See better for less!

Aetna Vision℠ Discounts

Save on glasses, contacts, LASIK and more.

We want you to know®

Aetna®

00.03.301.1 H (8/07)

The eye-opening

Save BIG on seeing better

It's easy, with Aetna Vision Discounts.* You receive special discounts on eyeglasses, contact lenses and solutions, LASIK and other eye-care services and accessories. And since it's automatically included with your Aetna health benefits or health insurance plan, you don't pay anything extra for program access.

And that's not all: your discount covers specialty vision care items not typically covered by insurance, like snazzy eyeglass chains, designer frames, sunglasses — even colored contacts. Now, you've got everything you need to keep you, and your vision, super-sharp!

There's no stopping the savings

That's right — there's no limits to how often you can use the discount. So grab a pair of summer shades. Then stop back another time for more-serious spectacles. You'll get on-the-spot savings *each* and *every* time you purchase a product or service from our wide selection of participating locations.

Thousands of locations to choose from

It's easy to find a provider, with a broad range** of participating independent locations as well as national chains like LensCrafters®, Target Optical®, and select Sears® Optical and Pearle Vision® locations.

Want to find a spot in your hometown? Visit our DocFind® directory at **www.aetna.com** and follow the standard search prompts to "Places/Eyecare" to find a participating professional in seconds. Or check your paper directory. If you don't have one, you can call the number on your ID card, or give EyeMed customer service a ring at 1-800-793-8616.

Get great rates on eye exams

For such a short and sweet procedure, a routine eye exam does the eyes — and the body — good. It's the #1 way to detect eye problems like glaucoma or astigmatism. And it can also spot symptoms of diabetes, hypertension and other medical problems early … before they become a bigger problem.[1]

That's why most of the participating locations have doctors of optometry practicing right on the premises or at a nearby location. Now, even if you don't have eye exam coverage through your medical benefits plan, you can still get a great rate on eye exams for eyeglasses or contact lenses through Aetna Vision Discounts. Check the price list on the back of this flyer for details.

If you already have eye exam coverage, Aetna Vision Discounts is a great way to supplement your insurance coverage. Covered eye exams are available from most participating locations. But remember — check your plan documents first, since your out-of-pocket expenses could be lower if you follow your plan requirements.

Need eye exams or eyewear?

1-800-793-8616
Monday – Saturday 8 a.m. to 11 p.m.
Sundays 11 a.m. to 8 p.m.
Eastern Time

Lost a Lens?

1-800-391-LENS (5367)

Ready for LASIK?

1-800-422-6600
Weekdays 8 a.m to 9 p.m.
Saturdays 9 a.m. to 6 p.m. Eastern Time

*Formerly known as the Vision One® discount program.

**EyeMed Select Network and Provider List, 1/07.

[1] Eyes show it: System diseases revealed in routine eye exams. *Employee Benefits News*. April 15, 2004. Accessed at **www.benefitnews.com**.

choice for healthy vision

Here's how to start saving

Purchasing eyewear and vision services is as easy as book, browse and save!

Book!

Schedule an eye exam, or visit any participating location.

Browse!

Choose from hundreds of fashionable frames and the latest in lens technology.

Save!

Present your Aetna ID card for on-the-spot savings. No claims, no waiting for reimbursement, no fuss!

Replace contacts in a blink

Lost a lens? Get additional pairs delivered right to your door! Just purchase your first pair of prescription contact lenses — then call our mail-order center at 1-800-391-LENS (5367) for a brand-new pair.

Get LASIK for less

LASIK surgery just got more affordable. Not only do you save on the procedure, you also receive education, an initial screening and follow-up care — all wrapped into the discounted price. Best of all, the initial consultation is always free, even if you choose not to have the surgery.

Here's how to get started:

1. Call the U.S. Laser Network at 1-800-422-6600 to schedule your FREE consultation. Our LASIK information specialists can help you find and choose a nearby doctor.
2. The doctor's office will contact you directly to schedule your free consultation.
3. Still ready to proceed? Schedule the surgery and call the U.S. Laser Network for instructions on submitting your $100 deposit. It's completely refundable if you don't have the surgery.
4. Check with your surgeon's office for convenient payment arrangements or pay the discounted price before your surgery date.

Save on everything you need to see better.

Vision savings snapshot

Keep this chart* handy — it lists the savings available through Aetna Vision Discounts.

