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Building Futures Together

1470 Worldwide Place • Vandalia, OH 45377-1156
Phone (937) 454-1744

To: All Non-Medicare Retiree Plan Participants

Enclosed are the following documents for:

- **2026 Self-Payment Rate**
- **Wellness Incentive**
- **VSP Vision Benefit Changes**
- **2026 Summary of Benefits and Coverage**
- **Benefit Trust Summary Annual Report**

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October 31, 2025

Dear Non-Medicare Plan Participant,

The non-Medicare Retiree self-pay rates **will remain the same** for the upcoming calendar year. The rates you pay for the non-Medicare Retiree plan represent only a portion of the actual cost of the benefit. The cost per adult for the non-Medicare retiree plans are subsidized by **approximately 24%** through active workers' hourly contributions paid into the Benefit Trust, an increase over the prior year.

If you or your spouse are covered by Medicare, you are not eligible for these Plans.

The new monthly self-pay rates for Non-Medicare Retiree Plan A and Plan B effective **January 1, 2026 remain unchanged, and are as follows:**

Non-Medicare Retiree Plan A: $1,021 per person per month. The projected cost for this plan is **$1,361** per month. You pay less than the cost due to the subsidy.

Non-Medicare Retiree Plan B: $881 per person per month. The projected cost for this plan is **$1,176** per month. Plan B has higher medical and prescription deductibles and coinsurances that are payable by the participant. You pay less than the cost due to the subsidy.

Dependent and/or Adult Children of an eligible retiree will be covered under the same plan as the retiree for **$500 per dependent/adult child** per month**.**

Two plan choices continue to be available for you for the monthly self-payment rates shown above. All members of your family will be required to be in the same plan unless a family member is on the Humana Medicare Advantage plan. Enclosed please find the ***Summary of Benefits and Coverage*** for Plan A and Plan B for the upcoming plan year.

If you are currently enrolled in Plan A, you may reduce your coverage by selecting Plan B effective January 1, 2026. If you are currently enrolled in Plan B, you will NOT be permitted to switch back to Plan A.

No action is necessary to continue coverage under your current plan for the 2026 calendar year.

MEDICARE ELIGIBILITY: Once you or your dependent(s) are eligible for Medicare, coverage under this Plan must end and you may be eligible for coverage under the Plan's insured program through Humana. Due to government guidelines, you must be covered under the Humana program as of your Medicare effective date; Humana cannot retro-activate your coverage. To ensure that you have continuous coverage, **you must notify the Trust Office at least 60 days before your Medicare coverage begins** to request a Retiree Health Insurance Enrollment Form to complete and return with a copy of your Medicare card. It is **your** responsibility to notify the Trust Office and enroll 60 days prior to the date Medicare coverage begins.

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Non-Medicare Retiree Incentive

October 31, 2025

Re: Non-Medicare Retiree Incentive

The Board of Trustees of the Iron Workers District Council of Southern Ohio & Vicinity Benefit Trust is pleased to once again offer an incentive plan designed to reduce the monthly non-Medicare Retiree self-pay cost of health coverage, while encouraging you to maintain your health.

Under the incentive program, while you and/or your spouse are enrolled in the non-Medicare Retiree Plan A or B you will:

- Save $42 per month in self-payments in **2027**, if you complete an annual physical with your primary care physician from November 1, 2025 through November 30, 2026.

- If your spouse is covered under the non-Medicare Retiree plan, save an additional $42 per month in **2027** if your spouse also completes an annual physical.

You must have an in-person annual physical to receive the incentive.

The incentive will be administered as a monthly reduction in the non-Medicare Retiree Plan A or B cost, worth up to **$500 per year** if you complete an annual physical and **$1,000 per year** if your covered spouse also completes an annual physical.

Deadline: You must get your annual physical by November 30, 2026, to be eligible for the incentive for the 2027 calendar year. If you or your spouse do not have a primary care physician, find one now so you can earn the self-pay reduction next year.

The Fund Office will obtain evidence of your routine physical(s) from the Medical Plan provider to apply the incentive.

Please note that you will NOT be penalized if you don't receive an annual physical from your primary care physician. You simply will not receive the self-pay reduction.

We are proud to continue supporting the health care needs of you and your families. If you have questions regarding the incentive, contact the Fund Office at 937-454-1744.

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Vision Insurance

Effective January 1, 2026, the Board of Trustees improved the non-Medicare Retiree vision plan to mirror the active plan benefit. This enhancement allows coverage every 12 months for Frames, Lenses or Contact Lenses, plus an increased allowance for the cost of Frames or Contact Lenses.

