NEW EMPLOYEE BENEFITS GUIDE

FY 2013

www.benefitenroll.com

Bloomberg BNA

ENROLL TODAY — DON'T DELAY!

This booklet provides a general overview of the health benefits for which benefits eligible Bloomberg BNA employees, retirees, and other plan participants may be eligible in 2013. Individual benefits are based on formal plan documents and contracts. If there is any disagreement between the information in this booklet and the terms of plan documents and contracts, the terms of the plan documents and contracts will govern in all cases. Bloomberg BNA reserves the right to improve, modify, or discontinue the benefit plans, policies, and/or practices described herein unless such action would conflict directly with the terms of a collective bargaining agreement or other controlling authority.

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WELCOME MESSAGE

Dear New Hire:

Welcome to Bloomberg BNA! We are pleased to offer you participation in the Company's rich program of health and welfare benefits, and we hope this guide will assist you in understanding your benefit options.

Step 1: Learn About Your Benefits

We encourage you to read through this **Benefits Guide**, as well as the supplemental materials provided in your New Hire Kit, to gain an understanding of the benefits available to you.

During your first month of employment you will also be invited to attend New Hire Orientation, at which time a benefits overview will be presented and you will have the opportunity to ask questions.

Step 2: Enroll for Benefits Online

Within the first two weeks of your start date you will receive an email from Ceridian with instructions on how to enroll for benefits online. Once you receive this email, please visit *www.benefitenroll.com* to enroll for benefits. Your **User ID** is your six-digit employee number (including leading zeroes) and your **Password** is 'BNA' (all caps) plus the last four digits of your social security number (ex. BNA9999).

To ensure prompt notification of your enrollments to our benefits administrators, and prompt receipt by you of your member ID cards, you should enroll for benefits within your first two weeks of employment.

All benefits eligible employees must enroll online within their first 30 days of employment.

Step 3: Complete and Return Benefits Forms to HR

In addition to enrolling online with Ceridian, you must also complete the enrollment forms included in your New Hire Benefits Enrollment Kit. Please refer to the **Checklist of Forms to be Returned** document included in your kit.

Please feel free to contact the Benefits Team with any questions or concerns. Our contact information is provided at the back of the **Benefits Guide**. Inquiries can also be emailed to *benefits@bna.com*

We look forward to serving you!

The Benefits Team

ELIGIBILITY TO PARTICIPATE IN THE BNA GROUP HEALTH PROGRAM

WHO IS ELIGIBLE?

The following individuals are eligible to participate in the BNA Group Health Program:

- **Employees**
  Full-time regular employees and part-time regular employees who are regularly scheduled to work at least 20 hours per week are eligible to participate in the program after one month of employment.
- **Employees' Dependents**
  Employees who enroll for coverage may enroll the following family members as their dependents at specified times, subject to the limitations listed on page 4: spouses, registered domestic partners, children (natural, adopted, foster, and those for whom the employee is the permanent legal guardian), stepchildren, and domestic partners' children.
- **Other Plan Participants**
  Certain former employees who experience qualifying events under COBRA, certain other plan participants who experience qualifying events under COBRA, certain former employees on long-term disability, certain surviving spouses of deceased employees, and certain surviving dependents of deceased retirees are eligible to participate in the BNA Group Health Program, subject to the limitations on page 4.
- **Other Plan Participants' Dependents**
  Other plan participants' dependents may enroll the following family members as their dependents at specified times, subject to the limitations on page 4: *spouses, children (natural, adopted, foster, those for whom the plan participant is the permanent legal guardian), and stepchildren.*

Note that although Bloomberg BNA considers registered domestic partners and the children of registered domestic partners to be eligible dependents under the BNA Group Health Program, IRS regulations require Bloomberg BNA to treat the value of their health benefits as taxable income to the employee. The IRS also stipulates a domestic partner or child of a domestic partner cannot receive pretax dollars on the following: premium contributions, medical or dependent care FSA, or the spousal surcharge. In these situations, the taxable value of health benefits is based on current premium equivalents.

LIMITATIONS ON ELIGIBILITY

Those who are eligible to participate in the program may enroll themselves and/or their eligible dependents for coverage only at specified times. See page 5 for details on enrolling yourself for coverage, enrolling dependents for coverage, and dropping dependents from coverage.

- **Children**
  Under the BNA/Aetna plan children may be covered until they reach age 26, regardless of student status, residency, marital status, or access to coverage through their employer. Under the Kaiser plan, children may be covered until they reach age 26, regardless of student status, residency, or marital status. However, if an adult child is working and has access to medical coverage they are no longer eligible under BNA's Group Health Program.

- **Survivors of Deceased Employees**
  A person who is the covered dependent of an employee at the time of the employee's death is eligible for coverage at Bloomberg BNA's expense for two years following the employee's death, subject to other applicable plan provisions concerning eligibility (such as, but not limited to, a dependent's age, student status, marital status, etc.). Any children of the employee born to the employee's covered surviving spouse or covered surviving domestic partner after the employee's death are also eligible for coverage at Bloomberg BNA's expense for two years following the employee's death. Thereafter, the survivors of a deceased employee are not eligible for coverage, except as provided by COBRA.

Bloomberg BNA reserves the right to conduct periodic audits of the eligibility of all dependents covered under the BNA Group Health Program, as well as to require written documentation of the eligibility of any or all of an employee's or retiree's covered dependents at any time.

ENROLLING FOR COVERAGE UNDER THE BNA GROUP HEALTH PROGRAM

ENROLLING YOURSELF FOR COVERAGE

If you are a person who is eligible to be a plan participant (employee, retiree, or other person eligible to be a plan participant), you may enroll yourself for coverage under the BNA Group Health Program only at the following times:

- **WHEN YOU ARE FIRST ELIGIBLE TO ENROLL (FOR ACTIVE EMPLOYEES, AFTER ONE MONTH OF EMPLOYMENT)**
  In this case, your coverage will begin one month after employment.
- **WITHIN ONE MONTH OF LOSING BOTH ELIGIBILITY FOR COVERAGE AND COVERAGE UNDER ANOTHER HEALTH PLAN**
  In this case, your coverage will begin on the date on which you lost both eligibility for coverage and coverage itself under another health plan.
- **DURING OPEN ENROLLMENT FOR THE NEXT CALENDAR YEAR**
  In this case, your coverage will begin on the first day of the next calendar year.

THESE ARE THE ONLY TIMES AT WHICH YOU MAY ENROLL YOURSELF FOR COVERAGE.

ENROLLING DEPENDENTS FOR COVERAGE

As a plan participant, you may enroll an eligible dependent for coverage only at the following times:

- **WHEN YOU ARE FIRST ELIGIBLE TO ENROLL (FOR ACTIVE EMPLOYEES, AFTER ONE MONTH OF EMPLOYMENT)**
  In this case, your dependent's coverage will begin on the same date on which your coverage begins.
- **WITHIN ONE MONTH OF A PERSON'S BECOMING YOUR ELIGIBLE DEPENDENT BECAUSE OF ANY OF THE FOLLOWING LIFE STATUS EVENTS:**

  SPOUSE
  You may enroll a spouse (and his/her children — your stepchildren — if any) for coverage within one month of your marriage to that person. In this case, your dependent's coverage will begin on the date of your marriage.

  REGISTERED DOMESTIC PARTNER
  You may enroll a registered domestic partner (and the partner's children, if any) for coverage within one month of registering your domestic partnership with that person. In this case, your dependent's coverage will begin on the date on which you jointly registered your domestic partnership.

  CHILD
  You may enroll a child for coverage within one month of your becoming the child's parent through birth, adoption, or permanent legal guardianship. In this case, your child's coverage will begin on the date on which you became the child's parent.

  STEPCHILD
  You may enroll a stepchild for coverage within one month of that child's becoming your stepchild. In this case, your stepchild's coverage will begin on the date of your marriage.

  YOUR DOMESTIC PARTNER'S CHILD
  You may enroll a domestic partner's child for coverage within one month of registering your domestic partnership with your partner. In this case, your domestic partner's child's coverage will begin on the date on which you register the partnership.

