Your global benefits solution

Summary of Benefits

The proposed plan of benefits is underwritten by Aetna Life Insurance Company (Delaware). This is only a brief summary of the 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). A separate policy may be required for membership located in Maryland or Washington.

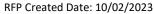
Below you'll find our initial recommendations based on our best understanding of your needs. Once you have a chance to review this proposal, we look forward to discussing what modifications we can make to deliver the right solution for your company.

Access US PPO Medical Summary of Benefits

On-shore Contract Situs Global Assignee Plan

Proposed Policy Year: 01/01/2024 through 12/31/2024

| Eligibility Provision | | | | |
|--|--|------------------------------------|--|--|
| Employee | Regular full-time employees participating in this plan working a minimum of 25 hours per week. | | | |
| Dependent | Spouse, domestic partner; child | ren up to age 26, regardless of s | tudent status | |
| | Access | US PPO Medical | | |
| | | In the U.S. | | |
| PLAN FEATURES | Outside the U.S. | Preferred Benefits (In-Network) | Non-Preferred Benefits (Out-of-Network) | |
| Individual Deductible | \$0 per calendar year | \$2,500 per calendar year | \$5,000 per calendar year | |
| Family Deductible | \$0 per calendar year | \$5,000 per calendar year | \$10,000 per calendar year | |
| Prior Plan Credit | Current Calendar Year | | | |
| Individual Payment Limit | \$0 per calendar year | \$6,600 per calendar year | \$13,500 per calendar year | |
| Plan Coinsurance Limit includes plan deductible and copayments. Excludes precertification penalties. | | | | |
| Family Payment Limit | \$0 per calendar year | \$13,200 per calendar year | \$27,000 per calendar year | |
| Plan Coinsurance Limit include | s plan deductible and copayments. | Excludes precertification penalt | ties. | |
| Lifetime Maximum | Unlimited | | | |





Access US PPO Medical In the U.S. **PLAN FEATURES** Outside the U.S. **Preferred Benefits Non-Preferred Benefits** (In-Network) (Out-of-Network) **Hospital Services** 20% after deductible No Charge 50% after deductible Inpatient Outpatient 20% after deductible 50% after deductible No Charge **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 precertification is needed for a procedure. Non-Emergency Use of the No Charge Not Covered Not Covered **Emergency Room Emergency Room** No Charge 20% deductible waived 20% deductible waived Non-Urgent Use of Urgent Not Covered Not Covered No Charge **Care Provider Urgent Care** No Charge No Charge after \$75 copay 50% after deductible Ambulance No Charge 20% deductible waived 20% deductible waived **Physician Services Physician Office Visit** No Charge after \$40 copay 50% after deductible No Charge **Telemedicine Consultation** No Charge No Charge deductible waived 50% after deductible with Non-Specialist **Specialist Office Visit** No Charge after \$60 copay 50% after deductible No Charge 50% after deductible **Telemedicine Consultation** No Charge deductible waived No Charge with Specialist **Walk in Clinics** 50% after deductible No Charge No Charge deductible waived **Designated Walk-in Clinics** No Charge deductible waived Walk-in Clinics are free-standing health care facilities that (a) may be located in or with a pharmacy, drug store, supermarket or other retail store; and (b) provide limited medical care and services on a scheduled or unscheduled basis. Urgent care centers, emergency rooms, the outpatient department of a hospital, ambulatory surgical centers, and physician offices are not considered to be Walk-in Clinics.

RFP Created Date: 10/02/2023

Virtual Care and Virtual

Not Covered

Quote ID: 9476 Option ID: 28840 Proprietary

Primary Care



Mental Health Services

No Charge deductible waived

Not Covered

| Access US PPO Medical | | | |
|---|------------------|------------------------------------|--|
| | | In the U.S. | |
| PLAN FEATURES | Outside the U.S. | Preferred Benefits (In-Network) | Non-Preferred Benefits (Out-of-Network) |
| Mental Health Inpatient Coverage Unlimited days per calendar year | No Charge | 20% after deductible | 50% after deductible |
| Mental Health Outpatient Coverage Unlimited visits per calendar year | No Charge | No Charge after \$40 copay | 50% after deductible |
| | А | lcohol/Drug Abuse Services | |
| Substance Abuse Inpatient Coverage Unlimited days per calendar year | No Charge | 20% after deductible | 50% after deductible |
| Substance Abuse Outpatient Coverage Unlimited visits per calendar year | No Charge | No Charge after \$40 copay | 50% after deductible |

