

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.

High Deductible Health Plan (HDHP) Summary of Benefits

On-shore Contract Situs

Global Assignee Plan

Proposed Policy Year: 01/01/2022 through 12/31/2022

| 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) |
| Employee Only Deductible | \$6,000 per calendar year | \$2,000 per calendar year | \$6,000 per calendar year |
| Family Deductible | \$12,000 per calendar year | \$4,000 per calendar year | \$12,000 per calendar year |
| <i>You and your covered dependents pay for covered services each year before the plan begins to pay. After the amount paid for covered services reaches this family deductible, this plan starts to pay for covered services for the rest of the year. The family deductible applies to a person enrolled with one or more dependents.</i> | | | |
| Prior Plan Credit | Prior plan credit accrued within the last calendar year from previous carrier applies to the current year | | |
| Employee Only Payment Limit | \$19,650 per calendar year | \$6,550 per calendar year | \$19,650 per calendar year |
| (Does not include precertification penalty. Includes Outpatient Prescription Drugs when outside the US) | | | |
| Family Payment Limit | \$39,300 per calendar year | \$8,700 per calendar year | \$39,300 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 | 50% after deductible | 20% after deductible | 50% after deductible | |
| Outpatient | 50% after deductible | 20% after deductible | 50% after deductible | |
| Private Room Limit | The institution's semiprivate rate | | | |
| Pre-certification Penalty | No Penalty | No Penalty | \$400 | |
| <p><i>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.</i></p> | | | | |
| Non-Emergency Use of the Emergency Room | 20% after deductible | Not Covered | Not Covered | |
| Emergency Room | 20% after deductible | 20% after deductible | 20% after deductible | |
| Urgent Care | 50% after deductible | 20% after deductible | 50% after deductible | |
| Physician Services | | | | |
| Physician Office Visit | 50% after deductible | 20% after deductible | 50% after deductible | |
| Telemedicine Consultation with Non-Specialist | 50% after deductible | No charge after deductible | 50% after deductible | |
| Specialist Office Visit | 50% after deductible | 20% after deductible | 50% after deductible | |
| Telemedicine Consultation with Specialist | 50% after deductible | No charge after deductible | 50% after deductible | |
| Walk in Clinics deductible | 50% after deductible | No charge after deductible | 50% after | |
| <p><i>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.</i></p> | | | | |

| Mental Health Services | | | |
|--|----------------------|----------------------|----------------------|
| Mental Health Inpatient Coverage Unlimited days per calendar year | 50% after deductible | 20% after deductible | 50% after deductible |
| Mental Health Outpatient Coverage Unlimited days per calendar year | 50% after deductible | 20% after deductible | 50% after deductible |
| Alcohol/Drug Abuse Services | | | |
| Substance Abuse Inpatient Coverage Unlimited days per calendar year | 50% after deductible | 20% after deductible | 50% after deductible |
| Substance Abuse Outpatient Coverage Unlimited days per calendar year | 50% after deductible | 20% after deductible | 50% 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 | | | | |
| Preferred Generic Drugs (365-day maximum supply) | 50% after deductible | | \$20 copay after deductible per month supply (includes Mail Order Drugs) | 50% after deductible |
| Preferred Brand Name Drugs (365-day maximum supply) | 50% after deductible | | \$70 copay after deductible per month supply (includes Mail Order Drugs) | 50% after deductible |
| Non-Preferred Generic Drugs and Non-Preferred Brand Name Drugs (365-day maximum supply) | 50% after deductible | | 30% copay after deductible per month supply (includes Mail Order Drugs) | 50% after deductible |
| Specialty Drugs (365-day maximum supply) | 50% after deductible | | No charge after deductible per month supply up to \$150 maximum | Not Covered |
| Preventive Benefits | | | | |
| Routine Children Physical Exams | 50% after deductible | | No charge | 50% 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 | 50% after deductible | | No charge | 50% after deductible |
| <i>Adults age 22+ & -65: One exam/12 months</i> <i>Adults age 65+: One exam/12 months includes immunizations</i> | | | | |
| Routine Gynecological Exams | 50% after deductible | | No charge | 50% after deductible |
| Includes one exam and pap smear per calendar year | | | | |
| Routine Mammograms | 50% after deductible | | No charge | 50% after deductible |
| Prostate Specific Antigen (PSA) | 50% after deductible | | No charge | 50% after deductible |
| Routine Digital Rectal Exam (DRE) | 50% after deductible | | No charge | 50% after deductible |
| Colorectal Cancer Screening Recommended: For all members age 45 and older. | 50% after deductible | | No charge | 50% after deductible |

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 Includes one routine exam every 24 months. | 50% after deductible | No charge | 50% after deductible | |
| Hearing Aids One hearing aid per ear to \$1,000 maximum per ear every three years for child to age 24 | 50% after deductible | 20% after deductible | 50% after deductible | |
| Vision Care | | | | |
| Routine Eye Exam (Covered under medical) Includes one routine exam every 12 months | 50% after deductible | No charge | 50% after deductible | |
| Vision Care Supplies Schedule maximums apply every 12 months | No charge up to \$150 maximum | No charge up to \$150 maximum | No charge up to \$150 maximum | |
| Other Services | | | | |
| Skilled Nursing Facility (120 days per calendar year) | 50% after deductible | 20% after deductible | 50% after deductible | |
| Hospice Care Facility Inpatient (30 days lifetime maximum) | 50% after deductible | 20% after deductible | 50% after deductible | |
| Hospice Care Facility Outpatient (Unlimited lifetime maximum) | 50% after deductible | 20% after deductible | 50% after deductible | |
| Home Health Care (120 visits per calendar year combined, includes Private Duty Nursing) | 50% after deductible | 20% after deductible | 50% after deductible | |
| Acupuncture (Unlimited visits per calendar year) | 50% after deductible | 20% after deductible | 50% after deductible | |
| Spinal Disorder Treatment (Unlimited visits per calendar year) | 50% after deductible | 20% after deductible | 25% after deductible | |
| Short Term Rehabilitation (Includes coverage for Occupational and Physical Therapies; Unlimited visits per calendar year) | 50% after deductible | 20% after deductible | 25% after deductible | |
| Speech Therapy (60 visits per calendar year) | 50% after deductible | 20% after deductible | 50% after deductible | |

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|--|---|----------------------|--|
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| | | | Preferred Benefits (In-Network) |
| Other Services | | | |
| Diagnostic Outpatient X-ray | 50% after deductible | 20% after deductible | 50% after deductible |
| Diagnostic Outpatient Lab | 50% after deductible | 20% after deductible | 50% after deductible |
| Base Infertility Services | 50% after deductible | 20% after deductible | 50% after deductible |
| (Base plan coverage includes coverage limited to the testing and treatment of underlying condition) | | | |
| Comprehensive Infertility Services | 50% after deductible | 20% after deductible | 50% after deductible |
| (6 cycles per lifetime for Comprehensive plan coverage which includes coverage for Artificial Insemination and Ovulation Induction.) | | | |
| ART Infertility Services | 50% after deductible | 20% after deductible | 50% after deductible |
| (6 cycles per lifetime for Advanced Reproductive Technology (ART) coverage with cryopreservation, storage and unlimited embryo transfers). | | | |
| Autism | <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> | | |
| Payment for Non-Preferred Providers* | Not Applicable | Not Applicable | Professional: 105% of Medicare Facility: 140% of Medicare |

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.

International Care Management Program



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



Enhanced Maternity Program

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



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.



Teladoc***

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



24-Hour Nurse Line**

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



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.

**Services and resources may vary depending on member location.*

*** Available to members in the U.S. only*

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).