ENROLLING FOR COVERAGE UNDER THE BNA GROUP HEALTH PROGRAM

- **WITHIN ONE MONTH OF AN ELIGIBLE DEPENDENT'S LOSS OF BOTH ELIGIBILITY FOR COVERAGE AND COVERAGE UNDER ANOTHER HEALTH PLAN**
  In this case, the eligible dependent's coverage will begin on the date on which he or she lost both eligibility for coverage under the other plan and coverage itself under the other plan.
- **DURING OPEN ENROLLMENT FOR THE NEXT CALENDAR YEAR**
  In this case, the eligible dependent's coverage will begin on the first day of the next calendar year.

THESE ARE THE ONLY TIMES AT WHICH YOU MAY ENROLL YOURSELF FOR COVERAGE.

DROPPING COVERAGE

DROPPING YOUR COVERAGE

IF YOU ARE INELIGIBLE FOR COVERAGE

- If you become ineligible for coverage under the BNA Group Health Program for any reason, **you must notify the Benefits Office in writing within one month**. Your written notification should include the date on which you are becoming ineligible for coverage and the reason for which you are becoming ineligible for coverage.
- If you become ineligible for coverage under the BNA Group Health Program for a reason that is considered a qualifying event under COBRA, the Benefits Office will send you the required notice of your right to continue your coverage at your own expense under COBRA.

IF YOU ARE STILL ELIGIBLE FOR COVERAGE

- If you want to drop your coverage under the BNA Group Health Program when you are still eligible for such coverage, you may do so by notifying the Benefits Office in writing. Your written notification should include the date on which you want to drop yourself from coverage and the reason for which you want to drop yourself from coverage.

If you notify the Benefits Office that you want to drop your coverage when you are still eligible for coverage, you will be able to re-enroll for coverage only at the times specified under Enrolling Yourself For Coverage.

DROPPING A DEPENDENT'S COVERAGE

IF THE DEPENDENT IS INELIGIBLE FOR COVERAGE

If any of your covered dependents becomes ineligible for coverage under the BNA Group Health Program, **you must notify the Benefits Office in writing within one month** of the dependent's becoming ineligible. The Benefits Office will drop your dependent from coverage as of the date on which he/she became ineligible for coverage.

The following are conditions under which dependents become ineligible for coverage:

- **SPOUSE**
  Your spouse loses eligibility for coverage on the date of legal separation or divorce.
- **REGISTERED DOMESTIC PARTNER**
  Your registered domestic partner loses eligibility for coverage on the earlier of (a) the date on which you and your partner no longer meet all of the criteria set forth in the Affidavit of Domestic Partnership or (b) the date that you and your registered domestic partner agree to terminate your domestic partnership.
- **CHILD**
  Your child loses eligibility for coverage on the date on which he/she no longer meets the following criteria for eligibility:

  UNDER THE BNA/AETNA PLAN
  Children may be covered until they reach age 26, regardless of student status, residency, marital status, or access to coverage through their employer.

DROPPING COVERAGE

UNDER ALL PLANS

A stepchild must meet the criteria in **Under the BNA/Aetna Plan** on page 7.

A domestic partner's child must meet the criteria

If one of your covered dependents becomes ineligible for coverage as your covered dependent under the BNA Group Health Program for a reason that is considered a qualifying event under COBRA, the Benefits Office will send both of you the required notice of the dependent's right to continue his/her coverage at his/her own expense under COBRA.

IF THE DEPENDENT IS STILL ELIGIBLE FOR COVERAGE

If you want to drop a covered dependent from coverage under the BNA Group Health Program when the dependent is still eligible for such coverage, you may do so by notifying the Benefits Office in writing. Your written notification should include the date on which you want to drop the dependent from coverage and the reason for which you want to drop the dependent from coverage.

If you notify the Benefits Office that you want to drop a dependent from coverage when that dependent is still eligible for coverage, you will be able to re-enroll that dependent for coverage only at the times specified under Enrolling Dependents For Coverage.

SPECIAL INFORMATION FOR BNA COUPLES

Many Bloomberg BNA employees are married to other Bloomberg BNA employees. A Bloomberg BNA employee who is married to another Bloomberg BNA employee may be covered under the BNA Group Health Program in only one capacity. This means that an employee may be enrolled in the BNA Group Health Program either as an employee, or as the dependent of another employee, but not in both capacities at the same time. Similarly, an employee's child may be enrolled in the BNA Group Health Program as the dependent of either parent who is a Bloomberg BNA employee, but not as the dependent of both parents at the same time.

If either employee in a Bloomberg BNA couple becomes ineligible to continue his/her participation in the BNA Group Health Program for any reason, Bloomberg BNA will continue to cover that spouse and any eligible children of the couple as the dependents of the other spouse who does remain eligible for participation. No eligible family member who is covered immediately prior to one spouse's loss of eligibility will lose his/her coverage in the course of the calendar year, so long as the other spouse remains eligible for participation.

This policy applies to Bloomberg BNA employees who are married to other Bloomberg BNA employees; to Bloomberg BNA employees who are married to Bloomberg BNA retirees; and to Bloomberg BNA retirees who are married to other Bloomberg BNA retirees.

EXAMPLE 1

John is married to Mary. Both are full-time regular employees who are eligible for participation in the BNA Group Health Program. On January 1, John elects "individual only" coverage. At the same time, Mary elects "individual + family" coverage, covering the couple's children as her dependents.

On July 1, Mary leaves Bloomberg BNA. Because Mary and the couple's children have already been covered under the BNA Group Health Program, their coverage continues. But they become covered as John's dependents, rather than Mary's, because John is still eligible to participate in the BNA Group Health Program.

EXAMPLE 2

Jim is married to Ann. Both are full-time regular employees who are eligible for participation in the BNA Group Health Program. On January 1, Jim elects "individual + family" coverage for himself, Ann, and their children. At the same time, Ann waives coverage as an employee.

On July 1, Jim reduces his schedule to 15 hours per week. He is no longer eligible for participation in the BNA Group Health Program. Because Jim, Ann, and the couple's children have already been covered under the BNA Group Health Program, their coverage continues. But they become covered through Ann, rather than Jim, because Ann is still eligible to participate in the BNA Group Health Program.

DOCUMENTATION WHEN ENROLLING FOR COVERAGE

New hires enrolling dependents for coverage must provide documentation to substantiate eligibility. A list of required documentation can be found below.

Bloomberg BNA reserves the right to request written documentation of any birth, adoption, permanent legal guardianship, marriage, legal separation, divorce, registration of domestic partnership, termination of domestic partnership, change in residence, change in marital status, change in employment status, and/or other aspect of an employee's, retiree's, or dependent's eligibility for coverage under the BNA Group Health Program. Bloomberg BNA reserves the right to request such documentation in connection with enrollment changes and at any other time, at its discretion.

RELATIONSHIP	REQUIRED DOCUMENTATION
Spouse	A copy of your marriage certification AND a copy of the first page of your **most recent** federal tax form (to demonstrate that you and your spouse file as married)
Registered Domestic Partner	Copies of any two of the following five forms of documentation, to demonstrate that you and your partner continue to share a household as the primary residence of both: your partner's driver's license; your partner's vehicle registration; your partner's paycheck stub/earnings statement; your partner's bank statement or credit card statement; and/or a utility bill addressed to your partner or to you jointly at the address you share.
Biological Child(ren)	Copies of birth certificates
Adopted Child(ren)	Copies of adoption decrees
Foster Child(ren)	Copies of documentation of their placement in foster care with you
Stepchild(ren)	Copies of birth certificates
Registered Domestic Partner's Child(ren) who live with you	Copies of birth certificates

PREMIUMS FOR COVERAGE UNDER THE BNA GROUP HEALTH PROGRAM

The BNA/Aetna POS II Group Health Plan includes medical, prescription, behavioral health, dental, and vision benefits. Participants make pretax premium contributions for their own and their dependents' coverage as follows:

Full-Time Regular Employees & Part-Time Regular Employees (30 or more hours per week)

TIER OF COVERAGE	MONTHLY CONTRIBUTION
Employee only	$0 / $20 Beginning Oct. 1, 2013
Employee + one	$40
Employee + two or more	$60

Part-Time Regular Employees (20 to 29 hours per week)

If you are regularly scheduled to work fewer than 30 hours per week, and elect dependent coverage for one or more dependents, you will continue to contribute 50% of the dependent premium. In addition, you are also responsible for the dependent premium based on your tier of coverage as indicated below.

