



**Group Insurance Plan of Benefits for
 The Church of Jesus Christ of Latter-day Saints-Senior Missionaries
 (Control 540071)
 Aetna Insurance Company, Limited - Europe
 Effective Date: January 1, 2019 – December 31, 2019**

PPO			
PLAN FEATURES	OUTSIDE THE U.S.	Care Received inside U.S. <i>or Purchased</i> from U.S.	
		Preferred Benefits (In-Network)	Non-Preferred Benefits (Out-of-Network)
Individual Deductible	None	\$2,000 per plan year	\$2,000 per plan year
Family Deductible	None	\$4,000 per plan year	\$4,000 per plan year
Important to Know	It is important that you are protected financially. As such, when receiving services inside the U.S. it is important that you go to in-network providers and receive the preferred benefits. Otherwise, providers who are not part of the Aetna network may bill you for additional costs, such as costs over the reasonable and customary charges for that service, amounts that don't apply to the deductible, or amounts that are not included in the coinsurance limit.		
Individual Coinsurance Limit	None	\$3,000 per plan year	\$3,000 per plan year
<i>(Does not include copays, 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)</i>			
Family Coinsurance Limit	None	\$6,000 per plan year	\$6,000 per plan year
<i>(Does not include copays, 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)</i>			
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
<i>To avoid penalties and/or benefit reductions for non-preferred benefits received in the U.S., contact the service center to determine if precertification is needed for a procedure.</i>			
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 \$30 co-pay	40% after deductible
Physician Services			
Physician Office Visit	No charge	\$20 copay	40% after deductible
Specialist Office Visit	No charge	\$20 copay	40% after deductible
Mental Health Services			
Mental Health Inpatient Coverage	No charge	20% after deductible	40% after deductible
<i>Unlimited days per plan year</i>			
Mental Health Outpatient Coverage	No charge	\$20 copay	40% after deductible
<i>Unlimited visits per plan year</i>			
Alcohol/Drug Abuse Services			
Substance Abuse Inpatient Coverage	No charge	20% after deductible	40% after deductible
<i>Unlimited days per plan year</i>			
Substance Abuse Outpatient Coverage	No charge	\$20 copay	40% after deductible
<i>Unlimited visits per plan year</i>			



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Prescription Drug Coverage			
Generic Drugs <i>(365 day maximum supply)</i>	30% Deductible waived	35% Deductible waived	50% Deductible waived
Formulary Brand Name Drugs <i>(365 day maximum supply)</i>	30% Deductible waived	50% Deductible waived	50% Deductible waived
Non Formulary Brand Name Drugs <i>(365 day maximum supply)</i>	30% Deductible waived	50% Deductible waived	50% Deductible waived
Other Services			
Global Emergency Assistance Program <i>(\$500,000 plan year maximum)</i>	No Charge	No Charge	No Charge
Wellness Benefits			
Routine Children Physical Exams	No charge	No charge	40% deductible waived
<i>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)</i>			
Routine Adult Physical Exams	No charge	No charge	40% deductible waived
<i>Adults age 22+ & -65: 1 exam/24 months Adults age 65+: 1 exam/12 months includes immunizations</i>			
Routine Gynecological Exams	No charge	No charge	40% deductible waived
<i>Includes 1 exam and pap smear per plan year</i>			
Mammograms <i>(Unlimited visits per plan year)</i>	No charge	No charge	40% deductible waived
Prostate Specific Antigen (PSA)	No charge	No charge	40% deductible waived
<i>Includes 1 PSA per plan year for males 40+</i>			
Digital Rectal Exam (DRE)	No charge	No charge	40% deductible waived
<i>Includes 1 DRE per plan year for males 40+</i>			
Cancer Screening	No charge	No charge	40% deductible waived
<i>Includes 1 flex sigmoid and double barium contrast every 5 years; and at age 50+ 1 colonoscopy every 10 years</i>			
Routine Hearing Exam	No charge	No charge	40% deductible waived
<i>Includes one routine exam every 24 months.</i>			
Hearing Aids	No charge	20% after deductible	40% after deductible
<i>1 hearing aid per ear to \$1,000 maximum per ear every 3 years for child to age 24</i>			
Vision Care			
Routine Eye Exam	No charge	No charge	40% deductible waived
<i>(Covers 1 routine eye exam every 12 months. No coverage for lenses, frames or contacts).</i>			



