National Health Care, Inc.
Effective Date: 01-01-2018
Aetna Choice™ POS II - ASC

BRONZE HDHP PLAN DESIGN & BENEFITS
ADMINISTERED BY AETNA LIFE INSURANCE COMPANY

| PLAN FEATURES | PREFERRED CARE | NON-PREFERRED CARE |
|---|---|---|
| **Deductible (per calendar year)** | $6,600 Individual<br>$13,200 Family | $20,000 Individual<br>$40,000 Family |
| All covered expenses accumulate toward both the preferred and non-preferred Deductible.<br>Unless otherwise indicated, the Deductible must be met prior to benefits being payable.<br>Once Family Deductible is met, all family members will be considered as having met their Deductible for the remainder of the calendar year. | | |
| **Member Coinsurance**<br>Applies to all expenses unless otherwise stated. | Covered 100% | 30% |
| **Out-Of-Pocket Maximum (per calendar year)** | $6,600 Individual<br>$13,200 Family | Unlimited Individual<br>Unlimited Family |
| All covered expenses including Deductible, accumulate toward both the preferred and non-preferred Payment Limit.<br>Only those out-of-pocket expenses resulting from the application of coinsurance percentage, deductibles (except any penalty amounts) may be used to satisfy the Payment Limit.<br>The family out-of-pocket limit can be met by a combination of family members. Unless otherwise indicated, the Deductible must be met prior to benefits being payable. | | |
| **Lifetime Maximum** | Unlimited except where otherwise | Unlimited except where otherwise |
| **Primary Care Physician Selection** | Optional | Not applicable |
| **Certification Requirements -**<br>Certification for certain types of Non-Preferred care must be obtained to avoid a reduction in benefits paid for that care.<br>Certification for Hospital Admissions, Treatment Facility Admissions, Convalescent Facility Admissions, Home Health Care, Hospice Care and Private Duty Nursing is required - excluded amount applied separately to each type of expense is $400 per occurrence. | | |
| **Referral Requirement** | None | None |
| **PREVENTIVE CARE** | **PREFERRED CARE** | **NON-PREFERRED CARE** |
| **Routine Adult Physical Exams/ Immunizations**<br>1 exam per 12 months for members age 22 and older. | Covered 100%; deductible waived | 30% after deductible |
| **Routine Well Child Exams/Immunizations**<br>7 exams in the first 12 months of life: 3 exams in the 2nd 12 months life; 3 exams in the 3rd 12 months of life; 1 exam per 12 months thereafter to age 22. | Covered 100%; deductible waived | 30% after deductible |
| **Routine Gynecological Care Exams**<br>Includes routine tests and related lab fees | Covered 100%; deductible waived | 30% after deductible |
| **Routine Mammograms**<br>For covered females age 40 and over. | Covered 100%; deductible waived | 30% after deductible |
| **Women's Health**<br>Includes: Screening for gestational diabetes, HPV (Human Papillomavirus) DNA testing, counseling for sexually transmitted infections, counseling and screening for Human Immunodeficiency Virus, screening and counseling for interpersonal and domestic violence, breastfeeding support, supplies, and counseling.<br>Contraceptive methods, sterilization procedures, patient education and counseling. Limitations may apply. | Covered 100%; deductible waived | 30% after deductible |
| **Routine Digital Rectal Exam / Prostate-specific Antigen Test**<br>For covered males age 40 and over. | Covered 100%; deductible waived | 30% after deductible |
| **Colorectal Cancer Screening**<br>For all members age 50 and over. | Covered 100%; deductible waived | 30% after deductible |

