AMERICAN ASSOCIATION OF AIRPORT EXECUTIVES

2022-2023 BENEFITS GUIDE

BENEFITS OVERVIEW

At American Association of Airport Executives we consider our employee benefits program to be one of our most important investments. Because we recognize the value our employees bring to our company, we are committed to providing you with a complete benefits program as part of your total compensation.

This guide has been prepared to assist you in making informed decisions regarding your employee benefits. We urge you to read this guide carefully and keep it as a reference. If you are well-informed, you will be better able to make the benefit choices that best meet your needs.

Elections made now will remain until the next open enrollment unless you or your family members experience a qualifying event. If you experience a qualifying event, you must contact HR within 30 days.

TABLE OF CONTENTS

ELIGIBILITY

You and your dependents are eligible for AAAE benefits on the first of the month following date of hire.

DEPENDENT ELIGIBILITY

Your eligible dependents include your legally married spouse, registered domestic partner, and children. Due to Affordable Care Act, your medical, dental, and vision plans cover dependents to age 26.

Coverage may be available for a mentally or physically disabled child who is age 26 or older. Requirements for such coverage and documentation of disability depend on the insurance carrier. Please contact Maria Bremis if you believe this issue applies to your family.

Open Enrollment

Submit your forms to HR to enroll or make changes starting September 15, 2022. Open Enrollment ends September 22, 2022.

If you have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please refer to the Medicare D notice in this benefits guide for more details.

This document is an outline of the coverage proposed by the carrier(s), based on information provided by your company. It does not include all of the terms, coverage, exclusions, limitations, and conditions of the actual contract language. The policies and contracts themselves must be read for those details. Policy forms for your reference will be made available upon request.

The intent of this document is to provide you with general information regarding the status of, and/or potential concerns related to, your current employee benefits environment. It does not necessarily fully address all of your specific issues. It should not be construed as, nor is it intended to provide, legal advice. Questions regarding specific issues should be addressed by your general counsel or an attorney who specializes in this practice area.

MEDICAL BENEFITS

Cigna

Comprehensive and preventive healthcare coverage is important in protecting you and your family from the financial risks of unexpected illness and injury. A little prevention usually goes a long way—especially in healthcare. Routine exams and regular preventive care provide an inexpensive review of your health. Small problems can potentially develop into large expenses. By identifying the problems early, often they can be treated at little cost.

	Open Access Plus In-Network Only (OAPIN H.S.A)	**Open Access Plus Plan (OAP H.S.A PLUS)**	
WHAT YOU PAY	**IN NETWORK ONLY PLAN**	**IN NETWORK**	**OUT OF NETWORK**
Plan Year Deductible (Single/Family)	$3,000 / $6,000*	$2,000 / $4,000*	$4,000 / $8,000*
Out-of-Pocket Maximum (Single/Family)	$6,000 / $12,000**	$4,000 / $8,000**	$8,000 / $16,000**
Co-insurance (Cigna/You)	100% / 0%	100% / 0%	80% / 20%
Preventive Services	No Charge	No Charge	Not Covered
Office Visits (Primary/Specialist)	$10 copay after ded. / $20 copay after ded.	0% after ded. / $10 copay after ded.	20% after ded./ 20% after ded.
Lab/X-ray/Complex Radiology	0% after ded.	0% after ded.	20% after ded.
Inpatient Hospital Services	0% after ded.	0% after ded.	20% after ded.
Outpatient Surgery	0% after ded.	0% after ded.	20% after ded.
Urgent Care	$50 copay after ded.	$50 copay after ded.	20% after ded.
Emergency Room (Wvd if Adm)	$250 copay after ded.	$250 copay after ded.	Covered as In-Network
Ambulance (Emergency Only)	0% after ded.	0% after ded.	0% after ded.
Physical, Speech, Occupational Therapy	$20 copay after ded.	$10 copay after ded.	20% after ded.
Chiropractic	$20 copay after ded.	0% after ded.	20% after ded.
Mental Health and Substance Abuse Inpatient Mental Health Outpatient Mental Health Inpatient Substance Abuse Outpatient Substance Abuse	 0% after ded. $20 copay after ded. 0% after ded. $20 copay after ded.	 0% after ded. 0% after ded. 0% after ded. 0% after ded.	 20% after ded. 20% after ded. 20% after ded. 20% after ded.
Maternity Pre-Natal and Post Natal Care Deliver	 0% after ded. 0% after ded.	 0% after ded. 0% after ded.	 20% after ded. 0% after ded.
Durable Medical Equipment	0% after ded.	0% after ded.	NC
Home Health Care	0% after ded.	0% after ded.	20% after ded.
PRESCRIPTION DRUGS			
Plan Year Year Drug Deductible	Medical Deductible, then	Medical Deductible, then	Medical Deductible, then
Generic (30 day / 90 Day)	$0 copay / $0 copay	$0 copay / $0 copay	50% / NC
Preferred Brand (30 day / 90 Day)	$25 copay / $75 copay	$25 copay / $75 copay	50% / NC
Non-Preferred Brand (30 day / 90 Day)	$45 copay / $135 copay	$45 copay / $135 copay	50% / NC
Speciality (30 day)	50%	50%	50%

* = All family members contribute toward the family deductible. An individual cannot have claims covered under the plan until the total family deductible has been satisfied

** = After each eligible family member meets his or her individual out-of-pocket maximum, the plan will pay 100% of their covered expenses. Or, after the family out-of-pocket maximum has been met, the plan will pay 100% of each eligible family member's covered expenses

Ded = Deductible

CHOOSE A PLAN WITH CONFIDENCE

Cigna One Guide service can help.

Whether you're a current Cigna customer or considering Cigna for the first time, we understand how confusing and overwhelming it can be to review your health plan options. And we want to help by providing the resources you need to make a decision with confidence. That's why **Cigna One Guide® is available to you now**.

Call a Cigna One Guide representative during preenrollment to get personalized, useful guidance.

Your personal guide will help you:

- Easily understand the basics of health coverage
- Identify the types of health plans available to you that best meet the needs of you and your family
- Check if your doctors are in-network to help you avoid unnecessary costs
- Get answers on any other questions you may have about the plans or provider networks available to you

The best part is, during the enrollment period, your personal guide is just a call away.*

Don't wait until the last minute to enroll.

Call **888.806.5042** to speak with a Cigna One Guide representative today.*

Cigna Group Number: 3345215

After enrollment, the support continues for Cigna customers.

Your Cigna One Guide representative will be there to guide you through the complexities of the health care system, and help you avoid costly missteps. Our goal is a simpler health care journey for you and your family.

Cigna One Guide service provides personalized assistance to help you:

- Resolve health care issues
- Save time and money
- Get the most out of your plan
- Find the right hospitals, dentists and other health care providers in your plan's network
- Get cost estimates and avoid surprise expenses
- Understand your bills

Access Cigna One Guide – after enrollment – in the way that's most convenient for you:

App | Chat | Phone

Together, all the way.®

Cigna®

Offered by: Cigna Health and Life Insurance Company, Connecticut General Life Insurance Company or their affiliates.

* During enrollment, personal guides available Monday through Friday, 8:00 am–9:00 pm EST. Once your coverage begins, call the number on your ID card to speak with a personal guide. Additional customer service representatives are available 24/7.

Product availability may vary by location and plan type and is subject to change. All group health insurance policies and health benefit plans contain exclusions and limitations. For costs and complete details of coverage, see your plan documents.

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WELCOME TO CIGNA

Make the most of your plan with this quick guide

Your life is busy, but that doesn't mean it has to be complicated. At Cigna, we want to help. That's why we offer programs and services to help make it easier to be your healthiest – both body and mind.

Get to know your plan. The more you learn, the better prepared you can be to make choices about your health and health spending.

myCigna
Find providers, access wellness resources, review claims and more, with the **myCigna**® website and App.

Virtual care
Connect with board-certified doctors, therapists and psychiatrists via video or phone.[1]

Cigna One Guide®
Get personalized, proactive support to take control of your health – and your health spending.[3]

Care management programs
Get help with a condition from a case manager or learn how to reach your health goals with online coaching.

WE CAN HELP YOU TO BE YOUR HEALTHIEST – BODY AND MIND.

Whole person health
Access in-network behavioral specialists, who are available for care in person or online. After all, your emotional well-being is just as important as your physical well-being.

Preventive care
Receive eligible preventive care services from an in-network doctor at no additional cost to you.[2]

Specialty medications
Get help with understanding, managing and treating complex conditions that require a specialty medication.

Health Information Line
Know before you go. Talk with a clinician who can help you choose the right care.

In-network care
Learn how using doctors, hospitals and health facilities in your plan's network can help save you money.

Together, all the way.®

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Offered by: Cigna Health and Life Insurance Company.

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myCigna

On **myCigna.com** and through the myCigna App, you can:

- Find in-network doctors and medical services
- Review coverage
- Manage and track claims
- View, print or fax your Cigna ID card
- See cost estimates for medical procedures and prescription drugs
- Compare quality-of-care information for doctors and hospitals
- Compare prescription costs for 30- and 90-day medications and see if a lower-cost drug alternative is available
- Find retail pharmacies that offer a 90-day supply
- Access a variety of health and wellness tools and resources, including:
  - Online health assessment
  - Apps & Activities interactive health goal tracking program
  - My Health Assistant digital lifestyle coaching
- Sign up to receive alerts when new plan documents are available

Cigna One Guide

Combining digital technology with our personalized customer service, your Cigna One Guide team is here to help you:

- Resolve health care issues
- Save time and money
- Get the most out of your plan
- Find the right hospitals, dentists and other health care providers in your plan's network
- Get cost estimates
- Understand your bills
- Navigate the health care system

Get it all in the way that's most convenient for you.

- Call the number on your Cigna ID card
- Access the Cigna One Guide support tool by downloading the myCigna App[4]

Specialty medications

We can help you understand, manage and treat complex conditions that require a specialty medication. Our therapy management teams, made up of health advocates with nursing backgrounds as well as pharmacists, are specially trained to help with your specific needs.

