



HCA COREPLUS BENEFITS

A Resource for Attracting and Retaining Employees



CorePlus Benefits HR Guide 2006



HCA COREPLUS BENEFITS IS ADMINISTERED AND MANAGED BY:

VEBA

© VEBA
One American Center
3100 West End Ave • Suite 940
Nashville, TN 37203
www.veba1.com



Table of Contents



Hi, I'm Mat with a special thanks to all the HRD's that help make CorePlus Benefits a success!



I. INTRODUCTION TO HCA COREPLUS BENEFITS	page 1
a. Introduction (p. 1)	
b. CorePlus Benefits Contact Guide (p. 2)	
c. Enrollment Basics (p. 4)	
d. CorePlus Benefits Eligibility (p. 4)	
II. NEWLY BENEFIT ELIGIBLE ENROLLMENTS	page 6
a. What's Available to Newly Benefit Eligible Employees? (p. 6)	
b. How do Employees become Benefit Eligible? (p. 7)	
c. How do Newly Benefit Eligible Employees Enroll? (p. 7)	
III. COMMONLY ASKED QUESTIONS	page 9
a. General/Enrollment (p. 9)	
b. Billing and Deductions (p. 12)	
c. Universal Life: UL (p. 14)	
d. Short-Term Disability: STD (p. 19)	
i. STD & EIB Explanation (p. 22)	
e. Legal Plan (p. 23)	
f. Long-Term Care: LTC (p. 26)	
g. Vision Benefit: Available for select union groups (p. 32)	
IV. COREPLUS BENEFITS HELPFUL INFORMATION	page 35
a. CorePlus Benefits Contact Guide (p. 35)	
b. About the CorePlus Benefits One Pager (p. 37)	
V. APPENDIX: INFORMATIONAL & SAMPLE COMMUNICATION MATERIALS	page 38
a. CorePlus Benefits One Pager	
b. Newly Benefit Eligible Enrollment Schedule	
c. Sample Confirmation Letter	
d. Sample Missed Deduction Letter	
e. Sample Ineligible Letter	
f. Sample ULOA Letter	
g. Sample Claim Form	
h. Sample Newly Benefit Eligible Enrollment Materials	

Section
1

Introduction to HCA CorePlus Benefits

Welcome! This CorePlus Benefits Human Resources Guide is designed to walk you through the basic elements of the CorePlus Benefits programs and lead you to the right place for any questions that may arise.

As an HR Director and Benefits Coordinator you have many responsibilities, so implementing supplemental benefits programs can add to that long list. CorePlus Benefits was designed differently from those traditional models.

SECTION 1
KEY
 Introduction
 Enrollment Basics
<input checked="" type="checkbox"/> CorePlus Eligibility

The key to the left will be used throughout this guide as a preview of items included in each section. This section includes:

Introduction



Many programs such as CorePlus Benefits have proven to be successful in improving employee relations for other large companies. We hope you will agree that CorePlus Benefits is beneficial for your facility, as well as, for your employees. Here are a few ways that CorePlus Benefits stands out from traditional voluntary benefit programs.

☑ **No Coordination of Enrollment**

CorePlus Benefits is unique from other benefit enrollments because there is virtually no coordination of enrollments for you as an HR Director. Employees will be able to make a toll-free call to the CorePlus Benefits Call Center, where an enrollment counselor will answer questions and help employees complete the enrollment process. This also means there will be no insurance agents soliciting employees and causing a work disruption at your facility.

☑ **No Reconciliation of Monthly Bills**

Another aspect of CorePlus Benefits that makes your job easier is there will be no reconciliation of monthly bills. All premiums are paid through after-tax payroll deduction, which is also administered by CorePlus Benefits.

☑ **Simple. Friendly. Easy.**

HR Directors are not expected to answer anything but general questions for CorePlus Benefits. However, if you find yourself in a position to answer a question from an employee, we have established an exclusive service number for you. The CorePlus Benefits HR HelpLine is 1-888-243-8322.

CorePlus Benefits Contact Guide



CorePlus Benefits has many resources for you and your employees to access information. Below we have detailed each contact resource and how it can help you.

CorePlus Benefits Enrollment Call Center 1-800-520-1553:

This number is only used for employees to enroll in CorePlus Benefits plans. All employees wishing to enroll may call this number during their two-week open enrollment period. During open enrollment, employees may talk to a benefit counselor who is trained to be a friend, advisor and coach and to help them make good decisions based on their benefit needs. The Call Center is open only during open enrollment periods and for the first two full weeks of each month for newly benefit-eligible employees.

CorePlus Benefits Customer Service 1-877-650-4251:

This [Customer Service Line](#) is for employees who have questions about their HCA CorePlus Benefits policies. If an employee has a question about their payroll deductions or would like to **cancel any of their HCA CorePlus Benefits policies**, they should call this number and **press "1" for Billings and Deductions**. If an employee has a specific policy question they should call this number and press the appropriate option for the respective benefit.

CorePlus Benefits HR HelpLine 1-888-243-8322:

This is an exclusive number for Human Resources personnel only. If an employee comes to you with a question or a problem, or if you have a question, please do not hesitate to call this number. Tracy Andrews or Ashley Clark can assist you in getting the information you need.

HCA CorePlus Benefits on the Web:

We have two different Web sites to help you and your employees access information.

www.coreplusbenefits.com

This Web site has information on all of the CorePlus Benefits policies. If an employee wants to enroll and cannot find their Enrollment Guide, this site has all the information the employee needs to make the call to enroll. Many HR Director's and Benefit Coordinators use this site to print information into hard copy for employees who need additional information or have lost or misplaced their original copies.

www.coreplusbenefits.com/hr

This Web site is an exclusive site for HR. Here you will find detailed information on our Enrollments, Information for Policy Holders, and Resources for you and your staff to help assist your employees with their CorePlus Benefits. We even have materials that you can download to help with employee meetings and claim forms with instructions for short-term disability.

- **Helpline Issue Request Form:**

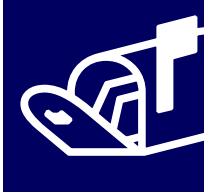
This [Helpline Issue Request Form](#) is for HR to use if you want to submit a question or an issue. This form is located on the HR Website and all requests are automatically emailed to CorePlus Benefits and you will be contacted within 24 to 48 business hours by a member of our HR HelpLine Team.

CorePlus Benefits Email:

coreplushelp@veba1.com

This email address is an exclusive, confidential email for HR to use if they have a question they would like to email instead of calling the HR HelpLine 1-888-243-8322.

Enrollment Basics



As you may recall, HCA CorePlus Benefits was not designed to have an annual enrollment as does LifeTimes Benefits. Employees are given an opportunity to enroll in HCA CorePlus Benefits when they become newly benefit eligible. We recently completed an Open Enrollment during the Summer of 2005 for all benefit eligible employees.

All eligible employees receive HCA CorePlus Benefits information at their home address during the enrollment in which they are eligible to enroll. Each employee receives a series of mailings including all necessary information to enroll. If you have an employee that has lost their enrollment guide, you may direct them to our Web site www.coreplusbenefits.com. This Web site contains all the information that is printed in the enrollment guide. To enroll, employees may call the HCA CorePlus Benefits Call Center at 1-800-520-1553 during their open enrollment between the hours of 8:00a.m.-9:00p.m. Monday thru Friday or Saturday 8:00a.m. - 5:00 p.m, Eastern Time.