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|---|---|---|
| **Routine Eye Exams**<br>1 routine exam per 24 months | Covered 100%; deductible waived | 30% after deductible |
| **PHYSICIAN SERVICES** | **PREFERRED CARE** | **NON-PREFERRED CARE** |
| **Office Visits to PCP**<br>Includes services of an internist, general physician, family practitioner or pediatrician. | Covered 100% after deductible | 30% after deductible |
| **Specialist Office Visits** | Covered 100% after deductible | 30% after deductible |
| **Pre-Natal Maternity** | Covered 100%; deductible waived | 30% after deductible |
| **Allergy Testing** | Covered as either PCP or specialist office visit after deductible | 30% after deductible |
| **Allergy Injections** | Covered as either PCP or specialist office visit after deductible | 30% after deductible |
| **DIAGNOSTIC PROCEDURES** | **PREFERRED CARE** | **NON-PREFERRED CARE** |
| **Diagnostic Laboratory and X-ray**<br>If performed as a part of a physician office visit and billed by the physician, expenses are covered subject to the applicable physician's office visit member cost sharing | Covered 100% after deductible | 30% after deductible |
| **EMERGENCY MEDICAL CARE** | **PREFERRED CARE** | **NON-PREFERRED CARE** |
| **Urgent Care Provider**<br>(benefit availability may vary by location) | Covered 100% after deductible | 30% after deductible |
| **Non-Urgent Use of Urgent Care Provider** | Not Covered | Not Covered |
| **Emergency Room** | Covered 100% after deductible | Same as preferred care; after deductible |
| **Non-Emergency care in an Emergency Room** | Not Covered | Not Covered |
| **Ambulance** | Covered 100% after deductible | Covered 100% after deductible |
| **HOSPITAL CARE** | **PREFERRED CARE** | **NON-PREFERRED CARE** |
| **Inpatient Coverage**<br>The member cost sharing applies to all covered benefits incurred during a member's inpatient stay | Covered 100% after deductible | 30% after deductible |
| **Inpatient Maternity Coverage**<br>(includes delivery and postpartum care)<br>The member cost sharing applies to all covered benefits incurred during a member's inpatient stay | Covered 100% after deductible | 30% after deductible |
| **Outpatient Surgery** | Covered 100% after deductible | 30% after deductible |
| **Outpatient Surgery** (Freestanding Facility) | Covered 100% after deductible | 30% after deductible |
| **Outpatient Hospital Expenses** (excluding surgery)<br>The member cost sharing applies to all Covered Benefits incurred during a member's outpatient visit | Covered 100% after deductible | 30% after deductible |
| **MENTAL HEALTH SERVICES** | **PREFERRED CARE** | **NON-PREFERRED CARE** |
| **Inpatient**<br>The member cost sharing applies to all covered benefits incurred during a member's inpatient stay | Covered 100% after deductible | 30% after deductible |
| **Outpatient**<br>The member cost sharing applies to all covered benefits incurred during a member's outpatient visit | Covered 100% after deductible | 30% after deductible |
| **ALCOHOL/DRUG ABUSE SERVICES** | **PREFERRED CARE** | **NON-PREFERRED CARE** |
| **Inpatient**<br>The member cost sharing applies to all covered benefits incurred during a member's inpatient stay | Covered 100% after deductible | 30% after deductible |
| **Outpatient** | Covered 100% after deductible | 30% after deductible |

The member cost sharing applies to all Covered Benefits incurred during a member's outpatient visit

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| OTHER SERVICES | PREFERRED CARE | NON-PREFERRED CARE |
|---|---|---|
| **Convalescent Facility** | Covered 100% after deductible | 30% after deductible |
| Limited to 60 days per calendar year.<br>The member cost sharing applies to all covered benefits incurring during a member's inpatient stay | | |
| **Home Health Care** | Covered 100% after deductible | 30% after deductible |
| Limited to 80 visits per calendar year. Includes Private Duty Nursing limited to 70 eight hour shifts per calendar year.<br>Each visit by a nurse or therapist is one visit. Each visit up to 4 hours by a home health care aide is one visit. | | |
| **Hospice Care - Inpatient** | Covered 100% after deductible | 30% after deductible |
| The member cost sharing applies to all covered benefits incurred during a member's inpatient stay | | |
| **Hospice Care - Outpatient** | Covered 100% after deductible | 30% after deductible |
| The member cost sharing applies to all covered benefits incurred during a member's outpatient visit | | |
| **Outpatient Short-Term Rehabilitation** | Covered 100% after deductible | 30% after deductible |
| Limited to 30 Speech Therapy, 30 Physical Therapy and 30 Occupational Therapy visits per calendar year. | | |
| **Spinal Manipulation Therapy** | Covered 100% after deductible | 30% after deductible |
| Limited to 20 visits per calendar year | | |
| **Autism Behavioral Therapy** | Covered 100% after deductible | 30% after deductible |
| Covered same as any other Outpatient Mental Health benefit. | | |
| **Autism Applied Behavior Analysis** | Covered 100% after deductible | 30% after deductible |
| Covered same as any other Outpatient Mental Health benefit with no age or visit limitations. | | |
| **Autism Physical, Occupational and Speech Therapy** | Covered 100% after deductible | 30% after deductible |
| Covered same as any other Short Term Rehabilitation expense. No age or visit limit restrictions. | | |
| **Routine Hearing Exams** | Covered 100%; after deductible | 30% after deductible |
| 1 routine exam per 24 months | | |
| **Hearing Aids** | Covered 100% after deductible | 30% after deductible |
| Covered for children twelve years of age or younger. | | |
| **Nutritional Counseling** | Covered 100% after deductible | 30% after deductible |
| Limited to 3 visits per calendar year. | | |
| **Durable Medical Equipment** | Covered 100% after deductible | 30% after deductible |
| **Teladoc™** | $40 per consultation | Not Covered |
| Teladoc is available for minor acute, episodic illnesses or when your primary care physician is not available. Teladoc's U.S. board-certified doctors can resolve many of your medical issues, 24/7/365, via phone 1-855-Teladoc (835-2362); or online video consults from wherever you happen to be. Teladoc may not be available in certain states and service limitations may apply (e.g., limited telephonic services for pharmacy in California). | | |
| **Transplants** | Covered 100% Preferred coverage is provided at an IOE contracted facility only; after deductible | 30% Non-Preferred coverage is provided at a Non-IOE facility; after deductible |
| **Mouth, Jaws and Teeth**<br>(oral surgery procedures, whether medical or dental in nature) | Member cost sharing is based on the type of service performed and the place of service where it is rendered; after deductible | 30% after deductible |
| **Out of Area Dependents** | Coverage provided at the preferred and non-preferred benefit level of the plan; after deductible | |
| **FAMILY PLANNING** | **PREFERRED CARE** | **NON-PREFERRED CARE** |
| **Infertility Treatment** | Covered 100% after deductible | 30% after deductible |
| Diagnosis and treatment of the underlying medical condition. | | |
| **Vasectomy** | Covered 100% after deductible | 30% after deductible |
| **Tubal Ligation** | Covered 100% after deductible | 30% after deductible |

