Summary of Benefits

Below you'll find our initial recommendations based on our best understanding of your needs. Once you have a chance to review this proposal, we look forward to discussing what modifications we can make to deliver the right solution for your company.

PPO Medical Summary of Benefits

On-shore Contract Situs
Global Assignee Plan
Proposed Policy Year: 01/01/2020 through 12/31/2020

Eligibility Provision	
Employee	Regular full-time employees participating in this plan working a minimum of 25 hours per week.
Dependent	Spouse, domestic partner; children up to age 26, regardless of student status

PPO Medical			
PLAN FEATURES	**Outside the U.S.**	**Inside the U.S.**	
		Preferred Benefits (In-Network)	**Non-Preferred Benefits (Out-of-Network)**
Individual Deductible	$1,500 per calendar year	$750 per calendar year	$1,500 per calendar year
Family Deductible	$4,500 per calendar year	$2,250 per calendar year	$4,500 per calendar year
Prior Plan Credit	Prior plan credit accrued within the last calendar year from previous carrier applies to the current year		
Individual Payment Limit	$7,500 per calendar year	$3,500 per calendar year	$7,500 per calendar year
(Does not include precertification penalty. Includes Outpatient Prescription Drugs when outside the US)			
Family Payment Limit	$15,000 per calendar year	$7,000 per calendar year	$15,000 per calendar year
(Does not include precertification penalty. Includes Outpatient Prescription Drugs when outside the US)			
Lifetime Maximum	Unlimited		

PPO Medical			
PLAN FEATURES	**Outside the U.S.**	**Inside the U.S.**	
		Preferred Benefits (In-Network)	**Non-Preferred Benefits (Out-of-Network)**
Hospital Services			
Inpatient	40% after deductible	20% after deductible	40% after deductible
Outpatient	40% after deductible	20% after deductible	40% after deductible
Private Room Limit	The institution's semiprivate rate		
Pre-certification Penalty	No Penalty	No Penalty	$400
Pre-Certification for certain types of Non-Preferred care received inside the U.S. must be obtained to avoid a reduction in benefits paid for that care. Pre-Certification for Hospital Admissions, Treatment Facility Admissions, Convalescent Facility Admissions, Home Health Care and Hospice Care is required — excluded amount applied separately to each type of expense. Contact the service center to determine if pre-certification is needed for a procedure.			
Non-Emergency Use of the Emergency Room	20% after deductible	Not Covered	Not Covered
Emergency Room	20% after deductible	20% after $150 copay	20% after $150 copay
Urgent Care	40% after deductible	No charge after $75 copay	40% after deductible
Physician Services			
Physician Office Visit	40% after deductible	No charge after $25 copay	40% after deductible
Specialist Office Visit	40% after deductible	No charge after $45 copay	40% after deductible
Mental Health Services			
Mental Health Inpatient Coverage Unlimited days per calendar year	40% after deductible	20% after deductible	40% after deductible
Mental Health Outpatient Coverage Unlimited days per calendar year	40% after deductible	No charge after $25 copay	40% after deductible
Alcohol/Drug Abuse Services			
Substance Abuse Inpatient Coverage Unlimited days per calendar year	40% after deductible	20% after deductible	40% after deductible
Substance Abuse Outpatient Coverage Unlimited days per calendar year	40% after deductible	No charge after $25 copay	40% after deductible

PPO Medical			
PLAN FEATURES	**Outside the U.S.**	**Inside the U.S.**	
		Preferred Benefits (In-Network)	**Non-Preferred Benefits (Out-of-Network)**
Prescription Drug Coverage			
Generic Drugs (365 day maximum supply)	40% after deductible	$15 copay per month supply (includes Mail Order Drugs)	40% after deductible
Formulary Brand Name Drugs (365 day maximum supply)	40% after deductible	$40 copay per month supply (includes Mail Order Drugs)	40% after deductible
Non Formulary Generic and Brand Name Drugs (365 day maximum supply)	40% after deductible	$60 copay per month supply (includes Mail Order Drugs)	40% after deductible
Specialty Drugs (365 day maximum supply)	40% after deductible	30% copay per month supply up to $150 maximum	40% after deductible
Other Services			
Employee Assistance Program (EAP)	Included	Included	Included
Includes up to five counseling sessions per issue per year per enrolled member. Access benefits by calling the member service number on ID card: 800-231-7729 or collect 813-775-0190. Services include: Cultural adjustment assistance, Marital/Family Stress, Child care and behavioral concerns, Social adaptation needs, Alcohol/Substance Abuse, Work/Life Balance and Depression.			
Preventive Benefits			
Routine Children Physical Exams	40% after deductible	No charge	40% after deductible
Seven exams in the first 12 months of life, three exams in the second 12 months of life, three exams in the third 12 months of life, one exam per 12 months thereafter to age 22 (includes immunizations)			
Routine Adult Physical Exams	40% after deductible Up to $1,000 calendar year maximum	No charge	40% after deductible
Adults age 22+ & -65: One exam/12 months *Adults age 65+:* One exam/12 months includes immunizations			
Routine Gynecological Exams	40% after deductible	No charge	40% after deductible
Includes one exam and pap smear per calendar year			
Routine Mammograms	40% after deductible	No charge	40% after deductible
Prostate Specific Antigen (PSA)	40% after deductible	No charge	40% after deductible
Routine Digital Rectal Exam (DRE)	40% after deductible	No charge	40% after deductible
Colorectal Cancer Screening	40% after deductible	No charge	40% after deductible
Recommended: For all members age 50 and older.			