CorePlus Benefits Eligibility



To become eligible for HCA CorePlus Benefits an employee must have a status of **Full** or **Part-time and** work a norm of **16 hours a week or 32 bi-weekly**. Since the inception of HCA CorePlus Benefits, the guaranteed issue policies have been offered to eligible employees on a one-time basis.

Monthly Newly Benefit Eligible Enrollments:

The Newly Eligible Enrollment process was developed to offer HCA CorePlus Benefits to employees once they became benefit eligible. This includes new hires or employees that have had a status change to benefit eligible that have not previously been offered CorePlus Benefits. This is a monthly process.

The Process:

VEBA prepares a census of eligible employees based on files received by HCA IT&S. To ensure that employees are not included in multiple Newly Eligible Enrollments, VEBA manages a cumulative census of solicited employees using their SSN as the unique identifier. When VEBA receives the monthly newly eligible census from HCA IT&S, it is compared with the cumulative census by SSN. Any SSN that appears in the cumulative census (already included in a previous enrollment) will be eliminated due to the eligibility rules for the guaranteed issued policies.

Portability:

CorePlus Benefits portability was designed for employees to maintain their coverage after a change in employment status for ***all products except Short-Term Disability***.

Section
2

Newly Benefit Eligible Enrollments

SECTION 2

KEY

◇ What's Available

☑ New Hire Eligibility

☎ How to Enroll

The subjects included in this section cover the process and schedule for the CorePlus Benefits Newly Benefit Eligible Enrollments.



What's Available to Newly Benefit Eligible Employees?

The HCA CorePlus Benefits plans available during the Newly Eligible Enrollments are:

- ☑ **Universal Life Insurance**
- ☑ **Short-Term Disability**
- ☑ **Legal Benefit**
- ☑ **Long -Term Care.**
- ☑ **Vision Care (for a small, select group of union groups only)**



How do Employees Become Benefit Eligible?

HCA Corporate IT&S transmits a weekly census file to HCA CorePlus Benefits. Employees contained in those files will be eligible for the HCA CorePlus Benefits enrollment the proceeding month. Please refer to the **“Newly Benefit Eligible Enrollment Schedule”** (Appendix B) to determine when an employee will be included in a CorePlus Benefits Enrollment.



How Do Newly Benefit Eligible Employees Enroll?

All eligible employees will receive information at home for their HCA CorePlus Benefits enrollment. Each employee will receive a series of mailings (Intro Letter, Enrollment Guide, Reminder Postcard, Final Letter) similar to the mailings received by employees in previous enrollments. Samples are included in Appendix H in the back of this guide)

One of the unique elements of HCA CorePlus Benefits is the guaranteed issue for most plans during the employee's initial open enrollment. The open enrollment is only scheduled for a two-week time period. Enrollment dates may be found in all the materials that eligible employees receive at home. Enrollments begin the first Monday of every month. You may refer to the **“Newly Benefit Eligible Enrollment Schedule” (Appendix B)** in this guide for specific dates.

To enroll, employees can call the HCA CorePlus Benefits Call Center at 1-800-520-1553 during their scheduled open enrollment period between the hours of **8 a.m.-9 p.m. Monday thru Friday or Saturday 8a.m. thru 5p.m, Eastern Time.**

Long-Term Care Enrollment Exception:

For the **Long-Term Care Insurance Plan** from MetLife employees may call 1-800-438-6388 for more information and a request an enrollment kit. Although you can apply for Long-Term Care Insurance at any time, you **only have 90 days from your eligibility date to apply without having to complete a full Statement of Health.**

Frequently Asked Questions (FAQ)

SECTION 3 KEY



General & Enrollment



Billing & Deductions



Universal Life



Short-Term Disability



Legal

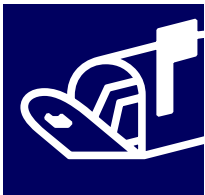


Long-Term Care



Vision

This section includes Frequently Asked Questions (FAQ's) covering all aspects of CorePlus Benefits and each of the products offered.



FAQ's: General/Enrollment

1. Is participation voluntary?

This benefits package is voluntary and is designed to complement and supplement the "core" benefits package your employees receive. All of the policies presented in the HCA CorePlus Benefits program are available as separate policies so that employees may build a benefits package that suits their needs.

2. Is a physical exam required?

Acceptance is guaranteed for all HCA CorePlus Benefits plans during the employee's initial open enrollment period, except for short-term disability where coverage may be dependent upon medical clearance or examination at the discretion of the provider. Employees must enroll before their enrollment ends to take advantage of the guaranteed enrollment offered by HCA CorePlus Benefits.

3. Are HCA CorePlus Benefits available to full-time and part-time employees?

To be eligible for HCA CorePlus Benefits an employee must have a status *of Full or Part-time and work a norm of 16 hours a week or 32 bi-weekly.*

4. I am a benefit-eligible employee and want to enroll in HCA CorePlus Benefits.

If the employee was a recent new hire: An employee can expect to be included in a Newly Eligible Enrollment two months from their hire month. Example: If an employee was hired in September, they will most likely be included in the November enrollment. Please refer to the **"Newly Benefit Eligible Enrollment Schedule"**, Appendix B, to determine when an employee will be included in a CorePlus Benefits Enrollment.

It is important to remember that the enrollment line is open the **first two-full weeks** of every month. If you have a unique situation or if an employee needs special attention about an enrollment situation you may call Mickey Ponder 1-812-542-2380 (during enrollments) or Tracy Andrews and Ashley Clark at 1-888-243-8322 outside of enrollment periods. For the **Long-Term Care Insurance Plan** from MetLife, employees have 90 days from their date of eligibility to enroll in this benefit. All other HCA CorePlus Benefits plans are only available during the employee's two-week enrollment period.

5. Will LifeTimes Connection have information about HCA CorePlus Benefits?

Yes, basic information regarding CorePlus Benefits has been provided to LifeTimes Connection. If an employee calls the LifeTimes Connections Benefits Center by mistake, they will be forwarded on to the CorePlus Benefits Call Center.

6. Is the CorePlus Benefit's Call Center separate from LifeTimes?

Yes, the voluntary benefits enrollment is handled by HCA CorePlus Benefits, and the toll-free enrollment line (1-800-520-1553) is different from the LifeTimes number.

7. How often will HCA be updating employee information regarding new hires and terminations?

HCA and CorePlus Benefits exchanges a weekly "changes" file of employee demographic changes, transfers and terminations.

8. Will the New Hire Enrollments continue during the Open Enrollments?

Yes.

9. What if an employee does not receive their enrollment guide in the mail?

Employees do not need the guide to call into the Enrollment Call Center. Additionally, all information that is included in the guide can be found on our Web site at

www.coreplusbenefits.com, where they can print out the information and also schedule a time an enrollment counselor to call them.

10. I have an employee that tried to call the Call Center but couldn't get through. What should they do?

On the rare occasion that a call goes into the voice mail queue, employees will have the opportunity to leave a message for an enrollment counselor to return the call. We hope that this does not happen, but there are also additional options. On our Web Site www.coreplusbenefits.com, employees can fill out a request for an enrollment counselor to call them. They just need to give their name, phone number and a time that would be convenient. If the employee does not have access to the Web site, you (the HRD) may call the CorePlus Benefits HR HelpLine at 1-888-243-8322 or email at coreplushelp@veba1.com with the employee's name, phone number and time for the call and we will relay the information to the Call Center.