TIER OF COVERAGE	MONTHLY PREMIUM FOR DEPENDENT COVERAGE	50% OF MONTHLY PREMIUM FOR DEPENDENT COVERAGE	TIER OF COVERAGE MONTHLY PREMIUM	TOTAL MONTHLY PREMIUM FOR DEPENDENT COVERAGE
Employee only	$0.00	$0.00	$0 / $20 Beginning October 1, 2013	$0.00
Employee + one	$580.68	$290.34	$40	$325.84
Employee + two or more	$1,211.78	$605.89	$60	$655.89

TABLE OF MONTHLY PREMIUM EQUIVALENTS

BNA/AETNA CHOICE POS II GROUP HEALTH PLAN

Bloomberg BNA self-funds the BNA/Aetna medical plans. This means that Bloomberg BNA does not pay premiums to Aetna, Medco, or Vision Service Plan. Instead, Bloomberg BNA pays fees for the administration of the plan, **plus** the actual claims costs incurred by Bloomberg BNA plan participants. The premium equivalents above are actuarial expressions of the monthly value of coverage under those plans.

COVERAGE TYPE	IND MEDICAL PREMIUM	DEP MEDICAL PREMIUM	IND DENTAL PREMIUM	DEP DENTAL PREMIUM	TOTAL MONTHLY PREMIUM
Employee only	$549.25	$0.00	$43.51	$0.00	$592.76
Employee + one dep	$549.25	$580.68	$43.51	$42.87	$1,216.31
Employee + family	$549.25	$1,211.78	$43.51	$87.63	$1,892.17

BNA/AETNA CHOICE POS II PLAN

TYPE OF PLAN

This is a "point of service" (POS II) plan that is available to all Bloomberg BNA employees.

Under this plan, you may obtain medical care and behavioral health care either from the doctors and hospitals who participate in Aetna's Choice POS II network or from any other doctor and hospital you choose. You may choose between Choice POS II network providers and non-network providers each time that you obtain medical or behavioral health care. You may use network and non-network providers in any combination.

Although you are always free to obtain care from the providers of your choice, you can achieve significant savings for yourself and Bloomberg BNA by using network providers. The office visit copayment for medical care from network doctors for **nonpreventive care** is only $15, not subject to the deductible. There is no copayment for preventive services. Preventive services are covered at 100%. Please refer to the Preventive Care Coverage document located under the Aetna heading on the *www.benefitenroll.com* website for details. The eligible charges for hospital care in network hospitals are covered at 90%, not subject to the deductible or copayment by you.

In addition to medical benefits for the diagnosis and treatment of illness and injury, this plan includes:

Preventive care for employees and their dependents	See page 18
Prescription drug benefits, through Medco/Express Scripts	See page 20
Behavioral health benefits	See page 21
Routine vision care benefits, through VSP	See page 23

Those who choose this plan (except COBRA participants who decline dental coverage) also are enrolled in the Aetna dental plan.

DEDUCTIBLES FOR MEDICAL CARE

- **Network care**
  Eligible charges for medical care from network providers are not subject to the deductible.
- **Non-network care**
  The annual deductible is the amount you must pay toward your eligible charges for medical care from non-network providers before the plan begins paying benefits each year. The deductible amounts are $600 for Employee only coverage, $1,100 for Employee + one coverage, and $1,600 for Family coverage.

BNA/AETNA CHOICE POS II PLAN

COPAYMENTS FOR MEDICAL CARE

- **Network care**
  The copayment for office visits for nonpreventive services is $15. **There is no copayment for preventive services. Preventive services are covered at 100%. Please refer to the Preventive Care Coverage document under the Aetna heading on the *www.benefitenroll.com* website for details.** There is no copayment for eligible charges from network hospitals. In addition, to the $15 copay, a person enrolled in the Aetna plan and Bloomberg BNA share (coinsurance) any additional charges until the person has met his or her individual out-of-pocket maximum (OOPM). The coinsurance will not apply to doctor's office visit copays. There is no copayment for eligible charges from network hospitals.
- **Non-network care**
  Once a person has met the annual deductible for eligible charges for medical care from non-network providers, Bloomberg BNA and the person share (coinsurance) any additional eligible charges until the person has met his or her individual OOPM. Most eligible charges for medical care from non-network providers are subject to the $375 deductible, 75% coinsurance by Bloomberg BNA, and 25% by you, until you reach your OOPM.

The individual OOPM for employees is 3% of salary as of January 1 (maximum 4% per family). Once a person has met his or her individual OOPM, Bloomberg BNA pays the rest of his or her eligible charges for medical care from non-network providers at 100%. Once the family OOPM has been met, Bloomberg BNA pays the rest of the family's eligible charges for medical care from non-network providers at 100%.

Certain expenses (including, but not limited to, copayments for care from network providers, deductibles, and charges that exceed reasonable and customary limits) do not count toward the OOPM. You are responsible for all charges from non-network providers that exceed reasonable and customary limits.

BNA/AETNA CHOICE POS II PLAN

GEOGRAPHIC AVAILABILITY

This plan is available to those who live in the Washington, D.C., area and other areas where Aetna networks are available.

If this plan was available in your geographic area in 2012, it is also available for 2013.

If this plan was not available in your geographic area in 2012, it may be available for 2013. Call the Benefits Office at 703.341.2016 (x2016) to check on this.

To locate providers who participate in Aetna's Choice POS II network, call Aetna at 800.962.6842, or check the Aetna website at *www.aetna.com*

ELIGIBILITY

See page 14 for information on who is eligible to enroll in this plan.

- **Age limits on children**
  Under the BNA/Aetna plan children may be covered until they reach age 26, regardless of student status, residency, marital status, or access to coverage through their employer.

BNA/AETNA CHOICE POS II PLAN SUMMARY

SUMMARY MAJOR PLAN PROVISIONS FOR MEDICAL CARE FOR 2013

PLAN PROVISION	FROM NETWORK PROVIDERS	FROM NON-NETWORK PROVIDERS
ANNUAL DEDUCTIBLE	The deductible does not apply to eligible charges for medical care from network providers (except for "nontrue" emergency room care in network hospitals).	Employee only: $600 Employee + 1: $1,100 Family: $1,600
YOUR COPAYMENTS	Your copayment for medical office visits is **$0 for preventive services.** Your copayment for medical office visits is **$15 per visit for non-preventive related expenses.** Your coinsurance is 10% of the medical charges for medical care from network providers (including lab and X-ray services, and other types of outpatient and inpatient care), up to the annual out-of-pocket maximum (OOPM). The plan pays the balance of eligible charges.	Once you have met the annual deductible, your copayment is 25% of most eligible charges for non-preventive related expenses, up to the annual out-of-pocket maximum (OOPM). The plan pays the balance of eligible charges.
OUT-OF-POCKET COPAYMENT MAXIMUM (OOPM)	Your annual OOPM is 2% of salary as of 1/1/2013 (maximum 4% per family). Once you have met the OOPM, the plan pays 100% of eligible charges.	Your annual OOPM is 3% of salary as of 1/1/2013 (maximum 6% per family). Once you have met the OOPM, the plan pays 100% of eligible charges.
OFFICE VISITS AND DOCTORS' FEES	Your copayment for medical office visits is **$0 for preventive services.** Your copayment for medical office visits is **$15 per visit for non-preventive related expenses.**	Once you have met the annual deductible, your coinsurance is 25%, up to the OOPM.

BNA /AETNA CHOICE POS II PLAN SUMMARY

(continued)

PLAN PROVISION	FROM NETWORK PROVIDERS	FROM NON-NETWORK PROVIDERS
HOSPITAL CARE *	Hospital expenses: Your coinsurance is 10%. Emergency room care: Your coinsurance is 10%. "Nontrue" emergency room care: Once you have met the annual deductible, your coinsurance is 25%.	Hospital expenses: Your coinsurance is 25%. Emergency room care: Your coinsurance is 10% after meeting your deductible. "Nontrue" emergency room care: Once you have met the annual deductible, your coinsurance is 25%.
LAB & X-RAY	Your coinsurance is 10% per visit to network lab and X-ray facilities.	Once you have met the annual deductible, your coinsurance is 25%, up to the out-of-pocket maximum (OOPM).
PREVENTIVE CARE	See following page.	

* All overnight hospital admissions must be precertified with Aetna 14 days in advance.

* Emergency overnight admissions must be certified with Aetna within 48 hours of admission (72 hours on weekends and holidays).