- Personalized, 24/7 support
- Condition-specific education on medication therapy and side effects
- Help with the medication approval process
- Financial assistance programs, if needed

For more information, call **800.351.3606**.

Preventive care

Getting and staying healthy is important. That's why eligible preventive care services are covered at no additional cost to you when you receive them from a doctor who participates in your plan's network. Covered preventive care services include, but are not limited to:[2]

- Screenings for blood pressure, cholesterol and diabetes
- Clinical breast exams and mammograms
- Pap tests
- Testing for colon cancer

Your physical and emotional health are connected. So, when you go for your annual check-up, be sure to talk with your doctor about what you're feeling both physically and emotionally.

Go to **myCigna.com** to see a full list of services covered under preventive care.

Health Information Line

Speak with a clinician who can help you understand and make informed decisions about health issues you are experiencing, at no extra cost.

Get help choosing the right care in the right setting at the right time, whether it's reviewing home treatment options, following up on a doctor's appointment or finding the nearest urgent care center in your plan's network. Just call the number on your Cigna ID card anytime day or night.

Virtual care

Convenient care, where and when it works for you.

With virtual care, you and your covered family members can get medical and behavioral care from the comfort and safety of home via video or phone. And, it's super easy to use.

Right from your phone, tablet or computer, you can:

- Connect with board-certified doctors and pediatricians for minor medical conditions, such as seasonal allergies, cold and flu, or upper respiratory infections
- Schedule appointments with licensed therapists or psychiatrists for behavioral or mental health conditions, such as stress and depression
- Have a prescription sent directly to your pharmacy, if appropriate

Contact your in-network provider or connect 24/7 with an MDLIVE[1] provider on **myCigna.com**.

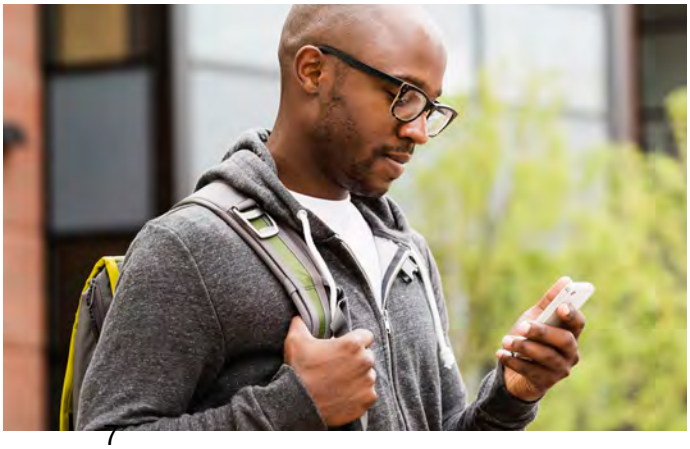
Wellness screenings.

With virtual wellness screenings through MDLIVE, getting your preventive check-up is more convenient than ever. Plus, it's covered at no cost to you, as part of your preventive care benefits through your health plan.[2]

How it works, step by step:

- Complete your MDLIVE online health assessment
- Choose an in-network lab and schedule an appointment[5]
- Choose an MDLIVE provider and schedule your virtual visit
- Go to your lab appointment; you'll receive a notification when the results are available in the MDLIVE customer portal
- Attend your virtual visit; you'll receive a summary of your screening results for your records

Access virtual care through myCigna.com anytime.



Behavioral health – online and in person

For behavioral health and substance use support, get access to quality care that's convenient too. You have access to the Cigna Behavioral Health network of providers. To find online care:

- Go to **myCigna.com** > Find Care & Cost
- Search for "Virtual Counselor" under "Doctor by Type"
- Call to make an appointment with your selected provider

Online visits with Cigna Behavioral Health network providers cost the same as in-office visits. Costs vary by plan.[6]

In-network care

Save money when you use doctors, hospitals and health facilities that are part of your plan's network. Chances are there's a network doctor or facility right in your neighborhood. It's easy to find quality, cost-effective care at **myCigna.com**.

Care management programs

Take advantage of our personal services to help you with your personal health needs. A Cigna case manager, trained as a nurse, can work closely with you and your doctor to check on your progress. You can get help with conditions and illnesses such as cancer, end-stage renal disease, neonatal care and pain management.

You also have access to My Health Assistant on **myCigna.com** to help you:

- Control stress
- Lose weight and eat better
- Enjoy exercise
- Quit tobacco
- Manage diabetes, COPD, asthma and other conditions

Enroll online today. Go to **myCigna.com** > Wellness > My Health Assistant – Online Coaching Program.

TIPS TO HELP YOU SAVE MONEY

1

Find where to get prescription drugs

- Find the complete list of covered medications on **myCigna.com**
- Remember generics offer the best value
- Know what brand-name drugs are covered in your plan
- Ask your doctor about a 90-day supply for your maintenance medication(s) through our home delivery pharmacy service[6]

2

Know where to go for care

- Use an emergency room for true emergencies
- Don't wait: Locate an in-network convenience care clinic or urgent care center near you, before you need it
- Don't be fooled: Some emergency rooms look like urgent care centers, so know what type of facilities are in your area

3

Choose your health care provider

- Know which providers are in your network by going to **myCigna** > Find Care & Costs
- Opt to connect with a board-certified doctor, therapist or psychiatrist via video or phone[1]
- Use in-network national labs to help save money

4

Be proactive in your health

- Use the health improvement tools available to you
- Get information on the cost of medications and treatments to avoid surprises
- Use your preventive care benefits, learn your core health numbers and get more information at **Cigna.com/TakeControl**

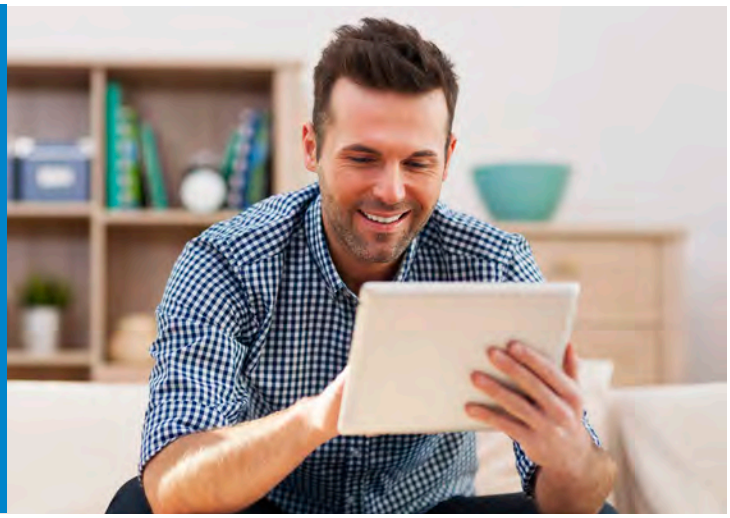
Find your way to better health.

Get more information on all the programs that are available to you.

Visit myCigna.com.

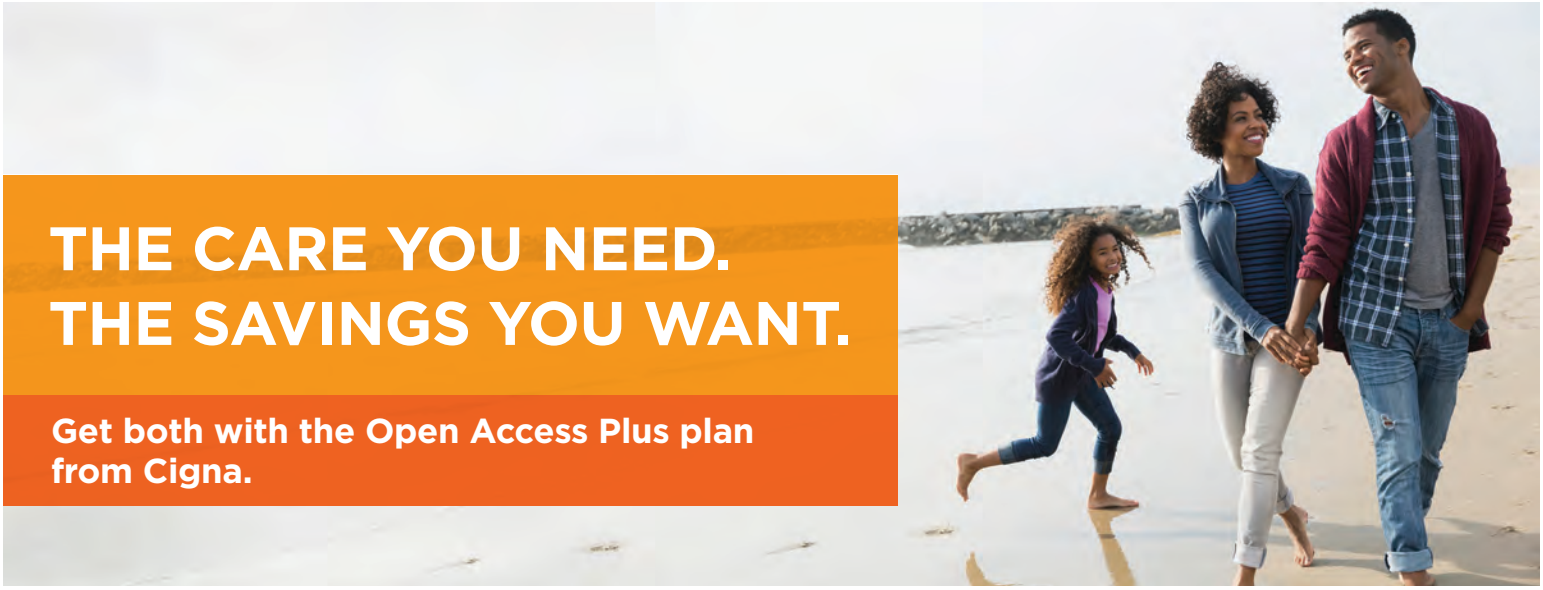
Download the myCigna App.[4]

Call the 24/7 customer service number on the back of your ID card.