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| PHARMACY | PREFERRED CARE | NON-PREFERRED CARE |
|---|---|---|
| **Pharmacy Plan Type** | N/A | N/A |
| **GENERAL PROVISIONS** | | |
| **Dependents Eligibility** | Spouse, children from birth to age 26 | |
| **Pre-existing Conditions Exclusion** | On effective date: Waived<br>After effective date: Waived | |

This plan does not cover all health care expenses and includes exclusions and limitations. Members should refer to their plan documents to determine which health care services are covered and to what extent. The following is a partial list of services and supplies that are generally not covered. However, your plan documents may contain exceptions to this list based on state mandates or the plan design or rider(s) purchased by your employer.

All medical or hospital services not specifically covered in, or which are limited or excluded in the plan documents; Charges related to any eye surgery mainly to correct refractive errors; Cosmetic surgery, including breast reduction; Custodial care; Dental care and X-rays; Donor egg retrieval; Experimental and investigational procedures; Hearing aids; Immunizations for travel or work; Infertility services, including, but not limited to, artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI and other related services, unless specifically listed as covered in your plan documents; Nonmedically necessary services or supplies; Orthotics; Over-the-counter medications and supplies; Reversal of sterilization; Services for the treatment of sexual dysfunction or inadequacies, including therapy, supplies, or counseling; and special duty nursing. Weight control services including surgical procedures, medical treatments, weight control/loss programs, dietary regimens and supplements, appetite suppressants and other medications; food or food supplements, exercise programs, exercise or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity, including Morbid Obesity, or for the purpose of weight reduction, regardless of the existence of comorbid conditions.

This material is for informational purposes only and is neither an offer of coverage nor medical advice. It contains only a partial, general description of plan benefits or programs and does not constitute a contract. Aetna does not provide health care services and, therefore, cannot guarantee results or outcomes. Consult the plan documents (i.e. Group Insurance Certificate and/or Group Policy) to determine governing contractual provisions, including procedures, exclusions and limitations relating to the plan.

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With the exception of Aetna Rx Home Delivery, all preferred providers and vendors are independent contractors in private practice and are neither employees nor agents of Aetna or its affiliates. Aetna Rx Home Delivery, LLC, is a subsidiary of Aetna Inc. The availability of any particular provider cannot be guaranteed, and provider network composition is subject to change without notice.

Some benefits are subject to limitations or visit maximums. Certain services require precertification, or prior approval of coverage. Failure to precertify for these services may lead to substantially reduced benefits or denial of coverage. Some of the benefits requiring precertification may include, but are not limited to, inpatient hospital, inpatient mental health, inpatient skilled nursing, outpatient surgery, substance abuse (detoxification, inpatient and outpatient rehabilitation). When the Member's preferred provider is coordinating care, the preferred provider will obtain the precertification. When the member utilizes a non-preferred provider, Member must obtain the precertification. Precertification requirements may vary. Depending on the plan selected, new prescription drugs not yet reviewed by our medication review committee are either available under plans with an open formulary or excluded from coverage unless a medical exception is obtained under plans that use a closed formulary.

They may also be subject to precertification or step-therapy. Non-prescription drugs and drugs in the Limitations and Exclusions section of the plan documents (received after open enrollment) are not covered, and medical exceptions are not available for them. While this information is believed to be accurate as of the print date, it is subject to change.

Plans are administered by Aetna Life Insurance Company.