MERITAIN® HEALTH

An Aetna Company

A Quick Look at Your Health Plan

Star Lumber & Supply Co., Inc.

Group #16962

When you enroll with Meritain Health®, you're taking the next step towards a healthier, more balanced you.

It's important for you to understand how your health plan works. This way, you can make the changes you want in your health and in your life.

Get the support you need for a healthy balance

Chances are, you try every day to keep a healthy balance in your life. But time can get away from you, or you might put other details first. That's why we're here: to help you focus and to support you each step of the way. You can think of your healthcare benefits as your resource to protect your body, mind and spirit.

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www.meritain.com

Benefit Highlights

Save when you visit network providers

This plan offers a network of doctors and other healthcare professionals who have agreed to accept lower amounts than their standard charges, just for members of this plan. These lower amounts are negotiated and predetermined. That means when you see a network provider, your share of costs is based on a lower charge—so your costs are lower, too. Network providers are conveniently located in both urban and rural areas. Lower costs and convenient doctors and clinics are important ways that Meritain Health can support your efforts to stay well and have a healthy lifestyle—or to get care as simply as possible when you're sick.

Remember: if you go outside the network, you may still have benefits, but your share of costs will be higher, and the amount you pay will not be based on a lower rate.

Nationwide provider access at a discount

When you and your family seek healthcare services, you have access to Aetna's broad national provider network of healthcare providers and facilities. Aetna's network contains more than 664,000 participating physicians and ancillary providers, with 5,667 hospitals.[1] When you visit providers in the Aetna network, you will receive services at strong, negotiated rates, helping you to save on the cost of healthcare.

[1] *https://www.aetna.com/about-us/aetna-facts-and-subsidiaries/aetna-facts.html*

Locate your preferred providers

With Aetna's comprehensive provider participation, many of your preferred doctors may already be in the Aetna network. To verify whether or not a doctor or healthcare facility participates, visit **http://www.aetna.com/docfind/custom/mymeritain/**.

File claims quickly and easily

If you visit a provider in your network, you shouldn't need to submit a claim for services or pay at the time of your service with the exception of a copay, if applicable. Your provider will submit the claim on your behalf and you will later receive a bill for any out-of-pocket or other balances due.

If you have visited an out-of-network provider, you may need to file a claim form to ensure that the service is billed properly. Claim forms can be found online at **www.meritain.com** or you can obtain one from your Human Resources department. Submit the claim by fax or by mail to the fax number or mailing address listed on the claim form.

Not all services are covered. See plan documents for a complete description of benefits, exclusions and limitations of coverage. Providers are independent contractors and are not agents of Meritain Health. Provider participation may change without notice. Meritain Health and Aetna do not provide care or guarantee access to health services.

Benefits Summary

		Plan A		Plan B (HDHP)	
		IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
MAJOR MEDICAL					
Deductible		$700/Individual $1,400/Family		$3,000/Individual $6,000/Family	
Out-of-Pocket Maximum (Including Deductible, Copayments & Coinsurance)		$3,750/Individual $7,500/Family	$8,000/Individual $16,000/Family	$3,750/Individual $7,500/Family	$8,000/Individual $16,000/Family
Coinsurance		80%	50%	80%	50%
PREVENTIVE CARE		80% after Deductible, First $300 per Benefit Year paid by the Plan at 100%	50% after Deductible	80% after Deductible, First $300 per Benefit Year paid by the Plan at 100%	50% after Deductible
PHYSICIANS OFFICE VISITS		80% after Deductible	50% after Deductible	80% after Deductible	50% after Deductible
SPECIALIST OFFICE VISITS		80% after Deductible	50% after Deductible	80% after Deductible	50% after Deductible
URGENT CARE		80% after Deductible	50% after Deductible	80% after Deductible	50% after Deductible
EMERGENCY ROOM		$100 co-pay (waived if admitted within 24 hours), 20% coinsurance after Deductible		$100 copay (waived if admitted within 24 hours), 20% coinsurance after Deductible	
HOSPITAL INPATIENT CARE		80% after Deductible	50% after Deductible	80% after Deductible	50% after Deductible
HOSPITAL OUTPATIENT CARE		80% after Deductible	50% after Deductible	80% after Deductible	50% after Deductible
PRESCRIPTION DRUG CARD					
Retail (34 days supply)	Generic	20% after Deductible		20% after Deductible	
	Preferred	20% after Deductible		20% after Deductible	
Mail Order (up to 90 days supply)	Generic	$30 co-pay, 10% of the Allowed Amount	N/A	20% after Deductible	N/A
	Preferred	$90 co-pay, 10% of the Allowed Amount		20% after Deductible	

This is a brief outline of your benefits. It is not a Summary Plan Description or intended to replace the Schedule of Benefits contained within the Plan Document. If any provision is inconsistent with the language of the Plan Document, the Plan Document will govern.