BNA/AETNA CHOICE POS II PLAN SUMMARY

PREVENTIVE CARE BENEFITS*

PLAN PROVISION	FROM NETWORK PROVIDERS	FROM NON-NETWORK PROVIDERS
WELL-CHILD CARE PRIOR TO AGE 3	7 checkups for the first 12 months 3 checkups for months 13 – 24 3 checkups for months 25 – 36 **Copayment $0** Covered at 100%	7 checkups for the first 12 months 3 checkups for months 13 – 24 3 checkups for months 25 – 36 Subject to deductible and 25% copay
WELL-CHILD CARE AGES 3 – 21	1 exam per year through age 21 **Copayment $0** Covered at 100%	1 exam per year through age 21 Subject to deductible and 25% copay
WELL-CHILD CARE AGES 22 – 26	1 exam every 24 months Appropriate tests based on age, sex, and health status **Copayment $0** Covered at 100%	1 exam every 24 months Appropriate tests based on age, sex, health status Subject to deductible and 25% copay
ROUTINE PHYSICAL EXAMS FOR ADULTS	1 exam every 24 months Appropriate tests based on age, sex, and health status **Copayment $0** Covered at 100%	1 exam every 24 months Appropriate tests based on age, sex, health status Subject to deductible and 25% copay
WELL-WOMAN EXAMS	Covered once every year, including routine screening Pap smear **Copayment $0** Covered at 100%	Covered once every year, including routine screening Pap smear Subject to deductible and 25% copay

BNA/AETNA CHOICE POS II PLAN SUMMARY

(continued)

PLAN PROVISION	FROM NETWORK PROVIDERS	FROM NON-NETWORK PROVIDERS
ROUTINE SCREENING MAMMOGRAMS	Covered once every year for women 40 and over **Copayment $0** Covered at 100%	Covered once every year for women 40 and over Subject to deductible and 25% copay
ROUTINE SCREENING COLONOSCOPIES FOR PATIENTS WITHOUT SYMPTOMS	Covered once every two years for patients with close family history and/or personal history Per Aetna clinical policy bulletin **Copayment $0** Covered at 100%	Covered once every two years for patients with close family history and/or personal history Per Aetna clinical policy bulletin Subject to deductible and 25% copay

* **Please refer to the Preventive Care Coverage document for more details.** For customer service questions about medical plan benefits, claims, precertification of inpatient hospital admissions, and locating Aetna network medical providers, call Aetna at 800.962.6842, or check the Aetna website at *www.aetna.com*

PRESCRIPTION DRUG BENEFITS PROVIDED THROUGH MEDCO/EXPRESS SCRIPTS

PLAN PROVISION	AT RETAIL PHARMACIES USING YOUR CARD	THROUGH THE MAIL ORDER OPTION
HOW IT WORKS	Present your Medco card and prescription at any of 40,000+ participating pharmacies nationwide.	Mail a Medco mail order form and your prescription to Express Scripts.
YOUR COPAYMENT	$10 for generic drugs $25 for brand name drugs with no generic equivalent $40 for brand name drugs with a generic equivalent	$25 for generic drugs $65 for brand name drugs with no generic equivalent $85 for brand name drugs with a generic equivalent
MAXIMUM SUPPLY OF MEDICATION	30-day supply	90-day supply

REMEMBER: To maximize savings for yourself and Bloomberg BNA, choose generic drugs when available, and use mail order for maintenance medications.

For customer service questions about prescription drug benefits at a retail pharmacy or by mail order, call Medco/Express Scripts at 800.711.0917, or check the website at *www.express-scripts.com*

BENEFITS FOR BEHAVIORAL HEALTH CARE UNDER THE BNA/AETNA CHOICE POS II PLAN

INPATIENT CARE

PLAN PROVISION	FROM NETWORK PROVIDERS	FROM NON-NETWORK PROVIDERS
ANNUAL DEDUCTIBLE	The deductible does not apply to eligible charges for behavioral health care from network providers.	Employee only: $600 Employee + 1: $1,100 Family: $1,600
YOUR COPAYMENTS	Your coinsurance is 10% of the medical charges for medical care from network providers up to the annual out-of-pocket maximum (OOPM). The plan pays the balance of eligible charges.	Once you have met the annual deductible, your copayment is 25% of most eligible charges, up to the annual out-of-pocket maximum (OOPM). The plan pays the balance of eligible charges.
CLARIFICATION OF CARE	Care must be certified by Aetna in advance (or within 48 hours in true emergencies). The provider is responsible for contacting Aetna to certify your care.	Care must be certified by Aetna in advance (or within 48 hours in true emergencies). This is your responsibility. Benefits will be reduced by $500 per stay if care is not certified. Call Aetna at 800.962.6842.

For customer service questions about behavioral health benefits, claims, precertification of inpatient hospital admissions, and to locate Aetna network behavioral health providers, call Aetna at 800.962.6842.

BENEFITS FOR BEHAVIORAL HEALTH CARE UNDER THE BNA/AETNA CHOICE POS II PLAN

OUTPATIENT CARE

PLAN PROVISION	FROM NETWORK PROVIDERS	FROM NON-NETWORK PROVIDERS
ANNUAL DEDUCTIBLE	The deductible does not apply to eligible charges for behavioral health care from network providers.	Employee only: $600 Employee + 1: $1,100 Family: $1,600
YOUR COPAYMENTS	Your copayment for medical office visits is $15 per visit. Your coinsurance is 10% of the medical charges for behavioral health care from network providers up to the annual out-of-pocket maximum (OOPM). The plan pays the balance of eligible charges.	Once you have met the annual deductible, your copayment is 25% of most eligible charges, up to the annual out-of-pocket maximum (OOPM). The plan pays the balance of eligible charges.
CLAIMS	The provider files the claims. You do not have to file your own claims and wait for reimbursement.	Typically, you will be required to pay the provider the entire fee, file your own claims, and wait for reimbursement.
CERTIFICATION OF CARE	You are not required to obtain certification from Aetna prior to obtaining outpatient behavioral health care. You may select a network provider via Aetna's DocFind website, or you may call Aetna at 800.962.6842 for assistance in selecting a network provider.	You are not required to obtain certification from Aetna prior to obtaining outpatient behavioral health care.

ROUTINE VISION BENEFITS CARE THROUGH VISION SERVICE PLAN (VSP)

PLAN PROVISION	FROM VSP NETWORK PROVIDERS	FROM NON-NETWORK PROVIDERS
HOW IT WORKS	Make an appointment with any VSP network provider. The provider will verify your eligibility with VSP. You make only the required copayment at the time of your appointment. The provider will file the claim with VSP for the balance.	You may see the provider of your choice. You must pay the provider the full amount, submit a copy of the itemized bill to VSP, and wait for reimbursement.
ROUTINE EYE EXAMS	Covered once a year. Your copayment is $10. The plan pays the balance.	Covered once a year. The plan pays up to $35. You pay the balance.
EYEGLASS LENSES & FRAMES	Lenses are covered once a year, frames once every other year. Your copayment is $30 for lenses and/or frames. The plan pays the balance, up to the plan allowance. You pay all charges that exceed the plan allowance.	Lenses are covered once a year, frames once every other year. The plan pays up to $35 toward frames, up to $25 toward single vision lenses, up to $40 toward bifocal lenses, up to $55 toward trifocal lenses, and up to $80 toward lenticular lenses.
CONTACT LENSES	Elective contact lenses: The plan provides an allowance of $95 toward contact lenses, instead of eyeglass lenses and frames. You pay the balance. Medically necessary contact lenses: Provided by VSP with prior approval.	Elective contact lenses: The plan provides an allowance of $95 toward contact lenses, instead of eyeglass lenses and frames. You pay the balance. Medically necessary contact lenses: The plan provides an allowance of $165.
PLAN LIMITATIONS: The plan is designed to cover visual needs rather than cosmetic materials. There will be an extra charge if you select the following: blended lenses, oversize lenses, progressive multifocal lenses, photochromic lenses, tinted lenses other than Pink #1 or Pink #2, coated or laminated lenses, cosmetic lenses, optional cosmetic processes, UV protected lenses, or a frame that costs more than the plan allowance.		
PLAN EXCLUSIONS: The plan covers routine vision care only. The plan provides no benefit for professional services or materials connected with: orthoptics or vision training or any associated supplemental testing, plano lenses, two pairs of glasses in lieu of bifocals, replacement of lost or broken lenses or frames (except at normal intervals for plan benefits), medical or surgical treatment of the eye, or any eye examination or corrective eye wear required by the employer as a condition of employment.		

