does not elect health care coverage continuation within this election period, rights to health care coverage continuation will end.
COST OF COVERAGE

Generally, each qualified beneficiary may be required to pay the entire cost of continuation coverage. The amount a qualified beneficiary may be required to pay may not exceed 102% (or, in the case of an extension of continuation coverage due to a disability, 150%) of the cost to the group health care plan (including both employer and retiree contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving continuation coverage. The required payment for each continuation coverage period for each option is described in this notice.

COBRA PREMIUM PAYMENTS

COBRA participants must pay all initial premiums due within 45 days of signing the COBRA enrollment form. Coverage will not be activated until the full initial payment is received. Once this payment is received COBRA coverage will be made retroactive to the initial loss of coverage.

COBRA premium payments are due on the first day of each month. Payments not received by the last day of the month are considered late. A 30-day grace period will be allowed, however if a COBRA participant fails to pay their premiums, coverage will be terminated retroactively back to the last paid date. If coverage is terminated due to nonpayment, the participant will not be allowed to reenroll for coverage at any later date. COBRA participants may pay for their premium by personal check, money order or cashier’s check. COBRA premium payments should be mailed to:

COBRA Administration & Health Services
ATTN: Accounts Receivable
3649 Post Road
Warwick, RI 02886
(401)921-3514

LENGTH OF COVERAGE CONTINUATION

If you elect continuation coverage, an extension of the maximum period of coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs. You must notify Accounts Receivable of a disability or a second qualifying event in order to extend the period of continuation coverage. Failure to provide notice of a disability or second qualifying event may affect the right to extend the period of continuation coverage.

Social Security Disability

An 11-month extension of coverage may be available if any of the qualified beneficiaries are determined by the Social Security Administration (SSA) to be disabled. The disability has to have started at some time before the 60th day of COBRA continuation
coverage and must last at least until the end of the 18-month period of continuation coverage. You are responsible for sending a copy of the SSA determination within 60 days of receipt to Accounts Receivable of COBRA Administration & Health Services, 3649 Post Road, Warwick, RI 02886. Each qualified beneficiary who has elected continuation coverage will be entitled to the 11-month disability extension if one of them qualifies. If the qualified beneficiary is determined by SSA to no longer be disabled, you must notify the plan of that fact within 30 days after SSA’s determination.

Secondary Qualifying Event

An 18-month extension of coverage will be available to spouses and dependent children who elect continuation coverage if a second qualifying event occurs during the first 18 months of continuation coverage. The maximum amount of continuation coverage available when a second qualifying event occurs is 36 months. Such second qualifying events may include the death of a covered retiree, divorce or separation from the covered retiree, the covered retiree’s becoming entitled to Medicare benefits (under Part A, Part B, or both), or a dependent child’s ceasing to be eligible for coverage as a dependent under the plan. These events can be a second qualifying event only if they would have caused the qualified beneficiary to lose coverage under the plan if the first qualifying event had not occurred. You must notify the plan within 60 days after a second qualifying event occurs if you want to extend your continuation coverage.

Medicare Entitlement

This extension applies only to a covered spouse and covered dependents children. An extension of the original 18 months of health care coverage continuation may also occur if the covered retiree becomes entitled to Medicare in the 18 months before the event causing the loss of coverage. If this occurs, then the original 18 months of health care coverage continuation may be extended up to 36 months from the date the covered retiree became entitled to Medicare.

36 Months of Coverage Continuation

If the original event causing the loss of coverage was the death of the employee, divorce, legal separation, or a dependent child ceasing to be a dependent child under the subject group health plan, each qualified beneficiary will have the opportunity to continue health care coverage for 36 months from the date of the qualifying event.

CANCELLATION OF HEALTH CARE COVERAGE CONTINUATION

The Law provides that COBRA health care coverage continuation will end prior to the maximum health plan continuation period for any of the following reasons.

- Any required premium is not paid in full on time,
A qualified beneficiary becomes, after the date of COBRA election, covered under another group health plan that does not contain any exclusion or limitation with respect to any pre-existing condition of such beneficiary other than such exclusion or limitation which does not apply to or is satisfied by such beneficiary by reason of the Health Insurance Portability and Accountability Act (HIPAA).

A qualified beneficiary becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing COBRA continuation coverage, or

The employer ceases to provide any group health care plan for its retirees.

A qualified beneficiary notifies COBRA Administration & Health Services that he/she wishes to cancel COBRA health care coverage continuation.

FOR MORE INFORMATION

If you have any questions concerning the information in this notice, your rights to coverage you should contact COBRA Administration & Health Services, 3649 Post Road, Warwick, RI 02886 at (401) 921-3514.

Rhode Island State Continuation Law - Group plans must offer employees the right to continue group coverage for up to 18 months (accumulating one month of state continuation coverage for every month enrolled on the group plan to a maximum of 18 months) in the event of the retiree’s involuntary termination or death. In the event of a divorce, covered spouses may continue indefinitely (as the courts dictate) or until (1) either spouse remarries; (2) a termination date is set by the court; or (3) the spouse becomes eligible for other group coverage. Premiums for state continuation coverage shall not exceed the group rate.

For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, visit the U.S. Department of Labor’s Employee Benefits Security Administration (EBSA) website at www.dol.gov/ebsa or call their toll-free number at (866) 444-3272. For more information about health insurance options available through a Health Insurance Marketplace, visit www.healthcare.gov.

CONVERSION RIGHTS

A conversion policy allows individuals covered under a group health care plan to convert their coverage to an individual policy without pre-existing condition limitations or a lapse in coverage upon termination from the group health care plan. Not all group health plans are subject to offering a conversion right. If you are enrolled in a plan that allows conversion, you will receive a notification explaining your conversion privileges in the last 180 days of your COBRA term. It will be your responsibility to work directly with the insurance carrier to establish a conversion to an individual policy.
HIPAA RIGHTS

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) contains certain other requirements of the Company’s health care plans. HIPAA applies only to medical, dental and vision plans. HIPAA does not apply to any other plans offered by the Company.

HIPAA PRE-EXISTING CONDITIONS LIMITATIONS

The Valero Retiree Health Care Plan does not contain a pre-existing condition clause. The following information is provided in the event a participant is enrolled or becomes eligible under a health care plan that does exclude coverage for pre-existing medical conditions.

HIPAA limits the circumstances under which coverage may be excluded for medical conditions present before enrolling. Under the law, pre-existing condition exclusions generally may not be imposed for more than 12 months (18 months for a late enrollee). The 12-month (or 18-month) exclusion period is reduced by prior health coverage unless there has been a break in coverage of 63 consecutive days. Participants are entitled to a certificate showing evidence of prior health coverage. If a participant buys health insurance other than through an employer group health care plan, a certificate of prior coverage may help obtain coverage without a pre-existing condition exclusion. Contact the state’s insurance department for other information.

Participants have the right to receive a certificate for prior health coverage if a participant has terminated or dropped coverage. Participants may need to provide other documentation to the employer for earlier periods of creditable health care coverage.

HIPAA SPECIAL ENROLLMENT RIGHTS

HIPAA provides special mid-year enrollment opportunities to certain dependents of retirees and COBRA qualified beneficiaries who are actually receiving COBRA coverage.

Loss of Coverage

If a retiree’s dependent is eligible for coverage but not currently enrolled because they had alternative health coverage, the dependent may enroll if the other coverage is lost because:

- Coverage was under COBRA, and the COBRA period was exhausted,
- Coverage was terminated as a result of loss of eligibility for coverage (e.g., termination of employment or reduction in hours), or
- Employer contributions for the coverage were terminated.
To enroll under the special enrollment right, the participant must request enrollment within 30 days after the loss of coverage. There is no HIPAA special enrollment right if the other coverage ceases as a result of an individual’s failure to pay premiums, or for cause.

**Acquisition of New Dependent**

A special enrollment opportunity is also available if a retiree marries or acquires a dependent by marriage, birth, adoption or placement for adoption. The special enrollment right applies to the retiree’s spouse and the newly acquired dependent. To obtain coverage under this special enrollment right, a retiree must request enrollment within 30 days of the marriage, birth, adoption or placement for adoption.
THE RIGHT OF SUBROGATION AND REIMBURSEMENT

Unless otherwise provided in a plan document or in this handbook, if an individual is entitled to or receives benefits under any plan described in this handbook with respect to any disability or medical condition, and is also entitled to or otherwise collects compensation or any other funds from another party (except another health care plan maintained by the Company) in connection with that same disability or medical condition, whether by insurance, litigation, settlement or otherwise:

- The plan shall be entitled to such funds to the extent of plan benefits paid to the individual, whether or not the individual has been “made whole,” and without regard to any common fund doctrine, and
- May recover such funds by constructive trust, equitable lien, right of subrogation, reimbursement or any other equitable or legal remedy.

