

# 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: 01/01/2019 through 12/31/2019

Eligibility Provision	
<b>Employee</b>	Regular full-time employees participating in this plan working a minimum of 25 hours per week.
<b>Dependent</b>	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)
<b>Individual Deductible</b>	\$2,000 per calendar year	\$1,000 per calendar year	\$2,000 per calendar year
<b>Family Deductible</b>	\$6,000 per calendar year	\$3,000 per calendar year	\$6,000 per calendar year
<b>Prior Plan Credit</b>	Prior plan credit accrued within the last calendar year from previous carrier applies to the current year		
<b>Individual Payment Limit</b>	\$8,000 per calendar year	\$4,000 per calendar year	\$8,000 per calendar year
	(Does not include precertification penalty. Includes Outpatient Prescription Drugs when outside the US)		
<b>Family Payment Limit</b>	\$16,000 per calendar year	\$8,000 per calendar year	\$16,000 per calendar year
	(Does not include precertification penalty. Includes Outpatient Prescription Drugs when outside the US)		
<b>Lifetime Maximum</b>	Unlimited		

## PPO Medical

PLAN FEATURES	Outside the U.S.	Preferred Benefits (In-Network)	Inside the U.S. Non-Preferred Benefits (Out-of-Network)
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### Hospital Services

<b>Inpatient</b>	40% after deductible	20% after deductible	40% after deductible
<b>Outpatient</b>	40% after deductible	20% after deductible	40% after deductible
<b>Private Room Limit</b>	The institution's semiprivate rate		
<b>Pre-certification Penalty</b>	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.*

<b>Non-Emergency Use of the Emergency Room</b>	20% after deductible	Not Covered	Not Covered
<b>Emergency Room</b>	20% after deductible	20% after \$150 copay	20% after \$150 copay
<b>Urgent Care</b>	40% after deductible	No charge after \$75 copay	40% after deductible

### Physician Services

<b>Physician Office Visit</b>	40% after deductible	No charge after \$25 copay	40% after deductible
<b>Specialist Office Visit</b>	40% after deductible	No charge after \$45 copay	40% after deductible

### Mental Health Services

<b>Mental Health Inpatient Coverage</b> Unlimited days per calendar year	40% after deductible	20% after deductible	40% after deductible
<b>Mental Health Outpatient Coverage</b> Unlimited days per calendar year	40% after deductible	No charge after \$25 copay	40% after deductible

### Alcohol/Drug Abuse Services

<b>Substance Abuse Inpatient Coverage</b> Unlimited days per calendar year	40% after deductible	20% after deductible	40% after deductible
<b>Substance Abuse Outpatient Coverage</b> 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

	Outside the U.S.	Preferred Benefits (In-Network)	Non-Preferred Benefits (Out-of-Network)
<b>Generic Drugs</b> (365 day maximum supply)	40% after deductible	\$15 copay per month supply (includes Mail Order Drugs)	40% after deductible
<b>Formulary Brand Name Drugs</b> (365 day maximum supply)	40% after deductible	\$40 copay per month supply (includes Mail Order Drugs)	40% after deductible
<b>Non Formulary Generic and Brand Name Drugs</b> (365 day maximum supply)	40% after deductible	\$60 copay per month supply (includes Mail Order Drugs)	40% after deductible
<b>Specialty Drugs</b> (365 day maximum supply)	40% after deductible	30% copay per month supply up to \$150 maximum	40% after deductible

### Other Services

#### International Employee Assistance Program (IEAP)

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

Recommended: For all members  
age 50 and older.

40% after deductible

No charge

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)
<b>Preventive Benefits</b>			
<b>Routine Hearing Exam</b> Includes one routine exam every 24 months.	40% after deductible	No charge	40% after deductible
<b>Hearing Aids</b> One hearing aid per ear to \$1,000 maximum per ear every three years for child to age 24	40% after deductible	20% after deductible	40% after deductible
<b>Vision Care</b>			
<b>Routine Eye Exam</b> (Covered under medical) Includes one routine exam every 12 months	40% after deductible	No charge	40% after deductible
<b>Vision Care Supplies</b> Schedule maximums apply every 12 months	No charge up to \$150 maximum	No charge up to \$150 maximum	No charge up to \$150 maximum
<b>Other Services</b>			
<b>Skilled Nursing Facility</b> (120 days per calendar year)	40% after deductible	20% after deductible	40% after deductible
<b>Hospice Care Facility Inpatient</b> (30 days lifetime maximum)	40% after deductible	20% after deductible	40% after deductible
<b>Hospice Care Facility Outpatient</b> (Unlimited lifetime maximum)	40% after deductible	20% after deductible	40% after deductible
<b>Home Health Care</b> (120 visits per calendar year combined, includes Private Duty Nursing)	40% after deductible	20% after deductible	40% after deductible
<b>Acupuncture</b>	40% after deductible	No charge after \$45 copay	40% after deductible
<b>Spinal Disorder Treatment</b> (Unlimited visits per calendar year)	25% after deductible	No charge after \$45 copay	25% after deductible
<b>Short Term Rehabilitation</b> (Includes coverage for Occupational, Physical, Speech and Massage Therapies; 60 visits combined maximum 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)
<b>Other Services</b>			
<b>Diagnostic Outpatient X-ray</b>	40% after deductible	20% after deductible	40% after deductible
<b>Diagnostic Outpatient Lab</b>	40% after deductible	20% after deductible	40% after deductible
<b>Base Infertility Services</b>	40% after deductible	20% after deductible	40% after deductible
(Base plan coverage includes coverage limited to the testing and treatment of underlying condition)			
<b>Comprehensive Infertility Services</b>	40% after deductible	20% after deductible	40% after deductible
(Comprehensive plan coverage includes coverage for Artificial Insemination and Ovulation Induction)			
<b>ART Infertility Services</b>	40% after deductible	20% after deductible	40% after deductible
(6 cycles per lifetime for Advanced Reproductive Technology (ART) coverage with cryopreservation, storage and unlimited embryo transfers).			
<b>Autism</b>	<i>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.</i>		
<b>Payment for Non-Preferred Providers*</b>	Not Applicable	Not Applicable	Professional: 105% of Medicare Facility: 140% of Medicare

## Services and Programs included in Quote

**Informed Health Line (24-hour nurse line)**  
**International Disease Management**  
**International Maternity Management Program**  
**Simple Steps To A Healthier Life®**  
**Wellness Checkpoint**

## 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](http://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](http://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).