For customer service questions about vision care benefits, claims, and to locate VSP network providers, call VSP at 800.877.7195, or check the VSP website at *www.vsp.com*

AETNA DENTAL PLAN

All employees, retirees, and participants in the BNA Group Health Program and their covered dependents (if any) are covered under the Aetna dental plan, regardless of the medical plan they choose. (The exception is COBRA participants in the BNA Group Health Program who decline dental coverage.)

TYPE OF PLAN

The Aetna dental plan is a PPO-type dental plan. This means that you may obtain dental care from the dentists who participate in Aetna's Preferred Dental Provider (PDP) network or from any other dentists you choose. You may choose between PDP network dentists and non-network dentists each time you obtain dental care. You may use network and non-network dentists in any combination.

NETWORK VS. NON-NETWORK CARE

Although you are always free to obtain dental care from the dentists of your choice, you can achieve significant savings for yourself and Bloomberg BNA in three ways by using PDP network dentists:

The annual deductible for dental care from PDP network dentists — the amount of the eligible charges that you must pay before plan benefits begin — is $100 (maximum $300 per family), versus an annual deductible for dental care from non-network dentists of $250 (maximum $750 per family).

When you use PDP network dentists, your copayments for dental care will be based on Aetna's allowable fees for its PDP network dentists, which are typically 15% – 30% lower than the average fees charged by nonparticipating dentists in a community. So, for example, instead of paying 25% of an $800 fee from a non-network dentist ($200), you could be paying 20% of a $637.50 fee from a PDP network dentist ($127.50). And that's assuming a network fee that's only 20% lower than the non-network fee. Your actual savings could be greater.

Again, because Aetna's allowable fees for its PDP network dentists are typically 15% – 30% lower than the average fees charged by nonparticipating dentists in a community, your $2,000 annual dental benefit maximum and your $2,000 lifetime orthodontic maximum will go further when you obtain dental care from PDP network dentists.

PREVENTIVE DENTAL CARE

Whether you use network or non-network dentists, the plan covers two dental checkups per person per year at 100%. Checkups are not subject to the dental deductible, although checkups from non-network dentists are subject to reasonable and customary limits. Dental checkups include oral examination, cleaning, and X-rays. Sealants are covered when applied by PDP network dentists. Dental checkups may occur at any time during the year.

AETNA DENTAL PLAN

DEDUCTIBLES FOR DENTAL CARE

The dental deductible is the amount you must pay toward your eligible charges for dental care before the plan begins paying benefits each year.

Network care

The annual dental deductible is $100 per person (maximum $300 per family) for dental care from PDP network dentists.

Non-network care

The annual deductible is $250 per person (maximum $750 per family) for dental care from non-network dentists.

COPAYMENTS FOR DENTAL CARE

Network care

Once a person has met the annual deductible for eligible charges for dental care from PDP network providers, the plan and the person share (coinsurance) any additional eligible charges. Your copayment for Type B expenses (fillings, extractions, endodontic treatment, oral surgery, etc.) is 20% of the maximum allowable charges. Your copayment for Type C expenses (major restorative work like bridges, dentures, inlays, onlays, and crowns) is 20% of the maximum allowable charges. Your copayment for Type D expenses (orthodontia) is 50% of the maximum allowable charges.

The plan will pay the balance of the eligible charges, up to the annual dental benefit maximum of $2,000 and the lifetime orthodontic maximum of $2,000.

Again, keep in mind that the maximum allowable charges for care from participating PDP network dentists are typically 15% to 30% lower than the average fees charged by non-network dentists in a community.

Non-network care

Once a person has met the annual deductible for eligible charges for dental care from non-network providers, the plan and the person share (coinsurance) any additional eligible charges. Your copayment for Type B expenses (fillings, extractions, endodontic treatment, oral surgery, etc.) is 25% of the reasonable and customary fees. Your copayment for Type C expenses (major restorative work like bridges, dentures, inlays, onlays, and crowns) is 25% of the reasonable and customary fees. Your copayment for Type D expenses (orthodontia) is 50% of the reasonable and customary fees.

The plan will pay the balance of the eligible charges, up to the annual dental benefit maximum of $2,000 and the lifetime orthodontic maximum of $2,000.

You are responsible for paying all charges from non-network dentists that exceed reasonable and customary limits.

AETNA DENTAL PLAN SUMMARY

MAJOR PLAN PROVISIONS FOR DENTAL CARE FOR 2013

PLAN PROVISION	NETWORK PLAN BENEFITS	NON-NETWORK PLAN BENEFITS
TYPE A EXPENSES — PREVENTIVE CARE	The plan covers two dental checkups per person per year at 100%, not subject to the deductible.	The plan covers two dental checkups per person per year at 100%, not subject to the deductible.
DEDUCTIBLE	The annual dental plan deductible for network care is $100 per person (maximum $300 per family). Note that two routine dental checkups per year are covered at 100%, not subject to the deductible.	The annual dental plan deductible for non-network care is $250 per person (maximum $750 per family). Note that two routine dental checkups per year are covered at 100%, not subject to the deductible.
TYPE B EXPENSES — BASIC CARE	Once the deductible for network care has been met, your copayment is 20% of Aetna's maximum allowable charges for Type B expenses (fillings, extractions, endodontic treatment, oral surgery, etc.)	Once the deductible for network care has been met, your copayment is 25% of the eligible charges for Type B expenses (fillings, extractions, endodontic treatment, oral surgery, etc.). You are responsible for any amounts over reasonable and customary limits as well.
TYPE C EXPENSES — MAJOR RESTORATIVE	Once the deductible for network care has been met, your copayment is 20% of Aetna's maximum allowable charges for Type C expenses.	Once the deductible for network care has been met, your copayment is 25% of the eligible charges for Type C expenses (bridges, dentures, inlays, onlays, and crowns). You are responsible for any amounts over reasonable and customary limits as well.

AETNA DENTAL PLAN SUMMARY

SUMMARY OF MAJOR PLAN PROVISIONS FOR DENTAL CARE FOR 2013

PLAN PROVISION	NETWORK PLAN BENEFITS	NON-NETWORK PLAN BENEFITS
TYPE D EXPENSES — ORTHODONTIA	Once the deductible for network care has been met, your copayment is 50% of Aetna's maximum allowable charges for Type D expenses.	Once the deductible for network care has been met, your copayment is 50% of the eligible charges for Type D expenses. You are responsible for any amounts over reasonable and customary limits as well.
PLAN BENEFIT MAXIMUMS	The annual dental benefit maximum is $2,000 per person. The lifetime orthodontic benefit maximum is $2,000 per person. Remember that your dental benefits will go further when you use PDP network dentists!	The annual dental benefits maximum is $2,000 per person. The lifetime orthodontic benefit maximum is $2,000 per person.

Note that network dental fees are typically 15% to 30% lower than the average fees from non-network dentists. So your $2,000 annual dental benefit maximum will go further when you choose network dentists.

For customer service questions about Aetna dental benefits, claims, and to locate Aetna network dental providers, call Aetna at 877.238.6200 or check the Aetna website at *www.aetna.com*

LIFE AND AD&D INSURANCE BENEFITS

EMPLOYER-PAID BASIC LIFE AND AD&D INSURANCE

Bloomberg BNA provides company-paid coverage of 2x annual salary, rounded to the next $1000, to a maximum coverage amount of $1,000,000. Bloomberg BNA also provides accidental death and dismemberment (AD&D) insurance.

The guaranteed issue amount for employer-paid basic life insurance coverage is $750,000.

Minnesota Life requires a paper application and proof of insurability before it can consider new or additional coverage in excess of $750,000. Regardless of your salary, coverage in excess of $750,000 will not be effective until Minnesota Life provides written approval of your application for that coverage.

(For sales reps with more than one full year of calendar earnings, comapny-paid coverage is based on average earnings for the past one to three full calendar years, not annual salary.)

EMPLOYEE-PAID SUPPLEMENTAL LIFE INSURANCE ON SELF

You may purchase supplemental life insurance on your own life in increments of $10,000.

The maximum coverage amount is the **lesser** of 3x annual salary or $500,000. The coverage amount is rounded to the nearest $10,000, not to exceed $500,000.

At the time of hire, the guaranteed issue amount is the **lesser** of 3x annual salary or $200,000. You may apply for additional coverage by providing a paper application and proof of insurability for Minnesota Life's consideration.

