aetna™

Group Insurance Plan of Benefits
Reliant Mission (Control # 142986)
administered by Aetna International®
Your Plan Effective Date: January 1, 2020

Eligibility Provision	
Employee	Regular full-time employees of Reliant Mission participating in this plan working a minimum of 30 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)**
Individual Deductible	$0 per calendar year	$2,000 per calendar year	$2,000 per calendar year
Family Deductible	$0 per calendar year	$4,000 per calendar year	$4,000 per calendar year
Prior Plan Credit	None		
Individual Payment Limit	$2,000 per calendar year	$2,000 per calendar year	Unlimited per calendar year
Plan Coinsurance Limit includes plan deductible and copayments. Excludes precertification penalties.			
Family Payment Limit	$4,000 per calendar year	$4,000 per calendar year	Unlimited per calendar year
Plan Coinsurance Limit includes plan deductible and copayments. Excludes precertification penalties.			
Lifetime Maximum	Unlimited		
Hospital Services			
Inpatient	No charge	No charge after deductible	20% after deductible
Outpatient	No charge	No charge after deductible	20% after deductible
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 pre-certification is needed for a procedure.			
Non-Emergency Use of the Emergency Room	No charge	50% after deductible	50% after deductible
Emergency Room	No charge	No charge after $25 copay	No charge after $25 copay
Urgent Care	No charge	No charge after $25 copay	20% after deductible
Non-Urgent Use of Urgent Care Provider	50%	50% after deductible	50% after deductible
Physician Services			
Physician Office Visit	No charge	No charge	20% after deductible
Specialist Office Visit	No charge	No charge	20% after deductible
Allergy Testing	No charge	No charge	20% after deductible
Allergy Serum & Injections	No charge	No charge after deductible	20% after deductible

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, Schedule of Benefits and any Booklet Amendments/Riders including g any state-specific variations, as applicable. For further details, refer to your Plan Documents.

Group Insurance Plan of Benefits
Reliant Mission (Control # 142986)
administered by Aetna International®
Your Plan Effective Date: January 1, 2020

PLAN FEATURES	PPO Medical Outside the U.S.	Inside the U.S. Preferred Benefits (In-Network)	Inside the U.S. Non-Preferred Benefits (Out-of-Network)
Mental Health Services			
Mental Health Inpatient Coverage Unlimited days per calendar year	No charge	No charge after deductible	20% after deductible
Mental Health Outpatient Coverage Unlimited days per calendar year	No charge	No charge	20% after deductible
Alcohol/Drug Abuse Services			
Substance Abuse Inpatient Coverage Unlimited days per calendar year	No charge	No charge after deductible	20% after deductible
Substance Abuse Outpatient Coverage Unlimited days per calendar year	No charge	No charge	20% after deductible
Prescription Drug Coverage			
Generic Drugs (365 day maximum supply) Includes contraceptives	No charge	$10 copay per month supply (includes Mail Order Drugs)	20% after deductible
Formulary Brand Name Drugs (365 day maximum supply) Includes contraceptives	No charge	$20 copay per month supply (includes Mail Order Drugs)	20% after deductible
Non Formulary Generic and Brand Name Drugs (365 day maximum supply) Includes contraceptives	No charge	$40 copay per month supply (includes Mail Order Drugs)	20% after deductible
Other Services			
Employee Assistance Program (EAP)	Included	Included	Included
Includes up to five 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, Childcare and behavioral concerns, Social adaptation needs, Alcohol/Substance Abuse, Work/Life Balance and Depression.			

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, Schedule of Benefits and any Booklet Amendments/Riders including g any state-specific variations, as applicable. For further details, refer to your Plan Documents.

Group Insurance Plan of Benefits
Reliant Mission (Control # 142986)
administered by Aetna International®
Your Plan Effective Date: January 1, 2020

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 Children Physical Exams	No charge	No charge	20% 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	No charge Up to $1,000 calendar year maximum (includes immunizations, x-rays and labs)	No charge	20% after deductible
Adults age 22+ & -65: One exam/12 months *Adults age 65+:* One exam/12 months includes immunizations			
Routine Gynecological Exams	No charge	No charge	20% after deductible
Includes one exam and pap smear per calendar year			
Routine Mammograms Unlimited tests per calendar year	No charge	No charge	20% after deductible
Prostate Specific Antigen (PSA) Unlimited tests per calendar year	No charge	No charge	20% after deductible
Routine Digital Rectal Exam (DRE) Unlimited exams per calendar year	No charge	No charge	20% after deductible
Colorectal Cancer Screening Recommended: For all members age 45 and older.	No charge	No charge	20% after deductible
Routine Hearing Exam	No charge	No charge	20% after deductible
Includes one routine exam every 24 months.			
Hearing Aids	No charge	No charge after deductible	20% after deductible
One hearing aid per ear to $1,000 maximum per ear every three years for child to age 24			
Vision Care			
Routine Eye Exam	No charge	No charge	20% after deductible
(Covered under medical) Includes one routine exam every 12 months			
Vision Care Supplies	No charge up to $200 maximum	No charge up to $200 maximum	No charge up to $200 maximum
Schedule maximums apply every 12 months			