11. I have an employee that recently enrolled in HCA CorePlus Benefits. When will their policies be effective?

Universal Life (UL), Short Term Disability (STD), Legal Plan, Vision Benefit (Vision is only offered to a select group of union employees) are all effective the same month payroll deductions begin provided that the employee is actively at work.

Long-Term Care (LTC) policies are effective on the first of the month after acceptance into the plan as long as the employee is actively at work (not absent due to disability, leave or illness).

Enrolled employees will receive information in the mail from the provider detailing the benefit they purchased. If an employee does not have this information, the provider can be reached through our policyholder service line 1-877-650-4251 and select the option for the benefit in which they are inquiring.

12. I have an employee with HCA CorePlus Benefits that would like increase their coverage.

UL: Employees may increase or take out additional coverage such as for a spouse, child or grandchild during a scheduled Open Enrollment. We recently completed an open enrollment during the summer of 2005.

STD: The STD policy does not automatically increase with an employee's salary. If an employee wishes to increase their monthly benefit amount, they may do so during the 2005 Open Enrollment or during the next scheduled open enrollment.

Legal: If your employee has the Legal Benefit their spouse and dependents (age 23 and younger) are covered under this benefit. This is the maximum benefit available under this plan.

ECPA: This benefit is only offered to a small, select group of union employees. These employees may add or delete a spouse or dependents at anytime by calling ECPA at 1-877-650-4251 option 5. They will need the Name, DOB and SSN handy when calling to make this change.

LTC: If an employee is interested in increasing their Long Term Care Insurance Plan, please contact the carrier (MetLife if purchased after May 2003, or Aetna if purchased before May 2003 and continually offered to a select group of union employees) of your policy and a Customer Service representative will be able to assist in this request.



FAQ's: Billing & Deduction

1. How will premiums be paid?

The premiums for the programs employees select will be paid by payroll deduction, and are easily set-up when they call the HCA CorePlus Benefits Call Center. An enrollment counselor can take their authorizations right over the phone.

2. Are payroll deductions taken a month in advance of the coverage period?

Yes.

3. When will payroll deductions begin for new hires?

You can find the payroll deduction date for each New Hire Enrollment in the [Enrollment Wave Schedule](#) in Appendix B of this guide.

4. How are HCA CorePlus Benefits premiums set up or cancelled in HCA's payroll system?

This is an automated process already set up between HCA and CorePlus Benefits. This process was set up in order to minimize the role of local HR and/or local Payroll departments. HCA CorePlus Benefits payroll adjustments should not be facilitated at the local level. For any billing or deduction issues, please refer employees to PolicyHolder Service at **1-877-650-4251** and select **option 1**. If any payroll adjustments need to be made, CorePlus Benefits will facilitate with HCA Corporate IT&S for the employee's future paycheck.

5. I have an employee that enrolled in HCA CorePlus Benefits, but their deductions have not yet started, or when will their deductions start?

Generally, deductions will begin two months from the employee's enrollment in HCA CorePlus Benefits. Employees will receive a confirmation letter (sample letter provided in this guide-Appendix C) in the mail two weeks before the deductions are to begin. This letter will confirm each benefit that they enrolled in and the corresponding payroll deduction as well as the month the deduction will begin. If an employee has questions about their deductions, they may call our billing and deductions department at 1-877-650-4251 (option 1).

6. I have an employee that wants to cancel their HCA CorePlus Benefit.

Employees may stop a deduction at anytime by contacting our Billing and Deductions Department at 1-877-650-4251 (option 1). Please note: It may take two weeks for the employee's request to process through the system. If an employee's deductions continue for more than one pay cycle, then they should contact the Billing and Deductions department to make them aware of the situation and to request a refund from the carrier.

7. I have an Employee that recently had a status change to PRN. Why are they still having deductions?

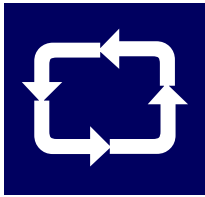
HCA CorePlus Benefits has a process to deal with PRN status changes for employees, and it works similar to the process for LifeTimes benefits. CorePlus Benefits receives a weekly file of status changes from HCA. If we receive a file for an employee that has gone to a benefit in-eligible status, their deductions are stopped and the employee is sent a letter of notification. Please remember that UL, Legal and LTC benefits are portable and can be continued on a direct bill basis. If you have an employee that has changed to PRN and is still having a deduction under the CorePlus Benefits slot (Legacy systems DN62/Core+/Lawson deduction codes 1064 – 1069,1071 & 1702)) please call the HR HelpLine at 1-888-243-8322.

8. I have an employee that received a letter in the mail for a missed deduction and they don't believe a deduction was missed.

Each month our Billing and Deductions Department generates letters to employees that have missed a deduction the prior month. If an employee feels this is an error or has questions about this letter, they may contact our billing and deductions department at 1-877-650-4251 (option 1). A sample of this letter is included in **Appendix D** of this guide.

9. I have an employee whose HCA CorePlus Benefits deduction has changed, how can I find out why?

HRD's and Benefit Coordinators are encouraged to call our HR HelpLine (1-888-243-8322) or fill out a request form on the HR Web site (www.coreplusbenefits.com/hr) for assistance with an employee's deduction. However, you may also refer the employee to call PolicyHolder Services at 1-877-650-4251 (option 1) and speak with a representative in our Billing and Deductions Department. They will be able to assist the employee with their issue.



FAQ's: Universal Life

1. How is universal life different from traditional life insurance?

The major difference is flexibility. Transamerica's plan meets the employee's changing circumstances. The face amount of the certificate can be increased (provided the employee is in good health) or decreased*. The employee's premium can be decreased, skipped, and even stopped as long as there is sufficient cash value to pay for the monthly cost of protection.

* A decrease in face amount may have adverse tax consequences.

2. What determines the current interest rate?

Current interest rates are determined by existing economic conditions and investment opportunities. While the rate is subject to change, employees are guaranteed that it will never be less than 4%.

3. Who is the beneficiary of the employee's insurance certificate?

The employee selects the beneficiary simply by indicating the name and the relationship on the application.

4. Does this certificate replace any present group insurance?

No. The Transamerica universal life plan neither duplicates nor replaces any of an employee's group coverage. It supplements it. Unlike your group term insurance, this plan builds cash values.

5. When is the certificate effective?

Universal Life Insurance is effective at midnight following the date of application.

6. Can the employee keep this insurance if they change jobs?

Yes. This plan is portable. The amount of coverage and the premiums will remain the same. They simply pay premiums directly to Transamerica.

7. How do employees know their certificate value?

Each year they will receive a statement of all financial transactions. It will tell them how much they paid into their certificate and how much interest has been accumulated.

It will also show how much has been deducted to pay for the amount of insurance selected.

8. Does the coverage amount decrease as the employee becomes older?

No. It cannot be reduced or canceled by Transamerica. Only the employee can reduce the coverage amount if they choose. (Any unpaid certificate loans and outstanding loan interest will reduce the certificate's death benefit.)

9. Can the employee put more money into their certificate above the scheduled premium payments?

Yes. They can make lump sum payments directly into their certificate or increase their payroll deduction amount without increasing the death benefit, not to exceed limits set by IRS regulations. By doing so, they will accelerate the cash value growth and earn additional tax deferred interest.

10. Can the insurance company cancel the employee's insurance?

No. Coverage cannot be canceled by Transamerica as long as premium payments are made or sufficient cash accumulation value exists.

11. What happens to the employee's coverage if the cash accumulation value becomes depleted?

The employee will be notified in advance if the cash accumulation value is not sufficient to pay the monthly expenses. The employee may then pay the necessary amount or let the certificate lapse.