Vision Plan Highlights

Benefits	**VSP Choice Plan**		
	In-Network		**Out-of-Network**
Frequency for Exams Frequency for Lenses, Frames, Contact Lenses	Once every 12 months Once every 12 months Benefits start over every January 1st		
Exam Copay	$0		$45
Lens Copays:			
Single Vision	$0		$30
Bifocal	$0		$50
Trifocal	$0		$65
Frame Allowance	$200 allowance, then 20% off any balance		$70 Allowance
Enhanced Feature Frame*	$250 allowance, then $20% off any balance		$70 Allowance
Contact Lens Fitting & Evaluation Allowance	$50 allowance		No Coverage
Contact Lenses	$200 allowance (instead of frames and lenses)		$105 allowance (instead of frames and lenses)
Lens Enhancement Copays:	**Single Vision**	**Bi-Focal or Tri-Focal**	**Out-of-Network**
Anti Reflective Coating	$41	$41	No Coverage
UV Protection	$10	$10	No Coverage
Polycarbonate Lenses (Child)	$0	$0	No Coverage
Polycarbonate Lenses (Adult)	$31	$35	No Coverage
Photochromic Lenses	$75	$75	No Coverage
Progressive Lenses			
Standard Progressive Lenses	N/A	$0	No Coverage
Premium Progressive Lenses**	N/A	$95 or $105	No Coverage
Custom Progressive Lenses**	N/A	$150 or $175	No Coverage
Scratch Resistant Coating	$17	$17	No Coverage

Enhanced Feature Frame: When using VSP providers in the "Premier Program"
****Progressive Lens copays vary based upon the lens manufacturer and retail cost.***

OMB Control number 1210-0040; Expiration Date 03/31/2026

SUMMARY ANNUAL REPORT FOR IRON WORKERS DISTRICT COUNCIL OF SO OH & VICINITY BENEFIT TRUST

This is a summary of the annual report of the Iron Workers District Council of SO OH & Vicinity Benefit Trust, a health, life insurance, dental, vision, temporary disability and death benefits plan (Employer Identification Number 31-0557391, Plan Number 501), for the plan year 02/01/2024 through 01/31/2025. The annual report has been filed with the Employee Benefits Security Administration, as required under the Employee Retirement Income Security Act of 1974 (ERISA).

Insurance Information

The plan has insurance contracts with Humana Insurance Company, Metropolitan Life Insurance Company, Berkshire Hathaway Specialty Insurance Company and Vision Service Plan to pay certain Health, ADD, Life insurance, Stop loss, Vision claims incurred under the terms of the plan. The total premiums paid for the plan year ending 01/31/2025 were $8,299,096.

Because they are so called "experience-rated" contracts, the premium costs are affected by, among other things, the number and size of claims. Of the total insurance premiums paid for the plan year ending 01/31/2025, the premiums paid under such "experience-rated" contracts were $2,369,171 and the total of all benefit claims paid under these experience-rated contracts during the plan year was $0.

Basic Financial Statement

The value of plan assets, after subtracting liabilities of the plan, was $55,530,443 as of the end of plan year, compared to $46,575,283 as of the beginning of the plan year. During the plan year the plan experienced a change in its net assets of $8,955,160. This change includes unrealized appreciation and depreciation in the value of plan assets; that is, the difference between the value of the plan's assets at the end of the year and the value of the assets at the beginning of the year or the cost of assets acquired during the year. During the plan year, the plan had total income of $79,655,445 including employer contributions of $68,501,297, employee contributions of $8,036,707, gains/(losses) of $0 from the sale of assets, other income of $1,058,700 and earnings from investments of $2,058,741. Plan expenses were $70,700,285. These expenses included $2,564,881 in administrative expenses, $68,135,404 in benefits paid to participants and beneficiaries, and $0 in other expenses.

Your Rights to Additional Information

You have the right to receive a copy of the full annual report, or any part thereof, on request. The items listed below are included in that report:

- An accountant's report.
- Financial information and information on payments to service providers.
- Assets held for investment.
- Insurance information, including sales commissions paid by insurance carriers.
- Information regarding any common or collective trusts, pooled separate accounts, master trusts or 103-12 investment entities in which the plan participates.

To obtain a copy of the full annual report, or any part thereof, write or call the office of Daivd Baker, who is a representative of the plan administrator, at 1470 Worldwide Pl, Vandalia, OH 45377-1156 and phone number, 937-454-1744. The charge to cover copying costs will be $5.00 for the full annual report, or $0.25 per page for any part thereof.

You also have the right to receive from the plan administrator, on request and at no charge, a statement of the assets and liabilities of the plan and accompanying notes, or a statement of income and expenses of the plan and accompanying notes, or both. If you request a copy of the full annual report from the plan administrator, these two statements and accompanying notes will be included as part of that report. The charge to cover copying costs given above does not include a charge for the copying of these portions of the report because these portions are furnished without charge.

You also have the legally protected right to examine the annual report at the main office of the plan: 1470 Worldwide Pl, Vandalia, OH 45377-1156, and at the U.S. Department of Labor in Washington, D.C., or to obtain a copy from the U.S. Department of Labor upon payment of copying costs. Requests to the Department should be addressed to: Public Disclosure Room, Room N-1513, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. The annual report is also available online at the Department of Labor website www.efast.dol.gov.

Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services

Coverage Period: 01/01/2026-12/31/2026

aetna® IRON WORKERS DISTRICT COUNCIL OF SOUTHERN OHIO AND VICINITY BENEFIT TRUST: ACTIVE AND NON MEDICARE PLAN A MEMBERS PACKAGE

Coverage for: Individual + Family | Plan Type: POS

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-800-735-8947 or visit https://aetna.com. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary/ or call 800-735-8947 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network: Individual $500 / Family $1,000. Out-of-Network: Individual $1,000 / Family $2,000.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Emergency care; plus in-network office visits & preventive care are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/
Are there other deductibles for specific services?	Yes. $65 per person for prescription drugs (RX).There are no other specific deductibles	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	In-Network: Individual $4,000 / Family $8,000. Out-of-Network: Individual $8,000 / Family $16,000. RX: In-network: $4,150 single/$8,300 family; Out-of-network: No limit	The out–of–pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out–of–pocket limits until the overall family out–of–pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, health care this plan doesn't cover & penalties for failure to obtain pre-authorization for services.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See www.aetna.com/docfind or call 1-800-735-8947 for a list of in-network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$30 copay/visit, deductible doesn't apply	30% coinsurance	None
	Specialist visit	$30 copay/visit, deductible doesn't apply	30% coinsurance	None
	Preventive care /screening /immunization	No charge	30% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	30% coinsurance	None
	Imaging (CT/PET scans, MRIs)	10% coinsurance	30% coinsurance	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.caremark.com	Generic drugs	$65 deductible/person (waived if using mail order); $10 copay/prescription (retail); $20 copay/prescription (mail order). Medical deductible does not apply.	$65 deductible/person; 50% coinsurance; Minimum $55 for retail pharmacies. Mail order not covered. Medical deductible does not apply.	Prescription Drug Benefits are administered by Sav-Rx Prescription Service. For detailed exclusions and plan limitations, refer to the Iron Workers District Council of Southern Ohio & Vicinity Benefit Trust Summary Plan Description located at https://iwtrustfund.com. Non-maintenance medications are limited to a 30-day supply (retail).

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Brand formulary drugs	$65 deductible/person (waived if using mail order); $40 copay/prescription (retail); $60 copay/prescription (mail order). Medical deductible does not apply.	$65 deductible/person; 50% coinsurance; Minimum $55 for retail pharmacies. Mail order not covered. Medical deductible does not apply.	Maintenance medications are limited to two 30-day supplies (retail). After that, you will need to move to a 90-day supply (mail order). If filling your maintenance medications (31-90 days) locally, please contact Sav-Rx at 888-662-(IRON) 4766, 24/7/365 to opt out of filling at Mail Order. Affordable Care Act (ACA) medications are covered at $0.00 copay. Please contact Sav-Rx for information. Specialty drugs are filled through Sav-Rx's preferred Specialty Pharmacy. Sav-Rx also has a High Impact Advocacy (HIA) Program that utilizes manufacturer coupons to help offset prescriptions costs. Sav-Rx will assist you with enrollment for the manufacturer coupon. Utilizing the Sav-Rx Specialty Pharmacy and the HIA Program will ensure your medications are a $0 cost to you. If you opt out of using the preferred Specialty Pharmacy or the HIA Program, you will be responsible for 30% coinsurance on Specialty medications. Please contact Sav-Rx at 888-662-(IRON) 4766 to speak to a representative regarding your prescription benefits, agents are available 24 hours a day, 7 days a week. Prescription Drug out-of-pocket limit: **$4,150/single or $8,300/family** in-network; no limit out of network.
	Brand non-formulary/specialty drugs	$65 deductible/person (waived if using mail order); $60 copay/prescription (retail); $90 copay/prescription (mail order). Medical deductible does not apply.	$65 deductible/person; 50% coinsurance. Minimum $55 for retail pharmacies. Mail order not covered. Medical deductible does not apply.	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	30% coinsurance	None
	Physician/surgeon fees	10% coinsurance	30% coinsurance	None
If you need immediate medical attention	Emergency room care	$135 copay/visit, deductible doesn't apply	$135 copay/visit, deductible doesn't apply	Out-of-network emergency use paid the same as in-network.
	Emergency medical transportation	$135 copay/trip, deductible doesn't apply	$135 copay/trip, deductible doesn't apply	Out-of-network emergency use paid the same as in-network. Non-emergency transport: not covered, except if pre-authorized.
	Urgent care	$65 copay/visit, deductible doesn't apply	$65 copay/visit, deductible doesn't apply	No coverage for non-urgent use.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	30% coinsurance	Penalty of $300 for failure to obtain pre-authorization for out-of-network care.
	Physician/surgeon fees	10% coinsurance	30% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office: $30 copay/visit, deductible doesn't apply; other outpatient services: 10% coinsurance	Office & other outpatient services: 30% coinsurance	None
	Inpatient services	10% coinsurance	30% coinsurance	Penalty of $300 for failure to obtain pre-authorization for out-of-network care.
If you are pregnant	Office visits	No charge Deductible does not apply	30% coinsurance	Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). Penalty of $300 for failure to obtain pre-authorization for out-of-network care may apply.
	Childbirth/delivery professional services	10% coinsurance	30% coinsurance	
	Childbirth/delivery facility services	10% coinsurance	30% coinsurance	
If you need help recovering or have	Home health care	10% coinsurance	30% coinsurance	120 visits/calendar year. Penalty of $300 for failure to obtain pre-authorization for out-of-network care.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
other special health needs	Rehabilitation services	$30 copay/visit, deductible doesn't apply	30% coinsurance	36 visits/calendar year for Physical & Occupational Therapy, 20 visits/calendar year for Speech Therapy, including outpatient hospital services.
	Habilitation services	10% coinsurance	30% coinsurance	None
	Skilled nursing care	10% coinsurance	30% coinsurance	180 days/calendar year. Penalty of $300 for failure to obtain pre-authorization for out-of-network care.
	Durable medical equipment	10% coinsurance	30% coinsurance	Limited to 1 durable medical equipment for same/similar purpose. Excludes repairs for misuse/abuse.
	Hospice services	10% coinsurance	30% coinsurance	Penalty of $300 for failure to obtain pre-authorization for out-of-network care.
If your child needs dental or eye care	Eye exam	$30 copay/visit, deductible doesn't apply	30% coinsurance	1 routine eye exam/12 months.
	Glasses	Not covered	Not covered	Not covered by the medical plan. You must pay 100% of this service, even from a network provider. The VSP vision plan is available through the Fund if you meet the eligibility requirements and you are covered under the plan; you are eligible for the VSP vision plan if you do not have to supplement or self-pay for your benefits; the vision plan includes coverage for glasses/contacts and eye exams, subject to any limits