1. MDLIVE is an independent company/entity and is not affiliated with Cigna. The services, websites and mobile Apps are provided exclusively by MDLIVE and not by Cigna. Providers are solely responsible for any treatment provided. Video chat may not be available in all areas or with all providers. MDLIVE services are separate from your health plan's provider network and may not be available in all areas. A primary care provider referral is not required for MDLIVE services.
2. Coverage for preventive care may vary, depending on the terms of your specific medical plan. Actual covered services may vary, depending on your age, gender and medical history. Not all preventive care services are covered. For example, immunizations for travel are generally not covered. For a complete list of covered preventive care services, contact your Cigna representative.
3. Not available with all plans.
4. The downloading and use of any mobile App is subject to the terms and conditions of the App and the online store from which it is downloaded. Standard mobile phone carrier and data usage charges apply.
5. Limited to labs contracted with MDLIVE for virtual wellness screenings.
6. Plans vary; please check your plan materials for more information on what is covered under your plan.

Product availability may vary by location and plan type and is subject to change. All group health insurance policies and health benefit plans have exclusions and limitations. For costs and complete details of coverage, see your plan documents. Providers that participate in the Cigna network are not agents of Cigna and are solely responsible for any treatment provided.



THE CARE YOU NEED. THE SAVINGS YOU WANT.

Get both with the Open Access Plus plan from Cigna.

Offering flexible access to thousands of providers – plus programs and services to support your whole health needs – the Open Access Plus (OAP) plan is designed to make it easier for you to get the quality care you need and the savings you want.

Here's how it works.

- **In-network savings**
  You have the freedom to use any provider or facility of your choice, whether they are in the Cigna OAP network or out of the network. Just know that staying in-network will help keep your costs down and avoid any additional paperwork.
- **No-referral specialist care**
  A primary care provider (PCP) is recommended, but not required. If you need to see a specialist for any reason, you don't need a referral to see an in-network health care provider. If you choose an out-of-network specialist, your care will be covered at the out-of-network level and you may be responsible for any preauthorizations needed.
- **Care coordination**
  Our robust medical management program provides you and your family a valuable resource for one-on-one support and guidance to the right programs and services.
- **Hospital stays**
  In an emergency, you have coverage. However, requests for nonemergency hospital stays (other than maternity stays) and some types of outpatient care must have prior authorization or be preauthorized. This lets Cigna determine if the services are covered by your plan.

  If your provider is in the Cigna OAP network, he or she will arrange for prior authorization. If you use an out-of-network provider, you must make the arrangements.
- **Out-of-pocket costs**
  Depending on your plan, you may have to pay an annual amount (deductible) before your plan begins to pay for covered health care costs. You may also need to pay a copay and/or coinsurance (a portion of the covered charge) for covered services. Then, your plan pays the rest. Once you reach an annual limit on your payments (out-of-pocket maximum), the health plan pays your covered health care costs at 100% for the rest of your plan year.

  If you receive out-of-network care, your costs will be higher. Out-of-network providers and facilities may also bill you for charges that are not covered by the plan. Charges not covered by the plan do not contribute to your deductible or out-of-pocket limits.

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Offered by Cigna Health and Life Insurance Company.

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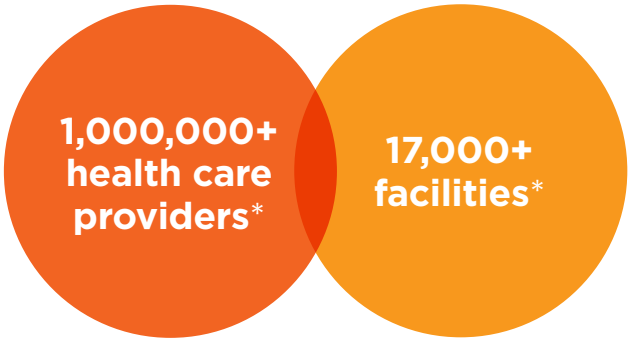
Great care anywhere. Where you live, work or travel



Added convenience and support

- **Virtual Care**
  Connect 24/7 with board-certified providers and pediatricians for minor medical conditions. You can also schedule online appointments for licensed counselors or psychiatrists for behavioral or mental health conditions. You and your covered family members can get care from anywhere via video or phone.**
- **Cigna Health Information Line**
  With the Cigna Health Information Line, clinicians are just a phone call away – 24/7, and at no extra cost. They can help you understand health issues you might be experiencing, and help you to make informed decisions – whether it's reviewing home treatment options, following up on a provider's appointment, or choosing and finding the right care in the right setting.
- **Live, 24/7/365 customer service**
  Customer service representatives are here for you where and when you need us – over the phone, via chat at **myCigna.com** or on the myCigna® App.
- **The myCigna website and app**
  On **myCigna.com** and the myCigna App, you have easy access to personalized tools to help you take control of your health and your health care spending. From your computer or mobile device, you can:
  - Manage and track claims
  - See cost estimates for medical procedures
  - Compare quality information for providers and hospitals
  - Track your account balances and deductibles
  - Use the easy health and wellness tools
  - Print a temporary ID card

Want to check if your provider is in the Cigna OAP network before you enroll?

Just go to Cigna.com and click on "Find a Provider, Dentist or Facility" and then click on "Plans through your employer or school" to search the provider directory.

* Based on Cigna internal provider data for OAP service area as of 2/2020. Subject to change.

** Not all plans include coverage for behavioral services. Check your plan documents for details. Cigna provides access to virtual care through national telehealth providers as part of your plan. Providers are solely responsible for any treatment provided to their patients. Video chat may not be available in all areas or with all providers. This service is separate from your health plan's network and may not be available in all areas. A primary care provider referral is not required for this service. In general, to be covered by your plan, services must be medically necessary and used for the diagnosis or treatment of a covered condition. Not all prescription drugs are covered. Product availability may vary by location and plan type and is subject to change. All group health insurance policies and health benefit plans contain exclusions and limitations. See your plan materials for costs and details of coverage, including other telehealth/telemedicine benefits that may be available under your specific health plan.

Product availability may vary by location and plan type and is subject to change. All group health insurance policies and health benefit plans contain exclusions and limitations. For costs and details of coverage, review your plan documents.

90-DAY PRESCRIPTION FILLS

Filling your medications just got easier with the Cigna 90 Now program

You have a lot going on. Remembering to pick up your refill each month isn't always easy. We have a program that can help – it's called Cigna 90 Now.

The **Cigna 90 Now℠** program makes it easier for you to fill your maintenance medications. These are the medications you take on a regular basis to treat an ongoing health condition like asthma, diabetes, high blood pressure or high cholesterol. With the Cigna 90 Now program, you have the choice of how and where you want to fill your prescriptions.

You choose the amount. A 30-day or 90-day supply.

- **If you choose to fill a 30-day supply**, you can use any retail pharmacy in your plan's network. You have the option of switching to a 90-day supply at any time.
- **If you choose to fill a 90-day (or 3-month) supply**,[1] you can use select in-network retail pharmacies that are approved to fill 90-day prescriptions. You also have the option to use Express Scripts Pharmacy®, our home delivery pharmacy (if your plan allows).[2]

A 90-day supply helps make life easier

You'll make fewer trips to the pharmacy for refills. And you're more likely to stay healthy because with a 90-day supply on-hand, you're less likely to miss a dose.[3]

You choose the pharmacy. Retail or home delivery.[2]

There are thousands of retail pharmacies in your plan's network. They include local pharmacies, grocery stores, retail chains and wholesale warehouse stores – all places where you may already shop. **Every pharmacy in your plan's network can fill 30-day prescriptions, and a select number of pharmacies can fill 90-day prescriptions.** Here are some of the retail pharmacies in your plan's network that can fill a 90-day prescription.[4] To see a full list, go to **Cigna.com/Rx90network**.

- **CVS** (including Target and Navarro)
- **Walmart**
- **Kroger** (including Harris Teeter Pharmacy, Pick N Save Pharmacy, Fred Meyer Pharmacy, Fry's Food and Drug)
- **Access Health** (including Benzer Pharmacy, Marcs, Big Y Pharmacy, Marsh Drugs, LLC, Snyder Drug Emporium)
- **Elevate Provider Network** (including Super RX Pharmacy, Medical Center Pharmacy, Family Pharmacy, King Kullen Pharmacy)
- **Cardinal Health** (including Freds Pharmacy, Medicine Shoppe Pharmacy, Medicap Pharmacy)

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Consider using Express Scripts Pharmacy.[2] They help make things easy by putting everything at your fingertips.

Home delivery is a convenient option when you're taking a medication on a regular basis. With just a few simple clicks of your mobile phone, tablet or computer, your important medications will be on their way to your door (or location of your choice). To learn more, go to **Cigna.com/homedelivery**. To get started using home delivery, go to **my.cigna.com/choosehomedelivery** and follow the online instructions for how to move your prescription from your retail pharmacy.

- **Easily order, manage and track your medications** on your phone or online
- Standard shipping at **no extra cost**[5]
- Fill up to a **90-day supply** at one time
- **Helpful pharmacists** available 24/7
- **Automatic refills** and refill reminders so you don't miss a dose
- **Payment options** if you need help paying for your medications

90-Day Fills

Ask your doctor for a 90-day prescription with refills

Have the office send your prescription electronically to an in-network retail pharmacy approved to fill 90-day supplies or to Express Scripts Home Delivery.[2]

Get a 90-day (or 3-month) supply for convenience

30-Day Fills

Ask your doctor for a 30-day prescription

Have the office send your prescription electronically to any retail pharmacy in your plan's network

Get your medication

1. Some medications aren't available in a 90-day supply and may only be packaged in lesser amounts. For example, three packages of oral contraceptives equal an 84-day supply. Even though it's not a "90-day supply," it's still considered a 90-day prescription.
2. Not all plans offer home delivery as a covered pharmacy option. Please log in to the myCigna App or website, or check your plan materials, to learn more about the pharmacies in your plan's network.
3. Internal Cigna analysis performed Jan 2019, utilizing 2018 Cigna national book of business average medication adherence (customer adherent > 80% PDC), 90-day supply vs. those who received a 30-day supply taking antidiabetics, RAS antagonist and statins.
4. Participating Cigna 90 Now pharmacies as of January 2020. Subject to change.
5. Standard shipping costs are included as part of your prescription plan.