| | Ac | ccess US PPO Medical | | |
|---|------------------|---|--|--|
| | | In t | In the U.S. | |
| PLAN FEATURES | Outside the U.S. | Preferred Benefits (In-Network) | Non-Preferred Benefits (Out-of-Network) | |
| | Pres | cription Drug Coverage | | |
| Generic Drugs (365 day maximum supply) Includes contraceptives | No Charge | \$15 copay per month supply (includes Mail Order Drugs) | 50% after deductible | |
| Formulary Brand Name Drugs (365 day maximum supply) Includes contraceptives | No Charge | \$40 copay per month supply (includes Mail Order Drugs) | 50% after deductible | |
| Non-preferred or Non- formulary Generic and Brand Name Drugs (365 day maximum supply) Includes contraceptives | No Charge | \$60 copay per month supply (includes Mail Order Drugs) | 50% after deductible | |
| Specialty Drugs (30 day maximum supply) | No Charge | No Charge After \$150 copay | Not Covered | |
| | | Preventive Benefits | | |
| Routine Children Physical Exams | No Charge | No Charge deductible waived | No Charge after deductible | |

RFP Created Date: 10/02/2023

months thereafter to age 22 (includes immunizations)

Quote ID: 9476 Option ID: 28840 Proprietary



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

| | Access | US PPO Medical | |
|--|----------------------------------|--------------------------------------|--|
| | | In t | he U.S. |
| PLAN FEATURES | Outside the U.S. | Preferred Benefits (In-Network) | Non-Preferred Benefits (Out-of-Network) |
| Routine Adult Physical Exams | No Charge | No Charge deductible waived | No Charge after deductible |
| Adults age 22+ & -65: 1 exam ever months | ery 12 months up to age 65, 1 e. | xam every 12 months age 65 and older | r Adults age 65+: 1 exam/12 |
| Routine Gynecological Exams | No Charge | No Charge deductible waived | 50% after deductible |
| Includes 1 exam and pap smear p | er calendar year | | |
| Routine Mammograms | No Charge | No Charge deductible waived | 50% after deductible |
| Prostate Specific Antigen (PSA) | No Charge | No Charge deductible waived | 50% after deductible |
| Routine Digital Rectal Exam (DRE) | No Charge | No Charge deductible waived | 50% after deductible |
| Colorectal Cancer Screening | No Charge | No Charge deductible waived | No Charge after deductible |
| Recommended: For all members of | ge 45 and older. | | |
| Routine Hearing Exam | No Charge | No Charge deductible waived | 50% after deductible |
| Includes one routine exam every 2 | 4 months | | |
| Hearing Aids | No Charge | 20% after deductible | 50% after deductible |
| 1 hearing aid per ear to \$1,000 m | aximum per ear every 3 years fo | or child to age 24 | |

| | Access US PP | O Medical | |
|---|----------------------------------|------------------------------------|--|
| | | e U.S. | |
| PLAN FEATURES | Outside the U.S. | Preferred Benefits (In-Network) | Non-Preferred Benefits (Out-of-Network) |
| | Vision | Care | |
| Routine Eye Exam | No Charge | No Charge deductible waived | 50% after deductible |
| (Covered under medical) Includes o | ne 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 Se | rvices | |
| Skilled Nursing Facility 120 days per calendar year | No Charge | 20% after deductible | 50% after deductible |
| Hospice Care Facility Inpatient 30 day lifetime maximum | No Charge | 20% after deductible | 50% after deductible |
| Hospice Care Facility Outpatient Unlimited lifetime maximum | No Charge | 20% after deductible | 50% after deductible |





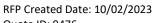
| | | In the U.S. | |
|--|---------------------------------------|------------------------------------|--|
| PLAN FEATURES | Outside the U.S. | Preferred Benefits (In-Network) | Non-Preferred Benefits (Out-of-Network) |
| Home Health Care 120 visits per calendar year ncludes Private Duty Nursing | No Charge | 20% after deductible | 50% after deductible |
| Acupuncture Unlimited visits per calendar year | No Charge | No Charge after \$40 copay | 50% after deductible |
| Spinal Disorder Treatment Unlimited visits per calendar year | No Charge | No Charge after \$10 copay | 25% after deductible |
| Short Term Rehabilitation | No Charge | No Charge after \$10 copay | 25% after deductible |
| Includes Occupational and Physical | Therapies; Unlimited visits combin | ed per calendar year | |
| Speech Therapy | No Charge | No Charge after \$60 copay | 50% after deductible |
| 60 visits per calendar year | | | |
| Diagnostic Outpatient X-ray | No Charge | 20% after deductible | 50% after deductible |
| Diagnostic Outpatient Lab | No Charge | 20% after deductible | 50% after deductible |
| Base Infertility Services | No Charge | 20% after deductible | 50% after deductible |
| Base plan coverage includes covera | ge limited to the testing and treatr | ment of underlying condition | |
| Comprehensive Infertility Services | No Charge | 20% after deductible | 50% after deductible |
| Comprehensive plan coverage inclu | des coverage for 6 cycles of Artifici | al Insemination and Ovulation Ind | uction |
| ART Infertility Services | No Charge | 20% after deductible | 50% after deductible |

