aetna®

Group Insurance Plan of Benefits for
OBO/USAID (Control # 840157)
administered by Aetna International®
Your Plan Effective Date: October 1, 2017

Eligibility Provision			
Employee	Regular full-time employees of OBO/USAID participating in this plan working a minimum of 25 hours per week.		
Dependent	Wife or husband; same or opposite sex domestic partner; children through age 26, regardless of student status.		
PPO			
		In the U.S.	
PLAN FEATURES	**OUTSIDE THE U.S.**	**Preferred Benefits (In-Network)**	**Non-Preferred Benefits (Out-of-Network)**
Individual deductible	$0 per plan year	$0 per plan year	$0 per plan year
Family deductible	$0 per plan year	$0 per plan year	$0 per plan year
Prior Plan Credit	Prior plan credit accrued within the last plan year from previous carrier applies to the current year		
Individual Coinsurance Limit	$1,000 per plan year	$1,000 per plan year	$2,000 per plan year
(Does not include deductibles, copays, benefit penalties, 50% items and Outpatient Prescription Drugs. Includes Outpatient Prescription Drugs when outside the US)			
Family Coinsurance Limit	$3,000 per plan year	$3,000 per plan year	$6,000 per plan year
(Does not include deductibles, copays, benefit penalties, 50% items and Outpatient Prescription Drugs. Includes Outpatient Prescription Drugs when outside the US)			
Lifetime Maximum	Unlimited		
Inpatient Per Confinement deductible *(Maximum of 3 per plan year)*	None	$250	$250
Member Payment Percentages			
Hospital Services			
Inpatient	10%	10% after $250 inpatient per confinement co-pay	30% after $250 inpatient per confinement deductible
Outpatient	10%	10% after $100 co-pay	30%
Private Room Limit	The institution's semiprivate rate		
Pre-certification Penalty	No Penalty	No Penalty	$400
To avoid penalties and/or benefit reductions for non-preferred benefits received in the U.S., contact the service center to determine if precertification is needed for a procedure.			
Non-Emergency Use of the Emergency Room	10%	50%	50%
Emergency Room	10%	10%	10%
Non-Urgent Use of Urgent Care Provider	10%	50%	50%
Urgent Care	10%	10%	30%
Physician Services			
PCP Office Visit	10%	10%	30%
Specialist Office Visit	10%	10%	30%
Allergy Testing & Treatment	10%	10%	30%
Allergy Serum & Injection	10%	10%	30%

Note: This is not evidence of coverage. You must enroll and be accepted for coverage with the Coverage Administrator before these documents will be effective. In the case of a discrepancy between the Plan Documents and this document, the Plan Documents will determine the Plan of Benefits. As used herein, the term "Plan Documents" includes, but is not limited to, the Booklet-Certificate, Schedule of Benefits and any Booklet Amendments/Riders including any state-specific variations, as applicable. For further details, refer to your Plan Documents.

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PLAN FEATURES	**OUTSIDE THE U.S.**	**Preferred Benefits (In-Network)**	**Non-Preferred Benefits (Out-of-Network)**
Member Payment Percentages			
Mental Health Services			
Mental Health Inpatient Coverage	10%	10% after $250 inpatient per confinement co-pay	30% after $250 inpatient per confinement deductible
Unlimited days per plan year			
Mental Health Outpatient Coverage	10%	10%	30%
Unlimited visits per plan year			
Alcohol/Drug Abuse Services			
Substance Abuse Inpatient Coverage	10%	10% after $250 inpatient per confinement co-pay	30% after $250 inpatient per confinement deductible
Unlimited days per plan year			
Substance Abuse Outpatient Coverage	10%	10%	30%
Unlimited visits per plan year			
Prescription Drug Coverage			
Generic Drugs *(365 day maximum supply)*	10%	No charge after $15 co-pay per month supply (includes Mail Order Drugs)	30%
Formulary Brand Name Drugs *(365 day maximum supply)*	10%	No charge after $30 co-pay per month supply (includes Mail Order Drugs)	30%
Non Formulary Brand Name Drugs *(365 day maximum supply)*	10%	No charge after $50 co-pay per month supply (includes Mail Order Drugs)	30%
Other Services			
Global Emergency Assistance Program *($500,000 plan year maximum)*	No charge	No charge	No charge
International Employee Assistance Program (IEAP)	Included	Included	Included
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.			

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Wellness Benefits			
Routine Children Physical Exams	10%	No charge	30%
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	10% up to $1,000 calendar year maximum (includes immunizations, x-rays and labs)	No charge	30%
Adults age 22+ & -65: 1 exam/24 months Adults age 65+: 1 exam/12 months includes immunizations			
Routine Gynecological Exams	10%	No charge	30%
Includes 1 exam and pap smear per plan year			
Mammograms *(Unlimited visits per plan year)*	10%	No charge	30%
Prostate Specific Antigen (PSA)	10%	No charge	30%
Includes 1 PSA per plan year for males 40+			
Digital Rectal Exam (DRE)	10%	No charge	30%
Includes 1 DRE per plan year for males 40+			
Cancer Screening	10%	No charge	30%
Includes 1 flex sigmoid and double barium contrast every 5 years; and at age 50+ 1 colonoscopy every 10 years			
Routine Hearing Exam *Includes one routine exam every 24 months.*	10%	No charge	30%
Hearing Aids	10%	10%	30%
1 hearing aid per ear to $1,000 maximum per ear every 3 years for child to age 24			
Vision Expenses			
Routine Eye Exam	10%	No charge	30%
(Covered under medical) Includes one routine exam every 24 months.			
Vision Care Supplies	No charge up to $250 maximum	No charge up to $250 maximum	No charge up to $250 maximum
(Schedule maximums apply every 24 months)			