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, Schedule of Benefits and any Booklet Amendments/Riders including g any state-specific variations, as applicable. For further details, refer to your Plan Documents.

aetna™

Group Insurance Plan of Benefits
Reliant Mission (Control # 142986)
administered by Aetna International®
Your Plan Effective Date: January 1, 2020

PPO Medical			
PLAN FEATURES	**Outside the U.S.**	**Inside the U.S.**	
		Preferred Benefits (In-Network)	**Non-Preferred Benefits (Out-of-Network)**
Other Services			
Skilled Nursing Facility (120 days per calendar year)	No charge	No charge after deductible	20% after deductible
Hospice Care Facility Inpatient (30 days lifetime maximum)	No charge	No charge after deductible	20% after deductible
Hospice Care Facility Outpatient (Unlimited lifetime maximum)	No charge	No charge after deductible	20% after deductible
Home Health Care (120 visits per calendar year combined, includes Private Duty Nursing)	No charge	No charge after deductible	20% after deductible
Spinal Disorder Treatment (Unlimited visits per calendar year)	No charge	No charge after deductible	20% after deductible
Short Term Rehabilitation (Includes coverage for Occupational, Physical, and Massage Therapies; Unlimited visits per calendar year)	No charge	No charge after deductible	20% after deductible
Speech Therapy (60 visits per plan year)	No charge	No charge after deductible	20% after deductible
Diagnostic Outpatient X-ray	No charge	No charge after deductible	20% after deductible
Diagnostic Outpatient Lab	No charge	No charge after deductible	20% after deductible
Durable Medical Equipment (Unlimited calendar year maximum)	No charge	No charge after deductible	20% after deductible
Base Infertility Services (Base plan coverage includes coverage limited to the testing and treatment of underlying condition *)*	No charge	No charge after deductible	20% after deductible
Comprehensive Infertility Services (6 cycles per lifetime for Comprehensive plan coverage which includes coverage for Artificial Insemination and Ovulation Induction.)	No charge	No charge after deductible	20% after deductible
ART Infertility Services (6 cycles per lifetime for Advanced Reproductive Technology (ART) coverage with cryopreservation, storage and unlimited embryo transfers).	No charge	No charge after deductible	20% after deductible
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% of Medicare RBRVS Facility: 140% of the Medicare Allowed Rate

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, Schedule of Benefits and any Booklet Amendments/Riders including g any state-specific variations, as applicable. For further details, refer to your Plan Documents.

Additional Services and Programs	
International Employee Assistance Program (IEAP)	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, Childcare and behavioral concerns, Social adaptation needs, Alcohol/Substance Abuse, Work/Life Balance and Depression.	
Aetna Assistance	Included
Unlimited calendar year maximum	
Red24	Included
Includes security, political & natural disaster coverage (Program is underwritten by Aetna Life & Casualty (Bermuda) Ltd.)	
Chronic Condition Disease Management	Included
Simple Steps To A Healthier Life®	Included
MedQuery	Included
Teladoc	Included
International Maternity Management	Included

Group Insurance Plan of Benefits
Reliant Mission (Control # 142986)
administered by Aetna International®
Your Plan Effective Date: January 1, 2020

PPO Dental			
PLAN FEATURES	**Outside the U.S.**	**Inside the U.S.**	
		Preferred Benefits (In-Network)	**Non-Preferred Benefits (Out-of-Network)**
Individual Deductible	$100	$100	$100
Family Deductible	$300	$300	$300
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
Calendar Year Maximum	$1,500	$1,500	$1,500
Orthodontic Treatment *Child Only*	50%	50%	50%
Orthodontic Lifetime Maximum	$1,500	$1,500	$1,500
Please refer to your Plan Documents for additional benefit coverages for Types A, B and C			

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, Schedule of Benefits and any Booklet Amendments/Riders including g any state-specific variations, as applicable. For further details, refer to your Plan Documents.

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.

This plan of benefits is underwritten by Aetna Life Insurance Company (Delaware).

This is only a brief summary of the PPO Medical and PPO Dental 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).

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, Schedule of Benefits and any Booklet Amendments/Riders including g any state-specific variations, as applicable. For further details, refer to your Plan Documents.

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 الشركة.
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 رایگان، با شماره درج 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.

Proprietary