During the annual open enrollment period, there is no guaranteed issue amount. You may apply for new or additional coverage by providing a paper application and proof of insurability for Minnesota Life's consideration.

Within one month of an eligible life status event. See pages E and F of your Certificate of Insurance for details.

(For sales reps with more than one full year of calendar earnings, the maximum coverage amount for supplemental life insurance is based on average earnings for the past one to three full calendar years, not annual salary.)

EMPLOYEE-PAID SUPPLEMENTAL LIFE INSURANCE ON SPOUSE/DP

You may purchase supplemental life insurance on your spouse/domestic partner's life in increments of $10,000. The maximum coverage amount is $100,000.

At the time of hire, the guaranteed issue amount is $20,000. You may apply for additional coverage by providing a paper application and proof of insurability for Minnesota Life's consideration.

During the annual open enrollment period, there is no guaranteed issue amount. You may apply for new or additional coverage by providing a paper application and proof of insurability for Minnesota Life's consideration.

Within one month of an eligible life status event. See pages E and F of your Certificate of Insurance for details.

EMPLOYEE-PAID SUPPLEMENTAL LIFE INSURANCE ON CHILDREN

You may purchase coverage on your children in increments of $5,000, to a maximum coverage amount of $25,000. All your children from the ages of 14 days to 19 years, your children ages 19 through 22 who are full-time students, and your disabled children age 19 and over as defined by Minnesota Life will be covered. The cost is the same, regardless of the number of children.

At the time of hire, the guaranteed issue amount is $25,000. Proof of insurability is not required.

During the annual open enrollment period, there is no guaranteed issue amount. You may apply for new or additional coverage by providing a paper application and proof of insurability for Minnesota Life's consideration.

Within one month of an eligible life status event. See pages E and F of your Certificate of Insurance for details.

ABOUT PROOF OF INSURABILITY

"Proof of insurability" means that, before Minnesota Life can make a decision about approving any coverage amount in excess of the guaranteed issue amount requested at the time of hire, or any new or increased coverage amount requested during the annual open enrollment period, you must submit a completed paper application to Minnesota Life, provide any additional medical information requested by Minnesota Life, and cooperate with any medical testing that Minnesota Life requests.

LIFE AND AD&D INSURANCE BENEFITS

Supplemental life insurance coverage in excess of the guaranteed issue amount that is requested at the time of hire, and new or increased coverage amounts that are requested during the annual open enrollment period, will not be effective until Minnesota Life provides written approval of your application for that coverage.

BENEFICIARY DESIGNATION

Minnesota Life Insurance will use the most recent beneficiary form on file to pay out your benefit. **The beneficiary form you have on file will be used to pay out the combined benefit of your basic employer-paid benefit and your employee-paid supplemental coverage on yourself. You are the automatic beneficiary for both the supplemental spouse/domestic partner and child policies**.

LONG TERM DISABILITY INSURANCE BENEFITS

Long Term Disability (LTD) Insurance helps replace a portion of your income for an extended period of time should you become disabled. Bloomberg BNA provides company-paid coverage to all active full-time and part-time employees working at least 20 hours per week.

Generally, you are considered disabled and eligible for long-term benefits if, due to sickness, pregnancy, or accidental injury, you are receiving appropriate care and treatment, and are unable to earn more than 80% or your predisability earnings at your own occupation.

The benefit amount is the lesser of 65% of the first $23,077 of your predisability earnings; or 70% of the first $21,429 of your predisability earnings less other income you may receive from other sources (e.g. Social Security, Worker's Compensation, Vacation Pay, etc.). The maximum monthly benefit under the plan is $15,000.

Benefits begin at the end of the elimination period. The elimination period begins on the day you become disabled and lasts for a period of 90 days.

For a complete description of this benefit and requirements that must be met, refer to the Certificate of Insurance/Summary Plan Description found on B>Home or contact the Benefits Office.

CUSTOMER SERVICE, CLAIMS, LOCATING NETWORK PROVIDERS

Medical and behavioral health benefits through Aetna

For customer service on questions about medical and behavioral health plan benefits, claims, or precertification of inpatient hospital admissions, call Aetna at 800.962.6842. Please be prepared with our group number (656135) and your Social Security number.

Aetna medical claim forms are available on the HR Home Page, Ceridian Self Self-Service website, Benefits Online website, or by calling the Benefits Office at 703.341.2016 (x2016). Send claims for non-network medical and behavioral health care to Aetna at P.O. Box 981106, El Paso, TX 79998-1106.

To locate medical providers and behavioral health providers who participate in the Aetna network, check the Aetna Doc-Find website, or call Aetna at 800.962.6842.

Prescription drug benefits through Express Scripts

For customer service about prescription drug benefits through a retail pharmacy or by mail order, call Express Scripts at 800.711.0917.

For online resources, check the Express Scripts website at *www.express-scripts.com*

Be sure to check out the Express Scripts Savings Advisor to see how much you can save by choosing generic drugs, when available, and using mail order for maintenance medications.

Vision care benefits through Vision Service Plan

For customer service on questions about vision care benefits and claims, call VSP at 800.877.7195. Please be prepared with your Social Security number.

VSP brochures explaining how to submit claims for non-network vision care are available by calling the Benefits Office at 703.341.2016 (x2016). Send claims for non-network vision care to VSP at P.O. Box 997105, Sacramento, CA 95899-7105.

To locate VSP network providers, call VSP at 800.877.7195, or check the VSP website at *www.vsp.com*

Dental benefits through Aetna

For customer service on questions about dental plan benefits, claims, and precertification's, contact Aetna at 877.238.6200. Please be prepared with our group number (656135) and your Social Security number.

Aetna dental claim forms are available on the HR Home Page, Ceridian Self Self-Service website, Benefits Online website, or by calling the Benefits Office at 703.341.2016 (x2016). Send claims for non-network dental care to Aetna at P.O. Box 14094 Lexington, KY 40512-4094.

To locate dental providers who participate in the Aetna network, check the Aetna Doc-Find website, or call Aetna at 877.238.6200.

IMPORTANT REMINDERS AND NOTICES

As a participant in the BNA Group Health Program, you have some important obligations. We're reminding you of them here and again on the Benefits On-line website:

- You must notify the Benefits Office in writing within one month of any change that might affect your own or a covered dependent's eligibility for continued medical/dental coverage. This includes (but is not limited to) legal separations, divorces, termination of domestic partnerships, and changes in the status of children 26 and older that may occur during the year. **Failure to notify the Benefits Office may result in Bloomberg BNA's terminating the coverage of the plan participant and all eligible dependents and taking legal action against the plan participant to recover any losses.**
- You may enroll an eligible dependent for medical/dental coverage only within one month of a dependent's becoming eligible for coverage as a result of a Qualified Life Status Event or during open enrollment for a new plan year.
- You may make changes in your enrollment and/or contributions to the Dependent Care FSA and Health Care FSA only within one month of a qualified Life Status Event that is related to the change or during open enrollment for a new plan year.
- Any misstatements, misrepresentations, and/or omissions on your part related to health benefits may result in disciplinary action (up to and including termination) and action against you to recover any losses. This includes (but is not limited to) misrepresenting ineligible persons as your eligible dependents, submitting (or allowing others to submit) claims for services to persons who were not your eligible dependents on the date of service, and submitting (or allowing others to submit) claims for services that were not provided as submitted.

We enjoy excellent health care coverage at low cost to ourselves. Preserving this exceptional benefit requires each of us to be honest, ethical, and personally responsible for ensuring that Bloomberg BNA's health care dollars are spent properly.

IMPORTANT REMINDERS AND NOTICES

Women's Health and Cancer Rights Act

The **Women's Health and Cancer Rights Act of 1998** requires group health plans to make certain benefits are available to participants who have undergone a mastectomy. In particular, a plan must offer to mastectomy patients benefits for the following:

- 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
- Treatment of physical complications of the mastectomy, include lymphedema

Our plans comply with these requirements. Benefits for these items generally are comparable to those provided under our plans for similar types of medical services and supplies. Of course, the extent to which any of these items is appropriate following mastectomy is a matter to be determined by consultation between the attending physician and the patient. Our plan neither imposes penalties (for example, reducing or limiting reimbursements) nor provides incentives to induce attending providers to provide care inconsistent with these requirements.