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PLAN FEATURES	**OUTSIDE THE U.S.**	**Preferred Benefits (In-Network)**	**Non-Preferred Benefits (Out-of-Network)**
Member Payment Percentages			
Other Services			
Skilled Nursing Facility *(120 days per plan year)*	10%	10% after $250 inpatient per confinement co-pay	30% after $250 inpatient per confinement deductible
Hospice Care Facility Inpatient *(30 Days lifetime maximum)*	10%	10% after $250 inpatient per confinement co-pay	30% after $250 inpatient per confinement deductible
Hospice Care Facility Outpatient *(Unlimited lifetime maximum)*	10%	10%	30%
Durable Medical Equipment *($2,500 plan year maximum)*	10%	10%	30%
Home Health Care *(120 visits per plan year combined, includes Private Duty Nursing per plan year)*	10%	10%	30%
Spinal Disorder Treatment *(Unlimited visits per plan year)*	10%	10%	25%
Short Term Rehabilitation	10%	10%	30%
(Includes coverage for Occupational, Physical and Speech Therapies; 60 Visits combined maximum visits per plan year)			
Diagnostic Outpatient X-ray	10%	10%	30%
Diagnostic Outpatient Lab	10%	10%	30%
Bariatric Surgery *$10,000 per lifetime*	50%	50% after $500 co-pay	50% after $500 deductible
Base Infertility Services	10%	10%	30%
(Base plan coverage includes coverage limited to the testing and treatment of underlying condition)			
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% Medicare Facility: 140% Medicare

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PPO Dental			
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PLAN FEATURES	**OUTSIDE THE U.S.**	**Preferred Benefits (In-Network)**	**Non-Preferred Benefits (Out-of-Network)**
Individual deductible	$50 deductible per plan year	$50 deductible per plan year	$50 deductible per plan year
Family deductible	$150 deductible per plan year	$150 deductible per plan year	$150 deductible per plan year
Type A Expense *(Diagnostic & Preventive)*	No Charge	No Charge	No Charge
Type B Expense *(Basic Restorative)*	20% after deductible	20% after deductible	20% after deductible
Type C Expense *(Major Restorative)*	50% after deductible	50% after deductible	50% after deductible
Plan Year Maximum	$1,500	$1,500	$1,500
Services and Programs			
Informed Health Line (24-hour nurse line) **COBRA** **International Disease Management** **International Maternity Management Program** **Wellness Checkpoint** **Simple Steps To A Healthier Life®** **red24 - Includes security, political & natural disaster coverage** *(Program is underwritten by Aetna Life & Casualty (Bermuda) Ltd.)*			

Other Health Care (Out-of-Area): *When care is provided in the U.S. in a geographic area in which Aetna has not contracted with a provider, charges are payable at 80% after any applicable Deductible (does not apply to those expenses paid at a reduced payment percentage). The benefit levels associated with the following In-Network provisions would apply: Deductible, Family Deductible, Inpatient Hospital Deductible, Out-of-pocket maximum(s).*

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Medical Plan Caveats

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 may be used to satisfy the payment limit. Deductibles, copays, benefit penalties and 50% items 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.

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.

For Plan 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

For language assistance in your language call the number listed on your ID card at no cost. (English)

Para obtener asistencia lingüística en español, llame sin cargo al número que figura en su tarjeta de identificación. (Spanish)
欲取得繁體中文語言協助，請撥打您 ID 卡上所列的號碼，無需付費。(Chinese)

Pour une assistance linguistique en français appeler le numéro indiqué sur votre carte d'identité sans frais. (French)

Para sa tulong sa wika na nasa Tagalog, tawagan ang nakalistang numero sa iyong ID card nang walang bayad. (Tagalog)

Benötigen Sie Hilfe oder Informationen auf Deutsch? Rufen Sie kostenlos die auf Ihrer Versicherungskarte aufgeführte Nummer an. (German)

للماسعقد يف (للاغة لاعربية)، الرجاء لااتاصل ىلإع لارقم لامجاني لامذكور يف بطاقتك لاعتريفية. (Arabic)

Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo a yo endike nan kat idantifikasyon ou gratis. (French Creole) Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente il numero riportato sulla Sua scheda identificativa. (Italian)
日本語で援助をご希望の方は、IDカードに記載されている番号まで無料でお電話ください。(Japanese)
한국어로 언어 지원을 받고 싶으시면 보험 ID 카드에 수록된 무료 통화번호로 전화해 주십시오. (Korean)

اربی ارمنهایی به زبان یسراف، دبون هچیر زهنیه ای اب شمرا ای که ربر ریو اکرت شناسایی شما آمده است تماس بیگرید. انگلیسی (Persian)

Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer podany na karcie ID. (Polish)

Para obter assistência linguística em português ligue para o número grátis listado no seu cartão de identificação. (Portuguese)

Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру, указанному в вашей ID-карте удостоверения личности. (Russian)

Để được hỗ trợ ngôn ngữ bằng (ngôn ngữ), hãy gọi miễn phí đến số được ghi trên thẻ ID của quý vị. (Vietnamese)