12. Can the employee take a loan on the certificate?

Yes, they may borrow from Transamerica against the cash accumulation value of their certificate. The employee chooses how to repay the loan, or whether to repay it. Any outstanding balance will reduce the employee's cash accumulation proceeds and death proceeds accordingly. Transamerica will charge 7.4% annual interest in arrears on the loan balance, which the employee may pay in cash or add to the loan amount. Transamerica will also credit 5.5% annual interest to the cash accumulation value securing the loan.

13. Does the Transamerica Universal Life Policy offer the employee any additional options or riders?

Yes. The Universal Life Insurance policy allows the employee to enhance his/her policy by adding one or all of the following riders:

- **Automatic Face Amount Increase Option Rider**-*No charge*
- **Children's Term Rider**-*Additional premium required*
- **Terminal Illness Accelerated Death Benefit Option Rider**-*included in policy, no additional premium.*

- **Accidental Death and Dismemberment Rider**-Additional premium required
- **Accelerated Death Benefit Rider for Long Term Care** –automatically added to all new policies since 2003. No additional charge/premium is required.

Below is an explanation of each of the riders:

Automatic Face Amount Increase Option Rider (AIO) Option

- The AIO option gives the employee the opportunity to automatically add additional coverage without providing evidence of insurability in the future.
- The AIO option allows the employee and spouse to protect their family's increasing standard of living.
- The AIO rider allows the insured to start small (in premium and coverage) now and add a little at a time to get up to where they want without a high premium on the front end and without answering medical questions.
- The employee can stop the AIO any time, but cannot start it back up once declined. The EE will not lose the benefit already selected.
- Each individual policy's AIO is based on the age of the EE at the time of the effective date of the original policy.
- AIO riders cannot be added to a child's UL policy.

Here's How AIO Works...

- ***For an Employee's Policy***

The employee can automatically add coverage on their first FIVE contract anniversary dates without answering any medical questions. The cost is \$1 per week (\$2 per pay period/biweekly). The face amount of the policy plus the AIO coverage cannot exceed \$150,000 of coverage for the employee. **An EE who leaves HCA can continue exercising the AIO option up to the time limit.**

- ***For a Spouse's Policy***

The spouse can automatically add coverage on their first three (3) contract anniversary dates without answering any medical questions. The cost is \$1 per week (\$2 per pay period). The face amount of the policy plus the AIO coverage cannot exceed \$100,000 of coverage for the spouse.

After the first year anniversary of the policy the employee and spouse will receive a letter, allowing them to exercise the AIO rider in order to purchase additional coverage. Once they deny this option they will not be offered this opportunity again in the future.

Children's Term Rider (CTR)

- Insurance for children is available through the addition of a Children's Term Rider attached to a spouse or an EE's certificate.
- If Rider coverage is elected, the EE or their spouse (but not both) can provide up to \$10,000 Term Life coverage for the eligible children.
- Term coverage is available to children 15 days through 18 years old, and can continue through the child's 25th birthday.

- At the time the Term coverage ends, the child has 31 days to convert the coverage to an individual UL Certificate. The child can convert the policy up to 5 times the original amount without medical questions – this is called Guaranteed Issue.
- CTR rider costs \$.70 per week (\$1.40 per pay period) and provides each child \$10,000.00 of coverage. The cost is fixed regardless of the number of children.
- CTR coverage will not only help the employee/spouse protect the child's life now but it also protects their **insurability** for the future.

Terminal Illness Accelerated Death Benefit Option Rider

- The Terminal Illness Accelerated Death Benefit Rider lets the insured "tap" into the life insurance in the event of a future terminal illness/diagnosis, yet still provide a benefit for the beneficiary.
- There is no cost for this living benefit until the Rider is exercised.
- If the employee uses the ADBR, the death benefit and cash accumulation value will be reduced. The balance will be paid to the beneficiary following the insured's death.
- Terminal illness and resulting death within 12 months must be certified by physician.
- The insured can receive up to 50% of the policy (or \$100,000.00, whichever is less) and beneficiary would get the remainder upon death.
- The Accelerated Death Benefit is not affected by other policies with the same option

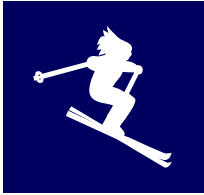
Accidental Death & Dismemberment Rider

- The AD&D Rider provides an additional death benefit if the cause of death for the EE or spouse/domestic partner is a covered accident.
- Doubles the face amount of the coverage up to an additional \$100,000 of insurance.
- This benefit is available for issue ages 16 to 60. AD&D coverage terminates on the insured's 70th birthday.
- A specified percentage (from 25 – 100%) of the death benefit is payable for various types of dismemberment.
- There is an additional cost for this coverage; however, it is minimal and the computer will calculate the cost. The cost factor is based on the face amount of coverage.
- War or act of war exclusion applies-see enrollment guide for details.
- AD&D coverage is not available to children

Accelerated Death Benefit Rider for Long Term Care

- Must be triggered by a chronically ill diagnosis by a licensed Health Care Practitioner.
- Cannot perform at least two of the six activities of daily living (ADL's-bathing, continence, dressing, eating, toileting, and transferring) for a period of 90 days or being so cognitively impaired that the insured requires substantial supervision to protect the insured from threats to his or her health and safety.
- LTC benefit paid up to 95 years of age.
- **Benefits:**
 - Nursing/Assisted Living benefit is 4% of death benefit—Monthly
 - Run out of money in 25 mos...extends to 50 mos.
 - Home HealthCare/Adult Day Care: 2% of Death Benefit-Monthly
 - Run out of money in 50 mos...extends to 100 mos
- A reload for LTC will not exceed the original death benefit.
- The LTC amount from the policy reduces the death benefit amount taken or until the policy is exhausted. Once the policy has been exhausted and reloaded, there is no life insurance benefit.
- Cost: no additional premium required.
- Difference between UL/LTC and separate LTC policy with MetLife: The rider is an alternative way to fund the LTC need for employees. The funding for a separate LTC policy can be more expensive. The advantage of the LTC feature with the UL policy is the likelihood of using it is small and it will retain its death benefit and reduced underwriting.
- LTC feature does not pay a benefit outside of the US and its territories
- Exclusion in which rider will not pay for care that is received or loss incurred as a result of war or any act of war, declare or undeclared or service in the armed forces of any country. See Enrollment Guide or policy for more details.

The information provided herein is provided as general information. It is not intended to replace the language of the contract. The language of the policy takes precedence. Final determination of a claim is based upon the documents that are submitted for review and the policy language.



FAQ's: Short-Term Disability

1. If an employee needs to file a claim, where do they obtain a form?

Two types of claim forms are available. The initial form to be completed is the Request For Disability Benefits. The second form is the Request for Continuing Benefits, which is used to file for additional/continuing benefits from the initial disability. (This form will always be included with the employee's disability check.) We have provided copies and instructions for both of these claim forms in **Appendix G** of this guide. You may also download these forms from the CorePlus Benefits HR web Site at www.coreplusbenefits.com/hr.

2. What portions of the claim form should the employee complete?

To avoid a delay in processing the employee's claim, they need to complete all parts of the form that pertain to them (including the provider listing). The HR Department needs to complete the employer's statement and the employee's attending physician completes the Attending Physician's Statement.

3. To what address should the form be sent?

All claim forms should be mailed/or faxed to Transamerica.