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Dental check-up	Not covered	Not covered	Not covered by the medical plan. You must pay 100% of this service, even from a network provider. A dental plan administered by Delta Dental is available through the Fund if you meet the eligibility requirements and you are covered under the plan; you are eligible for the dental plan if you do not have to supplement or self-pay for your benefits.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Cosmetic surgery
- Dental care (Adult & Child)
- Glasses (Child)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Bariatric surgery - $10,000 maximum/lifetime.
- Chiropractic care - 12 visits/calendar year.
- Infertility treatment - Limited to the diagnosis & treatment of underlying medical condition.
- Private-duty nursing
- Routine eye care (Adult) - 1 routine eye exam/12 months.

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is:

- For more information on your rights to continue coverage, contact the plan at 1-800-370-4526.
- If your group health coverage is subject to ERISA, you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or http://www.dol/gov/ebsa/healthreform
- For non-federal governmental group health plans, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.
- If your coverage is a church plan, church plans are not covered by the Federal COBRA continuation coverage rules. If the coverage is insured, individuals should

contact their State insurance regulator regarding their possible rights to continuation coverage under State law.
Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact:

- If your group health coverage is subject to ERISA, you may contact Aetna directly by calling the toll-free number on your Medical ID Card, or by calling our general number at 1-800-370-4526. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or http://www.dol/gov/ebsa/healthreform
- For non-federal governmental group health plans, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.
- Additionally, a consumer assistance program can help you file your appeal. Contact information is at: http://www.aetna.com/individuals-families-health-insurance/rights-resources/complaints-grievances-appeals/index.html.

Does this plan provide Minimum Essential Coverage? **Yes.**
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet Minimum Value Standards? **Yes.**
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

To see examples of how this plan might cover costs for a sample medical situation, see the next section

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	**$500**
Specialist copayment	**$30**
Hospital (facility) coinsurance	**10%**
Other coinsurance	**10%**

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$500
Copayments	$0
Coinsurance	$1,100
What isn't covered	
Limits or exclusions	$70
The total Peg would pay is	**$1,670**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	**$500**
Specialist copayment	**$30**
Hospital (facility) coinsurance	**10%**
Other coinsurance	**10%**

This EXAMPLE event includes services like:
Primary care provider office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Diabetic supplies *(glucose meter)*

Total Example Cost	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$100
Copayments	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$4,300
The total Joe would pay is	**$4,700**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	**$500**
Specialist copayment	**$30**
Hospital (facility) coinsurance	**10%**
Other coinsurance	**10%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$10
The total Mia would pay is	**$410**

The plan would be responsible for the other costs of these EXAMPLE covered services.

Assistive Technology

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 1-800-370-4526.

Smartphone or Tablet

To view documents from your smartphone or tablet, the free WinZip app is required. It may be available from your App Store.

Non-Discrimination

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

We provide free aids/services to people with disabilities and to people who need language assistance.

If you need a qualified interpreter, written information in other formats, translation or other services, call the number on your ID card.

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:
Civil Rights Coordinator,
P.O. Box 14462, Lexington, KY 40512 (CA HMO customers: P.O. Box 24030, Fresno, CA 93779),
1-800-648-7817, TTY: 711,
Fax: 859-425-3379 (CA HMO customers: 860-262-7705), CRCoordinator@aetna.com.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, or at 1-800-368-1019, 800-537-7697 (TDD).

TTY: 711

Language Assistance:

To access language services at no cost to you, call 1-800-370-4526.