PRODUCT OR SERVICE	WHAT YOU'LL PAY
Eye Exams for Plans That Cover Eye Exams	Refer to your health benefits plan documents for coverage details
Eye Exams for Plans That Do *Not* Cover Eye Exams	
■ Comprehensive eye exam	$42
■ Standard contact lenses fit & follow up	$40 (plus $42 exam fee)
■ Specialty contact lenses fit & follow up (e.g. Toric, Bifocal, Gas Permeable)	$10 off retail (plus $42 exam fee)
Lenses per Pair (uncoated plastic)	
■ Single Vision	$40
■ Bifocal	$60
■ Trifocal	$80
■ Standard Progressive (no-line bifocal)	$120
Eyeglass Frames (retail prices)	40% off retail prices
Lens Options per Pair (add to lens price above)	
■ Standard polycarbonate (includes UV coating and scratch-resistant coating)	$40
■ Scratch-resistant coating	$15
■ Ultraviolet (UV) coating	$15
■ Solid or gradient tint	$15
■ Standard antireflective coating	$45
■ Glass	20% off retail
■ Photochromic Glass	20% off retail
Contact Lenses Get a 15% discount (5% on disposables) off retail prices.	
Mail-Order Contact Lens Replacement Program Call 1-800-391-LENS (5367) to order replacement contact lenses. (Mail-order contact pricing is not subject to the discounts received at participating locations.)	
Additional Vision-Related Items Visit any participating location to receive a 20% discount off retail prices.	
LASIK Procedure Save up to 15% off the surgeon's fee through the U.S. Laser Network.	

*EyeMed Services and Compensation Schedule, 1/07. Prices are subject to change.

Aetna Vision Discounts is free with your Aetna medical plan. So take care of your eyes, for less, today!

00.03.301.1 H (8/07)

Available in Spanish. Disponible en Español.

We want you to know®

Aetna®

www.aetna.com

The Orthodox HealthPlan

The Orthodox Health Plan (OHP) provides benefits for the clergy and lay employees of:

- The Serbian Orthodox Church of the United States
- The Greek Orthodox Archdiocese of America
- The Antiochian Orthodox Christian Archdiocese (US)
- The Orthodox Church in America
- The Diocese of the Armenian Church (US)

and as of January 1, 2011, the **Russian Orthodox Church Outside of Russia** in the United States and its territories.

The Insurance and Pension Committee of the Eastern American Diocese arranged for the opening of the OHP to the clergy and lay employees for all ROCOR institutions throughout the United States (and territories), not just the Eastern American Diocese.

By joining this large group we are able to take advantage of a solid offering of benefits, including Medical, Dental, Vision, and Prescription Drug coverage with a group that has significant market power and a history of stable premiums. The Medical and Dental Benefits are provided by Aetna, Inc. Both the Medical and Dental Plan coverage are PPOs (Preferred Provider Organizations), which allow members to use both "in-network" and "out-of-network" providers; with a significant financial advantage to staying within the network.

ENROLLMENT: Open to all clergy and (at least half-time) employees of any parish or institution of the Russian Orthodox Church Outside of Russia in the United States of America or its territories. The Open Enrollment period permits all eligible clergy and employees to register, without regard to any pre-existing conditions, with no waiting periods. The Open Enrollment period runs from November 1 through December 31, 2010. Coverage is effective January 1, 2011. To enroll in the Aetna Open Choice PPO, complete the form and submit with the first month's premium to:

OHP PPO Enrollment Form

OHP PPO Enrollment Form.jpg

Orthodox Health Plans
PO Box 321101
Fairfield, CT 06825

Note: Required sections on form are highlighted in yellow. **The Plan:** Open Choice PPO; **Section C:** Social Security Number for employee is REQUIRED; **Section D:** all new enrollee entries are "A" Add/New; the Relation codes are "H" (husband), "W" (wife), "S" (son), and "D" (daughter).

Enrollment and other general administration questions should be directed to our Plan Administrator, The GDC Financial Group, at 1-800-785-4432 or by e-mail: ohpenrollment@orthodoxhealthplans.com (or click: mailto: OHP if your browser is configured to automatically open your e-mail program). The OHP website is located here: http://www.orthodoxhealthplans.com/. After the expiration of the open enrollment period, additional enrollees will have to wait until the next open enrollment period in most cases. We encourage you to seriously think about taking advantage of this opportunity.