The plan shall have the right to terminate or suspend benefit payments and/or recover the reimbursement due to the plan by withholding, offsetting and recovering such amount out of any future plan benefits or amounts otherwise due from the plan to or with respect to such individual if:

- An individual fails, refuses or neglects to reimburse the plan or otherwise comply with the provisions of this provision, or
- Payments are made under the plan based on fraudulent information or otherwise in excess of the amount necessary to satisfy the provisions of the plan, then, in addition to all other remedies and rights of recovery that the plan may have.

The plan shall also have the right in any proceeding at law or equity to assert a constructive trust, equitable lien, or any other equitable or legal remedy or recovery, against any and all persons that have assets that the plan may claim rights to. The plan has the right of first dollar recovery from any judgment, settlement or other payment, regardless of whether the individual has been “made whole,” and all funds resulting from and without regard to any common fund doctrine.

Upon notification that a claim may be related to an accident or injury caused by a third party and potentially reimbursed or settled by a third party or insurance company, the Company’s health care Plan Administrator (or their representative) will issue a subrogation claim to the participant. Before payment may be considered on any claim for medical benefits received in connection with the accident or third party incident, the participant must complete, sign and return the subrogation claim, or provide any requested information to the party initiating the subrogation claim. Any claims for medical benefits received prior to receipt of this information may be denied.
LEGAL NOTICES

This group health care plan complies with the following federal laws. Should you have any questions about these laws, please contact the Valero Retiree Administration Department.

HIPAA PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT A PERSON MAY BE USED AND DISCLOSED AND HOW A PERSON CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Some of the plans described in this handbook may involve the use and/or disclosure of health information that is protected by HIPAA. These plans include the Aetna Retiree Deductible Plan, the PPO Plan, the Out of Area Plan, the Aetna Retiree Dental Plan, and the VSP Retiree Vision Plan.

These plans are required by law to maintain the privacy of Protected Health Information (PHI). PHI includes any identifiable information that the Company obtains from participants or others that relates to a participant’s physical or mental health, the health care a participant has received, or payment for health care.

As required by law, this notice provides information about participants’ rights and the Company’s legal duties and privacy practices with respect to PHI. The Company must comply with the provisions of this notice; although it reserves the right to change the terms of this notice from time to time and to make the revised notice effective for all PHI maintained. Participants can always request a copy of the current privacy notice by contacting the Privacy Officer identified later in this section.

Permitted Uses and Disclosures

The Company is permitted to use or disclose participants’ PHI for purposes of treatment, payment, and health care operations.

Health Care Operations – The support functions of the administrative practice relating to treatment and payment, such as quality assurance activities, case management, audits, and administrative activities.

Treatment – The provision, coordination, or management of health care. For example, a doctor treating a participant for a broken leg may need to know if that participant has diabetes because diabetes may slow the healing process. The Company is therefore permitted to disclose the participant’s protected health information to help doctors determine whether the participant has potentially complicating conditions like diabetes.

Payment – Activities undertaken to obtain premiums, to determine responsibility for coverage, or to obtain reimbursement for the health care provided the participant. For
example, prior to providing health care services, the Company may need to provide to an insurance company, or an HMO, information about a participant’s medical condition to determine whether the proposed course of treatment will be covered.

The Company is also permitted to use or disclose participants’ PHI in the following special circumstances:

**Abuse, Neglect, or Domestic Violence** – The Company may disclose PHI about participants to appropriate authorities if a participant is reasonably believed to be a victim of abuse, neglect, or domestic violence. This disclosure will only be made if required by law or if the participant agrees to the disclosure.

**Averting a Serious Threat to Health or Safety** – The Company may disclose to appropriate authorities PHI that it is reasonably believed is necessary to prevent a serious and imminent threat to the health or safety of the public or of any individual.

**Coroners and Funeral Home Directors** – The Company may disclose PHI to a coroner, medical examiner or funeral director.

**Disclosure to Family Members or Close Personal Friends** – The Company may disclose PHI to family members, other relatives, close personal friends, or any other person identified by the participant if the PHI is relevant to the care or payment or for the purpose of notifying them about the participant’s condition or location. If the participant is present at the time of the disclosure, he will have the opportunity to object to the disclosure. If the participant is not present, the Company may exercise professional judgment to determine whether the disclosure is in the participant’s best interest.

**Health Oversight Activities** – The Company may disclose PHI to federal or state health oversight agencies that oversee company activities.

**Inmates** – If a participant is an inmate of a correctional institution or under the custody of a law enforcement official, the Company may disclose PHI to the relevant facility or official.

**Intelligence Activities and Protective Services for Government Officials** – The Company may disclose PHI to appropriate government authorities in connection with intelligence activities or protective services for the president or other officials.

**Judicial or Administrative Proceedings** – The Company may disclose PHI to be used in legal proceedings, if required by military command authorities.

**Law Enforcement Activities** – The Company may disclose PHI if asked to do so by a law enforcement official as part of law enforcement activities; in investigations of criminal conduct or of victims of crimes; in response to court orders; in emergency circumstances; or when required to do so by law.
Military and Veterans – If a participant is (or was) a member of the armed forces, the Company may disclose PHI as required by military command authorities.

Organ or Tissue Donation – If a participant is an organ donor, the Company may disclose PHI to organizations that handle organ procurement or transplantation.

Public Health Risks – The Company may disclose PHI to public health authorities for purposes of promoting public health activities, such as the prevention or control of disease, injury, or disability; reporting of child abuse or neglect; and reporting of reactions to medications or problems with products.

Research – In some circumstances, the Company may disclose PHI to researchers in connection with research projects that have been approved through an approval process that is required by law.

Uses and Disclosures Required by Law – The Company may use or disclose PHI to the extent required by federal, state or local law.

Workers’ Compensation – The Company may disclose PHI to the extent necessary to comply with laws relating to workers’ compensation for work-related injuries.

In any situation other than those described above, the Company will not use or disclose the participant’s PHI without the participant’s written consent. If a participant has given written consent to a use or disclosure, the participant may later revoke that consent by contacting the Company in writing. Participants may not revoke consent to a use or disclosure if action has already been taken in reliance on their written consent.

Rights

Participants may request that restrictions be placed on certain uses and disclosures of their PHI. The Company is not required to agree to any restriction that participants request, but if the Company does agree to a restriction, it must abide by the restriction unless otherwise necessary for emergency care.

Participants have the right to receive communications of PHI at an alternative address or through alternative contact methods. If participants wish to change the way the Company communicates protected health information to them, the participant must submit a written request to the Privacy Officer identified in this section.

Participants have the right to inspect and copy their PHI. Usually, this includes medical and billing records, but does not include psychotherapy notes. To inspect and copy their PHI, participants must submit the request in writing to our Privacy Officer; refer to the section below titled Privacy Officer. Participants may request a copy of their PHI in electronic form. In such a request, the Company will provide a readily producible electronic copy currently available on the Company’s system. The Company may
charge a fee for the costs of copying and mailing the information. The Company may also deny the request to inspect and copy in certain limited circumstances. The Company will select a health care professional to conduct reviews of the denials.

Participants have the right to request their PHI be amended if the participant feels that it is inaccurate or incomplete. To request an amendment, the request must be made in writing and submitted to the Privacy Officer. In addition, the participant must provide a reason that supports the request. If the request is denied, the participant will be provided with a written explanation of the basis for the denial and a description of further steps a participant may take if the participant feels the denial was in error.

Participants have the right to receive an accounting of disclosures that have been made of their PHI. To request this accounting of disclosures, the participant must submit the request in writing to the Privacy Officer. The first accounting of disclosures the participant requests will be provided free of charge, but the Company may charge a fee (that will be disclosed in advance) for the cost of providing additional accountings.

**Complaints**

If participants believe their privacy rights have been violated, participants may file a complaint with the Company or with the Secretary of the Department of Health and Human Services. To file a complaint with the Company, contact the Privacy Officer at the address below. All complaints must be submitted in writing. Participants will not be penalized for filing a complaint.