Amharic -	የቋንቋ አገልግሎቶችን ያለክፍያ ለማግኘት፣ በ 1-800-370-4526 ይደውሉ።.
Arabic -	للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء االتصال على الرقم 1-800-370-4526.
Armenian -	Անվճար լեզվական ծառայություններից օգտվելու համար զանգահարեք 1-800-370-4526 հեռախոսահամարով:
Carolinian (Kapasal Falawasch) -	ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-800-370-4526.
Chamorro -	Para un hago' i setbision lengguåhi ni dibåtde para hågu, ågang 1-800-370-4526.
Chinese Traditional -	如欲使用免費語言服務，請致電 1-800-370-4526.
Cushitic-Oromo	Tajaajiiloota afaanii garuu bilisaa ati argaachuuf,bilbili 1-800-370-4526.
French -	Afin d'accéder aux services langagiers sans frais, composez le 1-800-370-4526.
French Creole (Haitian)-	Pou jwenn sèvis lang gratis, rele 1-800-370-4526.
German -	Um auf für Sie kostenlose Sprachdienstleistungen zuzugreifen, rufen Sie 1-800-370-4526 an.
Greek -	Για να επικοινωνήσετε χωρίς χρέωση με το κέντρο υποστήριξης πελατών στη γλώσσα σας, τηλεφωνήστε στον αριθμό 1-800-370-4526.
Gujarati -	તમારેકોઇ જાતના ખર્ચવિના ભાષાની સે વિના ઓની પહોંચ્ માટે, કોલ કરોr 1-800-370-4526.
Hindi -	आपकेलिए बिना ककसी कीमत केभाषा सेवाओंका उपयोग करनेकेलिए, 1-800-370-4526 पर कॉल करें।.
Hmong -	Xav tau kev pab txhais lus tsis muaj nqi them rau koj, hu 1-800-370-4526.
Italian -	Per accedere ai servizi linguistici, senza alcun costo per lei, chiami il numero 1-800-370-4526.
Japanese -	言語サービスを無料でご利用いただくには、1-800-370-4526 までお電話ください。
Karen -	လၢတၫ်ကမၤန္ၢ်ကျိဉ်အတၫ်မၤစၢၤအတၫ်ဖံးတၫ်မၤတဖဉ်လၢတအိဉ်ဒီးအပူၤလၢကဘဉ်ဟ့ဉ်အီၤအဂိၢ်ဘဉ်နှဉ် ကိး 1-800-370-4526 တက့ၢ်.
Korean -	무료 언어 서비스를 이용하려면 1-800-370-4526 번으로 전화해 주십시오.
Laotian -	ເພື່ອເຂົ້າໃຊ້ການບໍລິການພາສາໂດຍບໍ່ເສຍຄ່າຕໍ່ກັບທ່ານ, ໃຫ້ໂທຫາເບີ 1-800-370-4526.

Mon-Khmer, Cambodian - ដើម្បីទទួលបានសេវាកម្មភាសាដែលឥតគិតថ្លៃសម្រាប់លោកអ្នក សូមហៅទូរស័ព្ទទៅកាន់លេខ 1-800-370-4526 ។

Navajo - T'áá ni nizaad k'ehjí bee níká a'doowoł doo bą́ąh ílínígóó kojį' hólne' 1-800-370-4526.

Pennsylvania Dutch - Um Schprooch Services zu griege mitaus Koscht, ruff 1-800-370-4526.

Persian-Farsi - برای دسترسی به خدمات زبان به طور رایگان، با شماره 1-800-370-4526 تماس بگیرید .

Polish - Aby uzyskać dostęp do bezpłatnych usług językowych proszę zadzwonoć 1-800-370-4526.

Portuguese - Para acessar os serviços de idiomas sem custo para você, ligue para 1-800-370-4526.

Punjabi - ਤੁਹਾਡੇ ਲਈ ਬਿਨਾਂ ਕਿਸੇ ਕੀਮਤ ਵਾਲੀਆਂ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ ਦੀ ਵਰਤੋਂ ਕਰਨ ਲਈ, 1-800-370-4526 'ਤੇ ਫ਼ੋਨ ਕਰੋ।.

Russian - Для того чтобы бесплатно получить помощь переводчика, позвоните по телефону 1-800-370-4526.

Samoan - Mo le mauaina o auaunaga tau gagana e aunoa ma se totogi, vala'au le 1-800-370-4526.

Serbo-Croatian - Za besplatne prevodilačke usluge pozovite 1-800-370-4526.

Spanish - Para acceder a los servicios de idiomas sin costo, llame al 1-800-370-4526.

Syriac-Assyrian - ܟܝ ܫܡܫܬܐ ܕܥܘܕܪ ܟܠ ܝܠܦܢܘܬܐ ܕܬܘܪܓܡܐ ܒܠܫܢܐ ܡܓܢܐܝܬ، ܡܩܪܝܬܘܢ: 1-800-370-4526.

Tagalog - Para ma-access ang mga serbisyo sa wika nang wala kayong babayaran, tumawag sa 1-800-370-4526.

Thai - หากท่านต้องการเข้าถึงการบริการทางด้านภาษาโดยไม่มีค่าใช้จ่าย โปรดโทร 1-800-370-4526.

Ukrainian - Щоб отримати безкоштовний доступ до мовних послуг, задзвоніть за номером 1-800-370-4526.

Vietnamese - Nếu quý vị muốn sử dụng miễn phí các dịch vụ ngôn ngữ, hãy gọi tới số 1-800-370-4526.