PPO Medical			
PLAN FEATURES	**Outside the U.S.**	**Inside the U.S.**	
		Preferred Benefits (In-Network)	**Non-Preferred Benefits (Out-of-Network)**
Preventive Benefits			
Routine Hearing Exam	40% after deductible	No charge	40% after deductible
Includes one routine exam every 24 months.			
Hearing Aids	40% after deductible	20% after deductible	40% after deductible
One hearing aid per ear to $1,000 maximum per ear every three years for child to age 24			
Vision Care			
Routine Eye Exam	40% after deductible	No charge	40% after deductible
(Covered under medical) Includes one routine exam every 12 months			
Vision Care Supplies	No charge up to $150 maximum	No charge up to $150 maximum	No charge up to $150 maximum
Schedule maximums apply every 12 months			
Other Services			
Skilled Nursing Facility (120 days per calendar year)	40% after deductible	20% after deductible	40% after deductible
Hospice Care Facility Inpatient (30 days lifetime maximum)	40% after deductible	20% after deductible	40% after deductible
Hospice Care Facility Outpatient (Unlimited lifetime maximum)	40% after deductible	20% after deductible	40% after deductible
Home Health Care (120 visits per calendar year combined, includes Private Duty Nursing)	40% after deductible	20% after deductible	40% after deductible
Acupuncture	40% after deductible	No charge after $45 copay	40% after deductible
Spinal Disorder Treatment (Unlimited visits per calendar year)	25% after deductible	No charge after $10 copay	25% after deductible
Short Term Rehabilitation	25% after deductible	No charge after $10 copay	25% after deductible
(Includes coverage for Occupational, Physical, and Massage Therapies; Unlimited visits per calendar year)			
Speech Therapy *(60 visits per calendar year)*	40% after deductible	No charge after $45 copay	40% after deductible

PPO Medical			
PLAN FEATURES	**Outside the U.S.**	**Inside the U.S.**	
		Preferred Benefits (In-Network)	**Non-Preferred Benefits (Out-of-Network)**
Other Services			
Diagnostic Outpatient X-ray	40% after deductible	20% after deductible	40% after deductible
Diagnostic Outpatient Lab	40% after deductible	20% after deductible	40% after deductible
Base Infertility Services (Base plan coverage includes coverage limited to the testing and treatment of underlying condition)	40% after deductible	20% after deductible	40% after deductible
Comprehensive Infertility Services (6 cycles per lifetime for Comprehensive plan coverage which includes coverage for Artificial Insemination and Ovulation Induction.)	40% after deductible	20% after deductible	40% after deductible
ART Infertility Services (6 cycles per lifetime for Advanced Reproductive Technology (ART) coverage with cryopreservation, storage and unlimited embryo transfers).	40% after deductible	20% after deductible	40% after deductible
Autism	*Autism covered same as any other expense.* Member cost sharing is based on the type of service performed and the place of service where it is rendered.		
Payment for Non-Preferred Providers*	Not Applicable	Not Applicable	Professional: 105% of Medicare Facility: 140% of Medicare

Service and Programs Included in Your Quote

24-Hour Nurse Line

- Provides 24-hour telephone, email and chat access to experienced registered clinicians to help members make informed health care decisions

Employee Assistance Program (EAP)

- Includes up to 5 counseling sessions per issue per year per enrolled member. Services include: Cultural adjustment assistance, marital/family stress, childcare and behavioral concerns, social adoption needs, alcohol/substance abuse, work/life balance and depression. Access benefits by calling the member service number on ID card: 800-231-7729 or collect 813-775-0190