If you would like more information about WHCRA-required coverage, please contact:

Sabrina Henderson
Manager, Benefits Administration & HRIS
Bloomberg BNA
1801 South Bell Street
Arlington, VA 22202
Phone: 703.341.2016
Email: shenderson@bna.com

IMPORTANT REMINDERS AND NOTICES

Medicaid and the Children's Health Insurance Program (CHIP) Offer Free or Low-Cost Health Coverage to Children and Families

If you are eligible for health coverage from your employer but are unable to afford the premiums, States have premium assistance programs that can help pay for coverage. States use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums.

If you or your dependents are already enrolled in Medicaid or CHIP, you can 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, you can 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, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employer's health plan is required to permit you and your dependents to enroll in the plan — as long as you and your dependents are eligible, but not already enrolled in the employer's plan. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance.**

To get started, make a free call to 1 877 KIDS NOW 1.877.543.7669). When you call our free and confidential hotline, you'll be connected directly to someone from your state who will help you apply. Families will need to complete an application and provide some documents. Depending on the state, you can complete the application through the mail, over the phone, or even online.

For more information on special enrollment rights, you can contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/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, Ext. 61565

OMB Control Number 1210-0137 (expires 09/30/2013)

IMPORTANT REMINDERS AND NOTICES

Notice of HIPAA Privacy Practices

Congress and the U.S. Department of Health & Human Services have implemented a law known as the **Health Insurance Portability and Accountability Act (HIPAA)**. Part of the law outlines our health plan's responsibility concerning the proper handling and protection of your Protected Health Information (PHI). This notice describes how your PHI may be used and disclosed, and how you can get access to it. **Please read this memo carefully and keep it where you can find it**.

Your privacy is a high priority for us. Your PHI will be treated with the highest degree of confidentiality. We are committed to maintaining the privacy of your information in accordance with state and federal laws.

We are required by law to:

- Maintain the privacy of your PHI.
- Provide to you this notice of our legal duties and privacy practices relating to your PHI.
- Abide by the terms of this notice.

Bloomberg BNA reserves the right to change the terms of the notice and to make the new notice provisions effective for all PHI that Bloomberg BNA maintains.

PROTECTED HEALTH INFORMATION (PHI)

State and federal laws protect information that can be used to identify you and which relates to your health care or your payment for health care. This is your Protected Health Information (PHI).

We may disclose or release your PHI in the following circumstances:

- **JUDICIAL AND ADMINISTRATIVE PROCEEDINGS**
  We may disclose your PHI in response to a court or administrative order. We may also disclose information in response to a subpoena, discovery request, or other lawful legal process. In these circumstances, we will make an effort to contact you regarding the request or to obtain an order or agreement protecting the information.
- **LAW ENFORCEMENT**
  We may release your PHI to law enforcement officials for the following purposes:
  - Pursuant to a court order, warrant, subpoena/summons, or administrative request
  - Identifying or locating a suspect, fugitive, material witness, or missing person
  - Regarding a crime victim, but only if the victim consents, or if the victim is unable to consent due to incapacity and the information is needed to determine if a crime has occurred; if nondisclosure would significantly hinder the investigation; and if disclosure is in the victim's best interest
  - Regarding a decedent, to alert law enforcement that the individual's death was caused by suspected criminal conduct
  - For reporting suspected criminal activity
- **CORONER, HEALTH CARE EXAMINERS, FUNERAL HOMES**
  We may release your PHI to a coroner, medical examiner, or funeral director. We may also release information to an organization involved in the donation of organs if you are an organ donor.

YOUR RIGHTS

You have the following rights regarding your Protected Health Information (PHI) at Bloomberg BNA:

- The right to receive notice of our policies and procedures used to protect your PHI
- The right to request that certain uses and disclosures of your PHI be restricted
- The right to request that your PHI be amended
- The right to obtain an accounting of certain disclosures by us of your PHI for the past six (6) years after April 13, 2003
- The right to revoke any prior authorizations for use or disclosure of your PHI, except to the extent that Bloomberg BNA has acted on your authorization
- The right to request the method by which your PHI is communicated

IMPORTANT REMINDERS AND NOTICES

OUR RIGHTS

- We have the right not to agree to your requested restrictions on the use of disclosure of your Protected Health Information (PHI). If we do agree to accept your requested restrictions, we will comply with your request, except as needed to provide you with emergency treatment.
- We have the right to deny your request to inspect or receive copies of your PHI in certain circumstances.
- We have the right to deny your request for amendment of PHI if it was not created by us, if it is not part of your PHI maintained by us, if it is not part of the information to which you have a right of access, or if it is already accurate and complete, as determined by us.

AUTHORIZATION

Uses and disclosures of your Protected Health Information (PHI) not allowed by law under this Notice of Privacy Practices will only be made with your authorization. You can revoke the authorization as described in your written authorization. If you revoke your authorization, we will no longer use or disclose your PHI for the purposes covered by the authorization, except where we have already relied on the authorization.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a written complaint with your Privacy Official. The Privacy Official will review and respond to you in a timely manner.

At any time, you may contact the Office of Civil Rights in the U.S. Department of Health and Human Services as follows:

Paul Cushing, Regional Manager
Office for Civil Rights
U.S. Department of Health and Human Services
150 S. Independence Mall West, Suite 372,
Public Ledger Building
Philadelphia, PA 19106-9111
Main Line: 215.861.4441
Hotline: 800.368.1019
FAX: 215.861.4431
TDD: 215.861.4440

You will not be retaliated against for filing a complaint.

CHANGE TO THIS NOTICE

Prompt revision and distribution of this notice will be made whenever there is a material change to the permitted uses or disclosures, your individual rights, our legal duties, or other privacy practices stated in this notice. Bloomberg BNA has the right to change this notice and to make the revised or new notice provisions effective for all Protected Health Information (PHI) already received and maintained by Bloomberg BNA, as well as for all PHI we receive in the future. A copy of the revised notice will be posted in a visible location within Bloomberg BNA. In addition, a copy of the revised notice will be provided to all employees.

CONTACT INFORMATION

If you have any questions about this notice or would like further information concerning your privacy rights, please contact:

Sabrina Henderson
HIPAA Privacy Official/Manager, Benefits Administration/HRIS
Bloomberg BNA
1801 South Bell Street
Arlington, VA 22202
Phone: 703.341.2016
Email: shenderson@bna.com

BENEFITS CONTACT INFORMATION

Below you will find important contact information for each of Bloomberg BNA's benefit providers. Once you are enrolled for benefits you can register online with each provider to perform a variety of activities, including:

- Search for Providers, Pharmacies, and Hospitals
- View Covered and Noncovered Services
- Order Additional ID Cards
- View Fund Balances and Satisfaction of Deductibles and OOPMs
- Review and Track Claims

BENEFIT	PROVIDER NAME	CONTACT INFORMATION	ONLINE REGISTRATION
Medical & Behavioral Health	**Aetna** Group Number: 656135	*www.aetna.com* Ph. 1.800.962.6842 **Claims Address:** P.O. Box 981106 El Paso, TX 79998-1103	Click **Register** and enter your Member ID Number (as it appears on your Aetna ID card).
Dental	**Aetna** Group Number: 656135	*www.aetna.com* Ph. 1.877.238.6200 **Claims Address:** P.O. Box 14094 Lexington, KY 40512-4094	Click **Register** and enter your Member ID Number (as it appears on your Aetna ID card).
Prescription Drug	**Medco/ Express Scripts** Group Number: 1305	*www.express-scripts.com* Ph. 1.800.711.0917 **Claims Address:** P.O. Box 14711 Lexington, KY 40512	Click **Create an Online Account**.
Vision	**Vision Service Plan (VSP)** Group Number: 12021314	*www.vsp.com* Ph. 1.800.877.7195 **Claims Address:** P.O. Box 997105 Sacramento, CA 95899-7105	Click **Register for a VSP.COM Account**.
Flexible Spending Account **Commuter & Transportation Benefits**	**HFS Benefits**	*www.hfsbenefits.com* Ph. 1.888.460.8005 **Claims:** Fax to 1.888.510.4218	Click **Participant Login** and then **Register**. Initial PIN when logging in for the first time is 2216.
Employee Assistance Program	**Aetna**	*www.aetnaeap.com*	Login: Aetna EAP Company ID: BNAEAP99
401(k) Plan	**Charles Schwab/ PSA Financial**	*www.retirementinfo.net*	User ID: SSN Password: Last 4 digits of SSN

BENEFITS CONTACT INFORMATION

Benefits Team:

Name	Title	Email	Phone
Karen Fisher	Manager, Benefits	karen.fisher@bna.com	703.341.2009 (x2009)
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GLOSSARY

Alternative Benefit Base (ABB)	The ABB is the basis for calculating the Aetna out-of-pocket copayment maximum for Sales representatives, retirees, and "COBRA and other" plan participants. It is also used for calculating the amount of long-term disability and life insurance coverage of Sales representatives.
Bundled Benefits	Employees enrolled in the Aetna POS II medical plan are also automatically enrolled in the Medco prescription benefits, Aetna behavioral health, and VSP routine vision care.
Case management*	This is the way health plans help people with complex care needs. Case managers help coordinate care to help people improve their health.
Claim*	This is a request to be paid by a health plan for health services given. An example would be the claim your doctor sends to your health plan for an office visit. It is also a request for payment under a disability or life insurance plan.
COBRA (Consolidated Omnibus Budget Reconciliation Act of 1986)*	This law allows you to continue your health plan coverage for a limited time. It is often used after people lose their job or become divorced. If you choose this option, you will pay the cost of coverage. Small employers with less than 20 workers are not subject to this law.
Coinsurance*	This is the percentage of health care expenses you pay after your deductible. Your health plan pays the rest up to any benefit or lifetime maximum.
Copay*	This is the dollar amount you pay for health care expenses. For example, you pay a set dollar amount to your doctor for an office visit. So, if your copay is $25, you pay that amount when you go to your doctor. Copays are also used for some hospital outpatient care services in the Original Medicare plan. In prescription drug plans, it is the amount you pay for covered drugs.
Customary and Reasonable*	A limit on the amount your health plan will pay. Also called "usual, customary, and reasonable (UCR)," "reasonable" or "prevailing" charge.
Deductible*	The amount you pay for covered services before your health plan begins to pay.
Disease management*	This is a type of program that comes with some health plans. It is used to help people who live with a chronic illness. It helps members manage their health and prevent future problems.
Effective date*	This is the date your health plan becomes active. Your coverage starts on this day.
Eligible Expenses*	Medical expenses for which a health insurance policy will provide benefits.
Emergency*	This is a serious illness or injury. It comes on suddenly. It is something that needs immediate medical care. If a person does not get care quickly, death or serious health problems may occur.
Employee Assistance Program (EAP)*	This can help people balance work and life issues. It gives support and counseling to help people deal with stress, family issues, and more. The program is for employees, their dependents, and household members. Employers buy it. Workers do not pay to use an EAP.

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Explanation of Benefits (EOB)*	A description, sent to patients by health plans, of benefits received and services for which the health care provider has requested payment.
Extend Health	A leading coordinator of supplemental health benefits to Medicare participants. Medicare-eligible retirees and their Medicare-eligible dependents can access the supplemental health care insurance market. They provide personalized assistance to help Medicare participants purchase their supplemental medical coverage.
Flexible Spending Account (FSA)*	This is a way workers can set aside money to help pay for health and dependent care. The worker asks for money to be taken from his or her pay each pay period. This money is not taxed in most states. The money goes into a fund the worker can use to pay for different health and dependent care expenses. All money must be used by the end of the stated year or it will be lost. This money cannot be transferred to another job or account.
Health Insurance Portability and Accountability Act (HIPAA)*	This is a federal law. It limits rules a group health plan can place on benefits for pre-existing health problems. It was passed to give people access to quality health care coverage when they switch jobs. This law does not let group health plans charge higher rates because of a person's prior health status. It can also limit rules on some individual health plans. The law also helps protect private health information. It sets national standards for handling private health records.
In network*	This means health plan has a contract with that doctor or other health care provider. They negotiate reduced rates with them to help you save money. Your out-of-pocket costs are lower when you stay in network. There are other benefits to using doctors in network. They won't bill you for the difference between their standard rates and the rate they've agreed to with us. All you have to pay is your coinsurance or copay, along with any deductible. And network doctors will handle any precertification your plan requires.
Lifetime maximum*	This is the total dollar amount of benefits you can receive. It can also be the total number of services you can receive. These totals are limits for a lifetime, not just for a plan year. Plans subject to Federal health care reform can only have lifetime dollar maximums on nonessential benefits.
Mail-order pharmacy*	People can get prescription drugs through the mail with this. Members can save time and money using it by getting a three-month supply all at once.
Maintenance medications*	These are prescription drugs that people take on a regular basis. These drugs help treat chronic conditions. These drugs include ones for asthma, diabetes, high blood pressure, and other health conditions. Buying them through a mail-order pharmacy can save money.
Medicare Part A*	This is part of the original Medicare plan. It is managed by the federal government. It covers some, but not all, expenses for: inpatient care at a hospital, medical care at a skilled nursing facility, hospice care, or home health care.
Medicare Part B*	This is part of the original Medicare plan managed by the federal government. People sign up for this plan. They usually pay a monthly premium for the plan. It covers: necessary services from doctors and outpatient care from a hospital.

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Network*	A network is a group of health care providers. It includes doctors, dentists, and hospitals. The health care providers in the network sign a contract with a health plan to provide services. Usually, the network provides services at a special rate. With some health plans, people get more coverage when they get care in the network.
Nonparticipating provider*	This is a health care provider who does not have a contract with a health plan. People might pay more when they visit this kind of doctor, hospital, or other health care professional. This may also be referred to as "out of network" or "nonpreferred."
Out of network*	This means the health plan does not have a contract for reduced rates with a doctor. They don't know exactly what an out-of-network doctor will charge you. If you choose a doctor or other health care provider who is out of network, your health plan may pay some of that doctor's bill. But it will pay less than if you get care from a doctor in our network. You will pay more money if you decide to use a doctor that is not in our network.
Out-of-pocket costs*	These are medical costs that a member must pay. Copays and deductibles are examples.
Out-of-pocket maximum*	This is a limit on the costs a health plan member must pay for covered services. The limit can be yearly or a dollar amount.
Participating provider*	This is a doctor, hospital, or other health care provider. The provider signs a contract with a health plan. The provider is part of the plan's network for covered services. People may pay less when they visit this type of provider.
Plan maximum*	This is a limit on the dollar amount of benefits a health plan will play.
Precertification*	This is an important process. It is approval a person gets for care before he or she receives the care. This helps people know if the care is covered by a health plan.
Premium*	This is the amount paid to a health plan company for coverage. The cost is shared between the person and the employer.
Preventive care*	This type of care is often covered in a health plan. It includes programs or services that can help people prevent disease. It may include yearly exams, shots, and tests for some diseases. The tests are sometimes called screenings.
Primary care physician (PCP)*	This is a doctor who is part of a health plan's network. He or she is a patient's main contact for care. PCPs give referrals for other care. They coordinate care their patients get from specialists or other care facilities. In some health plans, a person must choose a PCP to coordinate care.
Qualifying event*	This is an event that lets a member change his or her health benefits. Examples include death, job loss, divorce, and marriage.
Reasonable charge*	A limit on the amount your health plan will pay. Also called "usual, customary, and reasonable (UCR)," "customary and reasonable" or "prevailing" charge. The limit is based on data the health plan receives. The data is based on what doctors' charge for the health care service.

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Recognized charge*	A limit on the amount your health plan will pay. Also called the "allowed amount." If you choose to go out of network, your provider may not accept this amount as payment in full and may bill you for the rest. This is in addition to your plan's required copays and deductibles.
Service area*	This is an area served by a health plan. It is where the plan is licensed to accept members. It is also where a network of doctors exists to give health care services.
Specialist*	A physician who concentrates on medical activities in a particular specialty of medicine, based on education and qualifications.
Spousal Surcharge	This is the amount an employee pays to have their spouse or domestic partner on our health plan, when the spouse/domestic partner has access to health coverage at their employer.
Uncovered services*	These are also called "exclusions." They are specific conditions or services that are not covered under a health plan. They are listed in the plan documents.
Well baby care*	This is the routine care a child needs through the age of eight. It includes checkups, tests, and shots.
Well woman care*	This is the regular care a woman needs. It includes checkups with the Ob/Gyn and regular pregnancy care.
Urgent care*	Urgent care is not the same as emergency care. It is for a sudden illness or injury that is not life threatening. But care still needs to be given quickly so the person does not develop more serious pain or problems.

***Definitions are from the Aetna Glossary** — *http://www.aetna.com/glossary-aetna/glossaryA.html*

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