Your Guide to Enrollment

All eligible employees must complete the enrollment form, whether you're choosing this plan or declining benefits. Your enrollment form is included in the back of this packet.

Completing your enrollment

Complete, sign and return your enrollment form to your employer within 31 days of your eligibility date whether you're enrolling or declining benefits.

- **Write clearly**
  If your form is unreadable, your enrollment may be delayed, or incorrect.
- **Don't forget the back side**
  Missing or incomplete information will delay your enrollment.
- **Sign and date your enrollment form**
  Remember to sign and date the form, even if you're declining benefits.

Helpful Tips

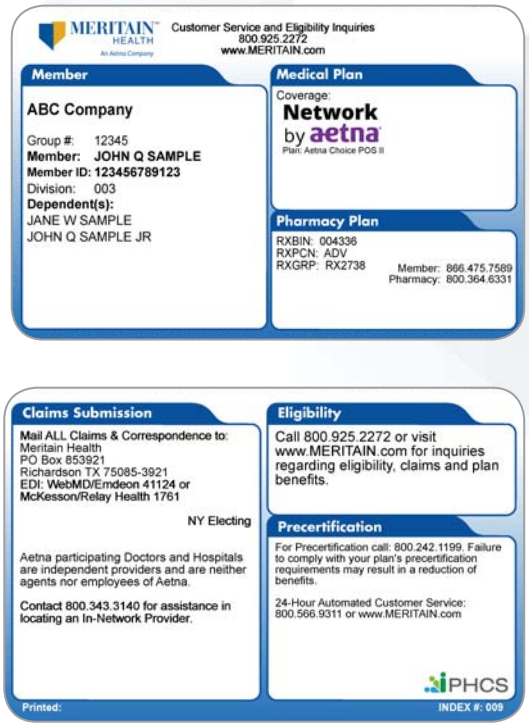
- Your healthcare plan includes a network of providers you can visit for healthcare services. When you visit providers in this network, you will receive the best service rate. Call the provider information number for participating providers.
- Your name, identification number, medical group number and your group name, are used to identify you and your covered dependents' benefits.
- Your medical copays are listed for you and your providers.
- Your pharmacy coverage information is listed on the front of your card.
- Please ensure that you precertify with medical management, if required.
- All claims should be submitted to Meritain Health at the address listed on the back of your card.
- You or your provider can call Meritain Health to verify eligibility of benefits or check on your claims status.
- You can call for information on a doctor or specialist who is close to you and serves your specific needs.

The final step toward better balance and better living

After you've completed enrollment, your employer has approved it and after any waiting period has passed, your benefits will be effective.

Your Meritain Health ID Card will be on its way to you soon. The card shows Meritain Health as your health plan administrator. Keep it in your wallet and carry it with you.

Sample ID Card



Convenient Tools and Resources

Your personalized member website

Once enrolled as a Meritain Health member, you will have access to the **Meritain Health Member Portal**. When you log in, you'll find everything you need to know about your benefits—from eligibility, to enrollment, to what's covered. It's another way we're working with you to help you get the most from your benefits—so you can live a life that's balanced and informed.

Registration for the member website is easy

If you're already registered to access your online account, simply enter **www.meritain.com** into your browser and login from the homepage.

If you're not yet registered, it's OK. Registration is an easy three-step process.

1. Go to **www.meritain.com**.
   Then, in the top right corner, click *Register*.
2. Next, select *Member* under *I am a* and enter your group ID.
   You can find your group ID on the front of your member ID Card.
   (If you are new to the plan, you will soon receive your member ID Card in the mail.) Then, click *Continue*.

   Please note: you may set up a login for yourself, as well as any children under age 18 who are covered by your plan. For privacy purposes, your spouse and dependents over the age of 18, covered by the plan, must each establish logins to access their individual information.
3. You will need to fill in your:
   - Group ID (located on your member ID Card)
   - Member ID (located on your member ID Card)
   - Date of birth
   - Name
   - ZIP code
   - Email address

A username will be provided to you. After you create a password and confirm your email address—you're done! You'll automatically be logged into your new Meritain.com account. The next time you log in, just use the same username and password from Step 3.

Members have the right to ask their health plan to place restrictions on (i) the way the health plan uses or discloses their PHI for treatment, payment or healthcare operations; and (ii) the health plan's disclosure of their PHI to persons who may be involved in their healthcare or payment thereof (e.g., family members, close friends).

Important plan contacts

What do you need help with?