Para obtener ayuda en español llame al número en su tarjeta de Cigna.

Health benefit plans vary, but in general to be eligible for coverage a drug must be approved by the Food and Drug Administration (FDA), prescribed by a health care professional, purchased from a licensed pharmacy and medically necessary. If your plan provides coverage for certain prescription drugs with no cost-share, you may be required to use an in-network pharmacy to fill the prescription. If you use a pharmacy that does not participate in your plan's network, your prescription may not be covered, or reimbursement may be limited by your plan's copayment, coinsurance or deductible requirements. Refer to your plan documents for costs and complete details of your plan's prescription drug coverage.

Product availability may vary by location and plan type and is subject to change. All group health insurance policies and health benefit plans contain exclusions and limitations. For costs and details of coverage, review your plan documents or contact a Cigna representative.

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HEALTH SAVINGS ACCOUNT

Paying For Health Care

AAAE offers medical plans that also allow you to open a Health Savings Account! You can set aside pre-tax dollars to pay for medical, prescription drug, dental and vision care expenses.

	HSA
What medical plan can I choose?	Both AAAE Plans are H.S.A Eligible
What expenses are eligible?	Medical, prescription, dental & vision care (See IRS publication 502 for a full list)
When can I use the funds?	Funds are available as you contribute to the account. These funds never expire and you can use the funds to pay for expenses once the money is in the account.
Can I roll over funds each year?	Yes, funds roll over from year-to-year and are yours to keep (even if you change jobs)
How do I pay for eligible expenses?	With your HSA Bank debit card (You can also submit claims for reimbursement online at www.hsabank.com)
How much can I contribute each year?	You can contribute $3,850 for individual coverage or $7,750 for family coverage (this total includes company funding) in 2023. This includes any funds that AAAE Contributes.
Can I change my contributions throughout the year?	Yes, you can log on to www.hsabank.com to change your HSA contributions at any time.
Can I sign up for an FSA?	The only FSA you are eligible for if you have a Health Savings Account is a **Limited Purpose FSA** which covers only dental and vision.

Does AAAE Contribute to my Health Savings Account?

AAAE generously contributes to your Health Savings Account. Please see the amounts based on enrollment below. Note that the AAAE contribution applies to the IRS Annual Maximum!

Plan	Open Access Plus In-Network Only (OAPIN H.S.A)	Open Access Plus Plan (OAP H.S.A PLUS)
Single	**$2,250**	**$2,000**
Single + Dependents	**$3,250**	**$3,000**

You enrolled in your HSA

What happens next?

We'll show you the way to a healthier financial future by helping you plan, save and pay for healthcare.

Getting started

- Use your HSA as soon as your qualified health plan is effective. If your effective date is mid-month, your HSA eligibility begins the first day of the following month.
- Pay for any IRS-qualified medical expenses that you incur once your HSA is active with funds in your HSA.
- Log in to the Member Website to add authorized signers and order debit cards.

Verifying your identity

In accordance with the USA Patriot Act, you may receive a letter verifying your identity. HSA Bank may close your account if you don't supply the proper forms of identification within 90 days of your account opening.

Watch your mail

Keep an eye out for two important mailings that should arrive at your mailbox 7-10 business days after your HSA application has been processed:

1. **Your welcome kit**
2. **Your debit card** — and additional cards for any authorized signers on your account

HSA Bank does not provide tax or legal advice. This communication is for informational purposes only and not intended as tax or legal advice. If tax or legal advice is needed, please consult with a qualified professional.

Visit **www.hsabank.com** or call the number on the back of your debit card for more information.

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A Division of Webster Bank, N.A., Member FDIC

How to use your HSA

An HSA from HSA Bank doesn't just make it easy to save money on your healthcare expenses — it makes it easy to manage your account, too.

Manage your account online

Sign up to access your account balances, transaction history, and statements, as well as track your expenses.

1. **HSA Bank Mobile App** – Download to check available balances, view HSA transaction details, save and store receipts, scan items in-store to see if they're qualified, and access customer service contact information.

2. **myHealth Portfolio℠** – Track your healthcare expenses, manage receipts and claims from multiple providers, and view expenses by provider, description, and more.

3. **Account preferences** – Designate a beneficiary, add an authorized signer, order additional debit cards, and keep important information up to date.

Deposit funds into your HSA

To maximize tax and savings benefits, fund your HSA as soon as you can. There are a few convenient ways to contribute.

- **Payroll deduction** – Money is deducted from your paychecks, pre-tax, and transferred to your HSA. Talk to your employer to sign up.
- **Online transfer** – Visit the Member Website to transfer funds from your personal checking or savings account to your HSA.
- **Check** – Mail your personal check and completed contribution form found on the Member Website to: HSA Bank, PO Box 939, Sheboygan, WI 53082

Pay for healthcare expenses

Whether you want to reimburse yourself for an IRS-qualified medical expense paid out of pocket or pay directly from your HSA, there are a few ways to get your funds.[1]

NOTE: Transactions are limited to your available cash balance.

- **HSA Bank Health Benefits Debit Card** – Access your HSA funds when you use your debit card at qualified merchants or ATMs for withdrawals.[2] You can add your debit card to your mobile wallet using Apple Pay or Samsung Pay.
- **Online transfer** – Visit the Member Website or use the mobile app to reimburse yourself for out-of-pocket expenses. Schedule a one-time or recurring online transfer from your HSA to your personal checking or savings account.
- **Online bill pay** – Use this feature to pay medical providers directly from your HSA.

[1] You can use your HSA to pay for a wide range of IRS-qualified medical expenses, including many that aren't typically covered by health insurance plans. This includes deductibles, co-insurance, prescriptions, dental and vision care, and more. Go to **irs.gov** or **hsabank.com/QME** for a list of IRS-qualified medical expenses.

[2] HSA Bank has set daily limits on debit card transactions for fraud protection. These limits are listed in your Health Savings Account Custodial Agreement.

Visit **hsabank.com** or call the number on the back of your debit card for more information.

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Invest your HSA today to benefit tomorrow

Health Savings Accounts (HSAs) are often thought of just for healthcare savings. But they can also be a powerful addition to your investment portfolio. Investing your HSA funds can help you grow your account to save for future healthcare expenses or your retirement nest egg.

Investing your HSA: A healthy boost for your future

1. **The only way to get three tax perks:** You don't pay federal taxes on contributions, withdrawals for qualified medical expenses, or investment earnings.

2. **Build long-term retirement savings:** Investments cover future healthcare costs and build your retirement savings.

3. **The money is yours — for life:** HSA funds carry over every year, even if you change jobs or retire.

4. **Move funds as needed:** You can transfer investment funds back into your HSA cash account at any time to pay for IRS-qualified healthcare expenses.

Your self-directed investment options

Devenir Guided Portfolio self-directed investment program[1]: This is a user-friendly program that combines professional guidance with an easy-to-use platform. Perfect for new investors, this helps you create a customized investment allocation that fits your lifestyle and HSA investment goals.

- Competitive fund lineup with professionally selected, low-cost, no-load mutual funds covering a range of asset classes and families.
- Easy-to-use online planning tool to help you start investing and manage your investment account.
- Options to automatically adjust your investments following your preferred schedule and auto-rebalance to align with goals.
- Quarterly performance review of mutual fund selections by FINRA-registered investment advisors.
- Online access to account history, balance information, future elections, trades, and more through the Member Website.
- Access to Morningstar® pages, fund fact sheets, and prospectuses.
- Low-cost with no minimum investment, free transfers between your investment and cash accounts, and no commission on investment trades. Devenir's quarterly asset-based fees may be applied on the amount invested and deducted pro rata from the investment account.

TD Ameritrade self-directed brokerage account: This is ideal for experienced investors looking for more control and flexibility.

- Wide selection of investment choices like stocks, bonds, ETFs, and thousands of mutual funds.
- Online access to real-time data[2], customizable charts, and one-click integrated trading, balance information, and more through the Member Website.
- Option to place trades by website, telephone, mobile device, and broker.
- Access to independent research tools, such as Morningstar® to help you make informed trades.
- Trading fees may be applied by TD Ameritrade, as well as possible additional fees by program, location, or arrangement.

SECURITIES AND INVESTMENTS

Not Insured by FDIC or Any Other Government Agency	Not Bank Guaranteed	Not Bank Deposits or Obligations	May Lose Value

You may be required to keep a minimum balance in your HSA cash account to invest funds.

HSA Bank does not provide brokerage/investment services; brokerage services are provided by TD Ameritrade, Inc., member FINRA/SIPC/NFA, and investment services are provided by Devenir. HSA Bank, TD Ameritrade, and Devenir are separate, unaffiliated companies and are not responsible for each other's services or policies. Self-directed investment accounts are the sole responsibility of the account owner. Carefully weigh the advantages and disadvantages of investing your HSA funds before investing. HSA Bank and other business entities receive compensation for providing various services to the funds including an annual asset-based fee for services rendered in association with the investment account. Your ability to replace losses in the investment account may be limited by the annual contribution limits of your HSA. HSA Bank does not offer investment advice.

Performance data and ratings represent past performance and are not a guarantee of future results. Investment returns and principal value will fluctuate and investors' shares, when sold, may be worth more or less than their original cost.

[1] Neither HSA Bank, nor Devenir Group, LLC, the third party, can provide investment advice to you on this program. Once you transfer funds from your HSA cash account to HSA investment account, these dollars are no longer covered by applicable FDIC or NCUA insurance. We recommend you speak with a licensed investment advisor or consult the prospectus should you have questions about any investment.

[2] Access to real-time market data is conditioned on acceptance of the exchange agreements. Professional access differs and subscription fees may apply. Research provided by unaffiliated third-party sources is deemed reliable to TD Ameritrade. However, TD Ameritrade does not guarantee accuracy and completeness and makes no warranties with respect to results to be obtained from use. TD Ameritrade does not recommend disabling the order preview screen when using the one-click feature. TD Ameritrade is not responsible for orders placed inadvertently. Past performance does not guarantee future results. TD Ameritrade is a trademark jointly owned by TD Ameritrade IP Company, Inc. and the Toronto-Dominion Bank. Used with permission. HSA Bank receives compensation from TD Ameritrade for performing certain services.

