aetna®

# Group Insurance Plan of Benefits
# Administered by Aetna International®
# Plan Effective Date: January 1, 2026

| Eligibility Provision | |
|---|---|
| **Employee** | Regular full-time employees participating in this plan working a minimum of 25 hours per week. |
| **Dependent** | Spouse, domestic partner; children up to age 26, regardless of student status. |

| OAMC Medical | Outside U.S. | Inside U.S. Preferred Benefits (In-Network) | Inside U.S. Non-Preferred Benefits (Out-of-Network) |
|---|---|---|---|
| **Individual Deductible** | $0 per calendar year | $3,250 per calendar year | $5,000 per calendar year |
| **Family Deductible** | $0 per calendar year | $9.750 per calendar year | $15,000 per calendar year |
| **Prior Plan Credit** | Previous Calendar Year | Previous Calendar Year | Previous Calendar Year |
| **Individual Payment Limit** *(Does not include precertification penalty. Includes Outpatient Prescription Drugs when outside the U.S.)* | $0 per calendar year | $5,500 per calendar year | $11,000 per calendar year |
| **Family Payment Limit** *(Does not include precertification penalty. Includes Outpatient Prescription Drugs when outside the U.S.)* | $0 per calendar year | $11,000 per calendar year | $22,000 per calendar year |
| **Lifetime Maximum** | Unlimited | Unlimited | Unlimited |
| **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. | The institution's semiprivate rate. | The institution's semiprivate rate. |
| **Pre-certification Penalty** *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.* | No penalty | No penalty | $400 |
| **Emergency Room** | No charge | 20% after $150 copay | 20% after $150 deductible |
| **Non-Emergency Use of the Emergency Room** | No charge | Not covered | Not covered |
| **Urgent Care** | No charge | No charge after $75 copay | 20% after deductible |
| **Non-Urgent Use of Urgent Care Provider** | No charge | Not covered | Not covered |
| **Ambulance Services** | No charge | 20% | 20% |

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| | OAMC Medical<br>Outside U.S. | Inside U.S. Preferred Benefits (In-Network) | Inside U.S. Non-Preferred Benefits (Out-of-Network) |
|---|---|---|---|
| **Physician Services** | | | |
| **Physician Office Visit** | No charge | No charge after $35 copay | 20% after deductible |
| **Telemedicine Consultation with Non-Specialist** | No charge | No charge | 20% after deductible |
| **Specialist Office Visit** | No charge | No charge after $50 copay | 20% after deductible |
| **Telemedicine Consultation with Specialist** | No charge | No charge | 20% after deductible |
| **Walk in Clinics**<br>*Walk-in Clinics are free-standing health care facilities that (a) may be located in or with a pharmacy, drug store, supermarket or other retail store; and (b) provide limited medical care and services on a scheduled or unscheduled basis. Urgent care centers, emergency rooms, the outpatient department of a hospital, ambulatory surgical centers, and physician offices are not considered to be Walk-in Clinics.* | No charge | No charge | 20% after deductible |
| **CVSH Virtual Care (Including Mental Health for Ages 13+) and CVSH Virtual Primary Care** | Not covered | No charge | Not covered |
| **Allergy Testing** | No charge | No charge after $50 copay | 20% after deductible |
| **Allergy Serum & Injections** | No charge | 20% after deductible | 40% after deductible |
| **Mental Health & Alcohol/Drug Abuse Services** | | | |
| **Mental Health Inpatient**<br>*Unlimited days per calendar year* | No charge | 20% after deductible | 40% after deductible |
| **Mental Health Outpatient**<br>*Unlimited visits per calendar year* | No charge | No charge after $35 copay | 20% after deductible |
| **Substance Abuse Inpatient**<br>*Unlimited days per calendar year* | No charge | 20% after deductible | 40% after deductible |
| **Substance Abuse Outpatient**<br>*Unlimited visits per calendar year* | No charge | No charge after $35 copay | 20% after deductible |