**Privacy Officer**

Angela Sanchez  
Valero Energy Corporation  
P.O. Box 696000  
San Antonio, Texas 78269-6000  
(210) 345-2000

**Employer Certifications**

The Company is the sponsor of the plans described in this handbook. As required by HIPAA, the plans will disclose PHI to the Company, or the appropriate subsidiary or affiliate of the Company, in its role as the employer only upon receipt of a certification from the Company that the relevant plan documents have been amended to incorporate the following provisions.

The Company agrees to:

- Not use or further disclose PHI other than as permitted or required by the plan document or as required by law,
• Ensure that any agents, including a subcontractor, to whom the plan sponsor provides PHI received from the plan agree to the same restrictions and conditions that apply to the plan sponsor with respect to such PHI,

• Not use or disclose PHI for employment-related actions and decisions unless authorized by an individual,

• Not use or disclose PHI in connection with any other benefit or retiree health care plan of the plan sponsor unless authorized by an individual,

• Report to the plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which it becomes aware,

• Make PHI available to an Individual in accordance with HIPAA’s access requirements,

• Make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA,

• Make available the information required to provide an accounting of disclosures,

• Make internal practices, books and records relating to the use and disclosure of PHI received from the plan available to the HHS Secretary for the purposes of determining the plan’s compliance with HIPAA, and

• If feasible, return or destroy all PHI received from the plan that the plan sponsor still maintains in any form, and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made (or if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible).

The Company further agrees to maintain adequate separation between the plans and Valero. In accordance with HIPAA, the only employees or classes of employees who may be given access to PHI are employees in the HR Department, the Legal Department, the Information Services Department, the Corporate Records Management Department, the Internal Audit Department, the Privacy Officer, the Chief Administrative Officer, the President, the Chief Executive Officer and the Benefit Plans Administrative Committee. These persons may only have access to and use and disclose PHI for plan administration functions that the Company performs for the plans. If any of these persons do not comply with this SPD, the Company shall provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.
THE NEWBORNS’ AND MOTHERS’ HEALTH PROTECTION ACT OF 1996

Under federal law, group health care 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 cesarean section delivery. However, federal law generally does not prohibit the mother’s or newborn’s attending physician from discharging the mother or her newborn child earlier than 48 hours (or 96 hours, as applicable). In any case, group health care plans may not require that a provider obtain authorization from the plan for prescribing a length of stay of less than 48 hours (or 96 hours) as described above.

Additionally 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.

This plan requires precertification for stays longer than 48 hours (or 96 hours). Deductibles and other conditions of coverage, including co-insurance requirements, apply to hospital stays in connection with childbirth on the same terms as with any other covered benefits provided under the plan.

THE WOMEN’S HEALTH AND CANCER RIGHTS ACT OF 1998

This plan provides coverage for:

- All stages of reconstruction of the breast on which the mastectomy has been performed,
- Surgery and reconstruction of the other breast to produce a symmetrical appearance, and
- Prostheses and physical complications of mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the patient.

Such coverage may be subject to annual deductibles and coinsurance provisions as may be deemed appropriate and are consistent with those established for other benefits under the plan or coverage.

THE CHILDREN’S HEALTH INSURANCE PROGRAM REAUTHORIZATION ACT (CHIPRA), EFFECTIVE APRIL 1, 2009

CHIPRA provides for certain special enrollment rights effective April 1, 2009. Eligible retirees, or any dependents of the eligible retiree, may enroll for group health insurance coverage under this plan if the:
• Individual’s coverage under their respective Medicaid or state child health care plan is terminated as a result of loss of eligibility for the state plan(s); and/or

• Individual becomes eligible for premium assistance under Medicaid or state child health care plan.

If an individual qualifies under either of these events, the retiree must request coverage no later than 60 days after the qualifying event(s) occur.

THE GENETIC INFORMATION NONDISCRIMINATION ACT OF 2008 (GINA), EFFECTIVE JANUARY 1, 2010

GINA is a Federal Law that prohibits discrimination in group health care plan coverage and employment based on genetic information.

GINA, together with already existing nondiscrimination provisions of the Health Insurance Portability and Accountability Act (“HIPAA”), generally prohibits health insurers or health care Plan Administrators from requesting or requiring genetic information of an individual or an individual’s family members, or using such information for decisions regarding coverage, rates or preexisting conditions.

The Department of Health and Human Services is responsible for the health insurance provisions under GINA.

THE MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT, EFFECTIVE JANUARY 1, 2010

The Mental Health Parity and Addiction Equity Act requires insurers who offer mental health benefits to cover the diagnosis and treatment of certain mental health and substance use disorders to the same extent they cover the diagnosis and treatment of physical disorders.

AFFORDABLE CARE ACT (ACA), EFFECTIVE MARCH 23, 2010

The Valero Retiree Health Care Plan is a stand-alone retiree plan and is not subject to the terms of ACA. Questions regarding which protections apply and which protections do not apply to a health care plan can be directed to the Employee Benefits Security Administration, U.S. Department of Labor at (866) 444-3272 or www.dol.gov/ebsa/healthreform.

GOVERNING DOCUMENTS

The information in this handbook describes the Company’s retiree health care plans and important provisions of each plan. Complicated legal terms and provisions have been simplified for ease of understanding. Additionally, sometimes there are special
provisions that apply to certain groups of retirees, due in many cases to corporate events such as acquisitions. The handbook descriptions of the Company sponsored retiree health care plans do not replace the official documents that legally govern those plans. In any cases of conflict between the handbook descriptions and the legal documents, the legal plan documents and plan procedures control. Participants who have any questions at any time concerning their benefits are strongly urged to contact AmWINS to obtain clarification about plan benefits.
# PLAN ADMINISTRATION AND FUNDING

## VALERO ENERGY CORPORATION RETIREE HEALTH CARE PLAN

<table>
<thead>
<tr>
<th>Common Name &amp; Type of Plan</th>
<th>Plan Administration &amp; Funding Method</th>
<th>Contact Information</th>
</tr>
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<tbody>
<tr>
<td>AmWINS Retiree Administration</td>
<td>Both self-insured and fully insured plans are third-party administered; self-insured plans are paid through the general assets of the Company</td>
<td>AmWINS Group Benefits 50 Whitecap Drive North Kingstown, RI 02852 (877) 422-4170</td>
</tr>
<tr>
<td>COBRA Administration</td>
<td>Both self-insured and fully insured plans are third-party administered; self-insured plans are paid through the general assets of the Company</td>
<td>COBRA Administration &amp; Health Services, Inc. 3649 Post Road, Warwick, RI 02886</td>
</tr>
<tr>
<td>Aetna Retiree Medical $1,000 Deductible Plan, Aetna Retiree Open Choice PPO Plan &amp; Aetna Retiree OOA Plan Plan type: Medical</td>
<td>Self-insured and third-party administered; paid through general assets of the Company</td>
<td>Aetna Life Insurance Company 151 Farmington Avenue Hartford, Connecticut 06156 (800) 522-6649</td>
</tr>
<tr>
<td>United American Basic, Enhanced &amp; Premium Medical Plan Plan type: Medicare Supplement Plans</td>
<td>Fully-insured plans are third-party administered</td>
<td>United American P.O. Box 8080 McKinney, Texas 75070 (877) 422-4170 Administered by AmWINS*</td>
</tr>
<tr>
<td>Express Scripts Plan type: Prescription (for non-Medicare plans)</td>
<td>Self-insured and third-party administered; paid through general assets of the Company</td>
<td>Express Scripts, Inc. One Express Way St. Louis, Missouri 63121 (800) 294-5060</td>
</tr>
<tr>
<td>United American Insurance Company Plan type: Prescription (for Medicare plans)</td>
<td>Fully insured plans are third-party administered</td>
<td>United American Insurance Company Attn: Medicare Part D P.O. Box 8080 McKinney, TX 75070-8080 (866) 524-4199 Administered by AmWINS*</td>
</tr>
<tr>
<td>Common Name &amp; Type of Plan</td>
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<td>Contact Information</td>
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</tbody>
</table>
| Aetna Retiree Dental $50 Deductible Plan  
Plan type: Dental | Self-insured and third-party administered; paid through general assets of the Company | Aetna  
P.O. Box 14094  
Lexington, KY 40512-4094  
(800) 843-3661 |
| VSP Retiree Vision Plan  
Plan type: Vision | Self-insured and third-party administered; paid through general assets of the Company | VSP  
3333 Quality Drive  
Rancho Cordova, California 95670  
(800) 877-7195 |
| Company Paid Life Insurance  
Plan type: Life insurance | Fully insured and insurer administered; paid through employer premiums | Metropolitan Life Insurance Company  
177 South Commons Drive  
Aurora, Illinois 60507  
(800) 638-6420 |

*For assistance with the fully insured Medicare supplement medical plans and corresponding prescription drug coverage, retirees should contact the plan administrator, AmWINS Group Benefits, at (877) 422-4170.*
ACRONYM INDEX

-A-
ACH – Automated Clearing House
ADA – American Dental Association
Aflac – American Family Life Assurance Company of Columbus family
ALS – Amyotrophic Lateral Sclerosis
ART – Advanced Reproductive Technology

-B-
BPAC – Benefit Plans Administrative Committee

-C-
C.R.N.A. – Certified Registered Nurse Anesthetist
CAT – Computed Axial Tomography scans
CHIPRA – Children’s Health Insurance Program Reauthorization Act
COBRA – Consolidated Omnibus Budget Reconciliation Act of 1985
CST – Central Standard Time

-D-
DCBE – Double Contrast Barium Enema
DME – Durable Medical and Surgical Equipment
DSM – Diagnostic and Statistical Manual of Mental Disorders

-E-
EOB – Explanation of Benefits
ERSD – End Stage Renal Disease
ESI – Express Scripts, Inc.

