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

STANDARD PLAN DESIGN & BENEFITS
ADMINISTERED BY AETNA LIFE INSURANCE COMPANY

PLAN FEATURES	PREFERRED CARE	NON-PREFERRED CARE
Deductible (per calendar year)	$1,000 Individual $3,000 Family	$20,000 Individual $40,000 Family
Unless otherwise indicated, the Deductible must be met prior to benefits being payable. The family Deductible is a cumulative Deductible for all family members. The family Deductible can be met by a combination of family members; however no single individual within the family will be subject to more than the individual Deductible amount.		
Member Coinsurance Applies to all expenses unless otherwise stated.	Covered 100%	30%
Out-of-Pocket Maximum (per calendar year)	$7,350 Individual $14,700 Family	Unlimited Individual Unlimited Family
Certain member cost sharing elements may not apply toward the Out-of-Pocket Maximum. Only those out-of-pocket expenses resulting from the application of coinsurance percentage, deductibles, and copays (except any penalty amounts) may be used to satisfy the Payment Limit. The family Payment Limit is a cumulative Payment Limit for all family members. The family Payment Limit can be met by a combination of family members; however no single individual within the family will be subject to more than the individual Payment Limit amount.		
Lifetime Maximum	Unlimited	Unlimited
All covered expenses, excluding prescription drugs, accumulate toward both the preferred and non-preferred Lifetime Maximum.		
Primary Care Physician Selection	Optional	Not applicable
Certification Requirements - Certification for certain types of Non-Preferred care must be obtained to avoid a reduction in benefits paid for that care. 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 is $400 per occurrence.		
Referral Requirement	None	None
PREVENTIVE CARE	**PREFERRED CARE**	**NON-PREFERRED CARE**
Routine Adult Physical Exams/ Immunizations 1 exam per 12 months for members age 22 and older.	Covered 100%; deductible waived	30% after deductible
Routine Well Child Exams/Immunizations 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 Includes routine tests and related lab fees	Covered 100%; deductible waived	30% after deductible
Routine Mammograms For covered females age 40 and over.	Covered 100%; deductible waived	30% after deductible
Women's Health 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. 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 For covered males age 40 and over.	Covered 100%; deductible waived	30% after deductible
Colorectal Cancer Screening For all members age 50 and over.	Covered 100%; deductible waived	30% after deductible
Routine Eye Exams 1 routine exam per 24 months	Covered 100%; deductible waived	30% after deductible
PHYSICIAN SERVICES	**PREFERRED CARE**	**NON-PREFERRED CARE**

STANDARD PLAN DESIGN & BENEFITS
ADMINISTERED BY AETNA LIFE INSURANCE COMPANY

Office Visits to PCP	$30 office visit copay; deductible waived	30% after deductible
Includes services of an internist, general physician, family practitioner or pediatrician.		
Specialist Office Visits	$45 office visit copay; deductible waived	30% after deductible
Pre-Natal Maternity	Covered 100%; deductible waived	30% after deductible
Allergy Testing	Covered as either PCP or specialist office visit; deductible waived	30% after deductible
Allergy Injections	Covered as either PCP or specialist office visit; deductible waived	30% after deductible
DIAGNOSTIC PROCEDURES	**PREFERRED CARE**	**NON-PREFERRED CARE**
Diagnostic Laboratory and X-ray except for Complex Imaging Services	Preventative Lab and X-Ray covered in Full. Diagnostic Lab and X-Ray $10 Copay- Free Standing Facility $25 copay- Hospital Based	30% after deductible
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		
Diagnostic X-ray for Complex Imaging Services	$250 copay- Free Standing Facility $500 copay- Hospital Based	30% after deductible
EMERGENCY MEDICAL CARE	**PREFERRED CARE**	**NON-PREFERRED CARE**
Urgent Care Provider (benefit availability may vary by location)	$75 copay; deductible waived	30% after deductible
Non-Urgent Use of Urgent Care Provider	Not Covered	Not Covered
Emergency Room	$150 copay; deductible waived	Same as preferred care; deductible waived
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	$500 copay after deductible	30% after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay		
Inpatient Maternity Coverage (includes delivery and postpartum care)	$500 copay after deductible	30% after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay		
Outpatient Surgery	$500 copay after deductible	30% after deductible
Outpatient Surgery (Freestanding Facility)	$500 copay after deductible	30% after deductible
Outpatient Hospital Expenses (excluding surgery)	$500 copay after deductible	30% after deductible
The member cost sharing applies to all Covered Benefits incurred during a member's outpatient visit		
MENTAL HEALTH SERVICES	**PREFERRED CARE**	**NON-PREFERRED CARE**
Inpatient	$500 copay after deductible	30% after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay		
Outpatient-Office Visit	$45 copay; deductible waived	30% after deductible
The member cost sharing applies to all Covered Benefits incurred during a member's outpatient visit		

Outpatient-Facility	$500 copay after deductible	30% after deductible

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

STANDARD PLAN DESIGN & BENEFITS
ADMINISTERED BY AETNA LIFE INSURANCE COMPANY

ALCOHOL/DRUG ABUSE SERVICES	PREFERRED CARE	NON-PREFERRED CARE
Inpatient	$500 copay after deductible	30% after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay		
Outpatient-Office Visit	$45 copay ; deductible waived	30% after deductible
The member cost sharing applies to all Covered Benefits incurred during a member's outpatient visit		
Outpatient-Facility	$500 copay after deductible	30% after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay		
OTHER SERVICES	**PREFERRED CARE**	**NON-PREFERRED CARE**
Convalescent Facility	$250 copay; deductible waived	30% after deductible
Limited to 60 days per calendar year.		
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. 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	$500 copay 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 $45 copay; deductible waived	30% after deductible
Limited to 30 Speech Therapy, 30 Physical Therapy and 30 Occupational Therapy visits per calendar year.		
Autism Behavioral Therapy	Covered 100% after $45 copay; deductible waived	30% after deductible
Covered same as any other Outpatient Mental Health benefit.		
Autism Applied Behavior Analysis	Covered 100% after $45 copay; deductible waived	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 $45 copay; deductible waived	30% after deductible
Covered same as any other Short Term Rehabilitation expense. No age or visit limit restrictions.		
Spinal Manipulation Therapy	Covered 100% after $45 copay; deductible waived	30% after deductible
Limited to 20 visits per calendar year		
Routine Hearing Exams	Member cost sharing is based on the type of service performed and the place of service where it is rendered	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	Member cost sharing is based on the type of service performed and the place of service where it is rendered	30% after deductible
Limited to 3 visits per calendar year.		
Durable Medical Equipment	Covered 60%; deductible waived	30% after deductible
Teladoc™	Covered at 100%	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

STANDARD PLAN DESIGN & BENEFITS
ADMINISTERED BY AETNA LIFE INSURANCE COMPANY

Mouth, Jaws and Teeth (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	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
Diagnosis and treatment of the underlying medical condition.		
Vasectomy	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
Tubal Ligation	Covered 100%; deductible waived	30% after deductible
PHARMACY	**PREFERRED CARE**	**NON-PREFERRED CARE**
Pharmacy Plan Type	N/A	N/A
GENERAL PROVISIONS		
Dependents Eligibility	Spouse, children from birth to age 26, regardless of student status.	
Pre-existing Conditions Exclusion	On effective date: Waived 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.

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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.

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.