| | OAMC Medical<br>Outside U.S. | Inside U.S. Preferred Benefits (In-Network) | Inside U.S. Non-Preferred Benefits (Out-of-Network) |
|---|---|---|---|
| **Preventive Care Services** | | | |
| **Routine Child Physical Exams**<br>*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)* | No charge | No charge | 20% |
| **Routine Adult Physical Exams**<br>*Adults age 22+ & -65: 1 exam/12 months Adults age 65+: 1 exam/12 months includes immunizations* | No charge | No charge | 20% |
| **Routine Gynecological Exams**<br>*Includes 1 exam and pap smear per calendar year* | No charge | No charge | 20% after deductible |
| **Routine breast cancer screenings**<br>*Unlimited tests per calendar year* | No charge | No charge | 20% |
| **Prostate Specific Antigen (PSA)**<br>*Unlimited tests per calendar year* | No charge | No charge | No charge |
| **Routine Digital Rectal Exam (DRE)**<br>*Unlimited exams per calendar year* | No charge | No charge | No charge |
| **Colorectal Cancer Screening**<br>*Recommended: For all members age 45 and older.* | No charge | No charge | 20% |
| **Routine Hearing Exams**<br>*Includes one routine exam every 24 months.* | No charge | No charge | 20% after deductible |
| **Hearing Aids**<br>*Covered to $1,400 per ear every 36 months* | No charge | 20% after deductible | 40% after deductible |
| **Vision Care** | | | |
| **Routine Eye Exams**<br>*(Covered under medical) Includes 1 exam every 12 months* | No charge | No charge | 20% after deductible |
| **Vision Care Supplies**<br>*Schedule maximums apply every 12 months* | No charge up to $150 maximum | No charge up to $150 maximum | No charge up to $150 maximum |

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| OAMC Medical | Outside U.S. | Inside U.S. Preferred Benefits (In-Network) | Inside U.S. Non-Preferred Benefits (Out-of-Network) |
|---|---|---|---|
| **Other Services** | | | |
| **Skilled Nursing Facility**<br>*120 visits per calendar year and 200 day per lifetime for Alzheimer's* | No charge | 20% after deductible | 40% after deductible |
| **Hospice Care Facility Inpatient**<br>*30 days lifetime maximum* | No charge | 20% after deductible | 40% after deductible |
| **Hospice Care Facility Outpatient**<br>*Unlimited lifetime maximum; includes bereavement counseling (Counseling covered for family up to 6 months or 15 visits after patients death (whichever comes first) per family member death.)* | No charge | 20% after deductible | 40% after deductible |
| **Home Health Care**<br>*120 visits per calendar year, includes Private Duty Nursing* | No charge | 20% after deductible | 40% after deductible |
| **Spinal Disorder Treatment**<br>*Unlimited visits per calendar year* | No charge | No charge after $10 copay | 20% after deductible |
| **Short Term Rehabilitation**<br>*(Includes coverage for Occupational and Physical Therapies; unlimited visits per calendar year)* | No charge | No charge after $10 copay | 20% after deductible |
| **Speech Therapy**<br>*60 visits per calendar year* | No charge | No charge after $50 copay | 20% after deductible |
| **Acupuncture** | No charge | No charge after $35 copay | 20% after deductible |
| **Diagnostic Outpatient X-ray** | No charge | 20% after deductible | 40% after deductible |
| **Diagnostic Outpatient Lab** | No charge | 20% after deductible | 40% after deductible |
| **Bariatric Surgery**<br>*Unlimited lifetime maximum* | No charge | 20% after deductible | 40% after deductible |
| **Base Infertility Services**<br>*(Base plan coverage includes coverage limited to the testing and treatment of underlying condition and Artificial Insemination)* | No charge | 20% after deductible | 40% after deductible |
| **ART Infertility Services**<br>*In vitro fertilization (IVF), intracytoplasmic sperm injection (ICSI) or ovum microsurgery. Covered after 2 years of infertility; limited to 3 attempts per live birth and up to a lifetime maximum of $100,000 including Comprehensive Infertility and 6 cycles of ovulation induction.* | No charge | 20% after deductible | 40% after deductible |
| **Male Sterilization** | No charge | No charge | No charge |
| **Durable Medical Equipment**<br>*Unlimited lifetime maximum* | No charge | 20% after deductible | 40% after deductible |
| **Transplants**<br>*Unlimited lifetime maximum* | No charge | 20% after deductible | 40% after deductible |
| **Payment for Non-Preferred Providers*** | Not Applicable | Not Applicable | Professional: 105% of Medicare RBRVS<br>Facility: 200% of the Medicare Allowed Rate |
| *For Maryland out-of-network hospitals, the amount is based on the rate approved by the Maryland Health Services Cost Review Commission.* | | | |
| **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.* | | |