-F-
FDA – Food and Drug Administration

-G-
GIFT – Gamete Intra-Fallopian Transfer
GINA – Genetic Information Nondiscrimination Act of 2008

-H-
HEART – Heroes Earnings Assistance and Relief Tax Act of 2008
HHS – Health and Human Services
HIPAA – Health Insurance Portability and Accountability Act
HR – Human Resources
IADL – Instrumental Activities of Daily Living
ICSI – Intra-Cytoplasmic Sperm Injection
ICU – Intensive Care Unit
IEP – Initial Enrollment Period
ID – Identification
IND – Investigational New Drug
IRS – Internal Revenue Service
ITA – Invitational Travel Authorization
ITO – Invitational Travel Order
IUD – Inter-Uterine Devices
IV – Intravenous
IVF – In Vitro Fertilization

L.P.N. – A licensed practical or vocational nurse

MDP – Maintenance drug program
MetLife – Metropolitan Life Insurance Company
MPD – Myofacial Pain Dysfunction
MRI – Magnetic Resonance Imaging

NCI – National Cancer Institute

OOA – Out-of-Area
OMB – Office of Management and Budge
OTC – Over-the-Counter

PCP – Primary Care Physician
PET – Positron Emission Tomography
PHI – Protected Health Information
PPACA – Patient Protection and Affordable Care Act
PPI – Proton pump inhibitors
PPO – Preferred Provider Organization
PSA – Prostate Specific Antigen

QDRO – Qualified Domestic Relations Order
QMCSO – Qualified Medical Child Support Order
QRD – Qualified Reservist Distribution
QSC – Qualified Status Change
-R-
RDIS – Retiree and Dependent Information Sheet
R.N. – A registered nurse

-S-
SPD – Summary Plan Description
SSA – Social Security Administration
SSDI – Social Security Disability Insurance

-T-
TMJ – Temporomandibular Joint
TPN – Total Parenteral Nutrition
TTD – Total Temporary Disability

-U-
USERRA – Uniformed Services Employment and Reemployment Rights Act of 1994

-W-
WC – Workers’ compensation

-Z-
ZIFT – Zygote Intra-Fallopian Transfer
### Summary of Benefits and Coverage: What this Plan Covers & What it Costs

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<tr>
<td><strong>What is the overall deductible?</strong></td>
<td>For each Calendar Year, Network: Individual $1,000/Family $0. Out-of-Network: Individual $1,000/Family $0. Does not apply to preventive care in-network.</td>
<td>You must pay all the costs up to the <strong>deductible</strong> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <strong>deductible</strong> starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the <strong>deductible</strong>.</td>
</tr>
<tr>
<td><strong>Are there other deductibles for specific services?</strong></td>
<td>$50 in-network and out-of-network combined calendar year deductible for preferred and non-preferred brand drugs. Separate $50 calendar year deductible for Specialty Drugs.</td>
<td>You must pay all of the costs for these services up to the specific <strong>deductible</strong> amount before this plan begins to pay for these services. See the chart starting on page 2 for other costs for services this plan covers.</td>
</tr>
<tr>
<td><strong>Is there an out-of-pocket limit on my expenses?</strong></td>
<td>Yes. Medical-Network: Individual $2,500/Family $5,000. Out-of-Network: Individual $5,000/Family $10,000. Prescription-Network: Individual $4,100/Family $8,200; includes the $1,000 Specialty out-of-pocket limit. The network medical and prescription out-of-pocket limits accumulate separately.</td>
<td>The <strong>out-of-pocket limit</strong> is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.</td>
</tr>
<tr>
<td><strong>What is not included in the out-of-pocket limit?</strong></td>
<td>Premiums, balance-billed charges, penalties for failure to obtain pre-authorization for service and health care this plan does not cover.</td>
<td>Even though you pay these expenses, they don't count toward the <strong>out-of-pocket limit</strong>.</td>
</tr>
<tr>
<td><strong>Is there an overall lifetime limit on what the plan pays?</strong></td>
<td>Yes. $2,000,000 maximum per person per lifetime with $20,000 annual restoration for in-network and out-of-network.</td>
<td>This plan will pay for covered services only up to this limit during each coverage period, even if your own need is greater. You're responsible for all expenses above this limit. The chart starting on page 2 describes specific coverage limits, such as limits on the number of office visits.</td>
</tr>
<tr>
<td><strong>Does this plan use a network of providers?</strong></td>
<td>Yes. See <a href="http://www.aetna.com">www.aetna.com</a> or call 1-800-414-0768 for a list of network providers.</td>
<td>If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred, or participating for providers in their network. See the chart starting on page 2 for how this plan pays different kinds of providers.</td>
</tr>
<tr>
<td><strong>Do I need a referral to see a specialist?</strong></td>
<td>No.</td>
<td>You can see the specialist you choose without permission from this plan.</td>
</tr>
<tr>
<td><strong>Are there services this plan doesn't cover?</strong></td>
<td>Yes.</td>
<td>Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about excluded services.</td>
</tr>
</tbody>
</table>
Coverage Period: 01/01/2016 - 12/31/2016

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

**Coverage for:** Individual + Family | **Plan Type:** POS

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is your share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network provider charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called balance billing.)
- This plan may encourage you to use network **providers** by charging you lower **deductibles**, **copayments**, and **coinsurance** amounts.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Your Cost If You Use a Network Provider</th>
<th>Your Cost If You Use an Out-of-Network Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
<td>Includes Internist, General Physician, Family Practitioner or Pediatrician.</td>
</tr>
<tr>
<td>If you visit a health care provider's office or clinic</td>
<td>Primary care visit to treat an injury or illness</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
<td>none</td>
</tr>
<tr>
<td></td>
<td>Other practitioner office visit</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
<td>Coverage is limited to 20 visits per calendar year for Chiropractic care.</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization</td>
<td>No charge</td>
<td>30% coinsurance, deductible waived</td>
<td>Age and frequency schedules may apply.</td>
</tr>
<tr>
<td>If you have a test</td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
<td>none</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
<td>none</td>
</tr>
</tbody>
</table>
### Summary of Benefits and Coverage: What this Plan Covers & What it Costs

**Coverage Period:** 01/01/2016 - 12/31/2016

**Coverage for:** Individual + Family  |  **Plan Type:** POS

<table>
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<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
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<th>Your Cost If You Use an Out-of-Network Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you need drugs to treat your illness or condition, <em>prescription drug coverage</em> is administered by Express Scripts. The Preferred Formulary, Maintenance Medication, Step Therapy and Prior Authorization drug lists are available by calling 1-800-294-5060.</td>
<td>Generic drugs</td>
<td>$7 copay/prescription (retail), $15 copay/prescription (Retail90 &amp; Home Delivery)</td>
<td>Applicable copay and difference between actual drug cost and the in-network contracted rate.</td>
<td>Coverage is limited up to a 30-day supply (retail), 84-90 day supply (Retail90) and up to a 90-day supply (Home Delivery). Coverage is subject to Preferred Formulary drug list. Some prescriptions may be subject to a Maintenance Medication Retail90 program, Step Therapy Program, Prior Authorization and/or quantity limits.</td>
</tr>
<tr>
<td></td>
<td>Preferred brand drugs</td>
<td>$20 copay/prescription (retail), $40 copay/prescription (Retail90 &amp; Home Delivery)</td>
<td>Applicable copay and difference between actual drug cost and the in-network contracted rate.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Non-preferred brand drugs</td>
<td>$35 copay/prescription (retail), $70 copay/prescription (Retail90 &amp; Home Delivery)</td>
<td>Applicable copay and difference between actual drug cost and the in-network contracted rate.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Specialty drugs</td>
<td>20% coinsurance up to $250/prescription</td>
<td>Not applicable</td>
<td>Specialty drugs covered only when obtained through Accredo Pharmacy. For more information call 1-800-922-8279.</td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
<td>none</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
<td>none</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room services</td>
<td>10% coinsurance</td>
<td>10% coinsurance</td>
<td>No coverage for non-emergency use.</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>10% coinsurance</td>
<td>10% coinsurance</td>
<td>none</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
<td>none</td>
</tr>
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Summary of Benefits and Coverage: What this Plan Covers & What it Costs