The mailing address is:

Transamerica Worksite Marketing
PO Box 8043,
Little Rock, AR 72203-8043.

Fax number: 866-586-6528

4. How long does it take to process a short-term disability claim?

In 2002, Transamerica created a special claims unit dedicated to servicing claims of Employees of an HCA-affiliated facility's. This unit maintains a proactive effort in maintaining their turnaround time. We suggest after submitting your claim form (Fax, mail, or both) to follow-up with the claims unit to ensure it has been received.

5. What is an elimination period, how does it affect the disability payment and what is the duration of benefits?

There is a 14-day elimination period. While an employee is disabled during this time, no benefits will be payable. Total disability benefits will begin on your fifteenth day of being disabled. Your benefit period is the 24 weeks following your elimination period.

6. If disabled for less than a month, what will be the benefit amount?

After meeting the elimination period, any benefits payable for periods less than one month will be paid at a rate of 1/30th of the monthly benefit for each day the employee is disabled.

7. How frequently can the employee anticipate receiving their disability check?

Unless otherwise noted, benefits will be paid in 30 day increments. Benefit periods that are paid for less than a month will be calculated as described above.

8. How does the STD benefit work with EIB (paid leave)?

Before benefits are payable, the 14 day elimination must be met. No benefits are paid during this time. Employee can use PTO or EIB to fill in the gap for this waiting period. For the next 16 days, full benefits are payable. At the end of this period, if the claimant is receiving compensation for EIB, benefits will be reduced based upon the amount of money they receive. In some cases, this could result in providing the minimum benefit monthly payment of one hundred dollars. The employee is not required to exhaust any or all PTO unless otherwise required by the Human Resources Department (*an extended explanation is included at the end of this section*).

9. Does the employee need to have their doctor complete a disability claim form each time?

When filing the initial claim form, the doctor needs to complete his portion (Attending Physicians Statement). Subsequent filings can be completed by the attending physician or HR.

10. How many weeks are covered for a normal delivery/c-section?

The disability is in part based upon the dates the doctor provides on the claim form. (Generally it is six weeks for a normal delivery and eight weeks for a c-section.) We do have the right to have a covered person examined as often as is reasonably necessary while a claim is pending. We will pay for such examination.

11. If there are complications with the Mother's Health during delivery....what are the guidelines for coverage?

It would be handled like any other illness.

12. Is an employee responsible for paying premium while they are on claim?

Yes, an employee is responsible for the payment of premium during the first 90 days of disability. If the employee is still on disability, the waiver of premium will begin on the 91st day. Waiver of Premium will continue until: (a) the end of your Total Disability; (b) the end of the Maximum Benefit Period; (c) the end of the period for which benefits would otherwise be payable; (d) the date the Policy terminates; or (e) the date your employment with the policyholder or subscribing employer unit ends, as determined by the employer, whichever first occurs.

13. Does this policy cover a disability due to mental illness?

If you are totally disabled and receiving regular treatment due to a covered mental illness, regardless of the cause, monthly disability benefits will be paid for 1/2 of the benefit period.

14. Is there a pre-existing condition clause included in the policy?

Yes, There will be no disability benefit payable for a Pre-Existing Condition until: (a) you have: (1) gone treatment-free; (2) incurred no expense; (3) taken no medication; or (4) received no diagnosis or advice from a physician for 12 consecutive months for such condition; or (b) you have been continuously covered under the policy for 1 year. "Pre-Existing Condition" means an injury, sickness, or physical condition for which you: (a) had treatment, (b) incurred expense; (c) took medication; or (d) received a diagnosis or advice from a physician, during the 12-month period immediately before the Effective Date of your coverage (6 months before the effective date of coverage in Alaska, Idaho and Wyoming). The term "Pre-Existing Condition" will also include conditions which are related to such injury, sickness, or physical condition.

Time Limit on Filing a Claim

Proof of loss:

Proof of loss must be given to the Company within 90 days after the loss.

Late proof may be accepted if:

It was **not reasonably possible to give proof in that time**; and **the proof is given within one year from the date of loss**. This one-year limit will not apply in the absence of legal capacity.

The information provided herein is provided as general information. It is not intended to replace the language of the contract. The language of the policy takes precedence. Final determination of a claim is based upon the documents that are submitted for review and the policy language

Suggested Talking Points & Examples of How EIB works with Short-Term Disability

Purpose: *Explaining the Sick Leave Offset for Employees who have accumulated sick days in what is called the Extended illness Bank. (EIB)*

- Before benefits are payable, the 14 day elimination must be met. No benefits are paid during this time. (Employee can use PTO or EIB to fill in the gap for this waiting period)
- For the next 16 days, full benefits are payable. At the end of this period, if the claimant is receiving compensation for EIB, benefits will be reduced based upon the amount of money they receive. In some cases, this could result in providing the minimum benefit monthly payment of one hundred dollars.
- The employee is not required to exhaust any or all PTO unless otherwise required by the Human Resources Department

Example for Determining Disability Benefit for EE's that have Sick Leave Days or EIB:

You have ____days of sick leave. While you are satisfying your 14 –day waiting period you will use 14 days of sick leave. On the 15th day of your short term disability, you become eligible for your monthly benefit amount of ____ (monthly benefit amount) which will be prorated ***for the next 16 days.***

If the employee has more than 30 days of sick leave:

Since you have more than 30 days of sick leave, during the second month you would only be eligible for the minimum monthly benefit of \$100. But after you exhaust your sick leave, you become eligible for the full benefit of up to 60 percent of your income. (max. of \$2500)

The information provided herein is provided as general information. It is not intended to replace the language of the contract. The language of the policy takes precedence. Final determination of a claim is based upon the documents that are submitted for review and the policy language.



FAQ's: Legal Plan

1. Who do I call with questions?

Legal Access Plans' Member Service Center – (800) 421-4340. Our Personal Access Specialists (PAS) can answer any questions the member may have regarding their benefits, coverage, eligibility, or enrollment, just to name a few. The PAS is fully trained in all areas where questions may arise.

2. Do I have to file a claim to use the service?

A claim form is not required with the Family Legal Protection Plan.

3. What are the top three most requested coverages under the plan?

Divorce, Wills and Estate Planning

4. How much do I have to pay the attorney for service provided?

All members will receive a guaranteed special plan hourly rate of \$75.00 per hour for all covered services that may not have a special rate or no cost attached to them as outlined in the Plan Booklet.

5. Who is covered under the plan? Will this cover my brother, cousin, roommate, girlfriend?

Eligible family members are the plan member's significant other and unmarried dependent children household who are under the age of 23 and any categorically dependent individuals living in the plan member's home. This plan covers the Elder Parents of both the member and their spouse, even if they are not living with the member/spouse.

6. How do I obtain a referral to a network attorney?

- Call Legal Access Plans – (800) 421-4340.
- A Personal Access Specialist (PAS) will answer the phone and ask you a few questions about your legal matter that will be kept confidential.
- Legal Access will then contact an attorney in your area and speak to him or her regarding your case.
- After the attorney accepts the referral, your PAS will contact you with the attorney's name and number.
- You will then be asked to contact the attorney and set up an appointment.
- Your Personal Access Specialist will be available to answer questions and assist you with any issues for the duration of your matter.

7. What if I am not happy with the attorney or have difficulty making contact with the attorney?

Simply contact the Member Service Center, or the Personal Access Specialist who originally assisted you. Legal Access will make every effort to connect you with an attorney who suits your needs. Please bear in mind that many attorneys have a demeanor that is effective in the courtroom and tough in negotiations, but may not seem empathetic in dealing with clients. Despite our attempts to pick service-oriented attorneys, we must also search for effective advocates. However, our Specialists are always ready to answer your questions and assist you if you are unhappy with your attorney.