Visit **hsabank.com** or call the number on the back of your debit card for more information.

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Health savings in the palm of your hand

HSA Bank Mobile

HSA Bank Mobile is all about giving you the tools to take control and better manage your health accounts. Safe and secure, the app offers instant access for all your account needs, 24/7. It's simple, intuitive and convenient.

The faster, easier way to manage your HSA Bank accounts

- Simple and secure login
- Check account balances and view activity
- Enter and track expenses
- Make a payment from your account
- Scan for IRS-qualified medical expenses
- Schedule HSA contributions
- File a claim
- Contact the Client Assistance Center

Download HSA Bank Mobile

GET IT ON Google Play

Download on the App Store

The mobile app is free to download at Google Play or the App Store. Message and data rates may apply.

Visit **www.hsabank.com** or call the number on the back of your debit card for more information.

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DENTAL BENEFITS

United Concordia

Good oral care enhances overall physical health, appearance and mental well-being. Problems with the teeth and gums are common and easily treated health problems. Keep your teeth healthy and your smile bright with the AAAE dental benefit plan.

DENTAL PPO PLAN BENEFITS	WHAT YOU PAY	
	IN NETWORK[1]	OUT OF NETWORK[2]
PLAN MAXIMUMS		
Calendar Year Deductible (Single)	**$50**	**$50**
Calendar Year Deductible (Family)	**$150**	**$150**
Calendar Year Maximum Benefit	**$10,000**	
PREVENTIVE & DIAGNOSTIC CARE		
Cleanings, Topical Fluoride, X-Rays, Bitewings, Sealants, Palliative Treatment (Emergency)	**100%**	**100%**
BASIC RESTORATIVE CARE		
Fillings, Simple Extractions, Periodontics, scaling & Root planning, General anesthesia, Space Maintainers	**10% after deductible**	**10% after deductible**
MAJOR RESTORATIVE CARE		
Bridges/Dentures, Inlays, Onlays and Crowns	**40% after deductible**	**40% after deductible**
Implants	**50% after deductible**	**50% after deductible**
ORTHDONTIA		
Orthodontia Lifetime Maximum (No age Limit)	**$2,500**	
Orthodontia Benefit (No age Limit)	**50%**	

Visit
www.unitedconcordia.com
for:

Online Services, Find a Dentist, Dental Plan Support Guide, SmileWay Wellness Site, and more!

1 PPO = Dentists agree to PPO contracted fees. No balance billing. Lowest out-of-pocket costs for the participant

2 Out-of-network = Reimbursement is based on 90% UCR. Possibly subject to balance billing.

VISION BENEFITS

VSP

Regular eye examinations can not only determine your need for corrective eyewear but also may detect general health problems in their earliest stages. Protection for the eyes should be a major concern to everyone.

SERVICE	IN-NETWORK
Eye Exam — once every 12 months	$10 copay
LENSES — (IN LIEU OF CONTACTS) ONCE EVERY 12 MONTHS	
Single Vision Lenses	$25 copay
Lined Bifocal Lenses	
Lined Trifocal Lenses	
FRAMES—ONCE EVERY 12 MONTHS	
Frames	$130 allowance for wide selection $150 allowance for featured frame brands; 20% savings on amount over allowance
CONTACTS (IN LIEU OF LENSES) - ONCE EVERY 12 MONTHS	
Fitting and Follow-up Care (after exam)	Up to $60
Medically Necessary	Covered in Full
Elective Conventional Elective Disposable	$130 Allowance

To find a provider, please go to https://www.vsp.com/eye-doctor and input your parameters. Then click SEARCH."

vsp PREMIER PROGRAM

BONUS OFFERS

Maximize your savings with bonus offers only available at Premier Program locations.

EYEWEAR PROTECTION

Get a one year worry-free warranty on featured frame brands.

BAUSCH+LOMB

See better. Live better.

Save up to $210 on an annual supply of contact lenses.

GLASSES REBATE

Get up to a $100 rebate on the perfect pair of glasses.*

EXTRA $20 TO SPEND

Get more value with an **Extra $20** to spend on select featured frame brands by bebe, CALVIN KLEIN, and many others.[14]

EXTRA $40 TO SPEND

Extra $40 to spend on select frame brands.[14]

UP TO 40% OFF LENS ENHANCEMENTS

Upgrade your lenses and save up to 40% off lens enhancements such as anti-glare coatings and light-reactive lenses.[15]

eyeconic

Savings on Eyeconic* when you shop for glasses, sunglasses, and contacts with your VSP benefits.

ZEISS

Try ZEISS SmartLife Lenses Risk-Free for six months.

techshield

Save up to 40% on all TechShield* Anti-Reflective Coatings.

vsp

Save an average of $325 on Nike prescription sunglasses.

sunsync

Save up to 40%* on SunSync* Light-Reactive Lenses.

unity

Try Unity* single vision or progressive lenses risk-free with The Unity Promise.

LIFE INSURANCE BENEFITS

LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE

Life Insurance

Life insurance provides financial security for the people who depend on you. Your beneficiaries will receive a lump sum payment if you die while employed by AAAE. The company provides basic life insurance of 3X Salary to $500,000 at no cost to you. All eligible employees are automatically enrolled in both the Life and AD&D.

Accidental Death and Dismemberment (AD&D) Insurance

Accidental Death and Dismemberment (AD&D) insurance provides payment to you or your beneficiaries if you lose a limb or die in an accident. AMERICAN ASSOCIATION OF AIRPORT EXECUTIVES provides AD&D coverage at 100% of the Basic Life benefit.

Benefits After Age 65

Your life benefits will reduce after age 65, and the reduction schedule is as follows:

- Age 70 - reduced 35%
- Age 75 - reduced 50%
- Benefits will terminate at retirement

MetLife

SUPPLEMENTAL LIFE AND AD&D INSURANCE

You may purchase life and AD&D insurance in addition to the company-provided coverage. You may also purchase life and AD&D insurance for your dependents if you purchase additional coverage for yourself. You are guaranteed coverage without answering medical questions if you enroll when you are first eligible up to the guaranteed issue amounts.

Employee— Employees may purchase additional coverage in $10,000 increments, not to exceed 5 times annual salary or $500,000, whichever is less.

- Guaranteed Issue amount is up to $100,000 if you are a new hire

Spouse— You may purchase additional coverage for your spouse in $5,000 increments, not to exceed 50% of employee coverage or $100,000, whichever is less

- Guaranteed Issue amount of $25,000 if you are a new hire
- Benefits terminate at age 70
- Spouse coverage may only be elected if the employee is enrolled

Children— You may purchase additional coverage for your child(ren) in the following amounts:

- 15 days to 6 months: $100
- 6 months to 19 (or 26 if full time student): $1,000, $2,000, $4,000, $5,000 or $10,000
- Child coverage may only be elected if the employee is enrolled

RATES ARE BASED ON YOUR AGE AND YOUR ELECTION AMOUNT!

Sample Rates:

30 YO Employee with $10,000 Coverage: $1.13 Per Month

40 YO Employee with $100,000 Coverage: $16.90 Per Month

54 YO Employee with $250,000 Coverage: $97.00 Per Month

55 YO Employee with $100,000 Coverage: $58.80 Per Month

MetLife

DISABILITY BENEFITS

These benefits are paid for 100% by the EMPLOYEE, 100% participation is required.

MetLife

LONG TERM DISABILITY INSURANCE

Eligible employees are automatically offered coverage for those unexpected situations that may keep you from performing the daily responsibilities of your job. Your disability plan is available to help supplement your income when you are not able to continue employment for a certain period of time. Please note that this is a separate benefit from the Worker's Compensation coverage for work-related injuries and illnesses.

MetLife Long Term Disability	
Monthly Benefit	60% of monthly salary to a maximum of $10,000 per month
Benefit Begins	91st day of disability
Maximum Duration	Social Security Normal Retirement Age (SSNRA)

Helping employees plan for their families' needs.

- **Will Preparation[1]** — **Ensuring final wishes are clear.** Employees can choose to work one-on-one with an attorney, in-person or on the phone, to prepare or update a will, living will, or power of attorney. Or, they can do-it-themselves with our online[2] will preparation services.
- **Funeral Discounts and Planning Services[3]** — **Alleviating the burden of making funeral arrangements** from their loved ones. Employees get exclusive access to the largest network of funeral homes and cemeteries to pre-plan with a counselor and receive discounts on funeral services.
- **Digital Legacy[4]** — **Sharing important documents is easy with *MetLife Infinity*®.** Employees can store important documents such as deeds, wills, and personal photos and videos safely on a secure online portal.
- **Retirement Planning[5]** — **Helping employees retire with confidence.** Employees can attend workshops that offer comprehensive retirement and financial education to help them plan for the future through ***Retirewise*®.**

26%
of survivors reported their spouse/partner had a will at the time of their death*

Offering compassionate support through difficult times.