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<th>Limitations &amp; Exceptions</th>
</tr>
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<tbody>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
<td>Pre-authorization required for out-of-network care.</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fee</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
<td></td>
</tr>
<tr>
<td>If you have mental health, behavioral health, or substance abuse needs</td>
<td>Mental/Behavioral health outpatient services</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
<td>Pre-authorization required for out-of-network care.</td>
</tr>
<tr>
<td></td>
<td>Mental/Behavioral health inpatient services</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Substance use disorder outpatient services</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Substance use disorder inpatient services</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
<td>Pre-authorization required for out-of-network care.</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Prenatal and postnatal care</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
<td>If your plan is subject to health care reform law, there will be no charge for in-network preventive prenatal care.</td>
</tr>
<tr>
<td></td>
<td>Delivery and all inpatient services</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
<td>Includes outpatient postnatal care. Pre-authorization may be required for out-of-network care.</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
<td>Coverage is limited to 120 visits per calendar year. Pre-authorization required for out-of-network care.</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
<td>Coverage is limited to 60 visits per calendar year for Autism Physical &amp; Occupational Therapy combined, 30 visits per calendar year for Autism Speech Therapy.</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
<td>Coverage is limited to 60 days per calendar year. Pre-authorization required for out-of-network care.</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
<td></td>
</tr>
</tbody>
</table>
# Summary of Benefits and Coverage: What this Plan Covers & What it Costs

**Coverage for:** Individual + Family  | **Plan Type:** POS

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Your Cost If You Use a Network Provider</th>
<th>Your Cost If You Use an Out-of-Network Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
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<tbody>
<tr>
<td>Hospice service</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
<td>Pre-authorization required for out-of-network care.</td>
<td></td>
</tr>
</tbody>
</table>

### If your child needs dental or eye care

<table>
<thead>
<tr>
<th>Service</th>
<th>Your Cost If You Use a Network Provider</th>
<th>Your Cost If You Use an Out-of-Network Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eye exam</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td>Glasses</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td>Dental check-up</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

### Excluded Services & Other Covered Services:

**Services Your Plan Does NOT Cover** (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Cosmetic surgery
- Dental care (Adult & Child)
- Glasses (Child)
- Hearing aids
- Long-term care
- Routine eye care (Adult & Child)
- Routine foot care
- Weight loss programs

**Other Covered Services** (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Acupuncture
- Bariatric surgery
- Chiropractic care - Coverage is limited to 20 visits per calendar year.
- Infertility treatment – Medical coverage is limited to the diagnosis and treatment of underlying medical condition, $25,000 per lifetime for artificial insemination, advanced reproductive technology and ovulation induction.
- Private-duty nursing - Coverage is limited to 70 - 8 hour shifts per calendar year.
- Non-emergency care when traveling outside the U.S.
## Summary of Benefits and Coverage: What this Plan Covers & What it Costs

**Coverage for:** Individual + Family  | **Plan Type:** PPO

<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why this Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the overall deductible?</td>
<td>For each Calendar Year, Network: Individual $500/Family $1,000. Out–of–Network: Individual $1,000/Family $2,000. Does not apply to office visits, emergency care, and preventive care in-network.</td>
<td>You must pay all the costs up to the <strong>deductible</strong> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible.</td>
</tr>
<tr>
<td>Are there other deductibles for specific services?</td>
<td>$50 in-network and out-of-network combined calendar year deductible for preferred and non-preferred brand drugs. Separate $50 calendar year deductible for Specialty Drugs.</td>
<td>You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services. See the chart starting on page 2 for other costs for services this plan covers.</td>
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<tr>
<td>Is there an out-of-pocket limit on my expenses?</td>
<td>Yes. Medical-Network: Individual $2,500/Family $5,000. Out–of–Network: Individual $5,000/Family $10,000. Prescription-Network: Individual $4,100/Family $8,200; includes the $1,000 Specialty out-of-pocket limit. The network medical and prescription out-of-pocket limits accumulate separately.</td>
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<td>Premiums, balance-billed charges, penalties for failure to obtain pre-authorization for service and health care this plan does not cover.</td>
<td>Even though you pay these expenses, they don't count toward the <strong>out-of-pocket limit</strong>.</td>
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<td>Is there an overall lifetime limit on what the plan pays?</td>
<td>Yes. $2,000,000 maximum per person per lifetime with $20,000 annual restoration for in-network and out-of-network.</td>
<td>This plan will pay for covered services only up to this limit during each coverage period, even if your own need is greater. You're responsible for all expenses above this limit. The chart starting on page 2 describes specific coverage limits, such as limits on the number of office visits.</td>
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<td>Does this plan use a network of providers?</td>
<td>Yes. See <a href="http://www.aetna.com">www.aetna.com</a> or call 1-800-414-0768 for a list of network providers.</td>
<td>If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred, or participating for providers in their network. See the chart starting on page 2 for how this plan pays different kinds of providers.</td>
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<td>Do I need a referral to see a specialist?</td>
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**Summary of Benefits and Coverage: What this Plan Covers & What it Costs**

**Coverage for:** Individual + Family  | **Plan Type:** PPO

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
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- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use network **providers** by charging you lower **deductibles**, **copayments**, and **coinsurance** amounts.

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<td>If you visit a health care provider's office or clinic</td>
<td>Primary care visit to treat an injury or illness</td>
<td>$25 copay/visit</td>
<td>40% coinsurance</td>
<td>Includes Internist, General Physician, Family Practitioner or Pediatrician.</td>
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<tr>
<td></td>
<td>Specialist visit</td>
<td>$35 copay/visit</td>
<td>40% coinsurance</td>
<td>none</td>
</tr>
<tr>
<td></td>
<td>Other practitioner office visit</td>
<td>$35 copay/visit</td>
<td>40% coinsurance</td>
<td>Coverage is limited to 26 visits per calendar year for Chiropractic care.</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization</td>
<td>No charge, except $35 copay/visit for hearing exams up to $150 allowance max combined with hearing hardware</td>
<td>40% coinsurance, deductible waived, except hearing exams no charge up to $150 max, combined with hearing hardware</td>
<td>Age and frequency schedules may apply.</td>
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<tr>
<td>If you have a test</td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td>none</td>
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<td>Imaging (CT/PET scans, MRIs)</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
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<td>Services You May Need</td>
<td>Your Cost If You Use a Network Provider</td>
<td>Your Cost If You Use an Out-of-Network Provider</td>
<td>Limitations &amp; Exceptions</td>
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<td>Generic drugs</td>
<td>$7 copay/prescription (retail), $15 copay/prescription (Retail90 &amp; Home Delivery)</td>
<td>Applicable copay and difference between actual drug cost and in-network contracted rate.</td>
<td>Coverage is limited up to a 30-day supply (retail), 84-90 day supply (Retail90) and up to a 90-day supply (Home Delivery). Coverage is subject to Preferred Formulary drug list. Some prescriptions may be subject to a Maintenance Medication Retail90 program, Step Therapy Program, Prior Authorization and/or quantity limits.</td>
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<td></td>
<td>Preferred brand drugs</td>
<td>$20 copay/prescription (retail), $40 copay/prescription (Retail90 &amp; Home Delivery)</td>
<td>Applicable copay and difference between actual drug cost and in-network contracted rate.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Non-preferred brand drugs</td>
<td>$35 copay/prescription (retail), $70 copay/prescription (Retail90 &amp; Home Delivery)</td>
<td>Applicable copay and difference between actual drug cost and in-network contracted rate.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Specialty drugs</td>
<td>20% coinsurance up to $250/prescription</td>
<td>Not applicable</td>
<td>Specialty drugs covered only when obtained through Accredo Pharmacy. For more information call 1-800-922-8279.</td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td>none</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td>none</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room services</td>
<td>$200 copay/visit</td>
<td>$200 copay/visit</td>
<td>No coverage for non-emergency use.</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td>none</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>$100 copay/visit</td>
<td>40% coinsurance</td>
<td>none</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td>Pre-authorization required for out-of-network care.</td>
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# Summary of Benefits and Coverage: What this Plan Covers & What it Costs