8. Are there any matters that are excluded from the plan?

Your plan does not cover any employment-related matters, immigration, trademarks, copyrights, patents, securities, tax matters or business issues. For a complete list of exclusions please refer to your Plan Booklet.

9. What if I need another copy of my Plan Booklet?

Contact the Legal Access Member Service Center. The Specialist will verify your membership and mail a new booklet to you immediately. You do not need to have your ID Card or Booklet in order to use the Plan Benefits.

10. Will the Plan Attorney need to see my Legal Plan ID Card?

No. If you lose your card, you do not need to wait until your new materials arrive. Simply contact the Member Service Center.

11. What are the hours during which I can contact the Member Service Center?

The Member Service Center is open Monday through Friday from 7:00 a.m. until 7:30 p.m. Central.

12. Can I get a list of attorneys on the plan?

Legal Access matches each case with the appropriate provider based on a number of factors besides geography, including expertise, conflicts, scheduling, court familiarity, demeanor and other factors. Because this matching process ensures a high level of service, members are not encouraged to contact a Plan Attorney without a referral through the Member Service Center. If you wish to find out whether a particular attorney is on the Plan, please express your concerns to a Personal Access Specialist at the Member Service Center and every effort will be made to accommodate your request.

13. How long will it take to get a referral to a Plan Attorney?

Most cases are referred within one business day. Once your Specialist completes your case profile, our Matching Specialists will contact the Plan Attorneys best suited to assist with your matter. Because the Matching Specialists speak directly to the attorney before providing you with a referral, there may be a slight delay if the attorney is in court or client meetings when the Specialist contacts him or her. You will be referred to a practicing attorney who is established in the location and area of practice pertaining to your matter. Even if you have what seems like a "simple question", Legal Access believes that the best advice is provided by a local attorney, rather than a "call center" attorney.

14. How close will the attorney be to my home/work?

Legal Access refers 99% of member's cases to an attorney within 23 miles of their home or work zip code. Typically, only very complex cases in outlying areas must be referred outside of this radius, usually to an attorney in a metropolitan area. Most cases are referred within 12 miles of their home/work zip code.

15. Is there a website with plan information?

Please visit <http://hca.legalaccessplans.com> for information. You may also access libraries of legal information on topics such as Wills, Small Claims, Elder Law and many others by logging in with the **password: hca**.



FAQ's: Long-Term Care

MetLife Long-Term Care Insurance:

(Enrollments After May 2003)

1. How can I determine the employee's Long-Term Care Provider?

As of May 2003, HCA CorePlus Benefits announced MetLife as the new provider for Long-Term Care Insurance. If you purchased LTC before May 2003, your provider is Aetna Long-Term Care. If an employee has any questions as to which provider they have for LTC, they can call our PolicyHolder Service line 1-877-650-4251 (option1) and a representative will be able to identify their provider.

2. Who is eligible for MetLife Long-Term Care Insurance Plan?

Benefit eligible employees of HCA's affiliated facilities and other eligible family members including spouses or surviving spouses, parents and parents in law, grandparents and grandparents in law, and adult children over age 18.

3. How do I enroll in MetLife Long-Term Care Insurance?

Employees can enroll through MetLife's website at www.metlife.com/mybenefits, or by calling MetLife at 1-800-438-6388 to request an enrollment kit. Premium payments will be available through convenient payroll deduction.

Aetna Long Term Care Insurance:

(Enrollments before May 2003, and for small select union groups)

1. Who's eligible for Aetna Long Term Care insurance?

A full-time, active employee or part-time employee regularly scheduled to work 16 or more hours a week is eligible. And so are some other people they care about:

- Their spouse
- Their parents and parents-in-law

The fact that so many others are eligible for coverage may be a surprise to you, because most company insurance plans only cover the employee. This means employees can offer their loved ones the same freedom from worry that they can enjoy. They're eligible to enroll for coverage even if employee decides not to apply.

2. Does the employee have to answer questions about their health?

Not if they're an active employee (not already eligible for claim) and they enroll during their enrollment period (Newly Benefit Eligible Enrollment or during a scheduled Open Enrollments). If an application is received outside of these enrollment periods, the employee will have to provide evidence of good health by completing a medical questionnaire.

3. How does an employee decide how much coverage to choose?

With this plan, the employee can select a Daily Benefit Amount of from \$50 to \$250. (The cost of the insurance varies, of course, depending on the Daily Benefit Amount they choose and their age at the time of purchase.) How do they decide what coverage they need? This might help: Recent figures show that a year in a nursing home costs anywhere from \$35,000 (roughly \$100 a day) to \$80,000. The average cost of a home visit by a nurse is around \$100. These numbers will vary depending on where the employee lives and the extent of their need.

4. Is there a maximum amount an employee can receive over their lifetime?

Employees have a choice of lifetime maximum amounts. They may choose a three or five year lifetime maximum. To find the Lifetime Maximum—the total amount they're entitled to— multiply the Daily Benefit Amount they've chosen by 365 (the number of days in a year; we don't count leap years.) Then multiply that result by the number of years. For example, if an employee selected a \$100 daily benefit and a five-year term, multiply \$100 by 365, which gives you \$36,500. Multiply that by 5, and their Lifetime Maximum is \$182,500. (If an employee needs more help, please talk to your Aetna Long Term Care specialist at 1-800-537-8521.)

5. What benefits does the employee receive?

They choose a daily dollar amount—and that money is theirs to use in any way they see fit. The employee will receive 100% of their Daily Benefit Amount if they are confined in a nursing care facility, or 50% of the Daily Benefit Amount if they are confined somewhere else. The employee can use the money as they choose: to pay for the cost of a licensed nursing care or hospice care facility... home care by an R.N., L.P.N. or L.V.N.... physical, occupational, speech or respiratory therapy... perhaps to pay a relative or neighbor to take care of them. By paying a cash benefit, the plan does not expressly define how you must use the funds.

And there's more:

- The employee can cancel the plan without obligation any time within the first 30 days. So they get a "free look" because any premium they paid will be refunded to them.
- The employee only has to satisfy the 90-day waiting period once in their lifetime.

And even more:

- Restoration of benefits: When the employee recovers, this restores the Lifetime Maximum by the amount of benefits paid on their behalf. If they qualify for a future claim, the full Lifetime Maximum will be available to them again.
- Bed reservation: If an they must leave a nursing facility or assisted living facility for any reason, the plan will pay the charges to reserve the room for up to 21 days each year.

6. How does a policyholder know when they qualify for benefits?

The plan pays benefits if they become unable to perform 2 of the following 5 activities of daily living without substantial assistance from another person: eating; transferring (getting in and out of bed); dressing; continence; toileting.

This plan will also pay benefits as a result of a severe cognitive impairment that requires supervision or verbal direction from another person in order to protect you or others from serious injury.

To be eligible to receive benefits, a licensed health care practitioner must certify annually that they have suffered either: (1) a functional loss in their ability to perform at least 2 activities of daily living for a period of at least 90 days; or (2) that they have severe cognitive impairment.

7. Will the employee have the opportunity to increase coverage?

Yes, they'll have the opportunity every 2 years to increase their coverage to keep up with inflation. And they won't have to provide proof of good health. Naturally, the cost of any increase in coverage will be based on their age at the time of the additional purchase. Even if they're actually receiving benefits, they'll be eligible for inflation protection offerings, as long as they haven't turned down a previous offering.