COSTS: The monthly premium for the Aetna Open Choice PPO for an individual is **$832** and **$1755** for a family. There are no "per dependent" add-ons in this plan for children. Overall, the more members we have in the Orthodox Health Plan group, the more affordable the coverage stays for all members. Premium adjustments (increases) occur on May 1st each year. The Medical plan includes a deductible and coinsurance/co-pays. If you are not familiar with these terms, here is a brief explanation.

- A **deductible** is a pre-determined dollar total for certain services (surgery, hospitalization, etc.) that must be satisfied by the member, prior to the start of the insurance company's responsibility to cover costs.

- Cost sharing between the member and the insurance company comes in the form of **Coinsurance** (the member pays a percentage of the cost) or **Co-pay** (the member pays a fixed dollar amount for certain in-network services). Examples: $25 for office visit to primary doctor, $15 for 30 day supply of generic prescription drug, 10% of diagnostic x-ray or lab.

The annual member deductible is $400 for individual and $800 for a family (in-network). It is important to note that many services are covered without being subject to the deductible. The deductible applies to services, such as:

- Hospital admission
- Outpatient surgery
- Inpatient at Skilled Nursing Facility
- Home Health Care
- Inpatient Hospice Care

*The maximum out-of-pocket exposure for our members, including the deductible is **$3000** for individual and **$6,000** for family*. Once this level is reached, the plan pays 100%. This maximum limits your exposure when you have high cost issues. In typical situations, many people will not utilize services that would have been subject to the deductible and many of the coinsurance categories.

NOTE to Residents of NY and CA: STATE REGULATIONS IN NEW YORK AND CALIFORNIA DO NOT PERMIT DEDUCTIBLES FOR IN-NETWORK SERVICES. ALSO, NEW YORK MEMBERS ARE NOT SUBJECT TO INPATIENT COINSURANCE.

The group health plan provider is **Aetna**. Aetna is a leading health insurance provider with a nationwide presence. Our plan is the Open Choice PPO, a "Preferred Provider Organization". The PPO provides a significant financial incentive for using "in-network" providers.

IN-NETWORK COPAYS: Primary **$25.00** / Specialist **$35.00**
Doctor Office Visits are not subject to deductible, but use a co-pay, instead.

The PPO Benefits Highlights for the AETNA **Open Choice PPO** can be viewed in chart form by clicking on the file located here:

OHP Medical Benefits

Additional information is available on the Aetna website:
http://www.aetna.com/individuals-families-health-insurance/index.html

A significant feature of the Aetna plan is the Aetna Navigator, an online, web-based management system for your healthcare, a source of valuable information and a portal to services. The navigator will help you find doctors, research conditions, and get help. Additional features of the Aetna plan include:

- 24-Hour Nurse Line
- Informed Health® Line
- Discount Programs
  - Alternative Health Care Discounts
  - Fitness Discounts
  - Hearing Discounts
  - Oral Health Care Discounts
  - Vision Discounts
- Pregnancy/Maternity Management Program*
  - Pregnancy Risk Survey
- Women's Health
  - Breast Health Survey
  - Women's Health
- Asthma
  - Caring for Asthma
- Diabetes
  - Caring for Diabetes
- Heart/Vascular
  - Caring for Congestive Heart Failure
  - Caring for Coronary Artery Disease

DENTAL

The **AETNA Dental PPO** is included in this plan. The deductible is $50 for individuals and $150 for families. The calendar year maximum per person is $1500 and the per person orthodontics maximum is $1500. The plan benefits can be viewed in chart form by finding the following file:

OHP Dental Benefits

VISION

The **Aetna Vision One** program is included in this plan. **This is an IN-NETWORK only plan.** There are a large number of participating providers, including Lenscrafters, Pearle Vision, Sears Optical, JCPenney Optical, Target Optical, and others, as well as many independent optometrist and ophthalmologist offices. Please visit http://www.aetna.com/docfind select your Medical plan (Open Choice PPO) and choose the specialty: Optometry (or Ophthalmology for medical issues) as the provider specialty or call Vision Care Customer Service: 1-877-9-SEE-AETNA (1-877-973-3238). The automated provider locator is operational 24 hours a day, 7 days a week. Representatives are also available Monday-Saturday from 8 am to 11 pm ET and Sundays from 11 am to 8 pm ET. For LASIK laser eye surgeons, call 1-800-422-6600. The plan benefits can be viewed in chart form by finding the following file:

Aetna Vision One

RETIREE MEDICAL

A **Retiree Medical** plan is available to persons enrolled in Medicare A&B as primary. For information on this plan, contact the Orthodox Health Plan administrator (GDC Financial) at 1-800-785-4432 or by e-mail: ohpenrollment@orthodoxhealthplans.com. The costs for this plan are: Individual: **$470** with dental ($417 without), Family: **$940** with ($834 without). The plan benefits can be viewed in chart form by finding the following file:

OHP Retiree Medical

OHP Retiree Enrollment Form

OUT-OF-AREA MEDICAL

Persons who reside outside the Aetna PPO Network (very few places in the US) will be covered by the Aetna Indemnity Medical Plan. Contact OHP with questions. The plan benefits can be viewed in chart form by finding the following file:

OHP Out-of-area Medical

Orthodox HealthPlans Summary of Benefits
PPO Dental Plan

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

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

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

Orthodox HealthPlans Medical Benefits

PPO Benefit Highlights

PLAN FEATURES	IN NETWORK	OUT OF NETWORK
Deductible (per calendar year)	$400 Individual $800 Family	$750 Individual $1500 Family
Coinsurance Limit	$3000 Individual $6000 Family	$4000 Individual $8000 Family

PREVENTATIVE CARE	IN NETWORK	OUT OF NETWORK
Routine Physicals - adults 19 & Older		
1 exam every 12 months	100% after $25 copay	70% after deductible
Well Baby Care/Immunizations	100% no deductible or copay	70% after deductible
Routine Mammogram	90% no deductible or copay	70% after deductible
Routine OB/GYN Exam - 1 per year	100% after $35 copay	70% after deductible

PHYSICIAN SERVICES	IN NETWORK	OUT OF NETWORK
Office Visits, non-surgical	100% after $25 copay	70% after deductible
Allergy Test/Treat (by Physician)	100% after $35 copay	70% after deductible
Allergy Injections (not by Physician)	90% after deductible	70% after deductible
Diagnostic X-ray & Lab	90% no deductible or copay	70% no deductible
Specialist Office Visits	100% after $35 copay	70% after deductible
Surgical Services	90% after deductible	70% after deductible
Physician In-Hospital Services	90% after deductible	70% after deductible
Other Physician Services	90% after deductible	70% after deductible
Maternity Care	SAAOCE*	SAAOCE*

HOSPITAL SERVICES	IN NETWORK	OUT OF NETWORK
Inpatient Coverage	90% after $250 per confinement and deductible	70% after $250 per confinement and deductible
Outpatient Coverage	90% after deductible	70% after deductible
Emergency Room Visit	90% after $150 copay waived if admitted	70% after $50 copay waived if admitted
Non-emergency use of ER	50% after deductible	50% after deductible
Maternity Care	SAAOCE*	SAAOCE*

PRESCRIPTION DRUG BENEFIT	IN NETWORK	OUT OF NETWORK
Retail: 30 day supply		
Generic	$15 copay	Not covered
Formulary	$25 copay	Not covered
Non-formulary	$40 copay	Not covered
Mail order: 90 day supply		
Generic	$30 copay	Not covered
Formulary	$50 copay	Not covered
Non-formulary	$80 copay	Not covered

Orthodox HealthPlans Medical Benefits

PPO Benefit Highlights

MENTAL HEALTH	IN NETWORK	OUT OF NETWORK
Inpatient- up to 30 days per calendar year	90% after $250 per confinement fee and deductible	70% after $250 confinement fee and deductible
Outpatient- up to 30 visits per calendar year	90% after deductible	70% after dedcutible
Crisis Intervention - 3 visits per calendar year	90% after deductible	70% after dedcutible

SUBSTANCE ABUSE	IN NETWORK	OUT OF NETWORK
Inpatient - up to 30 days per calendar year	90% after $250 confinement fee and deductible	70% after $250 confinement fee and deductible
Outpatient- up to 60 visits per calendar year	90% after deductible	70% after deductible