- My medical benefits
- In-network doctors or hospitals

  Meritain Health Customer Service
  1.800.925.2272 | www.meritain.com

- The Aetna Choice® POS II provider network

  Aetna provider line
  1.800.343.3140
  www.aetna.com/docfind/custom/mymeritain

- My prescription drug benefits

  MedTrak Customer Service
  1.800.771.4648

- Precertification

  Meritain Health Medical Management
  1.800.242.1199

- My enrollment or benefit elections

  Star Lumber & Supply Co., Inc.
  Human resources representative
  1.316.942.2221

Notes

COMPANY NAME: **Star Lumber & Supply Co., Inc.** *GROUP #:* **16962**

BENEFIT ENROLLMENT FORM

MERITAIN® HEALTH
An Aetna Company

THIS FORM IS TO BE COMPLETED FOR NEW ENROLLMENTS AND COVERAGE CHANGES

PLEASE PRINT CLEARLY AND COMPLETE THE ENTIRE FORM
(ALL INFORMATION MUST BE COMPLETED OR ENROLLMENT WILL BE DELAYED)

EMPLOYEE INFORMATION – ALL INFORMATION IS REQUIRED

LAST NAME	FIRST NAME	MI

SOCIAL SECURITY NO.	DATE OF BIRTH (MM/DD/YY)	GENDER	MARITAL STATUS
		☐ M ☐ F	☐ Single ☐ Married ☐ Divorced ☐ Widowed

MAILING ADDRESS	CITY	STATE	ZIP

EMAIL ADDRESS

HOME PHONE NUMBER	WORK PHONE NUMBER

ARE YOU THE **EMPLOYEE** COVERED UNDER **ANY** OTHER INSURANCE? ☐YES ☐NO (i.e. Medicare, Tricare, spouse's plan)

IF YES, NAME OF INSURANCE: _____ EFFECTIVE DATE: _____

TYPE OF POLICY (Retiree, COBRA, Spouse): _____ POLICY HOLDER (Self, Spouse): _____

IF ENROLLED IN MEDICARE: EFFECTIVE DATE: PART A _____ PART B _____ HICN _____

ENTITLEMENT TO MEDICARE DUE TO: ☐ AGE ☐ DISABILITY ☐ END STAGE RENAL DISEASE (ESRD)

EMPLOYER USE ONLY

DATE OF HIRE	EFFECTIVE DATE
DIVISION #	DEPT. # / CLOCK #

ANNUAL SALARY: $

☐ HOURLY ☐ SALARY

☐ NEW ENROLLMENT
- ☐ Active ☐ Retiree
- ☐ Full Time ☐ Part Time
- ☐ COBRA

☐ ENROLLMENT CHANGE
- ☐ Marriage ☐ Birth ☐ Adoption
- ☐ Reinstatement ☐ Loss of Coverage
- ☐ Other: _____

Employer Representative Signature: _____

Date: _____

BENEFIT SELECTION

COVERAGE TYPE	PLAN ELECTED (IF APPLICABLE)	COVERAGE LEVEL
☐ MEDICAL/RX	☐ PLAN A ☐ PLAN B (HDHP)	☐ SINGLE ☐ EMPLOYEE + CHILD ☐ FAMILY ☐ DECLINE

DEPENDENT INFORMATION (ALL INFORMATION MUST BE COMPLETED OR ENROLLMENT WILL BE DELAYED)

Special Enrollment due to coverage under Medicaid or under a State Children's Health Insurance Program (CHIP). If an employee or eligible dependent did not enroll in the plan when initially eligible, he or she will be permitted to later enroll in the plan under one of the following circumstances:

a. The employee or eligible dependent loses their eligibility status to participate in Medicaid or CHIP; or

b. The employee or eligible dependent qualifies for premium assistance under Medicaid or CHIP at the state level in which the individual resides.

The employee or eligible dependent must request enrollment in the plan within 60 days after coverage under Medicaid or CHIP terminates or within 60 days of being notified of eligibility for premium assistance from the state in which the individual resides.

DEPENDENT FULL NAME (REQUIRED) (LAST, FIRST, MIDDLE)	SOCIAL SECURITY NO. (REQUIRED)	RELATIONSHIP (REQUIRED)	DATE OF BIRTH (MM/DD/YY)	GENDER (M/F)	CHECK COVERAGE	DISABLED DEPENDENT*
					☐MEDICAL/RX	☐YES ☐NO
					☐MEDICAL/RX	☐YES ☐NO
					☐MEDICAL/RX	☐YES ☐NO
					☐MEDICAL/RX	☐YES ☐NO
					☐MEDICAL/RX	☐YES ☐NO

*IF YOUR CHILD IS MENTALLY OR PHYSICALLY DISABLED, PLEASE PROVIDE APPROPRIATE DOCUMENTATION

COMPANY NAME: **Star Lumber & Supply Co., Inc.**

COORDINATION OF BENEFITS – SPOUSE INFORMATION (IF APPLICABLE) COMPLETE **ALL** QUESTIONS

IS YOUR SPOUSE EMPLOYED? ☐YES ☐NO IF **YES**, ☐FULL TIME ☐PART TIME SPOUSE EMPLOYER NAME: SPOUSE DATE OF BIRTH:

INDICATE THE COVERAGE, CARRIER NAME AND EFFECTIVE DATE THAT YOUR SPOUSE IS **ENROLLED** IN WITH HIS/HER EMPLOYER

TYPE OF OTHER COVERAGE	CARRIER NAME	CARRIER ADDRESS	EFFECTIVE DATE (MM/DD/YY)	TYPE OF POLICY (I.E. EMPLOYER, RETIREE, COBRA)	LIST ALL FAMILY MEMBERS ENROLLED IN THIS PLAN
☐MEDICAL					
☐PRESCRIPTION					
☐DENTAL					
☐VISION					

COORDINATION OF BENEFITS – DEPENDENT CHILD(REN) INFORMATION (IF APPLICABLE) COMPLETE **ALL** QUESTIONS

ARE ANY OF YOUR DEPENDENT CHILD(REN) COVERED BY ANOTHER PARENT/GUARDIAN OR PLAN NOT LISTED ABOVE? ☐YES ☐NO
EMPLOYER PROVIDING COVERAGE:
IF **YES**, COMPLETE THE QUESTIONS BELOW

TYPE OF OTHER COVERAGE	CARRIER NAME	CARRIER ADDRESS	EFFECTIVE DATE (MM/DD/YY)	TYPE OF POLICY (I.E. EMPLOYER, RETIREE, COBRA)	COURT ORDER REQUIRING COVERAGE (I.E. DIVORCE DECREE, QMCSO)*	LIST ALL FAMILY MEMBERS ENROLLED IN THIS PLAN
☐MEDICAL						
☐PRESCRIPTION						
☐DENTAL						
☐VISION						

***COPY OF THE COURT ORDER MUST BE SUBMITTED. FAILURE TO DO SO WILL RESULT IN CLAIMS BEING DENIED.**

COORDINATION OF BENEFITS – GOVERNMENTAL INSURANCE (I.E. MEDICARE, MEDICAID,TRICARE, ETC.)

IS YOUR SPOUSE AND/OR ARE ANY DEPENDENTS ENROLLED IN ANY GOVERNMENTAL INSURANCE? ☐YES ☐NO IF **YES**, PLEASE COMPLETE BELOW

LIST ALL FAMILY MEMBERS ENROLLED	TYPE OF COVERAGE	EFFECTIVE DATE OR IF MEDICARE COVERAGE, PART A EFFECTIVE DATE	PART B EFFECTIVE DATE (IF APPLICABLE)	HICN	IS MEDICARE COVERAGE DUE TO:
					☐AGE ☐DISABILITY ☐ESRD
					☐AGE ☐DISABILITY ☐ESRD

PLAN DECLARATION

I understand that the above elections will remain in effect until the last day of the Plan Year for which they are effective and will continue in effect indefinitely beyond that Plan Year unless I make an election change permitted under the Plan. I understand that I may change my elections during the Plan Year only if (i) I experience a "status change", as defined under the Plan, and if my change in elections is consistent with that "status change", (ii) I exercise a Special Enrollment Period Right (as described in the Notice of Special Enrollment Periods below), or (iii) I qualify (under applicable law, as determined by the Plan Administrator) to make another election change because of certain changes in cost or coverage of a benefit option, or for certain other reasons. I understand that the cost of a benefit option that I have elected under the Plan may change from one Plan Year to the next and I hereby agree that my payroll deductions will automatically change accordingly unless I submit a new Election Form during the appropriate annual election period to change or terminate that coverage. I also understand, during a Plan Year, if there is a change in the cost of a benefit option that I have elected, the Employer may automatically increase the payroll deductions, if any, I am required to make per pay period to pay for that benefit option. I understand further that, except to the extent that I am permitted to make a change under the Plan, the payroll deduction elections I have made above will continue in effect notwithstanding any changes in the features or coverage offered under the benefit options I have elected above.

I understand that my employer may modify my benefit elections if appropriate to insure that the Plan complies with the terms of the Plan and the requirements (including tax-qualification requirements) of applicable law and that, subject to the requirements of applicable law or any applicable insurance contract, my employer retains the right to amend or terminate coverage under a benefit option. Also, I understand that the employer may modify my elections for health benefit options if required to do so by a Qualified Medical Child Support Order that requires me to provide health coverage for a dependent.

NOTICE OF SPECIAL ENROLLMENT PERIODS

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

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

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

SIGNATURE AND AUTHORIZATION

EMPLOYEE SIGNATURE	PRINT EMPLOYEE NAME	DATE