8. Is there a waiting period?

Yes, 90 days from the time they become eligible to receive benefits.

10. Does the employee pay premiums while they are receiving benefits?

No, not with Aetna Long Term Care insurance.

11. What happens if they don't pay the premiums? Do they lose everything?

No, not if the employee elects to add a Nonforfeiture provision. Then, the plan offers a special feature that allows an extension of their insurance coverage if they have to stop paying premiums. How much coverage the employee keeps depends on the total amount they've paid into the plan at the time they stop making payments.

Once they've paid premiums for 3 years, employees are eligible for the Benefit Bank feature. The adjusted lifetime maximum benefit payable is the amount of the premiums the employee has paid into the plan, with a minimum guarantee of one month's benefit.

12. How does an employee make a claim?

If the employee thinks they're eligible to receive benefits, simply telephone Long-Term Care Member Services at 1-800-537-8521. Aetna will send a Benefit Request form and we'll assign an Aetna Case Manager to help. Our Case Managers are registered nurses and professional social workers, so they can help through the whole process.

13. How will they receive benefits?

Employees will receive the benefits they've selected in a check made payable to them each month. How they use that money is up to them. They won't have to submit bills and they won't have to do any extra paperwork.

15. And what if they never have to make a claim?

Their premiums can actually be returned to their estate if the employee chooses to include the Return of Contribution features. Assuming the employee enrolled as an active employee or the spouse of an active employee, if they die while still paying premiums and covered under the plan, and they're not in claim or within a waiting period at the time of death, all the payments they made will be refunded to the beneficiary without interest and subject to these reductions: a 10% reduction per year beginning with their date of retirement or the date you reach age 65, whichever is later; for spouses and other insured members, the reduction begins at age 65.

16. What if they leave the company?

If they leave, they can continue coverage on a portable basis. Coverage is fully portable for their family members as well.

17. Is the Aetna Long Term Care benefit the same benefit HCA offered before CorePlus Benefits?

Yes. Placing LTC through CorePlus Benefits allows current and future employees to utilize premium payments through payroll deductions instead of direct bill as long as they remain benefit eligible.

18. Is there any enhanced benefit or reduced premium? If so, will people that are already enrolled in LTC receive the reduced rate?

There will be an enhanced benefit. Employees will be allowed to choose between four options. For those individuals currently enrolled, Aetna will allow them to convert into the new plan without medical underwriting. This conversation will take place later in the year after all CorePlus Benefits enrollment waves have been completed. Premiums for those individuals will vary (some more expensive, some less expensive). Those enrolled will get the benefits of premiums paid into the plan if they choose a lesser benefit. For example, if they went from paying \$1.25 for every dollar of coverage to a plan where the new rate is only \$1.00 per dollar of coverage, the rate they pay will be less, say \$.75 per dollar, since they would have technically overpaid Aetna for the time they have been enrolled.

Glossary of Terms Used for Long-Term Care

Activities of Daily Living (ADLs) or daily functions	These activities include things like dressing, eating, toileting, transferring (moving in or out of a bed or chair), and continence. They are used as one method of determining eligibility for long-term care benefits.
Adult Day Care	A day care program designed primarily for frail, impaired or disabled adults. It provides social and health-related services in a community setting.
Assisted Living Facility	A licensed facility that provides 24 hour services for people who are unable to perform certain activities of daily living, or who suffer from cognitive impairment. It is a facility with some of the resources of a nursing home (but in a more residential type of atmosphere).
Bed Reservation	Reservation of a place in a nursing care facility or assisted living facility when the insured needs to leave temporarily (e.g. for a hospital stay).
Benefit Bank	A type of nonforfeiture feature that specifies the number of years an insured must pay into the plan before they would receive the long term care benefit. Specifically, if the insured elects to stop paying premiums after contributing to the plan for at least three years, the plan will pay the greater of : 100% of the contributions paid; or one month of benefit.
Cognitive Impairment	A condition (such as Alzheimer's disease) that triggers eligibility for long-term care when there is a need for supervision or verbal cueing by another person to avoid <u>serious</u> injury to self or others.
Daily Benefit Amount	This is the <i>maximum</i> amount of coverage your plan will provide each day, once you become eligible for benefits. You select the amount that you want the policy to pay, as described in your plan summary.
Home Health Care	Care received at home such as part-time skilled nursing care, speech therapy, physical or occupational therapy, part-time services of home health aides or help from homemakers for assistance with housekeeping and chores.
Homemaker Services	Services such as assistance with meal preparation and light housekeeping.
Hospice Care	Care for the terminally ill given by (or arranged by) a Hospice Care Agency or Hospice Facility.
Informal Care	Care provided by family members, neighbors or private-hire caregivers.
Lifetime Maximum Benefit	The maximum benefit payable under the plan in the aggregate during the lifetime of each insured.
Medicaid	The joint state and federal program that provides payment for health care services to those with lower incomes or with very high medical bills. It does provide benefits for custodial and home health care once income and assets have been "spent down" to eligibility levels.
Medical Questionnaire	A special evidence of insurability form designed for long-term care coverage.

Medicare	The federal program designed to provide those over age 65, some disabled persons and those with end-stage renal disease with help in paying for hospital and medical expenses. It does not provide benefits for long-term care.
Nonforfeiture	Plan value that builds up after paying into the plan over time. If premium payments are stopped, the individual receives additional coverage. This is not a cash value.
Nursing Facility	A licensed institution that provides skilled inpatient care under the supervision of a physician or RN. It is not <i>mainly</i> a place for rest, the aged, drug addicts, alcoholics, mentally retarded people, for educational care, or care of mental disorders.
Respite Care	Temporary short-term care for the sick or disabled, sometimes provided in a nursing care facility. It allows families to have a brief rest from caring for chronically ill or disabled relatives at home.
Waiting Period	A period of days (sometimes called a deductible period) when no benefits will be paid. This waiting period begins on the date that Aetna determines a qualifying loss of functional capacity began.



FAQ's: Vision Benefit

**Transitioned to LifeTimes effective 1/1/2005
(Except for a select group of union employees at Bayonet Pointe Facility).**

1. What is covered in a comprehensive eye exam?

At ECPA, our focus is on healthy eyes. All of our scheduled benefit plans include a comprehensive vision examination which includes, but is not limited to: case history, including chief complaint, ocular disease and medical history, visual field screening, refraction and treatment plan.

2. Are contact lens fitting fees included in the vision exam?

Professional contact lens fitting fees are not considered a part of routine eye care and are not included in the vision exam. However, members who receive a contact lens fitting from a provider who also dispenses their contact lenses can apply the access of their materials benefit, if any, toward the cost of the fitting. It is important to remember that contact lenses must be purchased from the same provider who performed the fitting, and that only the balance of the materials benefit, after purchasing contact lenses, can be applied towards the fitting fee.

3. Are disposable contact lenses covered?

Typically, contact lenses are available every 12 or 24 months in lieu of spectacle lenses and frame, depending on your plan. When purchasing disposable contact lenses, members must use their entire allowance in a single purchase. It is important that members use their entire allowance at one time, since subsequent purchases within the same eligibility will be denied until the member becomes eligible again.