OTHER BENEFITS	IN NETWORK	OUT OF NETWORK
Skilled Nursing Facility	90% after deductible up to 90 days per yr.	70% after deductible
(other than at physician's office)	90% no deductible or copay	70% - deductible waived
Hospice care	Same as skilled nursing	Same as skilled nursing
Inpatient Coverage	80% after deductible up to 30 days per year	Same as In Network
Outpatient Coverage	80% after deductible. Max of $5000	Same as In Network
Ambulance	80% after deductible	Same as In Network
Durable Medical Equipment	80% after deductible	Same as In Network
Short Term Rehabilitation	80% after deductible	Same as In Network

*Same As Any Other Covered Expense

NOTE:

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

The Orthodox Health Plan
Indemnity Medical Insurance Plan

- The Traditional Choice plan is offered to employees located in areas other than in the service areas of the Open Choice (PPO) plan. Traditional Choice is an indemnity plan permitting freedom of choice of providers. Claim reimbursement is based upon reasonable and customary limits, rather than negotiated discounts.

  The plan design reflected on the following pages contains the basic provisions of our Traditional Choice product. It is subject to modification in response to state or federal legislation.

Plan Features	
Plan Deductible *(per calendar year; applies to all covered services)*	$300 Individual $600 Family
Coinsurance Limit	$1,500 Individual $3,000 Family
Lifetime Maximum	Unlimited
Physician Services *(except Mental Health/Alc/Drug)*	80% after deductible
Routine Physicals/Immunizations- *well-baby care to age 7; children age 7+ and adults: 1 routine exam per 24 months (1 routine exam annually for members age 65 and older), including*	80% after deductible

immunizations. *Routine ob/gyn exam:* *1 routine exam per calendar year, including 1 pap smear and related fees*	
Routine Mammography *One baseline mammogram for covered females age 35 but less than 40* *One mammogram every two years for covered females age 40 - 49* *One mammogram per calendar year for covered females age 50 and older*	80% after deductible
Hospital Services	
Inpatient coverage	80% after deductible
Outpatient coverage	80% after deductible

Skilled Nursing Facility	80% after deductible up to 90 days per calendar year
Home Health Care	80% after deductible up to 120 visits per calendar year
Private Duty Nursing	80% after deductible up to 70 eight-hour shifts per calendar year

Hospice Care	80% after deductible
Inpatient coverage	30 days inpatient maximum
Outpatient coverage	$5,000 outpatient maximum
Ambulance	80% after deductible
Durable Medical Equipment	80% after deductible

Prescription Drug	**Preferred Benefits**	**Non-Preferred Benefits**
Pharmacy Drugs	100% after $10 copay for generic formulary drugs, $15 copay for brand name formulary drugs and $30 copay for non-formulary brand drugs up to a 34 day supply at participating pharmacies.	80% after deductible
Mail Order Drugs	100% after $20 copay for generic formulary drugs, $30 copay for brand name formulary drugs and $60 copay for non-formulary brand drugs up to a 90 day supply at participating participating Mail Order vendor	80% after deductible for mail order drugs
Maternity		
(coverage includes voluntary sterilization and voluntary abortion)		80% after deductible

Mental Health Services and Alcohol/Drug Abuse *Inpatient coverage*	80% after deductible
Maximum	30 days per calendar year*
Outpatient coverage	50% after deductible up to 30 visits per calendar year

Institutes of Excellence®	
Expenses incurred in connection with transplant procedures	Payable as any other covered expense
Lodging Expenses Maximum	$50 per person per night
Travel and Lodging Maximum	$10,000 per one type of procedure
Other Expenses	80% after deductible

Members are responsible for obtaining precertification for inpatient hospital confinements; a $200 penalty will apply per occurrence, for failure to obtain precertification.

Eligibility	All employees
Dependents Eligibility	Spouse, children from birth to 19 or 23 if in school
Private Room Limit	Semi-Private

Actively-At-Work/Dependent Non-Confinement Rules	Apply (unless waiver required by law)
Pre-Existing Conditions Rule	Apply (unless waiver required by law)
Conversion	Standard conversion privilege applies
Continuation	Standard continuation applies - COBRA or state mandated
Extension of Benefits	12 months extension if totally disabled when coverage ceases - extension applies to all covered expenses
Medicare	Government Exclusion - Medicare eligible benefits are subtracted from Covered Medical Expenses before secondary Aetna benefits are calculated.
Coordination with Other Benefits	Up to 100% of Allowable Expenses per year
Subrogation	<Include unless prohibited by state law> Third party liability claims with recovery potential will be forwarded to the designated subrogation vendor for pursuit - $500 threshold applies.

