aetna

Group Insurance Plan of Benefits for
Group Health & Life Insurance Trust Fund (Control # 840366)
administered by Aetna International®
Effective Date: January 1, 2018

Eligibility Provision			
Employee	Regular full-time employees of an employer participating in this plan working a minimum of 25 hours per week.		
Dependent	Spouse, same or opposite sex domestic partner; children up to age 26, regardless of student status		
PPO – Low Option			
		In the CNMI and Guam only	
PLAN FEATURES	**OUTSIDE CNMI and Guam Excluding the U.S.**	**Preferred Benefits (In-Network) (For CNMI and Guam only)**	**Non-Preferred Benefits (Out-of-Network) (For CNMI and Guam only)**
Individual Deductible	None	$500 per calendar year	Not Covered
Family Deductible	None	$1,500 per calendar year	Not Covered
Prior Plan Credit	Prior plan credit accrued within the first two months of the current year from January through February applies to the following months of the current year		
Individual Payment Limit	$5,000 per calendar year	$5,000 per calendar year	Not Covered
(Does not include precertification penalty. Includes Outpatient Prescription Drugs when outside the U.S. Includes deductible, copays, 50% items and Outpatient Prescription Drugs when inside the U.S. in the network)			
Family Payment Limit	$10,000 per calendar year	$10,000 per calendar year	Not Covered
(Does not include precertification penalty. Includes Outpatient Prescription Drugs when outside the U.S. Includes deductible, copays, 50% items and Outpatient Prescription Drugs when inside the U.S. in the network)			
Lifetime Maximum	Unlimited		
Member Payment Percentages			
Hospital Services			
Inpatient	20%	20% after deductible	Not Covered
Outpatient	20%	20% after deductible	Not Covered
Private Room Limit	The institution's semiprivate rate.		
Pre-certification Penalty	No Penalty	No Penalty	Not Covered
Non-Emergency Use of the Emergency Room	20%	50% after deductible	Not Covered
Emergency Use of the Emergency Room	20%	20% after deductible	20% after deductible
Non-Urgent Use of Urgent Care Provider	20%	Not Covered	Not Covered
Urgent Care	20%	20% after deductible	Not Covered
Inpatient Maternity Coverage	20%	20% after deductible	Not Covered
Physician Services			
Physician Office Visit	20%	20% after deductible	Not Covered
Specialist Office Visit	20%	20% after deductible	Not Covered
Allergy Testing & Treatment	20%	20% after deductible	Not Covered
Allergy Serum & Injection	20%	20% after deductible	Not Covered

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Mental Health Services			
Mental Health Inpatient Coverage *Unlimited days per calendar year*	20%	20% after deductible	Not Covered
Mental Health Outpatient Coverage *Unlimited visits per calendar year*	20%	20% after deductible	Not Covered
Alcohol/Drug Abuse Services			
Substance Abuse Inpatient Coverage *Unlimited days per calendar year*	20%	20% after deductible	Not Covered
Substance Abuse Outpatient Coverage *Unlimited visits per calendar year*	20%	20% after deductible	Not Covered
Prescription Drug Coverage			
Generic Drugs *(365 day maximum supply)*	20%	20% (includes Mail Order Drugs)	Not Covered
Formulary Brand Name Drugs *(365 day maximum supply)*	20%	20% (includes Mail Order Drugs)	Not Covered
Non Formulary Brand Name Drugs *(365 day maximum supply)*	20%	50% (includes Mail Order Drugs)	Not Covered
Other Services			
International Employee Assistance Program (IEAP) *Includes up to 5 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.*	Included	Included	Not Covered

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Other Services			
Skilled Nursing Facility *(60 Days per calendar year per calendar year)*	20%	20% after deductible	Not Covered
Hospice Care Facility Inpatient *(30 Days lifetime maximum)*	20%	20% after deductible	Not Covered
Hospice Care Facility Outpatient *(Unlimited lifetime maximum)*	20%	20% after deductible	Not Covered
Durable Medical Equipment *(Unlimited calendar year maximum)*	20%	20% after deductible	Not Covered
Home Health Care *(150 visits combined, includes Private Duty Nursing per calendar year)*	20%	20% after deductible	Not Covered
Spinal Disorder Treatment *(15 visits per calendar year)*	20%	20% after deductible	Not Covered
Short-Term Rehabilitation *(Includes coverage for Occupational, Physical and Speech Therapies; 20 Visits combined maximum visits per calendar year)*	20%	20% after deductible	Not Covered
Diagnostic Outpatient X-ray and Lab	20%	20% after deductible	Not Covered
Base Infertility Services *(Base plan coverage includes coverage limited to the testing and treatment of underlying condition)*	20%	20% after deductible	Not Covered
Payment for Non-Preferred Providers*	Not Applicable	Not Applicable	Professional: 105% of Medicare Facility: 140% of Medicare