4. Can members purchase contact lenses and glasses?

Members who choose the contact lens benefit elect to receive contact lenses in lieu of frames and spectacle lenses. However, members are entitled to purchase additional materials, like glasses, from ECPA providers at ECPA contracted Preferred Pricing. These purchases can be made as frequently as desired. Preferred Pricing allows ECPA members to purchase high quality eyewear at special pricing that ECPA has negotiated on their behalf. There is no paperwork to fill out. At the time of purchase, members simply pay the provider the Preferred Pricing in full. Members are welcome to ask the provider to show them the savings they received using their ECPA membership card.

Preferred Pricing is not available from non-ECPA providers.

5. Does ECPA cover non-prescription items like sunglasses?

ECPA does not cover items that are not necessary for vision correction. However, ECPA members will receive savings when purchasing sundry items, including non-prescription sunglasses through Preferred Pricing, available to them only from ECPA providers.

6. Are high index lenses covered under the lens benefit?

High index lenses are lenses that are specially processed to be thin. Since high index lenses are cosmetic, they are not covered by the lens benefit. However, ECPA providers will use Preferred Pricing to determine the cost, ensuring that each ECPA member receives a savings on this feature.

7. How can a member find out what benefits are available to them and how often?

Members can call ECPA's automated Easy Access Automated Service Line at **1-800-843-3272, 24 hours a day, 7 days a week** for information on benefits and providers.

8. Do members have an ECPA identification number?

Yes. The subscriber's social security number is his/her ID number for all eligible members of his/her family.

9. Do members have to use ECPA providers?

Most programs offer non-ECPA provider coverage, but members will receive lower benefits than if they use ECPA providers. Please refer to your Agreement for Services to determine if non-panel benefits are available to your employees.

10. Do members need to complete claim forms?

ECPA providers complete the paperwork and send it directly to ECPA. Members pay their applicable co-payments, any excess charges above their benefit allowances, and any charges for non-covered services and materials. There are no claim forms to complete.

Non-ECPA providers may provide members with a completed claim form for submission, although it is not necessary for reimbursement. Members must submit a fully itemized original invoice in lieu of a completed claim form, together with a copy of their ECPA card directly to ECPA claims for reimbursement.

11. How often can members use their benefits?

The frequency of benefits appears on the card carrier that accompanies the ECPA card that is provided to all members.

Once the member's benefits are exhausted, he/she is entitled to purchase materials from ECPA providers at ECPA contracted Preferred Pricing, as frequently as desired. There is no paperwork to fill out. At the time of purchase, members simply pay the provider in full according to the Eye Care Plan of America Preferred Pricing.

Preferred Pricing is not available from non-panel providers.

12. Does ECPA offer a provider directory?

ECPA does not offer a provider directory because they are continuously adding to their provider network to give members as much choice and flexibility as possible. Provider information is available around-the-clock through ECPA's advanced, Easy Access Automated Service Line 1-877-650-4251 (option 5), or employees can access ECPA's website by visiting the Vision Care section at www.coreplusbenefits.com. This site always contains the most accurate, up-to-the-minute Provider information.

13. Will ECPA add providers to their network at the members request?

ECPA's Provider Network is the largest and most comprehensive of its type. ECPA strives to maintain a 2,000:1 ratio of members to providers. Generally, ECPA focuses its network development activities to areas where there is critical mass of members and the number of ECPA providers is limited.

14. Who do members call if they need further information?

Members are encouraged to call ECPA's Easy Access Automated Service Line at **1-877-650-4251 (option 5)**. The automated system will give members a menu to choose from: Provider Locator, Plan Benefits, ID cards, Claim Form, Claim Status, Laser Surgery. If your inquiry does not fall into one of these categories, hold on and you will be given an opportunity to speak with a representative.

CorePlus Benefits Helpful Information

SECTION 4
KEY

 Contact Guide

 One Pager

 NH Schedule

In this section you will find several documents that are designed to provide you with useful information to help direct employees that may come to you with questions regarding CorePlus Benefits.



CorePlus Benefits Contact Guide

CorePlus Benefits has many resources for you and your employees to access information. Below we have detailed each contact resource and how it can help you.

CorePlus Benefits Enrollment Call Center 1-800-520-1553:

This number is only used for employees to enroll in CorePlus Benefits plans. All employees wishing to enroll may call this number during their two-week open enrollment period. During open enrollment, employees may talk to a benefit counselor who is trained to be a friend, advisor and coach and to help them make good decisions based on their benefit needs. The Call Center is open only during open enrollment periods and for the first two full weeks of each month for newly benefit-eligible employees.

CorePlus Benefits Customer Service 1-877-650-4251:

This [Customer Service Line](#) is for employees who have questions about their HCA CorePlus Benefits policies. If an employee has a question about their payroll deductions or would like to **cancel any of their HCA CorePlus Benefits policies**, they should call this number and **press "1" for Billings and Deductions**. If an employee has a specific policy question they should call this number and press the appropriate option for the respective benefit.

CorePlus Benefits HR HelpLine 1-888-243-8322:

This is an exclusive number for Human Resources personnel only. If an employee comes to you with a question or a problem, or if you have a question, please do not hesitate to call this number. Tracy Andrews or Ashley Clark can assist you in getting the information you need.

HCA CorePlus Benefits on the Web:

We have two different Web sites to help you and your employees' access information.

www.coreplusbenefits.com

This Web site has information on all of the CorePlus Benefits policies. If an employee wants to enroll and cannot find their Enrollment Guide, this site has all the information the employee needs to make the call to enroll. Many HR Director's and Benefit Coordinators use this site to print information into hard copy for employees who need additional information or have lost or misplaced their original copies.

www.coreplusbenefits.com/hr

This Web site is an exclusive site for HR. Here you will find detailed information on our Enrollments, Information for Policy Holders, and Resources for you and your staff to help assist your employees with their CorePlus Benefits. We even have materials that you can download to help with employee meetings and claim forms with instructions for short-term disability.

- **Helpline Issue Request Form:**

This [Helpline Issue Request Form](#) is for HR to use if you want to submit a question or an issue. All requests are automatically emailed to CorePlus Benefits and you will be contacted within 24 to 48 business hours by a member of our HR HelpLine Team.

CorePlus Benefits Email:

coreplushelp@veba1.com

This email address is an exclusive, confidential email for HR to use if they have a question they would like to email instead of calling the HR HelpLine 1-888-243-8322.



CorePlus Benefits One Pager

The “CorePlus Benefits One Pager” was developed as a one page summary that may be used by Human Resource Departments for Recruitment, Orientation, Benefit Fairs or as needed by each individual facility. This document is available on our HR Web site (www.coreplusbenefits.com/hr) in PDF format so that you may download and print on demand.

You will find a version of the “One Pager” in **Appendix A** found in the back of this Guide.



Newly Benefit Eligible Enrollment Schedule

The Newly Benefit Eligible Enrollment Schedule (**Appendix B**) allows you to quickly determine the Enrollment Period for Newly Benefit Eligible Employees. Not only does the chart include the start and stop of each monthly Newly Benefit Eligible Enrollment, it also includes the date that each piece of mail is received, the first payroll deduction, and the effective dates for benefit selections. This schedule is also available on our HR Web site and it is updated each year.

The Basic Mail Template for CorePlus Benefits Enrollment Pieces to be received during each monthly enrollment is as follows:

Introductory Letter:	Hits on Wednesday before enrollment begins
Enrollment Guide:	Hits on the first day of the enrollment
Postcard:	Hits on the second Monday of the enrollment
Final Letter:	Hits on the second Thursday of the enrollment

This schedule is included in the Appendix B in the back of this Guide.

