Group Insurance Calendar of Benefits for
The Church of Jesus Christ of Latter-Day Saints-Senior Missionaries
Control 176786 (ALIC-WA) - *Serving in Washington State*
administered by Aetna International®
Effective Date: January 1, 2026 – December 31, 2026

PPO			
		In the U.S.	
CALENDAR FEATURES	**OUTSIDE THE U.S.**	**Preferred Benefits (In-Network)**	**Non-Preferred Benefits (Out-of-Network)**
Individual Deductible	None	$2,000 per calendar year	$2,000 per calendar year
Family Deductible	None	$4,000 per calendar year	$4,000 per calendar year
Prior Calendar Credit	Prior calendar credit accrued from previous carrier SSMP applies to the current year for the initial enrollment period. Prior calendar credit from current and active Senior Service Medical Calendar coverage applies to the initial enrollment period of the Aetna International Senior Service Calendar.		
Individual Coinsurance Limit	None	$3,000 per calendar year	$3,000 per calendar year
(Does not include benefit penalties, 50% items, amounts above negotiated costs charged by non-network providers and Outpatient Prescription Drugs. Includes Outpatient Prescription Drugs when outside the US)			
Family Coinsurance Limit	None	$6,000 per calendar year	$6,000 per calendar year
(Does not include benefit penalties, 50% items, amounts above negotiated costs charged by non-network providers and Outpatient Prescription Drugs. Includes Outpatient Prescription Drugs when outside the US)			
Lifetime Maximum	Unlimited		
Member Payment Percentages			
Hospital Services			
Inpatient	No charge	20% after deductible	40% after deductible
Outpatient	No charge	20% after deductible	40% after deductible
Private Room Limit	The institution's semiprivate rate.		
Pre-certification Penalty	No Penalty	No Penalty	$200
To avoid penalties and/or benefit reduction for non-preferred benefits received in the U.S., contact the service center to determine if precertification is needed for a procedure. In addition to the possible need for precertification, providers in the U.S. who are not part of the Aetna network may bill you for additional costs. The calendar pays for the negotiated rate or the reasonable & customary charges for that service, but your provider not in the Aetna network may invoice you for the difference in that cost and their billed charges.			
Emergency Room	No charge	20% after deductible and $75 copay	20% after deductible and $75 copay
Urgent Care	No charge	No charge after deductible and $40 co-pay	40% deductible waived
Designated Walk-in Clinic *(CVS Minute Clinic)*	Not available outside of the United States	100% no deductible, no copay	Not applicable
Physician Services			
Physician Office Visit	No charge	No charge after $20 copay	40% deductible waived
Specialist Office Visit	No charge	No charge after $30 copay	40% deductible waived

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CALENDAR FEATURES	OUTSIDE THE U.S.	Preferred Benefits (In-Network)	Non-Preferred Benefits (Out-of-Network)
Mental Health Services			
Mental Health Inpatient Coverage	No charge	20% after deductible	40% after deductible
Unlimited days per calendar year			
Mental Health Outpatient Coverage	No charge	No charge after $30 copay	40% deductible waived
Unlimited visits per calendar year			
Alcohol/Drug Abuse Services			
Substance Abuse Inpatient Coverage	No charge	20% after deductible	40% after deductible
Unlimited days per calendar year			
Substance Abuse Outpatient Coverage	No charge	No charge after $30 copay	40% deductible waived
Unlimited visits per calendar year			
Prescription Drug Coverage (Standard Opt out Formulary)			
Generic Drugs *(365-day maximum supply)*	30% copay per month supply Deductible waived	35% copay per month supply Deductible waived	50% copay per month supply Deductible waived
Formulary Brand Name Drugs *(365-day maximum supply)*	30% per month supply Deductible waived	50% copay per month supply Deductible waived	50% copay per month supply Deductible waived
Non-Formulary Brand Name Drugs (365-day maximum supply)	30% per month supply Deductible waived	50% copay per month supply Deductible waived	50% copay per month supply Deductible waived
NOTE: **Medications** for the treatment of **diabetes** are covered/reimbursable 100%. GLP-1 (glucagon-like peptide-1) drugs such as any semaglutide *(Ozempic, Rybelsus, Wegovy)*, duaglutide *(Trulicity)*, liraglutide *(Saxenda)*, exenatide *(Byetta, Bydureon BCise)*, and tirzepatide *(Mounjaro)* are **covered for the treatment of type 2 diabetes only**.			

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CALENDAR FEATURES	OUTSIDE THE U.S.	Preferred Benefits (In-Network)	Non-Preferred Benefits (Out-of-Network)
Wellness Benefits			
Routine Children Physical Exams	No charge	No charge	40% deductible waived
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 up to $1,500 maximum per calendar year (Includes immunizations, x-rays and labs)	No charge	40% deductible waived
Adults age 22+ & -65: 1 exam/12 months adults age 65+: 1 exam/12 months includes immunizations			
Routine Gynecological Exams	No charge	No charge	40% deductible waived
Includes 1 exam and pap smear per calendar year			
Mammograms *(Unlimited visits per calendar year)*	No charge	No charge	40% deductible waived
Prostate Specific Antigen (PSA)	No charge	No charge	40% deductible waived
(Unlimited visits per calendar year)			
Digital Rectal Exam (DRE)	No charge	No charge	40% deductible waived
(Unlimited visits per calendar year)			
Colorectal Cancer Screening	No charge	No charge	40% deductible waived
Recommended: For all members age 50			
Routine Hearing Exam	No charge	No charge	40% deductible waived
Includes one (1) routine exam every 24 months. ***No coverage for hearing aids.***			
Vision Care			
Routine Eye Exam	No charge	No charge	30% deductible waived
Covers one (1) routine eye exam every 12 months. ***No coverage for lenses, frames or contacts.***			

