Group Insurance Plan of Benefits for The Navigators (Control 706366) administered by Aetna International®
Effective Date: January 1, 2020
Choice POSII HDHP-HSA Plan

Eligibility Provision			
Employee	Regular full-time Navigator employees participating in the plan as an Active Headquarter employee working a minimum of 30 hours per week or a Field employee working a minimum of 20 hours per week also eligible Retirees* who have elected to continue participating in the plan. *A Retiree must be age 62 with 10 years of continuous coverage under the plan.		
Dependent	The lawful Spouse of the employee or Retiree, excludes same gender marriage partner or a domestic partner of the same or opposite sex; children up to age 26, regardless of student status.		
Choice POSII		**In the U.S.**	
PLAN FEATURES	**OUTSIDE THE U.S.**	**Preferred Benefits (In-Network)**	**Non-Preferred Benefits (Out-of-Network)**
Individual Deductible	$1,500 per calendar year	$1,500 per calendar year	$3,000 per calendar year
Family Deductible	Employee +1: $3,000 per calendar year Family: $3,000 per calendar year	Employee + 1: $3,000 per calendar year Family: $3,000 per calendar year	Employee + 1: $6,000 per calendar year Family: $6,000 per calendar year
Prior Plan Credit	Does not apply		
Individual Payment Limit	$3,000 per calendar year	$3,000 per calendar year	$6,000 per calendar year
(Does not include precertification penalty (Includes Outpatient Prescription Drugs when outside the US))			
Family Payment Limit	Employee +1: $6,000 per calendar year Family: $6,000 per calendar year	Employee +1: $6,000 per calendar year Family: $6,000 per calendar year	Employee +1: $12,000 per calendar year Family: $12,000 per calendar year
(Does not include precertification penalty) (Includes Outpatient Prescription Drugs when outside the US)			
Lifetime Maximum	Unlimited		
Member Payment Percentages ***Hospital Services***			
Inpatient	20% after deductible	20% after deductible	40% after deductible
Outpatient	20% after deductible	20% after deductible	40% after deductible
Private Room Limit	The institution's semiprivate rate.		
Pre-certification Penalty	No Penalty	No Penalty	$250
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
Ambulance	20% after deductible	20% after deductible	20% after deductible
Non-Emergency Use of an Ambulance	20% after deductible	20% after deductible	40% after deductible
Non-Urgent Use of Urgent Care Provider	20% after deductible	20% after deductible	40% after deductible
Urgent Care	20% after deductible	20% after deductible	40% after deductible
Physician Services			
Physician Office Visit	20% after deductible	20% after deductible	40% after deductible
Specialist Office Visit	20% after deductible	20% after deductible	40% after deductible
Allergy Testing and Treatment	20% after deductible	20% after deductible	40% after deductible
Allergy Serum and Allergy Injections	20% after deductible	20% after deductible	40% after deductible

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PLAN FEATURES	OUTSIDE THE U.S.	Choice POSII In the U.S. Preferred Benefits (In-Network)	Choice POSII In the U.S. Non-Preferred Benefits (Out-of-Network)
Mental Health Services			
Mental Health Inpatient Coverage	20% after deductible	20% after deductible	40% after deductible
Unlimited days per calendar year			
Mental Health Outpatient Coverage	20% after deductible	20% after deductible	40% after deductible
Unlimited visits per calendar year			
Alcohol/Drug Abuse Services			
Substance Abuse Inpatient Coverage	20% after deductible	20% after deductible	40% after deductible
Unlimited days per calendar year			
Substance Abuse Outpatient Coverage	20% after deductible	20% after deductible	40% after deductible
Unlimited visits per calendar year			
Prescription Drug Coverage			
Generic Drugs *(365 day maximum supply)*	10% after deductible	Retail:$10 copay per 31 day supply Mail Order: $30 copay per 90 day supply *Preventative Drugs - $0 copay*	Not Covered
Formulary Brand Name Drugs *(365 day maximum supply)*	10% after deductible	Retail: 30% copay with $45 maximum per 31 day supply Mail Order: 30% copay $135 maximum per 90 day supply	Not Covered
Non Formulary Brand Name Drugs *(365 day maximum supply)*	10% after deductible	Retail: 50% copay with $75 maximum per 31 day supply Mail Order: 50% copay $225 maximum per 90 day supply	Not Covered
Other Services			
Global Emergency Assistance Program *($500,000 calendar year maximum)*	No charge after deductible	No charge after deductible	No charge after deductible
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: to 855-829-9558 or collect 813-775-0449. 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	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: 1 exam/12 months Adults age 65+: 1 exam/12 months includes immunizations			
Routine Gynecological Exams	No charge	No charge	Not Covered
Includes 1 exam and pap smear per calendar year			
Mammograms *(Unlimited visits per calendar year)*	No charge	No charge	Not Covered
Prostate Specific Antigen (PSA)	No charge	No charge	Not Covered
(Unlimited tests per calendar year)			
Digital Rectal Exam (DRE)	No charge	No charge	Not Covered
(Unlimited exams per calendar year)			
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	Not Covered	Not Covered	Not Covered
Vision Care			
Routine Eye Exam	No charge	No charge	Not Covered
(Covered under medical) Includes one routine exam every 24 months			

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Choice POSII			
		In the U.S.	
PLAN FEATURES	OUTSIDE THE U.S.	Preferred Benefits (In-Network)	Non-Preferred Benefits (Out-of-Network)
Other Services			
Skilled Nursing Facility *(120 Days per calendar year)*	20% after deductible	20% after deductible	40% after deductible
Hospice Care Facility Inpatient *(Unlimited lifetime maximum)*	No charge after deductible	No charge after deductible	40% after deductible
Hospice Care Facility Outpatient *(Unlimited lifetime maximum)*	No charge after deductible	No charge after deductible	40% after deductible
Home Health Care *(120 visits per calendar year)*	20% after deductible	20% after deductible	40% after deductible
Private Duty Nursing *(70 shifts per calendar year)*	20% after deductible	20% after deductible	40% after deductible
Spinal Disorder Treatment *(Unlimited visits)*	20% after deductible	20% after deductible	40% after deductible
Short-Term Rehabilitation	20% after deductible	20% after deductible	40% after deductible
(Includes coverage for Occupational, Physical and Speech Therapies; 60 Visits combined maximum visits per calendar year)			
Durable Medical Equipment *(Unlimited calendar year maximum)*	20% after deductible	20% after deductible	40% after deductible
Diagnostic Outpatient X-ray	20% after deductible	20% after deductible	40% after deductible
Diagnostic Outpatient Lab	20% after deductible	20% after deductible	40% after deductible
Base Infertility Services	20% after deductible	20% after deductible	40% after deductible
(Base plan coverage includes coverage limited to the testing and treatment of underlying condition)			
Aetna's Institutes of Quality (IOQ) Bariatric Surgery	Not Covered	20% after deductible	Not Covered
TMJ	20% after deductible	20% after deductible	40% after deductible
($1,000 Lifetime maximum)			
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*		
Services and Programs included in Quote			
Informed Health Line (24-hour nurse line) **COBRA** **Flexible Spending Account** **International Disease Management** **International Maternity Management Program** **Simple Steps To A Healthier Life®**			

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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, deductible and copayments may be used to satisfy the payment limit. Precertification penalty is 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*

This 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.*

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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.