Aetna contractual definitions will apply to all treatment.

Deductible

- Deductible - an out-of-pocket expense applicable to all benefits. Calendar year deductibles are individual and family, with family limits equal to none, 2x or 3x the individual deductible.

Covered expenses are reduced by the amount of the deductible at the time of claim adjudication by the claim processor.

All out-of-pocket expenses (except those resulting from application of a coinsurance percentage, e.g., 80%) are referred to as deductibles.

Deductibles apply independently (i.e., no cross application between calendar year and per confinement deductibles). There is no deductible carryover provision.

Coinsurance Limits

Coinsurance limits are the maximum amount of out-of-pocket expenses (other than copays and deductibles) that an employee/family will have to pay in a calendar year. Expenses are reimbursed at 100% once these limits are met. Coinsurance limits apply on a calendar year basis only. Coinsurance limits are individual and family, with family limits equal to none, 2x or 3x the individual limit.

Expenses applicable to coinsurance limit - Only those out-of-pocket expenses resulting from the application of a coinsurance percentage (except outpatient mental disorders and alcoholism and drug expenses and any penalty amounts) may be used to satisfy the coinsurance limit.

Claims Submission

Members are responsible for submission of claims under Traditional Choice.

Enrollment/Change Request

Aetna Life Insurance Company

Aetna US Healthcare

Check One: ☐ Elect Choice® EPO ☐ HMO ☐ Managed Choice® POS ☐ Traditional Choice® ☐ Open Choice® PPO ☐ Other _____

A. Transaction Information

EFFECTIVE DATE (MM/DD/YYYY)

1. Enrollment (Check One)

☐ New Enrollee
Hire Date ___/___/___ MM DD YR

☐ Rehired/Reinstatement
Date ___/___/___ MM DD YR

☐ Return to Work
Date ___/___/___ MM DD YR

2. Change From ___-___-___ To ___-___-___

☐ Social Security Number
☐ Control/Suffix/Acct (B.2.) _____
☐ Stop Continuation of Health Coverage (i.e., COBRA)
☐ Other _____

3. Termination

☐ Terminating Employment - Reason _____
☐ Cancelling Coverage - Reason _____
☐ Continue Employee Health Coverage (i.e., COBRA)
☐ Continue Dependent Health Coverage (i.e., COBRA)

B. Employer Information

1. Employer Name - Full Name of Business or Organization	2. Control No.	Suffix	Account	3. Plan Number	4. Group Number (HMO Only)	5. SFO
Orthodox Health Plan	658408	10				076

6. Employer Address (Street, City, State, ZIP Code) - Primary Location of Business or Organization	7. Claim Office Code	8. Customer Code (Optional)	9. Network ID

C. Employee Information - Please Print All Information

1. Employee Social Security Number	2. Employee Name (Last, First, Middle Initial)	3. Employee Home Address
___-___-		Number, Street, Apt.

4. Employee Status	5. Sex	6. Home Telephone Number	7. Work Telephone Number	City	State	ZIP Code
☐ Active ☐ Retired		( ) -	( ) -			

8. Beneficiary Designation - **Full Beneficiary Name** (First, Middle, Last) If more than one beneficiary, use Special Remarks.	Social Security Number of Beneficiary	Relationship to Employee	9. Earnings	
	___-___-		☐ Annually $ _____	☐ Insurance Amount $ _____
			☐ Weekly $ _____	☐ Supplemental Life $ _____
				☐ AD&D Amount $ _____

D. Individuals Covered (List individuals for whom you are electing/changing coverage.)

☐ **Check this box if you are refusing coverage for your dependents.**

(A)dd/New (C)hange (R)emove	Relation. Code	Name (First, Middle Initial, Last) (Explain difference in last names in Special Remarks)	Social Security Number (If dependent has no SSN, write "None")	Birthdate MM / DD / YYYY	Dependent Address (If different than employee)	Prior Insur. Plan	Other Health Coverage	Currently Covered by Medicare	Handi-capped	Student Age 19 or Older	Primary Care Provider ID # / Primary Care Provider Name	Prev. Seen
	Self		___-___-	/ /	Not Applicable	Yes* ☐	Yes* ☐	Yes ☐	Yes* N/A	Yes* N/A	ID # Name	Yes ☐
			___-___-	/ /		☐	☐	☐	☐	☐	ID # Name	☐
			___-___-	/ /		☐	☐	☐	☐	☐	ID # Name	☐
			___-___-	/ /		☐	☐	☐	☐	☐	ID # Name	☐
			___-___-	/ /		☐	☐	☐	☐	☐	ID # Name	☐