| Access US PPO Medical | | | | |
|--|------------------|------------------------------------|--|--|
| | | In the U.S. | | |
| PLAN FEATURES | Outside the U.S. | Preferred Benefits (In-Network) | Non-Preferred Benefits (Out-of-Network) | |
| | | Other Services | | |
| Prosthetic Devices | No Charge | 20% after deductible | 50% after deductible | |
| Complex Imaging | No Charge | 20% after deductible | 50% after deductible | |
| Durable Medical Equipment Unlimited per calendar year maximum | No Charge | 20% after deductible | 50% after deductible | |
| Allergy Testing | No Charge | No Charge after \$60 copay | 50% after deductible | |
| Allergy Serum & Injections | No Charge | 20% after deductible | 50% after deductible | |
| Transplants Unlimited per lifetime | No Charge | 20% after deductible | 50% after deductible | |
| Diabetics Supplies | No Charge | 20% after deductible | 50% after deductible | |

RFP Created Date: 10/02/2023



| | Ac | ccess US PPO Medical | |
|---|------------------|--|---|
| | | In the U.S. | |
| PLAN FEATURES | Outside the U.S. | Preferred Benefits (In-Network) | Non-Preferred Benefits (Out-of-Network) |
| Payment for Non-Preferred Providers* | Not Applicable | Not Applicable | Professional: 105% of Medicare Facility: 140% of Medicare |
| Autism | | any other expense. Member cost sha of service where it is rendered. | ring is based on the type of service |





Additional services and programs included in your quote



Employee Assistance Program (EAP)

Our EAP helps members balance the demands of work, life and personal issues. Whether it's finding balance between work and life, dealing with the loss of a loved one, managing anxiety or depression, or parenting advice, EAP offers free, confidential support delivered by qualified counselors. Includes up to 5 counseling sessions per issue per year per enrolled member.



24-Hour Nurse Line**

Provides 24-hour telephone, email and chat access to experienced registered nurses to help members make informed health care decisions on a variety of health topics.



Teladoc®**

Gives members access to a national network of certified physicians right at their fingertips, through phone and online-video consultations.



CVS Health Virtual Care™ and CVS Health Virtual Primary Care™

In addition to their traditional network of providers, these two telehealth solutions give members access to virtual primary care, mental health services and 24/7 on-demand care – through one convenient digital platform. Members can easily schedule a virtual appointment from anywhere in the U.S., providing a convenient path to quality virtual care with shorter wait times and affordable pricing.



International Care Management program

Led by our clinical care management team, our program supports everything from clinical precertification and pre-trip planning, to acute and chronic care management, and much more. With ongoing assistance from a clinician, we offer personalized, culturally relevant support no matter where members are in the world.



Well-being Assessment**

This personalized, online health and wellness program includes a suite of online health coaching programs in addition to a health assessment. The program encourages participants to identify and reduce health risks and improve and maintain healthy lifestyles, with a focus on prevention and long-term success.



Pharmacy shipping

We make sure members can fill their prescriptions quickly, safely and easily with our pharmacy shipping solutions. We help coordinate medication management for members preparing for assignments or travel, as well as offering a 90-day supply of maintenance medicine delivered directly to the member's home.



Member offers (discount program)

Our member offers gives members choice and flexibility in their day-to-day life. They get a variety of discounts on products and services that keep them healthy, fit and help them save money. In addition to offers on personal wellness products and services, we also offer deals on everyday needs such as travel, tickets, car rentals, electronics and more.



Enhanced Maternity program

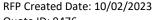
Provides a holistic, end-to-end family building solution for U.S.-based members. It starts with family-planning and fertility support and uses predictive analytics, educational resources and guided genetic counseling to address at-risk members.



Transform Oncology**

This high-touch program offers a comprehensive, member-focused support and an elevated standard of oncology care to members with cancer. They get a personal navigator, guided genetic testing, precision medicine and site-of-care support to help them achieve their best health while controlling costs.

^{**} Available to members in the U.S. only





^{*}Services and resources may vary depending on member location.

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.

Benefit maximums per Calendar year are calculated between 01/01/2023 and 12/31/2023.

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.

RFP Created Date: 10/02/2023



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