**Coverage Period:** 01/01/2016 - 12/31/2016

**Coverage for:** Individual + Family  |  **Plan Type:** PPO

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</thead>
<tbody>
<tr>
<td><strong>If you have mental</strong></td>
<td>Physician/surgeon fee</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td>——none——</td>
</tr>
<tr>
<td><strong>health, behavioral</strong></td>
<td>Mental/Behavioral health outpatient services</td>
<td>$25 copay/office visit, all other: 20% coinsurance</td>
<td>40% coinsurance</td>
<td>Pre-authorization required for out-of-network care.</td>
</tr>
<tr>
<td><strong>health, or substance</strong></td>
<td>Mental/Behavioral health inpatient services</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td>Pre-authorization required for out-of-network care.</td>
</tr>
<tr>
<td><strong>abuse needs</strong></td>
<td>Substance use disorder outpatient services</td>
<td>$25 copay/office visit, all other: 20% coinsurance</td>
<td>40% coinsurance</td>
<td>——none——</td>
</tr>
<tr>
<td><strong>If you are pregnant</strong></td>
<td>Substance use disorder inpatient services</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td>Pre-authorization required for out-of-network care.</td>
</tr>
<tr>
<td><strong>Prenatal and postnatal care</strong></td>
<td>20% coinsurance</td>
<td>40% coinsurance, deductible waived</td>
<td>Pre-authorization required for in-network preventive prenatal care.</td>
<td></td>
</tr>
<tr>
<td><strong>Delivery and all inpatient services</strong></td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td>Includes outpatient postnatal care. Pre-authorization may be required for out-of-network care.</td>
<td></td>
</tr>
<tr>
<td><strong>If you need help recovering or have other special health needs</strong></td>
<td>Home health care</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td>Coverage is limited to 120 visits per calendar year. Pre-authorization required for out-of-network care.</td>
</tr>
<tr>
<td><strong>Rehabilitation services</strong></td>
<td>$35 copay/visit, except no charge for outpatient hospital</td>
<td>40% coinsurance</td>
<td>Coverage is limited to 90 visits per calendar year for Physical and Occupational Therapy combined, 90 visits per calendar year for Speech Therapy.</td>
<td></td>
</tr>
<tr>
<td><strong>Habilitation services</strong></td>
<td>$35 copay/visit</td>
<td>40% coinsurance</td>
<td>Coverage is limited to 60 visits per calendar year for Autism Physical &amp; Occupational Therapy combined, 30 visits per calendar year for Autism Speech Therapy.</td>
<td></td>
</tr>
<tr>
<td><strong>Skilled nursing care</strong></td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td>Coverage is limited to 100 days per calendar year. Pre-authorization required for out-of-network care.</td>
<td></td>
</tr>
<tr>
<td><strong>Durable medical equipment</strong></td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td>——none——</td>
<td></td>
</tr>
</tbody>
</table>
### Summary of Benefits and Coverage: What this Plan Covers & What it Costs

#### Coverage for: Individual + Family | Plan Type: PPO

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Your Cost If You Use a Network Provider</th>
<th>Your Cost If You Use an Out-of-Network Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Hospice service</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td>Pre-authorization required for out-of-network care.</td>
</tr>
</tbody>
</table>

**If your child needs dental or eye care**

|                      | Eye exam              | Not covered                             | Not covered                                  | Not covered              |
|                      | Glasses               | Not covered                             | Not covered                                  | Not covered              |
|                      | Dental check-up       | Not covered                             | Not covered                                  | Not covered              |

#### Excluded Services & Other Covered Services:

**Services Your Plan Does NOT Cover** (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Cosmetic surgery
- Dental care (Adult & Child)
- Glasses (Child)
- Long-term care
- Routine eye care (Adult & Child)
- Routine foot care
- Weight loss programs

**Other Covered Services** (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Acupuncture
- Bariatric surgery
- Chiropractic care - Coverage is limited to 26 visits per calendar year.
- Hearing aids - Coverage is limited to $150 maximum per calendar year combined with hearing exam.
- Non-emergency care when traveling outside the U.S.
- Infertility treatment – Medical coverage is limited to the diagnosis and treatment of underlying medical condition, $25,000 per lifetime for artificial insemination, advanced reproductive technology and ovulation induction.
- Private-duty nursing - Coverage is limited to 70 - 8 hour shifts per calendar year.
### Summary of Benefits and Coverage: What this Plan Covers & What it Costs

**Coverage for:** Individual + Family  |  **Plan Type:** Indemnity

**This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at [www.valero.amwins.com](http://www.valero.amwins.com) or by calling (877) 422-4170.

<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why this Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the overall deductible?</td>
<td>For each Calendar Year, Individual $500/ Family $1,000. Does not apply to preventive care.</td>
<td>You must pay all the costs up to the <strong>deductible</strong> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <strong>deductible</strong> starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the <strong>deductible</strong>.</td>
</tr>
<tr>
<td>Are there other deductibles for specific services?</td>
<td>$50 in-network and out-of-network combined calendar year deductible for preferred and non-preferred brand drugs. Separate $50 calendar year deductible for Specialty Drugs.</td>
<td>You must pay all of the costs for these services up to the specific <strong>deductible</strong> amount before this plan begins to pay for these services. See the chart starting on page 2 for other costs for services this plan covers.</td>
</tr>
<tr>
<td>Is there an out-of-pocket limit on my expenses?</td>
<td>Yes. Medical-Individual $2,500/Family $5,000. Prescription-Individual $4,100/Family $8,200; includes the $1,000 Specialty out-of-pocket limit. The medical and prescription out-of-pocket limits accumulate separately.</td>
<td>The <strong>out-of-pocket limit</strong> is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.</td>
</tr>
<tr>
<td>What is not included in the out-of-pocket limit?</td>
<td>Premiums, balance-billed charges, penalties for failure to obtain pre-authorization for service and health care this plan does not cover.</td>
<td>Even though you pay these expenses, they don't count toward the <strong>out-of-pocket limit</strong>.</td>
</tr>
<tr>
<td>Is there an overall lifetime limit on what the plan pays?</td>
<td>Yes. $2,000,000 maximum per person per lifetime with $20,000 annual restoration for in-network and out-of-network.</td>
<td>This plan will pay for covered services only up to this limit during each coverage period, even if your own need is greater. You're responsible for all expenses above this limit. The chart starting on page 2 describes specific coverage limits, such as limits on the number of office visits.</td>
</tr>
<tr>
<td>Does this plan use a network of providers?</td>
<td>No.</td>
<td>This plan treats <strong>providers</strong> the same in determining payment for the same services.</td>
</tr>
<tr>
<td>Do I need a referral to see a specialist?</td>
<td>No.</td>
<td>You can see the <strong>specialist</strong> you choose without permission from this plan.</td>
</tr>
<tr>
<td>Are there services this plan doesn't cover?</td>
<td>Yes.</td>
<td>Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about <strong>excluded services</strong>.</td>
</tr>
</tbody>
</table>
**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs

**Coverage Period:** 01/01/2016 - 12/31/2016

**Coverage for:** Individual + Family | **Plan Type:** Indemnity

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your coinsurance payment of 20% would be $200. This may change if you haven't met your deductible.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network provider charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the allowed amount is $1,000, you may have to pay the $500 difference. (This is called balance billing.)
- Your cost sharing does not depend on whether a provider is in a network.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Your Cost</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you visit a health care provider's office or clinic</td>
<td>Primary care visit to treat an injury or illness</td>
<td>20% coinsurance</td>
<td>__<strong><strong><strong><strong><strong><strong><strong><strong>none</strong></strong></strong></strong></strong></strong></strong></strong></td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>20% coinsurance</td>
<td>__<strong><strong><strong><strong><strong><strong><strong><strong>none</strong></strong></strong></strong></strong></strong></strong></strong></td>
</tr>
<tr>
<td></td>
<td>Other practitioner office visit</td>
<td>20% coinsurance</td>
<td>Coverage is limited to 26 visits per calendar year for Chiropractic care.</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization</td>
<td>No charge</td>
<td>Age and frequency schedules may apply.</td>
</tr>
<tr>
<td>If you have a test</td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>20% coinsurance</td>
<td>__<strong><strong><strong><strong><strong><strong><strong><strong>none</strong></strong></strong></strong></strong></strong></strong></strong></td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>20% coinsurance</td>
<td>__<strong><strong><strong><strong><strong><strong><strong><strong>none</strong></strong></strong></strong></strong></strong></strong></strong></td>
</tr>
</tbody>
</table>
**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Your Cost</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If you need drugs to treat your illness or condition, prescription drug coverage</strong> is administered by Express Scripts. The Preferred Formulary, Maintenance Medication, Step Therapy and Prior Authorization drug lists are available by calling 1-800-294-5060.</td>
<td>Generic drugs</td>
<td>$7 copay/prescription (retail), $15 copay/prescription (Retail90 &amp; Home Delivery)</td>
<td>Coverage is limited up to a 30-day supply (Retail), an 84-90 day supply (Retail90), and up to a 90-day supply (Home Delivery).</td>
</tr>
<tr>
<td></td>
<td>Preferred brand drugs</td>
<td>$20 copay/prescription (retail), $40 copay/prescription (Retail90 &amp; Home Delivery)</td>
<td>Coverage is subject to Preferred Formulary drug list. Some prescriptions may be subject to a Maintenance Medication Retail90 program, Step Therapy Program, Prior Authorization and/or quantity limits.</td>
</tr>
<tr>
<td></td>
<td>Non-preferred brand drugs</td>
<td>$35 copay/prescription (retail), $70 copay/prescription (Retail90 &amp; Home Delivery)</td>
<td>If you use an Out-of-Network pharmacy, your cost will be the applicable copay and difference between the actual drug cost and the in-network contracted rate.</td>
</tr>
<tr>
<td></td>
<td>Specialty drugs</td>
<td>20% coinsurance up to $250/prescription</td>
<td>Specialty drugs covered only when obtained through Accredo. For more information call 1-800-922-8279.</td>
</tr>
<tr>
<td><strong>If you have outpatient surgery</strong></td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>20% coinsurance</td>
<td>none</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>20% coinsurance</td>
<td>none</td>
</tr>
<tr>
<td><strong>If you need immediate medical attention</strong></td>
<td>Emergency room services</td>
<td>20% coinsurance</td>
<td>No coverage for non-emergency use.</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>20% coinsurance</td>
<td>none</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>20% coinsurance</td>
<td>none</td>
</tr>
<tr>
<td><strong>If you have a hospital stay</strong></td>
<td>Facility fee (e.g., hospital room)</td>
<td>20% coinsurance</td>
<td>Precertification required.</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fee</td>
<td>20% coinsurance</td>
<td>none</td>
</tr>
</tbody>
</table>
## Summary of Benefits and Coverage: What this Plan Covers & What it Costs

**Coverage Period:** 01/01/2016 - 12/31/2016

**Coverage for:** Individual + Family | **Plan Type:** Indemnity

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Your Cost</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you have mental health, behavioral health, or substance abuse needs</td>
<td>Mental/Behavioral health outpatient services</td>
<td>20% coinsurance</td>
<td>Pre-authorization required for care.</td>
</tr>
<tr>
<td></td>
<td>Mental/Behavioral health inpatient services</td>
<td>20% coinsurance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Substance use disorder outpatient services</td>
<td>20% coinsurance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Substance use disorder inpatient services</td>
<td>20% coinsurance</td>
<td></td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Prenatal and postnatal care</td>
<td>20% coinsurance</td>
<td>If your plan is subject to health care reform law, there will be no charge for in-network preventive prenatal care.</td>
</tr>
<tr>
<td></td>
<td>Delivery and all inpatient services</td>
<td>20% coinsurance</td>
<td>Includes outpatient postnatal care. Pre-authorization may be required for care.</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>20% coinsurance</td>
<td>Coverage is limited to 120 visits per calendar year. Pre-authorization required for care.</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>20% coinsurance</td>
<td>Coverage is limited to 90 visits per calendar year for Physical, Speech and Occupational Therapy combined.</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>20% coinsurance</td>
<td>Coverage is limited to 60 visits per calendar year for Autism Physical &amp; Occupational Therapy, combined, 30 visits per calendar year for Autism Speech Therapy.</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>20% coinsurance</td>
<td>Coverage is limited to 60 days per calendar year. Pre-authorization required for care.</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>20% coinsurance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Hospice service</td>
<td>20% coinsurance</td>
<td>Pre-authorization required for care.</td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td>Eye exam</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Glasses</td>
<td>Not covered</td>
<td></td>
</tr>
</tbody>
</table>
### Summary of Benefits and Coverage: What this Plan Covers & What it Costs

**Coverage Period:** 01/01/2016 - 12/31/2016

**Coverage for:** Individual + Family | **Plan Type:** Indemnity

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Your Cost</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dental check-up</td>
<td>Not covered</td>
<td></td>
<td>Not covered</td>
</tr>
</tbody>
</table>

#### Excluded Services & Other Covered Services:

**Services Your Plan Does NOT Cover**  
(This isn't a complete list. Check your policy or plan document for other excluded services.)

- Cosmetic surgery
- Dental care (Adult & Child)
- Glasses (Child)
- Long-term care
- Routine eye care (Adult & Child)
- Routine foot care
- Weight loss programs

**Other Covered Services**  
(This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Acupuncture
- Bariatric surgery
- Chiropractic care - Coverage is limited to 26 visits per calendar year.
- Hearing aids
- Infertility treatment – Medical coverage is limited to the diagnosis and treatment of underlying medical condition, $25,000 per lifetime for artificial insemination, advanced reproductive technology and ovulation induction.
- Private-duty nursing
- Non-emergency care when traveling outside the U.S.
<table>
<thead>
<tr>
<th>PLAN FEATURES</th>
<th>United American BASIC PLAN</th>
<th>United American ENHANCED PLAN</th>
<th>United American PREMIUM PLAN</th>
</tr>
</thead>
<tbody>
<tr>
<td>ANNUAL DEDUCTIBLE</td>
<td>$0 for Part A Services</td>
<td>$0 for Part A Services</td>
<td>$0</td>
</tr>
<tr>
<td></td>
<td>$166 Part B Deductible</td>
<td>$166 Part B Deductible</td>
<td></td>
</tr>
<tr>
<td>COINSURANCE AMOUNT</td>
<td>20% for part B Services Only</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>COINSURANCE MAXIMUM</td>
<td>Single: $1,000 (incl DED)</td>
<td>$166 Part B Deductible</td>
<td></td>
</tr>
<tr>
<td>OUT-OF-POCKET AMOUNT (OOP)</td>
<td>Office Visit Copayments</td>
<td></td>
<td></td>
</tr>
<tr>
<td>LIFETIME MAXIMUM BENEFIT</td>
<td>UNLIMITED</td>
<td>UNLIMITED</td>
<td>UNLIMITED</td>
</tr>
<tr>
<td>NETWORK REQUIREMENTS</td>
<td>ANY MEDICARE PROVIDER</td>
<td>ANY MEDICARE PROVIDER</td>
<td>ANY MEDICARE PROVIDER</td>
</tr>
<tr>
<td>PART A HOSPITAL SERVICES</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>PART B MEDICAL SERVICES</td>
<td>20% after Deductible up to OOP max, then $0</td>
<td>$0 after Part B Deductible</td>
<td>$0</td>
</tr>
<tr>
<td>PHYSICIAN/URGENT CARE OFFICE VISIT CDPAY</td>
<td>$20</td>
<td>$20</td>
<td>$0</td>
</tr>
<tr>
<td>EMERGENCY ROOM CDPAY</td>
<td>$50 (waived if admitted)</td>
<td>$50 (waived if admitted)</td>
<td></td>
</tr>
<tr>
<td>PREVENTIVE/WELLNESS SERVICES</td>
<td>$0 for Medicare Schedule</td>
<td>$0 for Medicare Schedule</td>
<td>$0 for Medicare Schedule</td>
</tr>
</tbody>
</table>

In case of errors or omissions, the plan documents govern.
# PRESCRIPTION DRUG SUMMARY