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CALENDAR FEATURES	OUTSIDE THE U.S.	Preferred Benefits (In-Network)	Non-Preferred Benefits (Out-of-Network)
Other Services			
Ambulance Services	100% Covered at 100% for all medically necessary ambulance services.	20% after deductible	40% after deductible
Skilled Nursing Facility *(120 Days per calendar year)*	No charge	20% after deductible	40% after deductible
Hospice Care Facility Inpatient *(30 Days lifetime maximum)*	No charge	20% after deductible	40% after deductible
Hospice Care Facility Outpatient *(Unlimited lifetime maximum)*	No charge	20% after deductible	40% after deductible
Home Health Care *(120 visits per calendar year combined, includes Private Duty Nursing per calendar year)*	No charge	20% after deductible	40% after deductible
Spinal Disorder Treatment *(Unlimited visits per calendar year maximum)*	No charge	No charge after $10 copay	25% deductible waived
Short-Term Rehabilitation	No charge	No charge after $10 copay	25% after deductible
(Includes coverage for Occupational and Physical Therapies; unlimited visits per calendar year)			
Speech Therapy	No charge	No charge after $30 copay	40% after deductible
(Includes coverage for 60 visits per calendar year)			
Durable Medical Equipment *$2500 Maximum*	No charge	20% after deductible	40% after deductible
Bariatric Surgery	Not Covered	Not Covered	Not Covered
Diagnostic Outpatient X-ray	No charge	20% after deductible	40% after deductible
Diagnostic Outpatient Lab	No charge	No charge after deductible	40% after deductible
Allergy Testing	No charge	No charge after $30 copay	40% after deductible
Allergy Serum and Injections	No charge	20% after deductible	40% 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*		
Base Infertility Services	Not Covered	20% after deductible	40% after deductible
(Base calendar coverage includes coverage limited to the testing and treatment of underlying condition)			
Comprehensive Infertility Services	Not Covered	20% after deductible	40% after deductible
(6 cycles of Comprehensive calendar coverage includes coverage for Artificial Insemination and Ovulation Induction)			
ART Infertility Services	Not Covered	20% after deductible	40% after deductible
(6 cycles per lifetime for Advanced Reproductive Technology (ART) coverage with cryopreservation, storage and unlimited embryo transfers).			

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Other Services			
Emergency Assistance Program *(Unlimited calendar year maximum)*	No Charge	No Charge	No Charge
Global Crisis Management Program, powered by WorldAware *(Includes security, political & natural disaster coverage (Program is underwritten by Aetna Life & Casualty (Bermuda) Ltd.)*	Included	Included	Included
Medical Evacuation and Repatriation of Mortal Remains	Approval is **REQUIRED**. If "approved" covered at 100%. **Contact Missionary Medical to coordinate.**		

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Medical Calendar Caveats

This calendar includes coverage for women's preventive health benefits to the extent required under U.S. federal law effective beginning with calendar years starting on or after August 1, 2012.

Coinsurance Limits, also known as payment limits, apply per individual on a calendar year basis. The deductible met and those out-of-pocket expenses resulting from the application of a payment percentage may be used to satisfy the payment limit. Copays, benefit penalties and 50% items are excluded from the payment limit. Also excluded from the coinsurance limit are those amounts which providers not in an Aetna network may charge as costs above Reasonable & Customary charges. Providers who are not part of an Aetna network may invoice you directly for amounts they charge which are above negotiated rates. These amounts will not apply toward your coinsurance limit.

calendar

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 calendar 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 expenses. Coverage is provided for an employee and spouse and all female family members.

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.

Co-payments and coinsurance for chiropractic visits are capped at 25% of the amount due to the chiropractor

Benefit maximums per Calendar year are calculated between 01/01/2026 and 12/31/2026.

Pre-Existing Conditions:

- *Option: - (No Restriction)*

When receiving treatment within the United States, you are strongly encouraged to use Aetna network providers. *An Aetna customer service representative can help you identify doctors, hospitals, clinics, pharmacies, and other contracted network providers for you to consider. These network providers have contracted with Aetna to provide medical services and supplies at a reduced fee called the negotiated charge. This is how Aetna can control medical costs for its participants and keep premiums affordable. Your deductibles, copayments, and payment percentage will generally be lower when you use participating network providers and facilities. You may choose to use non-contracted providers; however, your out-of-pocket costs will then generally be higher. If you receive treatment or supply from providers that have not contracted with Aetna, Aetna will only pay the amount that they would have paid if a network provider had been used. In other words, Aetna will not usually pay the full amount charged to you by a non-network provider. Since out-of-network providers have not agreed to accept Aetna's negotiated charge as payment in full, they may bill you for the difference between what they bill, and the "in-network" negotiated amount that Aetna actually pays. YOU WILL BE RESPONSIBLE TO PAY FOR THESE EXCESS OUT-OF-NETWORK CHARGES EVEN IF YOU HAVE ALREADY SURPASSED YOUR CALENDAR YEAR'S DEDUCTIBLE AND OUT-OF-POCKET MAXIMUM EXPENSE LEVELS since your deductibles and out-of-pocket maximums apply to in-network costs.*

The proposed calendar 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 calendar requirements****, please refer to the booklet.*

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For Calendars 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 against 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 calendars and their affiliates (Aetna).
TTY: 711

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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。
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.

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