Special Remarks

E. Acknowledgments - Signatures Required

Employee's E-mail Address:

I have read and agree to the terms of the authorization on the back of this Enrollment/Change Request form. I understand that, in the event I fail to sign this form within 31 days after the above transaction request or that for any reason Aetna does not receive notice of the above transaction request within a reasonable time following the event, my and my dependents' eligibility may be affected.

Employee Signature X _____ Date _____ **Employer Signature X** _____ Date _____

Orthodox Health Plans
Retiree Medical Insurance Plan Enrollment Form
Underwritten by: AUSA Life Insurance Company, Inc., Purchase, NY
A Transamerica Company

You Must Return Your Enrollment Form to Put Your Coverage In Force!

Please Print

Retiree Information:

Name: _____ Date of Birth: Month_____/Day_____/Year_____

Address: _____ Social Security Number: _____ -_____-_____

City: _____ Medicare Number: _____

State: _____ Zip Code: _____ Sex: _____ Phone Number: (_____)_____

Email Address: _____

Spouse Information:

Name: _____ Date of Birth: Month_____/Day_____/Year_____

Social Security Number: _____ -_____-_____ Medicare Number: _____

Address: _____ Phone Number: (_____)_____

City: _____ Email Address: _____

State: _____ Zip Code: _____ Sex: _____

Please Choose Type of Coverage:

❑ **Retiree** | ❑ **Retiree and Spouse** | ❑ **Spouse Only**

Please Sign and Date:

I/We hereby enroll in the Orthodox Health Plans Limited Medical Expense Plan provided under group Master Policy Number MZ0100796H0001A issued by AUSA Life Insurance Company. I/We am/are 65 or over and covered by Medicare Parts A & B. I/We understand this insurance will be effective on the date shown on the certificate schedule.

FRAUD WARNING

NY Residents: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Retiree Signature: _____ Date: _____

Spouse Signature: _____ Date: _____

For customer service: call 1-800-785-4432,
Monday through Friday, 9:00 a.m. to 5:00 p.m., Eastern Time.

Orthodox Health Plans
Retiree Medical Insurance
Plan Description

Underwritten by Monumental Life Insurance Company
In New York by AUSA Life

- **MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD***

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies:			
First 60 days	All but $812	$812 (Part A Deductible)	$0
61st thru 90th day	All but $203 a day	$203 a day	$0
91st day and after :			
While using 60 lifetime reserve days	All but $406 a day	$406 a day	$0
Once lifetime reserve days are used:			
Additional 365 days	$0	100% of Medicare Eligible Expenses	$0
Beyond the Additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			

You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital:			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $101.50 a day	Up to $101.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services.			
	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR*

- *Once you have been billed $100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Medicare Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES **In or Out of the Hospital and Outpatient Hospital Treatment**, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment:			

First $100 of Medicare Approved Amounts*	$0	$100 (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
• Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $100 of Medicare Approved Amounts*	$0	$100 (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES			
Blood tests for Diagnostic Services	100%	$0	$0

MEDICARE PARTS A & B

HOME HEALTH CARE			
Medicare Approved Services:			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment:			
First $100 of Medicare Approved Amounts*	$0	$100 (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0

OTHER BENEFITS - NOT COVERED BY MEDICARE

FOREIGN TRAVEL Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA:			
First $250 each calendar year Remainder of charges	$0 $0	$0 80% to a lifetime maximum of $50,000	$250 20% and amounts over the $50,000 lifetime maximum
PRIVATE DUTY NURSING			
	$0	$25 per shift; maximum number of shifts is 30 per benefit period	Balance

EXCLUSIONS:

Benefits will not be paid for any expenses which are not determined to be Medicare-eligible expenses by the federal Medicare Program or its administrators, except as otherwise specified in the policy.