Aetna MedPremier 1K90 Major Medical

Benefit Overview of plan features for full-time employees. Please see Plan Summary for detailed information about the benefits and exclusions and shall prevail over the terms of this benefit overview.

	Full-Time Benefits	
Monthly Hours	120+	
Medical Benefits	**In-Network**	**Out-of-Network**
Plan Coinsurance	90%	70%
Individual / Family Deductible	$1,000 / $2,000	$2,000 / $4,000
Individual / Family Coinsurance Limit	$3,000 / $6,000	$6,000 / $12,000
Lifetime Maximum	Unlimited	Unlimited
Doctor's Office Visit		
▪ Non-Specialist	$25 copay	Plan pays 70%; after deductible
▪ Specialist	$45 copay	Plan pays 70%; after deductible
Inpatient Hospital	Plan pays 90%; after deductible	Plan pays 70%; after deductible
Outpatient Hospital	Plan pays 90%; after deductible	Plan pays 70%; after deductible
Emergency Room Benefit	Plan pays 90%; after $300 copay	Same as In-Network Care
Urgent Care Benefit	Plan pays 90%; after $45 copay	Plan pays 70%; after deductible
Pharmacy Benefit	Copay:	
▪ Prescription Drug	Preferred Generic: $5 Preferred Brand: $30 Non-Preferred Generic and Brand: $50 Preferred Specialty*: Plan pays 60% Non-Preferred Specialty*: Plan pays 50%	Plan pays 70% of submitted cost; after applicable in-network cost share
Mail Order Pharmacy * *Specialty Drugs are not covered by Mail Order or Out-of-Network*	2x copay	Not Applicable
Durable Medical Equipment	Plan pays 90%; after deductible	Plan pays 70%; after deductible
Ancillary Benefits		
Aetna Dental Benefit		
Annual Maximum per covered person	$2,000	
Annual Deductible per covered person	$25	
Preventive and Diagnostic Care	100% up to the Annual Maximum	
Basic Care	80% up to the Annual Maximum	
Major Restorative Care	50% up to the Annual Maximum	
Aetna Vision Benefits		
Vision Exam (every 12 months)	$85	
Single Lenses (every 24 months)	$95	
Contact Lenses (every 24 months)	$95	
Bi-focal Lenses (every 24 months)	$120	
Frames (every 24 months)	$120	
Transamerica Short Term Disability Benefits (EE Only)**		
Maximum Weekly Benefit+	$400	
Maximum Benefit Period *(number of months)*	3	
Elimination Period (number of days)	14	
+ *The actual weekly benefit will be the amount selected or 80% of the employee's salary, whichever is less*		
Transamerica Life and AD&D (EE only)		
Life	$10,000	
Accidental Death and Dismemberment	$10,000	
Aetna Employee Assistance Program (EAP)	Included	
HealthiestYou Telehealth Services	Included	
Employee Monthly Premium:	$759.71	
Elective Monthly Dependent Premium:		
Spouse	$936.68	
Child(ren)	$761.62	
Spouse & Child(ren)	$1,625.83	

If Employee Only coverage is chosen, Employer will pay 50% of the $759.71 as the employer monthly contribution, (unless benefits are declined with valid proof of other acceptable Major Group Medical Coverage.

** *Coverage is not available if you reside in California, Hawaii, New Jersey, New York, Rhode Island, and Puerto Rico.*

** *12 month pre-ex provision on Disability income, even for coverage issued on GI basis. Rates include load for Waiver of Premium beginning the next premium due date after satisfaction of the elimination period.*

** *Mental Illness Benefit is limited to 50% of the illustrated Maximum Disability Benefit Period. Policy is issued as monthly benefit; if the disability lasts less than one month, the benefits will be pro-rated based on the days of actual disability following the satisfaction of the Elimination Period.*