Yiddish - צו צוטריט שפּראך באַדינונגען אין קיין פּרייַז צו איר, רופן 1-800-370-4526

Yoruba - Lati wọnú awọn isẹ èdè l'ọfẹ fun ọ, pe 1-800-370-4526.

aetna®

IRON WORKERS DISTRICT COUNCIL OF SOUTHERN OHIO AND VICINICTY BENEFIT TRUST: Non Medicare Retiree Plan B Package

Coverage Period: 01/01/2026-12/31/2026

Coverage for: Individual + Family | Plan Type: POS

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-800-735-8947 or visit https://aetna.com. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary/ or call 800-735-8947 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network: Individual $1,000 / Family $2,000. Out-of-Network: Individual $2,000 / Family $4,000.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Network: preventive care, primary care & specialist visits, prenatal office visits, outpatient mental/behavioral health/substance abuse office visits, preventive vision exams & outpatient rehabilitation services.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/
Are there other deductibles for specific services?	Yes. $200 per person for prescription drugs (RX). There are no other specific deductibles.	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
What is the out-of-pocket limit for this plan?	Medical In-Network: Individual $5,250 / Family $10,500. Out-of-Network: Individual $10,500 / Family $21,000. RX: Network: $2,900 single/ $5,800 family; Out-of-network: unlimited	The out–of–pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out–of–pocket limits until the overall family out–of–pocket limit has been met
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, health care this plan doesn't cover & penalties for failure to obtain pre-authorization for services.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See www.aetna.com/docfind or call 1-800-735-8947 for a list of in-network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$30 copay/visit, deductible doesn't apply	50% coinsurance	None
	Specialist visit	$30 copay/visit, deductible doesn't apply	50% coinsurance	None
	Preventive care /screening /immunization	No charge. Deductible does not apply	50% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	30% coinsurance	50% coinsurance	None
	Imaging (CT/PET scans, MRIs)	30% coinsurance	50% coinsurance	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at	Generic drugs	$200 deductible/person (waived if using mail order); $10 copay/prescription (retail); $20 copay/prescription (mail order). Medical deductible does not apply.	$200 deductible/person; 50% coinsurance; Minimum $50 for retail pharmacies. Medical deductible does not apply	Prescription Drug Benefits are administered by Sav-Rx Prescription Service. For detailed exclusions and plan limitations, refer to the Iron Workers District Council of Southern Ohio & Vicinity Benefit Trust Summary Plan Description located at https://iwtrustfund.com. Non-maintenance medications are limited to a 30-day supply (retail).

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
www.caremark.com.	Brand formulary drugs	$200 deductible/person (waived if using mail order); $30 copay/prescription (retail); $70 copay/prescription (mail order). Medical deductible does not apply.	$200 deductible/person; 50% coinsurance; Minimum $50 for retail pharmacies; Mail order not covered. Medical deductible does not apply.	Maintenance medications are limited to two 30-day supplies (retail). After that, you will need to move to a 90-day supply (mail order). If filling your maintenance medications (31-90 days) locally, please contact Sav-Rx at 888-662-(IRON) 4766, 24/7/365 to opt out of filling at Mail Order. Affordable Care Act (ACA) medications are covered at $0.00 copay. Please contact Sav-Rx for information. Specialty drugs are filled through Sav-Rx's preferred Specialty Pharmacy. Sav-Rx also has a High Impact Advocacy (HIA) Program that utilizes manufacturer coupons to help offset prescriptions costs. Sav-Rx will assist you with enrollment for the manufacturer coupon. Utilizing the Sav-Rx Specialty Pharmacy and the HIA Program will ensure your medications are a $0 cost to you. If you opt out of using the preferred Specialty Pharmacy or the HIA Program, you will be responsible for 30% coinsurance on Specialty medications. Please contact Sav-Rx at 888-662-(IRON) 4766 to speak to a representative regarding your prescription benefits, agents are available 24 hours a day, 7 days a week. Prescription Drug out-of-pocket limit: **$2,900/single or $5,800/family** in-network; no limit out of network.
	Brand nonformulary/Specialty drugs	$200 deductible/person (waived if using mail order); 50% coinsurance with $50 minimum/$100 maximum (retail); $125 copay/prescription (mail order). Medical deductible does not apply.	$200 deductible/person; 50% coinsurance; Minimum $50 for retail pharmacies; Mail order not covered. Medical deductible does not apply.	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance	50% coinsurance	None
	Physician/surgeon fees	30% coinsurance	50% coinsurance	None
If you need immediate medical attention	Emergency room care	30% coinsurance	30% coinsurance	Out-of-network emergency use paid the same as in-network.
	Emergency medical transportation	30% coinsurance	30% coinsurance	Out-of-network emergency use paid the same as in-network. Non-emergency transport: not covered, except if pre-authorized.
	Urgent care	30% coinsurance	30% coinsurance	No coverage for non-urgent use.
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance	50% coinsurance	Penalty of $300 for failure to obtain pre-authorization for out-of-network care.
	Physician/surgeon fees	30% coinsurance	50% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office: $30 copay/visit, deductible doesn't apply; other outpatient services: 30% coinsurance	Office & other outpatient services: 50% coinsurance	None
	Inpatient services	30% coinsurance	50% coinsurance	Penalty of $300 for failure to obtain pre-authorization for out-of-network care.
If you are pregnant	Office visits	No charge. Deductible does not apply	50% coinsurance	Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). Penalty of $300 for failure to obtain pre-authorization for out-of-network care may apply.
	Childbirth/delivery professional services	30% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	30% coinsurance	50% coinsurance	
If you need help recovering or have	Home health care	30% coinsurance	50% coinsurance	120 visits/calendar year. Penalty of $300 for failure to obtain pre-authorization for out-of-network care.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
other special health needs	Rehabilitation services	$30 copay/visit, deductible doesn't apply. Inpatient: 30% coinsurance	50% coinsurance	Speech therapy only covered for the correction of a speech impairment. 36 visits/calendar year for Physical & Occupational Therapy, 20 visits/calendar year for Speech Therapy, including outpatient hospital services.
	Habilitation services	30% coinsurance	50% coinsurance	None
	Skilled nursing care	30% coinsurance	50% coinsurance	180 days/calendar year. Penalty of $300 for failure to obtain pre-authorization for out-of-network care.
	Durable medical equipment	30% coinsurance	50% coinsurance	Limited to 1 durable medical equipment for same/similar purpose. Excludes repairs for misuse/abuse. Covered up to the Maximum Allowable Amount for the standard item that is a Covered Service. Rental costs must not be more than the purchase price.
	Hospice services	30% coinsurance	50% coinsurance	Penalty of $300 for failure to obtain pre-authorization for out-of-network care.
If your child needs dental or eye care	Eye exam	$30 copay/visit, deductible doesn't apply	50% coinsurance	1 routine eye exam/12 months.
	Glasses	Not covered	Not covered	You must pay 100% of this service, even from a network provider.
	Dental check-up	Not covered	Not covered	You must pay 100% of this service, even from a network provider.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Cosmetic surgery
- Dental care (Adult & Child)
- Glasses (Child)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Infertility Treatment
- Routine foot care
- Weight loss programs
- Routine eye Care, except eye exams