- **Grief Counseling[6]** — **Offering professional support in times of need.** Face-to-face sessions with a licensed counselor to help employees cope with a loss or major life change. Or employees can speak to a licensed counselor in the comfort of their home through the helpline.
- **Funeral Assistance[3]** — **Helping to simplify funeral arrangements.** Employees work can customize funeral arrangements with the help of compassionate counselors through a personalized, one-on-one service.
- **Beneficiary Claim Assistance[5]** — **Making the claims process easy.** Beneficiaries receive guidance from experts as they work through their options and financial needs with our ***Delivering The Promise*®** services.
- **Estate Resolution Services[1]** — **Settling an estate with confidence.** With unlimited consultations, either face-to-face with an attorney or by phone, your employees and/or their beneficiaries can settle an estate with assurance.
- **Life Settlement Account[3]** — **Reducing the pressure of immediate financial decisions.** Beneficiaries can take their time to make the right decision with the flexible settlement option that gives them full access to policy funds while earning a guaranteed minimum interest rate through ***Total Control Account.***

EMPLOYEE ASSISTANCE PROGRAM (EAP)

Up to 5 sessions of distance counseling (phone or video) per issue per year included

Call: 1-888-319-7819

LifeWorks Mobile App:
Apple & Android Stores
User ID: metlifeeap
Password: eap

Website:
metlifeeap.lifeworks.com
User ID: metlifeeap
Password: eap

Support for Employees

Integrated services, including

- Educational Materials
- Resources and Personalized Researched Referrals
- EAP Consultation – access to qualified EAP consultants for information, support, crisis intervention, educational materials in electronic format, and referral to local resources and assistance
- Distance Counseling includes up to five (5) virtual sessions – assessment and short-term problem resolution by network of qualified EAP consultants. If it is determined that the presenting clinical issue is not appropriate for short-term counseling, the participant will be referred to the appropriate resources

Work-Life Services

- Work-Life Consultation – access to qualified consultants for information, assessment, action planning and resources, educational materials in electronic format, and referral to local resources and assistance in areas like:
  - Parenting, Eldercare and aging
  - Consumer and community needs
  - Education
  - Disability
  - Adoption
  - Referrals matched and confirmed for vacancies for child care and elder care
  - Emotions and stress
  - Workplace issues

Financial Services

- Financial Consultation – access to qualified consultants for information, assessment, action planning and resources, educational materials in electronic format, and referral to local resources and assistance
- Financial Professional Consultation – access to consultation with certified financial professionals; LifeWorks does not provide investment advice or loan funds

Legal Services

- Access to qualified consultants for information, assessment, action planning and resources, educational materials in electronic format, and referral to local resources and assistance
- Network Attorney Consultation – access to consultation with network attorneys delivered via telephone or in-person to include up to thirty (30) minutes of consultation per legal issue ("Initial Attorney Consultation"). LifeWorks does not provide legal advice or representation, or review of real estate or trust documents; discount on Attorney Services – following Initial Attorney Consultation, discount off standard legal fees as offered by LifeWorks' network of attorneys

Identity Theft Recovery Services

- This service includes a telephonic consultation up to sixty (60) minutes in length with a financial counselor who will help the Member to determine if the Member was a victim of identity theft and recommend options on how to place fraud alerts, freeze credit, file police reports, and conduct other activities necessary to resolve fraud. General information on identity theft prevention is also available

Telephonic Life Coaching

- Access to life coaches who are Masters level counselors/consultants with disciplines in social work, counseling and psychology,); are board certified coaches (BCCs) and are credentialed through the (CCE) Center for Credential and Education. Each coach received their training from the ILTC (Institute for Life Coach Training)
- Ability for participants to partner with a life coach to help address issues, overcome obstacles and attempt to achieve goals agreed to between the life coach and the Participant

VOLUNTARY SHORT TERM DISABILITY COVERAGE

Individual Short Term Disability insurance can help replace a portion of your income when you're unable to work. It helps when you're sidelined with an illness or injury lasting a few weeks to a few months.

This is not an exhaustive list of benefits. Please refer to your kits for more information about these important benefits.

What you should know

- You can choose to replace up to 50% or 60% of your regular monthly income
- Money is payable directly to employees to use however they choose
- Maximum monthly benefit: $3,000
- Maximum benefit period: 3 months
- Pre-existing condition limitation: 12/12
- 9 month pregnancy limitation
- Benefit does not offset with other disability benefits the employee receives
- Premium waiver
- Employee-paid benefit

Every year, **5.6%** of working Americans will experience a short term disability due to illness, injury or pregnancy.[1]

What it covers

- Recovering from normal pregnancy
- Joint disorders
- Injuries
- Behavioral health issues
- Digestive disorders

How Short Term Disability Insurance helped

Bill didn't see the car coming toward him until it ran the red light. He also didn't predict that he'd need leg surgery that would keep him out of work for four weeks.

His Short Term Disability Insurance didn't replace 100% of his income, but it helped him cover his living expenses and medical costs while he wasn't getting a paycheck.

Bill can use the money any way he wants to.

Please refer to your UNUM kit for a complete description of the plan benefits and information on how to enroll.

VOLUNTARY ACCIDENT COVERAGE

With the high cost of medical care today, a trip down the stairs can hurt your bank account as much as your body. Accident insurance can pay you money based on the injury and the treatment you receive, whether it's a simple sprain or something more serious, like an injury from a car accident. Your plan can pay you a benefit for an emergency room treatment, stitches, crutches, injury-related surgery and a list of other accident-related expenses. The money is paid directly to you and you decide how to spend it. *This benefit is voluntary, paid for 100% by employees through after-tax payroll deductions.*

This is not an exhaustive list of benefits. Please refer to your kits for more information about these important benefits.

Benefit Type	UNUM Accident Insurance Pays **YOU**
Injuries	
Fractures	Up to $7,500
Dislocations	Up to $6,000
Second and Third Degree Burns	$0 - $10,000
Concussions	$150
Cuts/Lacerations	$25-$600
Eye Injuries	$300
Medical Services & Treatment	
Ambulance	$400 - $1,500 (Air Ambulance)
Emergency Care	$150 + $75
Pain Management	$100
Physician Follow-Up	$75 (2 per accident)
Therapy Services (including physical therapy)	$25 (10 per accident)
Medical Testing Benefit	$200
Medical Appliances	$100
Inpatient Surgery	$150 - $1,500
Hospital Coverage (Accident)	
Admission	$1,000
Confinement	$200 per day
Inpatient Rehab (paid per accident)	$100 per day up to 15 days
Accidental Death and Other Covered Losses	
Employee Accidental Death	$50,000
Employee Catastrophic Accidental Dismemberment	$100,000
Accidental loss – paralysis, sight, hearing, speech	$7,500 - $15,000

These plans offer additional benefits such as Accidental Death, Dismemberment, Loss, Paralysis, Lodging, etc. Please refer to your UNUM kit for a complete description of the plan benefits and information on how to enroll.

VOLUNTARY CRITICAL ILLNESS

What's a critical illness? Some common examples are heart attack, stroke and cancer. But this coverage also includes serious conditions like permanent paralysis – the kind of injury that can happen to a healthy person in a car or skiing accident, for example. The medical treatment for these conditions can be very expensive. Critical illness insurance can help by paying a lump sum payment directly to you at the first diagnosis of a covered condition. You decide how to spend it. You can use this coverage more than once for different conditions, but each condition is payable once per lifetime.
This benefit is voluntary, paid for 100% by employees through after-tax payroll deductions.

This is not an exhaustive list of benefits. Please refer to your kits for more information about these important benefits.

Benefit Type	Coverage Information
Covered Individuals	
Employees	$10,000 or $20,000
Spouses	Age 17-64: $10,000
Children	Children to age 26 are automatically covered at no extra cost. Their coverage is 50% of yours. They are covered for the same illnesses, plus these specific childhood conditions: cerebral palsy, cleft lip or palate, cystic fibrosis, Down syndrome, and spina bifida.

What's Covered

- Heart attack
- Blindness
- Major organ failure
- End-stage kidney failure
- Benign brain tumor
- Coronary artery bypass surgery (25% of benefit)
- Coma that lasts at least 14 consecutive days
- Stroke whose effects are confirmed at least 30 days after the event
- Occupational HIV
- Permanent paralysis of at least two limbs due to a covered accident
- Cancer
- Carcinoma in situ – pays 25%

Health Screening Benefit
After your coverage is effective, UNUM will provide an annual benefit of $50 per calendar year for taking one of the eligible screening/ prevention measures. UNUM will pay only one health screening benefit per covered person per calendar year.

These plans offer additional benefits such as Accidental Death, Dismemberment, Loss, Paralysis, Lodging, etc. Please refer to your UNUM kit for a complete description of the plan benefits and information on how to enroll.

VOLUNTARY LEGAL SERVICES

Everyone deserves legal protection. And no, with Legal Resources, everyone can access it. Proven, professional advice is just a phone call away on all matters, from the trivial to the traumatic.

Plan members may receive services through a nationwide network of more than 14,000 attorneys, or from an out-of-network attorney.

Extensive Legal Services

Legal Resources provides easy, direct access to a national network of attorneys who provide telephone advice and office consultations on an unlimited number of personal legal matters and fully covered services for the most frequently needed personal legal matters (excluding employment issues.) Participants may also receive services from out-of-network attorneys.

General Advice and Consultation
- Unlimited in-person or telephone advice and consultation for covered services.

Wills and Estate Matters
- Will Preparation and Periodic Updates
- Advanced Medical Directive
- Financial Powers of Attorney
- Contingent Trust for Minor Children

Traffic Violations*
- Traffic Infractions and Misdemeanors
- Speeding
- Reckless Driving
- Driving Under the Influence *(1st offense)*

Preparation and Review of Routine Legal Documents
- Unlimited preparation and review of routine legal documents, including, but not limited to, powers of attorney, bills of sale, and affidavits.

Criminal Matters**
- Defense of Misdemeanor
- Misdemeanor Defense of Juveniles *(including 1st offense involving alcohol or illegal drugs)*

Civil Actions*
- Representation as Defendant
- Representation as Plaintiff
- Insurance Matters
- Initial Administrative Hearing *(local government commission or board)*

Family Law
- Uncontested Domestic Adoption
- Uncontested Divorce
- Uncontested Name Change

Real Estate Matters
- Purchase, Sale or Refinance of Primary Residence
- Deed Preparation
- Tenant-Landlord Matters*
- Landlord-Tenant Matters *(includes hour of advice, preparation of late notice, and advice on filing of suit for Landlord)*

Consumer Relations and Credit Protection*
- Warranty Dispute
- Advice, consultation & representation on billing disputes and collection agency harassment

Elder Law Matters
- Estate Advice *(limitations apply)*
- Power of Attorney for the Members' Parents

Identity Theft Assistance
- Prevention Services
- Education Services

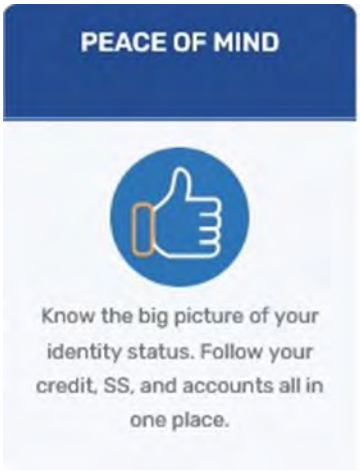
$19/month!