Insured by United American Insurance Company for Valero

<table>
<thead>
<tr>
<th>Prescription Drug Tier</th>
<th>Up to 30-Day Supply: Retail</th>
<th>Up to 90-Day Supply: Retail</th>
<th>Up to 90-Day Supply: Mail Order</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Tier 1: Preferred Generics</strong></td>
<td>$7</td>
<td>$21</td>
<td>$14</td>
</tr>
<tr>
<td><strong>Tier 2: Non-Preferred Generics</strong></td>
<td>$7</td>
<td>$21</td>
<td>$14</td>
</tr>
<tr>
<td><strong>Tier 3: Preferred Brand</strong></td>
<td>$30</td>
<td>$90</td>
<td>$60</td>
</tr>
<tr>
<td><strong>Tier 4: Non-Preferred Brand</strong></td>
<td>$60</td>
<td>$180</td>
<td>$120</td>
</tr>
<tr>
<td><strong>Tier 5: Specialty</strong></td>
<td>30% (Maximum of $120) per prescription</td>
<td>30% (Maximum of $360) per prescription</td>
<td>30% (Maximum of $240) per prescription</td>
</tr>
</tbody>
</table>

Total Out-of-Pocket Costs: Once you pay $4,700 in Total Out-of-Pocket Prescription Drug Costs, you will then pay the greater of 5% or $2.65 for Generics and $6.60 for Brand name drugs.
2016 Aetna Dental $50 Deductible Plan

This is a summary of benefits, and is not all inclusive of plan benefits, services, limitations or exclusions. All services are subject to the plan provisions in effect at the time services are rendered. All covered services are subject to allowable charges. Participants should refer to www.aetna.com for Network Provider information. The Aetna network is the “Dental PPO/PDN with PPOII Network.” For additional plan details contact Aetna Customer Service at (800) 843-3661 or the Valero Health and Welfare Benefits Department at (800) 333-3377, extension 4000.

<table>
<thead>
<tr>
<th>Aetna Dental $50 Deductible Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Individual Calendar Year Deductible</strong></td>
</tr>
<tr>
<td>- No deductible for preventive and diagnostic services</td>
</tr>
<tr>
<td>- $50 individual calendar year deductible for basic and major restorative services combined</td>
</tr>
<tr>
<td><strong>Maximum Benefit Amount</strong></td>
</tr>
<tr>
<td>- $2,500 per individual, per plan year for basic and major dental services (combined)</td>
</tr>
<tr>
<td>- $2,000 per individual, lifetime maximum for orthodontics payable over the comprehensive treatment period</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Features</th>
<th>Benefits</th>
<th>Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventive and Diagnostic Care</td>
<td>• Paid at 100% of allowable charge</td>
<td>• 4 routine cleanings</td>
</tr>
<tr>
<td></td>
<td>• Treatment limited to specified items of care, per calendar year</td>
<td>• 2 oral exams (routine or problem focused)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• 2 fluoride treatments</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• 1 full mouth x-ray or 1 panoramic x-ray per plan year</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• 1 set of bitewing x-rays per plan year</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Sealants for permanent molars only</td>
</tr>
<tr>
<td>Basic and Major Restorative Care</td>
<td>• Paid at 80% of allowable charge</td>
<td>• X-ray and Pathology</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Oral surgery</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Periodontics</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Endodontics</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Restorative Dentistry (fillings, inlays/onlays, crowns)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Space Maintainers</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Prosthodontics (dentures, bridges, pontics)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Emergency treatment</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Anesthetics</td>
</tr>
<tr>
<td>Orthodontics</td>
<td>• Paid at 50% of allowable charge</td>
<td>• The appliance necessary to straighten and reposition teeth</td>
</tr>
<tr>
<td></td>
<td>• Interceptive/limited treatment payable in one lump sum</td>
<td>• Examinations and the installation and adjustment of appliances</td>
</tr>
<tr>
<td></td>
<td>• No age limit</td>
<td>•</td>
</tr>
</tbody>
</table>
Protect your vision with VSP.

Get the best in eyecare and eyewear with Valero Services, Inc. and VSP® Vision Care.

Why enroll in VSP? We invest in the things you value most—the best care at the lowest out-of-pocket costs. Because we’re the only national not-for-profit vision care company, you can trust that we’ll always put your wellness first.

You’ll like what you see with VSP.

- **Value and Savings.** You’ll enjoy more value and the lowest out-of-pocket costs.
- **High Quality Vision Care.** You’ll get the best care from a VSP provider including a WellVision Exam®—the most comprehensive exam designed to detect eye and health conditions.
- **Choice of Providers.** The decision is yours to make—choose a VSP doctor, a participating retail chain, or any out-of-network provider.
- **Great Eyewear.** It’s easy to find the perfect frame at a price that fits your budget.

Using your VSP benefit is easy.

- **Register at vsp.com.** Once your plan is effective, review your benefit information.
- **Find an eyecare provider who’s right for you.** To find a VSP provider, visit vsp.com or call 800.877.7195.
- **At your appointment, tell them you have VSP.** There’s no ID card necessary. If you’d like a card as a reference, you can print one on vsp.com.

That’s it! We’ll handle the rest—there are no claim forms to complete when you see a VSP provider.

**Choice in Eyewear**

From classic styles to the latest designer frames, you’ll find hundreds of options. Choose from featured frame brands like Anne Klein, bebe®, Calvin Klein, Flexon®, Lacoste, Nike, Nine West, and more. Visit vsp.com to find a VSP provider who carries these brands.
## Your VSP Vision Benefits Summary

Valero Services, Inc. and VSP provide you with an affordable eyecare plan.

### VSP Provider Network: VSP Signature

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Description</th>
<th>Copay</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>WellVision Exam</strong></td>
<td>• Focuses on your eyes and overall wellness</td>
<td>$10</td>
<td>Every calendar year</td>
</tr>
<tr>
<td><strong>Prescription Glasses</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Frame</td>
<td>• $130 allowance for a wide selection of frames</td>
<td>$0</td>
<td>Every calendar year</td>
</tr>
<tr>
<td></td>
<td>• $150 allowance for featured frame brands</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>• 20% savings on the amount over your allowance</td>
<td></td>
<td></td>
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<tr>
<td>Lenses</td>
<td>• Single vision, lined bifocal, and lined trifocal lenses</td>
<td>$0</td>
<td>Every calendar year</td>
</tr>
<tr>
<td></td>
<td>• Polycarbonate lenses for dependent children</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lens Enhancements</td>
<td>• Tints/Photochromic adaptive lenses</td>
<td>$0</td>
<td>Every calendar year</td>
</tr>
<tr>
<td></td>
<td>• Standard progressive lenses</td>
<td>$50</td>
<td></td>
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<tr>
<td></td>
<td>• Premium progressive lenses</td>
<td>$80 - $90</td>
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<tr>
<td></td>
<td>• Custom progressive lenses</td>
<td>$120 - $160</td>
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<tr>
<td></td>
<td>• Average savings of 35-40% on other lens enhancements</td>
<td></td>
<td></td>
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<tr>
<td>Contacts (instead of glasses)</td>
<td>• $130 allowance for contacts and contact lens exam (fitting and evaluation)</td>
<td>$0</td>
<td>Every calendar year</td>
</tr>
<tr>
<td></td>
<td>• 15% savings on a contact lens exam (fitting and evaluation)</td>
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</tr>
<tr>
<td>Diabetic Eyecare Plus Program</td>
<td>• Services related to diabetic eye disease, glaucoma and age-related macular degeneration (AMD). Retinal screening for eligible members with diabetes. Limitations and coordination with medical coverage may apply. Ask your VSP doctor for details.</td>
<td>$20</td>
<td>As needed</td>
</tr>
<tr>
<td><strong>Extra Savings</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Glasses and Sunglasses</td>
<td>• Extra $20 to spend on featured frame brands. Go to vsp.com/specialoffers for details.</td>
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<tr>
<td></td>
<td>• 30% savings on additional glasses and sunglasses, including lens enhancements, from the same VSP provider on the same day as your WellVision Exam. Or get 20% from any VSP provider within 12 months of your last WellVision Exam.</td>
<td></td>
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</tr>
<tr>
<td>Retinal Screening</td>
<td>• No more than a $39 copay on routine retinal screening as an enhancement to a WellVision Exam</td>
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</tr>
<tr>
<td>Laser Vision Correction</td>
<td>• After surgery, use your frame allowance (if eligible) for sunglasses from any VSP doctor</td>
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</tr>
</tbody>
</table>

### Your Coverage with Out-of-Network Providers

Visit vsp.com for details, if you plan to see a provider other than a VSP network provider.

| Coverage with a participating retail chain may be different. Once your benefit is effective, visit vsp.com for details. Coverage information is subject to change. In the event of a conflict between this information and your organization’s contract with VSP, the terms of the contract will prevail. Based on applicable laws, benefits may vary by location. |   |

Contact us. 800.877.7195 | vsp.com

1 Brands/Promotion subject to change.

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