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		Preferred Benefits (In-Network)	Non-Preferred Benefits (Out-of-Network)
Other Services			
Skilled Nursing Facility <i>(120 Days per plan year)</i>	No charge	20% after deductible	40% after deductible
Hospice Care Facility Inpatient <i>(30 Days lifetime maximum)</i>	No charge	20% after deductible	40% after deductible
Hospice Care Facility Outpatient <i>(Unlimited lifetime maximum)</i>	No charge	20% after deductible	40% after deductible
Home Health Care <i>(120 visits per plan year combined, includes Private Duty Nursing per plan year)</i>	No charge	20% after deductible	40% after deductible
Spinal Disorder Treatment <i>(9 visits per plan year maximum)</i>	No charge	\$20 copay	40% after deductible
Short-Term Rehabilitation <i>(Includes coverage for Occupational, Physical and Speech Therapies; 60 Visits combined maximum visits per plan year)</i>	No charge	\$20 copay	40% after deductible
Diagnostic Outpatient X-ray	No charge	20% after deductible	40% after deductible
Diagnostic Outpatient Lab	No charge	No charge after deductible	40% after deductible
Bariatric Surgery	Not Covered	Not Covered	Not Covered
Infertility	Not Covered under Medical nor Pharmacy	Not Covered under Medical nor Pharmacy	Not Covered under Medical nor Pharmacy
Autism <i>Member cost sharing is based on the type of service performed and the place of service where it is rendered</i>	Autism covered same as any other expense. Applied behavioral analysis services are limited to \$36,000 per plan year. Once the plan year limit has been met; applied behavioral analysis services will be covered as a Mental Health benefit.		

Services and Programs included in Quote
International Disease Management International Maternity Management Program Wellness Checkpoint



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Medical Plan Caveats

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.

Coinurance Limits, also known as payment limits, apply per individual on a plan 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.

There is cross-application between plan 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 plan 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.

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.

Benefit maximums per Plan year are calculated between 01/01/2019 and 12/31/2019.

Pre-Existing Conditions:

- *Option: Option 5 - (No Restriction)*
- *On Effective Date: Pre-existing condition limitation is waived on the effective date.*
- *After Effective Date: Pre-existing condition limitation is waived after the effective date.*
- *Pre-Existing Conditions is waived for dependents under age 19.*

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 is able to control medical costs for its members and keep premiums affordable. Your deductibles, copayments, and payment percentage will generally be lower when you use participating network providers. You may choose to use non-contracted providers, however your out-of-pocket costs will then generally be higher. If you receive treatment at a non-network provider that has 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 rate 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. **BE RESPONSIBLE TO PAY FOR THESE EXCESS OUT-OF-NETWORK CHARGES EVEN IF YOU HAVE ALREADY SURPASSED YOUR PLAN YEAR DEDUCTIBLE AND OUT-OF-POCKET MAXIMUM EXPENSE LEVELS since your deductibles and out-of-pocket maximums apply to in-network costs.**

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 booklet.

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	For language assistance in your language call the number listed on your ID card at no cost.
Spanish	Para obtener asistencia lingüística en español, llame sin costo alguno al número que figura en su tarjeta de identificación.
Chinese	欲取得繁體中文語言協助，請撥打您保險卡上所列的號碼，無需付費。
Arabic	لتلقي المساعدة اللغوية باللغة العربية، اتصل مجاناً بالرقم الموضح على بطاقة الاشتراك في التأمين الصحي.
French	Pour une assistance linguistique en français, appelez gratuitement le numéro indiqué sur votre carte d'assurance santé.
French Creole	Pou ou jwenn asistans lang pou Kreyòl Ayisyen, rele gratis nan nimewo ki sou kat idantifikasyon asirans sante ou.
German	Benötigen Sie Hilfe oder Informationen auf Deutsch? Rufen Sie kostenlos die auf Ihrer Versicherungskarte aufgeführte Nummer an.
Italian	Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente il numero riportato sulla Sua scheda identificativa.
Japanese	日本語でのアシストは、IDカードに記載の番号に無料でお電話ください。
Korean	한국어로 언어 지원을 받고 싶으시면 보험 ID 카드에 수록된 무료 통화 번호로 전화해 주십시오.
Persian	برای راهنمایی به زبان فارسی، بدون هیچ هزینه ای با شماره ای که بر روی کارت شناسایی شما آمده است تماس بگیرید. انگلیسی
Polish	Aby uzyskać pomoc językową w języku polskim, zadzwoń bezpłatnie pod numer podany na karcie identyfikacyjnej.
Portuguese	Para obter assistência linguística em português ligue para o número grátis indicado no seu cartão de identificação.
Russian	Чтобы получить языковую поддержку на русском языке, бесплатно позвоните по номеру, указанному на вашей идентификационной карте.
Tagalog	Para sa language assistance na nasa Tagalog, tawagan ang nakalistang numero sa iyong ID card nang walang bayad.
Vietnamese	Để được hỗ trợ ngôn ngữ bằng tiếng Việt, hãy gọi đến số được ghi trên thẻ ID của quý vị, miễn phí cước gọi.