Emergency Assistance Services

- Supports members during a medical emergency with necessary resources and personalized care. If a medical evacuation is needed, our in-house team focuses on getting members proper care in the most efficient way

In Touch Care

- Delivers consistent and continuous care to members by working one-on-one with our CARE team clinicians to address both chronic and acute conditions holistically

International Maternity Management Program

- Offers resources and personalized tools throughout pregnancy, delivery and post-partum care, delivered by our dedicated CARE team

Teladoc® • Gives members access to a national network of certified physicians right at their fingertips, through phone and online-video consultations
Health Assessments • Provides a personal health risk assessment and online wellness programs that address convenient ways to help members make healthy choices

Medical Plan Caveats

This plan includes coverage for women's preventive and other preventive health benefits to the extent required under the Affordable care act beginning with plan years starting on or after August 1, 2012. For plan years effective on or after January 1, 2017, this plan also includes coverage for benefits in accordance with the nondiscrimination provisions under Section 1557 of the Affordable Care Act.

Payment limits apply per individual on a calendar year basis. Only those out-of-pocket expenses resulting from the application of a payment percentage, deductibles and copays may be used to satisfy the payment limit. Precertification penalty are excluded from the payment limit.

There is cross-application between calendar year deductible, out of pocket maximum and lifetime maximum across overseas, in-network and out-of network level of benefits.

Coverage maximums up to a certain number of days/visits per calendar year are reached by combining the Preferred and Non-Preferred benefits up to the limit for either one plan or the other, but not both. (Example, if the Preferred benefit is for 120 days and the Non-Preferred benefit is for 120 days, the maximum benefit is 120 days, not 240 days).

In-Network - deductible and coinsurance may apply to pap smears, DRE tests and PSA tests if billed by an independent laboratory provider.

Maternity expenses are covered as any other medical expense. Coverage is provided for an employee and eligible dependents. Pregnancy benefits do not continue to be payable after coverage ends except in the event of total disability.

For contracted hospitals, the non-contracted Radiologist, Anesthesiologist and Pathologist (RAPS) are paid at the preferred level, and will be subject to reasonable and customary charges. Note that this payment method may apply to other providers.

Copayments and coinsurance for chiropractic visits are capped at 25% of the amount due to the chiropractor.

* Payment for Non-Preferred Providers

We cover the cost of care differently based on whether health care providers, such as doctors and hospitals, are "in network" or "out of network." We want to help you understand how much Aetna pays for your out-of-network care. At the same time, we want to make it clear how much more you will need to pay for this out-of-network care.

As an example, you may choose a doctor in our network. You may choose to visit an out-of-network doctor. If you choose a doctor who is out of network, your Aetna health plan may pay some of that doctor's bill. Most of the time, you will pay a lot more money out of your own pocket if you choose to use an out-of-network doctor or hospital.

When you choose out-of-network care, Aetna limits the amount it will pay. This limit is called the "recognized" or "allowed" amount. When you choose out-of-network care, Aetna "recognizes" an amount based on what Medicare pays for these services. The government sets the Medicare rate. Exactly how much Aetna "recognizes" depends on the plan you or your employer picks.

Your out-of-network doctor sets the rate to charge you. It may be higher -- sometimes much higher -- than what your Aetna plan "recognizes" or "allows." Your doctor may bill you for the dollar amount that Aetna doesn't recognize. You must also pay any copayments, coinsurance and deductibles under your plan. No dollar amount above the recognized charge counts toward your deductible or maximum out-of-pocket. To learn more about how we pay out-of-network benefits visit Aetna.com. Type "how Aetna pays" in the search box.

You can avoid these extra costs by getting your care from Aetna's broad network of health care providers. Go to ***www.aetna.com*** and click on "Find a Doctor" on the left side of the page. If you are already a member, sign on to your Aetna Navigator member site.
This way of paying out-of-network doctors and hospitals applies when you choose to get care out of network. When you have no choice (for example: emergency room visit after a car accident), we will pay the bill as if you got care in network. You pay your plan's copayments, coinsurance and deductibles for your in-network level of benefits. Contact Aetna if your provider asks you to pay more. You are not responsible for any outstanding balance billed by your providers for emergency services beyond your copayments, coinsurance and deductibles.

The proposed plan of benefits is underwritten by Aetna Life Insurance Company (Delaware).

This is only a brief summary of the PPO Medical benefits available. Some restrictions may apply.

For more specific information about the coverage details, **including limitations, exclusions and other plan requirements**, please refer to the employee booklet (which will be provided near the time the plan becomes effective).