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Wellness Benefits			
Routine Children Physical Exams	No charge	No charge	Not Covered
7 exams in the first 12 months of life, 3 exams in the second 12 months of life, 3 exams in the third 12 months of life, 1 exam per 12 months thereafter to age 22 (includes immunizations)			
Routine Adult Physical Exams	No charge	No charge	Not Covered
Adults age 22-65 and 65+: 1 exam every 12 months			
Routine Gynecological Exams	No charge	No charge	Not Covered
Includes 1 exam and pap smear per calendar year			
Mammograms	No charge	No charge	Not Covered
(Unlimited visits per calendar year)			
Prostate Specific Antigen (PSA)	No charge	No charge	Not Covered
Includes 1 PSA per calendar year for males 40+			
Digital Rectal Exam (DRE)	No charge	No charge	Not Covered
Includes 1 DRE per calendar year for males 40+			
Cancer Screening	No charge	No charge	Not Covered
Includes 1 flex sigmoid and double barium contrast every 5 years; and at age 50+ 1 colonoscopy every 10 years			
Routine Hearing Exam	No charge	No charge	Not Covered
Includes one routine exam every 24 months.			
Hearing Aids	20%	20% after deductible	Not Covered
1 hearing aid per ear to $750 maximum per ear every 5 years			
Vision Care			
Routine Eye Exam	No charge	No charge	Not Covered
(Covered under medical) Includes one routine exam every 24 months			
Services and Program			
Informed Health Line (24-hour nurse line) **International Disease Management** **International Maternity Management Program** **Wellness Checkpoint** **red24 - Includes security, political & natural disaster coverage** *(Program is underwritten by Aetna Life & Casualty (Bermuda) Ltd.)*			

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Medical Plan Caveats

This plan includes coverage under the extent required in accordance with the Federal Mental Health Parity and Addiction Equity Act (MHPAEA) beginning with plan years starting on or after January 1, 2018.

This plan includes coverage for women's preventive health benefits to the extent required under U.S. federal law effective beginning with plan years starting on or after August 1, 2012.

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).

Maternity expenses are covered as any other medical expense. Coverage is provided for an employee and spouse and all female family members 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.

*** 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.

*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).*

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For Plans Compliant with United States Federal Affordable Care Act (ACA) legislation
Aetna complies with applicable Federal civil rights laws and does not discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, or disability.

Aetna provides free aids/services to people with disabilities and to people who need language assistance.

If you need a qualified interpreter, written information in other formats, translation or other services, call the number on your ID card.

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:
Civil Rights Coordinator, P.O. Box 14462, Lexington, KY 40512 (CA HMO customers: PO Box 24030 Fresno, CA 93779), 1-800-648-7817, TTY: 711, Fax: 859-425-3379 (CA HMO customers: 860-262-7705), CRCoordinator@aetna.com.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, or at 1-800-368-1019, 800-537-7697 (TDD).

Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company, Coventry Health Care plans and their affiliates (Aetna).

TTY: 711

English	**To access language services at no cost to you, call the number on your ID card.**
Spanish	Para acceder a los servicios lingüísticos sin costo alguno, llame al número que figura en su tarjeta de identificación.
Chinese Traditional	如欲使用免費語言服務，請撥打您健康保險卡上所列的電話號碼
Arabic	للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء الاتصال على الرقم الموجود على بطاقة اشتراكك.
French	Pour accéder gratuitement aux services linguistiques, veuillez composer le numéro indiqué sur votre carte d'assurance santé.
French Creole (Haitian)	Pou ou jwenn sèvis gratis nan lang ou, rele nimewo telefòn ki sou kat idantifikasyon asirans sante ou.
German	Um auf den für Sie kostenlosen Sprachservice auf Deutsch zuzugreifen, rufen Sie die Nummer auf Ihrer ID-Karte an.
Italian	Per accedere ai servizi linguistici senza alcun costo per lei, chiami il numero sulla tessera identificativa.
Japanese	無料の言語サービスは、IDカードにある番号にお電話ください。
Korean	무료 다국어 서비스를 이용하려면 보험 ID 카드에 수록된 번호로 전화해 주십시오.
Persian Farsi	**برای دسترسی به خدمات زبان به طور رایگان، با شماره قید شده روی کارت شناسایی خود تماس بگیرید.**
Polish	Aby uzyskać dostęp do bezpłatnych usług językowych, należy zadzwonić pod numer podany na karcie identyfikacyjnej.
Portuguese	Para aceder aos serviços linguísticos gratuitamente, ligue para o número indicado no seu cartão de identificação.
Russian	Для того чтобы бесплатно получить помощь переводчика, позвоните по телефону, приведенному на вашей идентификационной карте.
Tagalog	Upang ma-access ang mga serbisyo sa wika nang walang bayad, tawagan ang numero sa iyong ID card.
Vietnamese	Để sử dụng các dịch vụ ngôn ngữ miễn phí, vui lòng gọi số điện thoại ghi trên thẻ ID của quý vị.