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| | OAMC Medical | | |
|---|---|---|---|
| | **Outside U.S.** | **Inside U.S. Preferred Benefits (In-Network)** | **Inside U.S. Non-Preferred Benefits (Out-of-Network)** |
| **Prescription Drug Coverage** | | | |
| **Generic Drugs**<br>*(365 day maximum supply)*<br>*Includes contraceptives* | No charge | $15 copay per month supply (includes Mail Order Drugs) | 20% after deductible |
| **Formulary Brand Name Drugs**<br>*(365 day maximum supply)*<br>*Includes contraceptives* | No charge | $40 copay per month supply (includes Mail Order Drugs) | 20% after deductible |
| **Non-preferred and Non-Formulary Generic and Brand Name Drugs**<br>*(365 day maximum supply)* | No charge | $60 copay per month supply (includes Mail Order Drugs) | 20% after deductible |
| **Specialty Drugs**<br>*(30 day maximum supply)* | No charge | $150 Copay per month supply | Not covered |

Other Health Care (Out-of-Area): When care is provided in the U.S. in a geographic area in which Aetna has not contracted with a provider, charges are payable at 80% after any applicable Deductible (does not apply to those expenses paid at a reduced payment percentage). The benefit levels associated with the following In-Network provisions would apply: Deductible, Family Deductible, Inpatient Hospital Deductible, Out-of-pocket maximum(s).

| Member programs and services included in your plan<br>*Resources and details may vary depending on member location.* |
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| **OTCHS**<br>With Aetna Over-the-Counter Health Solutions® (OTCHS), plan subscribers get $35 every three months to spend on common over-the-counter products like pain relievers, first aid supplies, allergy relief, digestive health, and feminine care items. |
| **Aetna Smart Compare Intelligent Matching***<br>Using Artificial Intelligence to analyze 100+ provider and member data points, our provider search is able to identify high-quality, high-performing and cost-effective U.S. doctors with the highest likelihood to meet a member's preferences and specific health needs. |
| **CVS Health Virtual Primary Care™ and CVS Health Virtual Care™***<br>Our telehealth solutions give members in the U.S. access to virtual primary care, 24/7 on-demand care, and mental health services for ages 13 and up, all through one convenient digital platform. It's shorter wait times and affordable pricing. |
| **Global maternity program with Maven**<br>From conception to postpartum and newborn care support, our clinical care management team of nurses direct members to the best resources, including Maven's digital health platform. It's worldwide access to unlimited, 24/7 virtual support from quality providers across 35+ specialties, who speak 35+ languages. Within the U.S., members also have access to the Aetna Enhanced Maternity Program®* which includes family-planning and fertility support using predictive analytics, educational resources and guided genetic counseling to address at-risk members. |
| **Transform Oncology***<br>High-touch, member-focused support delivers an elevated standard of cancer care. Members diagnosed with cancer can benefit from a personal navigator, guided genetic testing, precision medicine and site-of-care support, while controlling costs. |
| **Teladoc®***<br>Access to anytime, on-demand, virtual care through a national network of certified physicians by phone and online-video consultations. |
| **All Aetna International plans also include these valuable member resources:**<br>• 24-hour Nurse Line*<br>• Discounts on health, wellness and fitness services- including Class Pass<br>• Employee Assistance Program (EAP) for personalized physical and mental health support and 5 therapy sessions annually, per member, per condition<br>• International Care Management with pre- and post-assignment consultation at no additional cost<br>• Prescription management and world-wide shipping |

**Available only in the United States.*

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| Medical Plan Caveats | |
|---|---|
| *Women's preventive and other preventive health benefits* | *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* | *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.* |
| *Calendar Year and Per Confinement Deductibles* | *There is no cross-application between calendar year and per confinement deductibles. If a member is hospitalized, he or she must meet both per confinement and calendar year deductibles (as applicable) before the plan pays any benefits.* |
| *Coverage Maximum (Days/Visits)* | *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/Coinsurance* | *In-Network - deductible and coinsurance may apply to pap smears, DRE tests and PSA tests if billed by an independent laboratory provider.* |
| *Maternity Care* | *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.* |
| *Ancillary Services* | *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.* |
| *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.*<br>*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.*<br>*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.*<br>*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.*<br>*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 (Maryland).*

*This is only a brief summary of the 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).*

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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

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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。 |
| Korean | 무료 다국어 서비스를 이용하려면 보험 ID 카드에 수록된 번호로 전화해 주십시오. |
| 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. |