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Bariatric surgery - $10,000 maximum/lifetime.
- Chiropractic care - 12 visits/calendar year.
- Infertility treatment - Limited to the diagnosis & treatment of underlying medical condition.
- Private-duty nursing
- Emergency care when traveling outside the U.S. or Canada

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is:

- For more information on your rights to continue coverage, contact the plan at 1-800-370-4526.
- If your group health coverage is subject to ERISA, you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or http://www.dol/gov/ebsa/healthreform
- For non-federal governmental group health plans, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.
- If your coverage is a church plan, church plans are not covered by the Federal COBRA continuation coverage rules. If the coverage is insured, individuals should contact their State insurance regulator regarding their possible rights to continuation coverage under State law.

Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact:

- If your group health coverage is subject to ERISA, you may contact Aetna directly by calling the toll-free number on your Medical ID Card, or by calling our general number at 1-800-370-4526. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or http://www.dol/gov/ebsa/healthreform
- For non-federal governmental group health plans, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.

- Additionally, a consumer assistance program can help you file your appeal. Contact information is at: http://www.aetna.com/individuals-families-health-insurance/rights-resources/complaints-grievances-appeals/index.html.

Does this plan provide Minimum Essential Coverage? Yes.

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet Minimum Value Standards? Yes.

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

To see examples of how this plan might cover costs for a sample medical situation, see the next section

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	**$1,000**
Specialist copayment	**$30**
Hospital (facility) coinsurance	**30%**
Other coinsurance	**30%**

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$1,000
Copayments	$0
Coinsurance	$3,200
What isn't covered	
Limits or exclusions	$70
The total Peg would pay is	**$4,270**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	**$1,000**
Specialist copayment	**$30**
Hospital (facility) coinsurance	**30%**
Other coinsurance	**30%**

This EXAMPLE event includes services like:
Primary care provider office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Diabetic supplies *(glucose meter)*

Total Example Cost	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$100
Copayments	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$4,300
The total Joe would pay is	**$4,700**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	**$1,000**
Specialist copayment	**$30**
Hospital (facility) coinsurance	**30%**
Other coinsurance	**30%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$1,000
Copayments	$200
Coinsurance	$300
What isn't covered	
Limits or exclusions	$10
The total Mia would pay is	**$1,510**

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: 1-800-370-4526.

The plan would be responsible for the other costs of these EXAMPLE covered services.

Assistive Technology

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 1-800-370-4526.

Smartphone or Tablet

To view documents from your smartphone or tablet, the free WinZip app is required. It may be available from your App Store.

Non-Discrimination

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

We provide free aids/services to people with disabilities and to people who need language assistance.

If you need a qualified interpreter, written information in other formats, translation or other services, call the number on your ID card.

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:
Civil Rights Coordinator,
P.O. Box 14462, Lexington, KY 40512 (CA HMO customers: P.O. Box 24030, Fresno, CA 93779),
1-800-648-7817, TTY: 711,
Fax: 859-425-3379 (CA HMO customers: 860-262-7705), CRCoordinator@aetna.com.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, or at 1-800-368-1019, 800-537-7697 (TDD).

TTY: 711

Language Assistance:

To access language services at no cost to you, call 1-800-370-4526.