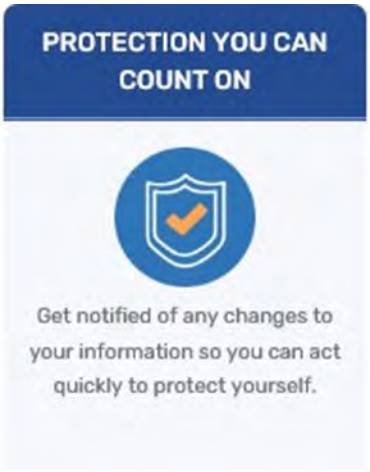
LEGAL RESOURCES
Relax... you're covered.®

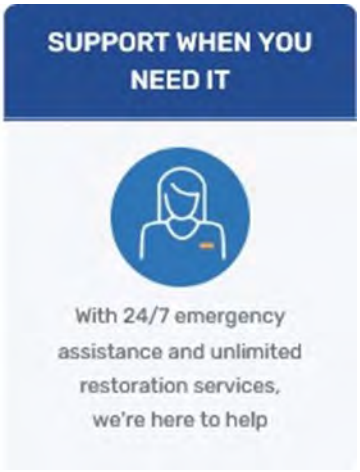
VOLUNTARY IDENTITY THEFT PROTECTION

3 million cases of fraud were reported in 2019 alone. Identity theft is upsetting and can hurt you financially for years to come. IDShield offers a comprehensive tool to monitor your presence online and be notified of any unusual activity so you can take action before you become a victim of identity theft.

We're here for you, to protect and help you restore your identity.







- 877.235.0638
- Covers all 7 types of Identity Theft!
- 24/7 Access to Investigators, Credit Score Tracker
- Continuous Daily Credit Monitoring with Immediate Notification

10 Family Members are Covered

- **Employee, Spouse & Up to 8 Children to age 26**
- **$3.68 / week, $15.95 / month**
- **Individual, $1.95/ wk, $8.45/mo**

FLEXIBLE SPENDING ACCOUNT

Paying for Health Care

AAAE provides you the opportunity to pay for out-of-pocket medical, dental, vision, and dependent care expenses with pre-tax dollars through the Flexible Spending Accounts. You must enroll/re-enroll in the plan to participate for the plan each year. You can save approximately 25% of each dollar spent on these expenses when you participate in a FSA.

A health care FSA is used to reimburse out-of-pocket medical expenses incurred by you and your dependents. If you have an HSA, you may only contribute to a Limited Purpose FSA for Dental and Vision expenses. A dependent care FSA is used to reimburse expenses related to care of eligible dependents while you and your spouse work.

Contributions to your FSA come out of your paycheck before any taxes are taken out. You should contribute the amount of money you expect to pay out of pocket for eligible expenses for the plan period. If you do not use the money you contributed it will not be refunded to you or carried forward to a future plan year. This is the use-it-or-lose-it rule.

How Flexible Spending Accounts Work

- Each year during Annual Enrollment, you decide how much to set aside for health and/or dependent care expenses.
- Your contributions are deducted from your paycheck on a pre-tax basis in equal installments throughout the year.
- After you incur eligible expenses throughout the benefit year, submit a claim form for reimbursement. Your claim will be processed and you will be reimbursed from your account. For some healthcare expenses, you may also use your FSA debit card to pay at the point of sale.

	Health Care Flexible Spending Account	Dependent Care Flexible Spending Account
Eligibility	All eligible employees are able to enroll in this benefit. You do not need to be enrolled in our medical coverage to elect Medical FSA	All eligible employees are able to enroll in this benefit ONLY if both spouses are working or in school full-time
What expenses are eligible?	Medical, prescription drug, dental and vision care (See IRS publication 502 for a full list of eligible expenses)	Childcare expenses for children up to age 14 (preschool, summer camp, before and after care, etc.) and elder care.
When can I use the funds?	All of the funds you elect for the year are available October 1, 2022—September 30, 2023	The funds are only available to use only if you have contributed to the fund.
Can I roll over funds each year?	Yes, you can rollover up to $570 into the next plan year	No. It is use it or lose it!
How do I pay for eligible expenses?	With your debit card (you can also submit claims for reimbursement online at www.wageworksonline.com)	With your debit card (you can also submit claims for reimbursement online at www.wageworksonline.com)
How much can I contribute each year?	Up to $2,850 for the 2022 plan year	Up to $5,000 for the 2022 plan year
Can I change my contributions throughout the year?	No, unless you have a qualifying life event, you choose an annual election amount during open enrollment and that amount is taken out of each paycheck in equal increments throughout the year	No, unless you have a qualifying life event, you choose an annual election amount during open enrollment and that amount is taken out of each paycheck in equal increments throughout the year

EMPLOYEE PER PAY CONTRIBUTIONS

BENEFIT PLAN		
Cigna Medical Rates	**OAPIN H.S.A**	**OAP H.S.A PLUS**
Employee	$23.95	$76.71
Employee + Spouse	$124.98	$350.01
Employee + Child(ren)	$91.30	$258.91
Family	$154.92	$430.97

BENEFIT PLAN	
United Concordia Dental Rates	
Employee	$10.35
Employee + Spouse	$20.51
Employee + Child(ren)	$22.40
Family	$34.87
VSP Vision Rates	
Employee	$1.58
Employee + Spouse	$2.67
Employee + Child(ren)	$2.72
Family	$4.38

BENEFIT PLAN	
Legal Plan Rates	
Legal Resources	$8.77
ID Theft—ID Shield	
Individual	$3.90
Family	$7.36
Unum Voluntary Accident Rates	
Employee	$8.15
Employee + Spouse	$13.17
Employee + Child(ren)	$15.21
Family	$20.24

AGE RATED PLANS—SEE KITS FOR INFORMATION
Voluntary Life/AD&D—MetLife
Voluntary Critical Illness w/ Cancer—UNUM
Supplemental Individual Short Term Disability Insurance—UNUM

Get the right plan with ALEX at: https://www.myalex.com/aaae/aaae2022

SUMMARY OF BENEFITS

Benefit Available	Waiting Period	Effective Date	Notes
Medical	End of the month, following date of hire; No wait period if hired on 1st of the month	1st of the month, following the wait period	Employees select 1 of the 2 plans
Dental	End of the month, following date of hire; No wait period if hired on 1st of the month	1st of the month, following the wait period	1 plan
Vision	End of the month, following date of hire; No wait period if hired on 1st of the month	1st of the month, following the wait period	1 plan
Life/AD&D	None	Date of hire	Employer paid, 3 x annual salary, max $500,000
Long Term Disability	90 Days	Date of hire	Employee Paid, 60% of your monthly salary to a max of $10,000 per month
FSA	End of the month, following date of hire	1st of the month, following the wait period	Employee paid
Vacation	Accrues immediately	Date of Hire	All fulltime employees are eligible. 0-5 years, 5.23 hours per pay; 5-10 years, 7.07 hours per pay; 11-20 years, 8.0 hours per pay; Roll-over to sick leave at year end.
Sick Leave	Accrues immediately	Date of Hire	Full time employees accrue 3.7 hours of sick leave per pay. Employees who work a min. 17.5 hours accrue on a pro-rated basis. Up to 1040 hours may be carried over.
Vacation Bonus	Must be employed here on Jan 1	Jan 1 after hire date in a previous year	Eligible employees may take 4 vacation days in a row and earn a $1,000 vacation bonus (1 time/year)
401k	Can contribute own funds after 90 days; automatic enrollment at 6%; AAAE contributes 3% after 1 year + beginning of next quarter and contributes up to 8% according to schedule	See HR	6 year vesting period for discretionary contribution
Holidays	No waiting period	Date of hire	11 Federal holidays
Family Medical Leave Act	12 months of employment with AAAE and must have worked 1250 hours within that time	Available the 1st day of qualifying event as long as all eligible requirements have been met	Employee must complete required paperwork and notification. For detailed information about this benefit contact HR.
Tuition Assistance	2 years of employment with AAAE	Based on meeting eligibility	Must be approved by Supervisor & HR, must make a "C" or better, and 75% upon course completion, 25% on 2nd anniversary after course completion
Student Loan Forgiveness	1 year of employment with AAAE	Based on meeting eligibility	AAAE contributes $1,000 annually up to $5,000 to the student loans of eligible employees with qualified loans
Tuition Savings Contribution	1 year of employment with AAAE	Based on meeting eligibility	AAAE contributes $1,000 annually up to $5,000 to a qualified Section 529 Tuition Savings Plan of the employee's choice provided the employee is eligible

ADDITIONAL BENEFITS AND RESOURCES

AMERICAN ASSOCIATION OF AIRPORT EXECUTIVES

Employee Development

Training/Seminars: Eligibility Date: Day of hire
- Seminars/workshops must generally be job related and approved by your supervisor
- AAAE pays 100% of seminar/workshop

Performance Appraisals: "Strategic Goals"
- Formal performance feedback concerning staff member's Strategic Goals. This occurs twice annually with employees providing input to supervisor.

Other Automatically Applied Benefits (no cost to employee)
- Membership to the American Society of Association Executives (ASAE)
- Paid parking or Metro transportation contribution of $115 per month available for most public commuting methods
- Assist America: Emergency International Travel Assistance with medical, financial or legal emergencies while traveling on corporate Amex card
- Cell phone reimbursement of $100 per month.