Amharic -	የቋንቋ አገልግሎቶችን ያለክፍያ ለማግኘት፣ በ 1-800-370-4526 ይደውሉ።.
Arabic -	للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء االتصال على الرقم 1-800-370-4526.
Armenian -	Անվճար լեզվական ծառայություններից օգտվելու համար զանգահարեք 1-800-370-4526 հեռախոսահամարով:
Carolinian (Kapasal Falawasch) -	ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-800-370-4526.
Chamorro -	Para un hago' i setbision lengguåhi ni dibåtde para hågu, ågang 1-800-370-4526.
Chinese Traditional -	如欲使用免費語言服務，請致電 1-800-370-4526.
Cushitic-Oromo	Tajaajiiloota afaanii garuu bilisaa ati argaachuuf,bilbili 1-800-370-4526.
French -	Afin d'accéder aux services langagiers sans frais, composez le 1-800-370-4526.
French Creole (Haitian)-	Pou jwenn sèvis lang gratis, rele 1-800-370-4526.
German -	Um auf für Sie kostenlose Sprachdienstleistungen zuzugreifen, rufen Sie 1-800-370-4526 an.
Greek -	Για να επικοινωνήσετε χωρίς χρέωση με το κέντρο υποστήριξης πελατών στη γλώσσα σας, τηλεφωνήστε στον αριθμό 1-800-370-4526.
Gujarati -	તમારેકોઇ જાતના ખર્ચવિના ભાષાની સે વિના ઓની પહોોંચ માટે, કોલ કરોr 1-800-370-4526·
Hindi -	आपकेलिए बिना ककसी कीमत केभाषा सेवाओंका उपयोग करनेकेलिए, 1-800-370-4526 पर कॉल करें।.
Hmong -	Xav tau kev pab txhais lus tsis muaj nqi them rau koj, hu 1-800-370-4526.
Italian -	Per accedere ai servizi linguistici, senza alcun costo per lei, chiami il numero 1-800-370-4526.
Japanese -	言語サービスを無料でご利用いただくには、1-800-370-4526 までお電話ください。
Karen -	လၢတၢ်ကမၤနှၢ်ကျိဉ်အတၢ်မၤစၢၤအတၢ်ဖံးတၢ်မၤတဖဉ်လၢတအိဉ်ဒီးအပူၤလၢကဘဉ်ဟူဉ်အီၤအဂီၤဘဉ်နှဉ် ကိး 1-800-370-4526 တက့ၢ်.
Korean -	무료 언어 서비스를 이용하려면 1-800-370-4526 번으로 전화해 주십시오.
Laotian -	ເພື່ອເຂົ້າໃຊ້ການບໍລິການພາສາໂດຍບໍ່ເສຍຄ່າຕໍ່ກັບທ່ານ, ໃຫ້ໂທຫາເບີ 1-800-370-4526.
Mon-Khmer,	ដើម្បីទទួលបានសេវាកម្មភាសាដែលឥតគិតថ្លៃសម្រាប់លោកអ្នក សូមហៅទូរស័ព្ទទៅកាន់លេខ 1-800-370-4526 ។

Cambodian -

Navajo - T’áá ni nizaad k’ehjí bee níká a’doowoł doo bą́ą́h ílínígóó kojį’ hólne’ 1-800-370-4526.

Pennsylvania Dutch - Um Schprooch Services zu griege mitaus Koscht, ruff 1-800-370-4526.

Persian-Farsi - برای دسترسی به خدمات زبان به طور رایگان، با شماره 1-800-370-4526 تماس بگیرید .

Polish - Aby uzyskać dostęp do bezpłatnych usług językowych proszę zadzwonoć 1-800-370-4526.

Portuguese - Para acessar os serviços de idiomas sem custo para você, ligue para 1-800-370-4526.

Punjabi - ਤੁਹਾਡੇ ਲਈ ਬਿਨਾਂ ਕਿਸੇ ਕੀਮਤ ਵਾਲੀਆਂ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ ਦੀ ਵਰਤੋਂ ਕਰਨ ਲਈ, 1-800-370-4526 ‘ਤੇ ਫ਼ੋਨ ਕਰੋ।

Russian - Для того чтобы бесплатно получить помощь переводчика, позвоните по телефону 1-800-370-4526.

Samoan - Mo le mauaina o auaunaga tau gagana e aunoa ma se totogi, valaʾau le 1-800-370-4526.

Serbo-Croatian - Za besplatne prevodilačke usluge pozovite 1-800-370-4526.

Spanish - Para acceder a los servicios de idiomas sin costo, llame al 1-800-370-4526.

Syriac-Assyrian - ܠܡܬܚܫ ،ܒܗ ܡܫܬܡܫ ܕܨܝܢ ܠܫܘܢ ܕܝܠܟ ܕܠܐ ܡܨܪܝ ܠܟ ܕܬܗܘܐ ܒܗ ܕܡܬܚܫ ،ܐܢ ܒܥܝ ܐܢ ܡܕܒܪ ܠ 1-800-370-4526.

Tagalog - Para ma-access ang mga serbisyo sa wika nang wala kayong babayaran, tumawag sa 1-800-370-4526.

Thai - **หากท่านต้องการเข้าถึงการบริการทางด้านภาษาโดยไม่มีค่าใช้จ่าย โปรดโทร** 1-800-370-4526.

Ukrainian - Щоб отримати безкоштовний доступ до мовних послуг, задзвоніть за номером 1-800-370-4526.

Vietnamese - Nếu quý vị muốn sử dụng miễn phí các dịch vụ ngôn ngữ, hãy gọi tới số 1-800-370-4526.

Yiddish - צו צוטריט שפּראַך באַדינונגען אין קיין פּריַז צו איר, רופן 1-800-370-4526

Yoruba - Lati wọnú awọn iṣẹ èdè l’ọfẹ fun ọ, pe 1-800-370-4526.