Paid Leave

Maternity and Paternity Paid Leave
Benefits eligible after one year of employment
- 20 days of paid leave for new mothers
- 20 days of paid leave for new fathers

Caregiver Paid Leave
All employees eligible for FMLA leave to care for the serious health condition of an immediate family member
- 5 days of paid leave

Bereavement Paid Leave
- 15 days of paid leave for immediate family
- 5 days of paid leave for extended family
- Option to use an additional 5 days of sick leave in either case

Volunteer Leave
All employees may use leave to volunteer for a 501(c)(3) organization of their choosing
- 8 hours of paid leave

Miscellaneous (No waiting period)

Wellness Reimbursement Program available for employee memberships or subscriptions at gyms or with online services, fitness classes or training sessions, weight management programs, and stress management services.

- Up to $150 for any initiation fee and $80/month paid quarterly

Gym Equipment and Showers available on site for employee use

Patient Protections Disclosure

The American Association of Airport Executives Health Plan generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation, Cigna designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Cigna at 866.494.2211 or www.mycigna.com.

For children, you may designate a pediatrician as the primary care provider.
You do not need prior authorization from Cigna or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Cigna at 866.494.2211 or www.mycigna.com.

Women's Health & Cancer Rights Act

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 ("WHCRA"). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under the plan. Therefore, the following deductibles and coinsurance apply:

Plan 1: Open Access Plus HDHPQ Plan (Individual: 100% / 0% coinsurance and $2,000 deductible; Family: 100% / 0% coinsurance and $4,000 deductible)

Plan 2: Open Access Plus IN HDHPQ Plan (Individual: 100% / 0% coinsurance and $3,000 deductible; Family: 100% / 0% coinsurance and $6,000 deductible)

If you would like more information on WHCRA benefits, please call your Plan Administrator at 703.797.2528 or maria.bremis@aaae.org.

Newborns' and Mothers' Health Protection Act

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

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2022. Contact your State for more information on eligibility –

ALABAMA — Medicaid	CALIFORNIA — Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
ALASKA — Medicaid	**COLORADO — Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442
ARKANSAS — Medicaid	**FLORIDA — Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA — Medicaid	**MASSACHUSETTS — Medicaid and CHIP**
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: (678) 564-1162, Press 2	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: (617) 886-8102

INDIANA — Medicaid	MINNESOTA — Medicaid
Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584	Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739
IOWA — Medicaid and CHIP (Hawki)	**MISSOURI — Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
KANSAS — Medicaid	**MONTANA — Medicaid**
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov
KENTUCKY — Medicaid	**NEBRASKA — Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
LOUISIANA — Medicaid	**NEVADA — Medicaid**
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
MAINE — Medicaid	**NEW HAMPSHIRE — Medicaid**
Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: -800-977-6740. TTY: Maine relay 711	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218
NEW JERSEY — Medicaid and CHIP	**SOUTH DAKOTA — Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: http://dss.sd.gov Phone: 1-888-828-0059
NEW YORK — Medicaid	**TEXAS — Medicaid**
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Website: http://gethipptexas.com/ Phone: 1-800-440-0493

NORTH CAROLINA — Medicaid	UTAH — Medicaid and CHIP
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
NORTH DAKOTA — Medicaid	**VERMONT — Medicaid**
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
OKLAHOMA — Medicaid and CHIP	**VIRGINIA — Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-800-432-5924
OREGON — Medicaid	**WASHINGTON — Medicaid**
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
PENNSYLVANIA — Medicaid	**WEST VIRGINIA — Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
RHODE ISLAND — Medicaid and CHIP	**WISCONSIN — Medicaid and CHIP**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
SOUTH CAROLINA — Medicaid	**WYOMING — Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2022, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

HIPAA Notice of Privacy Practices Reminder

Protecting Your Health Information Privacy Rights
AAAE is committed to the privacy of your health information. The administrators of the AAAE Health Plan (the "Plan") use strict privacy standards to protect your health information from unauthorized use or disclosure.

The Plan's policies protecting your privacy rights and your rights under the law are described in the Plan's Notice of Privacy Practices. You may receive a copy of the Notice of Privacy Practices by contacting Maria Bremis - Vice President, Compliance, Diversity & Human Resources at 703.797.2528 or maria.bremis@aaae.org.

HIPAA Special Enrollment Rights

AAAE Health Plan Notice of Your HIPAA Special Enrollment Rights

Our records show that you are eligible to participate in the AAAE Health Plan (to actually participate, you must complete an enrollment form and pay part of the premium through payroll deduction).

A federal law called HIPAA requires that we notify you about an important provision in the plan - your right to enroll in the plan under its "special enrollment provision" if you acquire a new dependent, or if you decline coverage under this plan for yourself or an eligible dependent while other coverage is in effect and later lose that other coverage for certain qualifying reasons.

Loss of Other Coverage (Excluding Medicaid or a State Children's Health Insurance Program). If you decline enrollment for yourself or for an eligible dependent (including your spouse) while other health insurance or group health plan coverage is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward 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).

Loss of Coverage for Medicaid or a State Children's Health Insurance Program. If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or a state children's health insurance program.

New Dependent by Marriage, Birth, Adoption, or Placement for Adoption. 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 new dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Important Warning

If you decline enrollment for yourself or for an eligible dependent, you must complete our form to decline coverage. On the form, you are required to state that coverage under another group health plan or other health insurance coverage (including Medicaid or a state children's health insurance program) is the reason for declining enrollment, and you are asked to identify that coverage. If you do not complete the form, you and your dependents will not be entitled to special enrollment rights upon a loss of other coverage as described above, but you will still have special enrollment rights when you have a new dependent by marriage, birth, adoption, or placement for adoption, or by virtue of gaining eligibility for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, as described above. If you do not gain special enrollment rights upon a loss of other coverage, you cannot enroll yourself or your dependents in the plan at any time other than the plan's annual open enrollment period, unless special enrollment rights apply because of a new dependent by marriage, birth, adoption, or placement for adoption, or by virtue of gaining eligibility for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan.

Notice of Creditable Coverage

Important Notice from AMERICAN ASSOCIATION OF AIRPORT EXECUTIVES

About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with AAAE and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. **Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.**

2. **AAAE has determined that the prescription drug coverage offered by the medical plans are, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

When Can You Join a Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens to Your Current Coverage if You Decide to Join a Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current AAAE coverage may be affected. You may keep your coverage if you elect Part D and this plan may coordinate with Part D coverage.

If you do decide to join a Medicare drug plan and drop your current AAAE coverage, be aware that you and your dependents may not be able to get this coverage back. The plan will follow the eligibility guidelines as stated in plan documents.

If you do decide to join a Medicare drug plan and drop your current AAAE coverage, be aware that you and your dependents may not be able to get this coverage back.

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with AAAE and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice or Your Current Prescription Drug Coverage…

Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through AAAE changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage Notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date:	**October 01, 2022**
Name of Entity/Sender:	**AMERICAN ASSOCIATION OF AIRPORT EXECUTIVES**
Contact—Position/Office:	**Maria Bremis - Vice President, Compliance, Diversity & Human Resources**
Office Address:	**The Barclay Building, 601 Madison St. Alexandria, Virginia 22314 United States**
Phone Number:	**703.797.2528**

COBRA General Notice

** Continuation Coverage Rights Under COBRA**

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: Maria Bremis.

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at **www.healthcare.gov/**.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period[1] to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit **www.healthcare.gov**.

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information

AMERICAN ASSOCIATION OF AIRPORT EXECUTIVES
Maria Bremis - Vice President, Compliance, Diversity & Human Resources
The Barclay Building, 601 Madison St.
Alexandria, Virginia 22314
United States
703.797.2528

[1] https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods.

Notices Disclaimer

The amount the plan pays for covered services provided by non-network providers is based on a maximum allowable amount for the specific service rendered. Although your plan stipulates an out-of-pocket maximum for out-of-network services, please note the maximum allowed amount for an eligible procedure may not be equal to the amount charged by your out-of-network provider. Your out-of-network provider may bill you for the difference between the amount charged and the maximum allowed amount. This is called balance billing and the amount billed to you can be substantial. The out-of-pocket maximum outlined in your policy will not include amounts in excess of the allowable charge and other non-covered expenses as defined by your plan. The maximum reimbursable amount for non-network providers can be based on a number of schedules such as a percentage of reasonable and customary or a percentage of Medicare. The plan document or carrier's master policy is the controlling document, and this Benefit Highlight does not include all of the terms, coverage, exclusions, limitations, and conditions of the actual plan language. Contact your claims payer or insurer for more information.

This document is an outline of the coverage proposed by the carrier(s), based on information provided by your company. It does not include all of the terms, coverage, exclusions, limitations, and conditions of the actual contract language. The policies and contracts themselves must be read for those details. Policy forms for your reference will be made available upon request.

The intent of this document is to provide you with general information regarding the status of, and/or potential concerns related to, your current employee benefits environment. It does not necessarily fully address all of your specific issues. It should not be construed as, nor is it intended to provide, legal advice. Questions regarding specific issues should be addressed by your general counsel or an attorney who specializes in this practice area.

Contact Information

Do you need help deciding what benefits to sign up for?

All AAAE employees and your families have access to ALEX, a decision making tool that can help decide what plans would best fit your needs.

Visit **www.myalex.com/aaae/aaae2022** to use this helpful tool!

BENEFIT	CARRIER	PHONE	WEBSITE/EMAIL
Medical	Cigna	Pre-Enrollment Line: 888.806.5042 Member Line: 866.494.2211	www.mycigna.com
Dental	United Concordia	800.332.0366	www.unitedconrodia.com
Vision	VSP	800.877.7195	www.vsp.com
Life/AD&D Voluntary Life/AD&D Long Term Disability	MetLife	800.275.4638	www.metlife.com
Voluntary Accident Insurance Voluntary Critical Illness	UNUM	800.635.5597	customerservices@unum.com
Pre-Paid Legal Services	Legal Resources	877-924-3967	www.legalresources.com
Flexible Spending Account (FSA)	Wage Works	877-924-3967	www.wageworks.com/employees
Health Savings Account (HSA)	HSA Bank	800.357.6246	www.hsabank.com
Benefit Advocate Center	Gallagher	833.202.8900	bac.aaaeadvocates@ajg.com

This benefit summary prepared by

Gallagher

Insurance | Risk Management | Consulting