



**Group Insurance Plan of Benefits for  
Brookhaven Science Associates LLC (Control 499953)  
administered by Aetna International  
Effective Date: January 1, 2020**

Eligibility Provision			
<b>Employee</b>	Regular full-time employees participating in this plan working a minimum of 20 hours per week.		
<b>Dependent</b>	Spouse, same or opposite sex domestic partner; children up to age 26, regardless of student status		
PPO Medical			
PLAN FEATURES	In the U.S.		
	OUTSIDE THE U.S.	Preferred Benefits (In-Network)	Non-Preferred Benefits (Out-of-Network)
<b>Individual Deductible</b>	None	None	\$1,000 per plan year
<b>Family Deductible</b>	None	None	\$3,000 per plan year
<b>Prior Plan Credit</b>	Prior plan credit accrued within the last calendar year from previous carrier applies to the current year.		
<b>Individual Payment Limit</b>	None	\$3,500 per plan year	\$3,500 per plan year
<i>(Does not include precertification penalty. Includes Outpatient Prescription Drugs when outside the US)</i>			
<i>(Maximum in-network out of pocket is \$6,850)</i>			
<b>Family Payment Limit</b>	None	\$7,000 per plan year	\$7,000 per plan year
<i>(Does not include precertification penalty. Includes Outpatient Prescription Drugs when outside the US)</i>			
<i>(Maximum in-network out of pocket is \$13,700)</i>			
<b>Lifetime Maximum</b>	Unlimited		
<b>Inpatient Per Confinement Deductible</b>	None	None	None
Member Payment Percentages			
Hospital Services			
<b>Inpatient</b>	No charge	No charge	30% after deductible
<b>Outpatient</b>	No charge	No charge	30% after deductible
<b>Private Room Limit</b>	The institution's semiprivate rate. Should a facility have only one type of room, which is a private room, we are able to code the standard rates within the system		
<b>Pre-certification Penalty</b>	No Penalty	No Penalty	\$400
<i>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.</i>			
<b>Emergency Room</b>	No charge	No charge after \$100 copay	No charge after \$100 copay
<b>Urgent Care</b>	No charge	No charge after \$50 copay	30% after deductible
Physician Services			
<b>Physician Office Visit</b>	No charge	No charge after \$20 copay	30% after deductible
<b>Specialist Office Visit</b>	No charge	No charge after \$35 copay	30% after deductible

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		Preferred Benefits (In-Network)	Non-Preferred Benefits (Out-of-Network)
<b>Mental Health Services*</b>			
<b>Mental Health Inpatient Coverage</b>	No charge	No charge	30% after deductible
<i>Unlimited days per plan year</i>			
<b>Mental Health Outpatient Coverage</b>	No charge	No charge after \$35 copay	30% after deductible
<i>Unlimited visits per plan year</i>			
<b>Alcohol/Drug Abuse Services*</b>			
<b>Substance Abuse Inpatient Coverage</b>	No charge	No charge	30% after deductible
<i>Unlimited days per plan year</i>			
<b>Substance Abuse Outpatient Coverage</b>	No charge	No charge after \$35 copay	30% after deductible
<i>Unlimited visits per plan year</i>			
<b>Prescription Drug Coverage</b>			
<b>Individual Deductible</b>	None	\$100 per calendar year	\$100 per calendar year
<b>Family Deductible</b>	None	\$300 per calendar year	\$300 per calendar year
<b>Individual Payment Limit</b>	None	\$1,500 per calendar year	\$1,500 per calendar year
<b>Family Payment Limit</b>	None	\$3,000 per calendar year	\$3,000 per calendar year
<b>Generic Drugs</b> <i>(365 day maximum supply)</i>	No charge	Formulary: \$10 copay per month supply Non-Formulary: \$50 copay per month supply (includes Mail Order Drugs)	30% after deductible
<b>Brand Name Drugs</b> <i>(365 day maximum supply)</i>	No charge	\$20 copay per month supply (includes Mail Order Drugs)	30% after deductible
<b>Non Formulary Brand Name Drugs</b> <i>(365 day maximum supply)</i>	No charge	\$50 copay per month supply (includes Mail Order Drugs)	30% after deductible
<b>Other Services</b>			
<b>Aetna Assistance Program</b>	No charge	No charge	No charge
<b>International Employee Assistance Program (IEAP)</b>	Included	Included	Included
<i>Includes up to 5 counseling sessions per issue per year per enrolled member. Access benefits by calling the member service number on ID card: 800-231-7729 or collect 813-775-0190. Services include: Cultural adjustment assistance, Marital/Family Stress, Child care and behavioral concerns, Social adaptation needs, Alcohol/Substance Abuse, Work/Life Balance and Depression.</i>			
<b>WorldAware Program</b> <i>(Includes security, political &amp; natural disaster coverage (Program is underwritten by Aetna Life &amp; Casualty (Bermuda) Ltd.)</i>	No charge	No charge	No charge

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<b>Wellness Benefits</b>			
<b>Routine Children Physical Exams</b>	No charge	No charge	30% after deductible
<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>			
<b>Routine Adult Physical Exams</b>	No charge up to \$1,000 plan year maximum (includes immunizations, x-rays and labs)	No charge	30% after deductible
<i>Adults age 22+ &amp; -65: 1 exam/12 months Adults age 65+: 1 exam/12 months includes immunizations</i>			
<b>Routine Gynecological Exams</b>	No charge	No charge	30% after deductible
<i>Includes 1 exam and pap smear per plan year</i>			
<b>Mammograms</b> <i>(Unlimited visits per plan year)</i>	No charge	No charge	30% after deductible
<b>Prostate Specific Antigen (PSA)</b> <i>(Unlimited visits per plan year)</i>	No charge	No charge	30% after deductible
<b>Digital Rectal Exam (DRE)</b> <i>(Unlimited visits per plan year)</i>	No charge	No charge	30% after deductible
<b>Cancer Screening</b>	No charge	No charge	30% after deductible
<i>Includes 1 flex sigmoid and double barium contrast every 5 years; and at age 45+ 1 colonoscopy every 10 years</i>			
<b>Routine Hearing Exam</b>	No charge	No charge	30% after deductible
<i>Includes one routine exam every 24 months.</i>			
<b>Hearing Aids</b>	No charge	No charge	30% after deductible
<i>1 hearing aid per ear to \$1,000 maximum per ear every 3 years for child to age 24</i>			
<b>Vision Care</b>			
<b>Routine Eye Exam</b>	No charge	No charge	30% after deductible
<i>(Covered under medical) Includes one routine exam every 12 months</i>			
<b>Vision Care Supplies</b>  Schedule maximum apply every 12 months	No charge up to \$200 maximum	No charge up to \$200 maximum	No charge up to \$200 maximum

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<b>Other Services</b>			
<b>Skilled Nursing Facility</b> <i>(60 Days per plan year)</i>	No charge	No charge	30% after deductible
<b>Hospice Care Facility Inpatient</b> <i>(30 Days lifetime maximum)</i>	No charge	No charge	30% after deductible
<b>Hospice Care Facility Outpatient</b> <i>(Unlimited lifetime maximum)</i>	No charge	No charge	30% after deductible
<b>Home Health Care</b> <i>(40 visits per plan year combined, includes Private Duty Nursing)</i>	No charge	No charge	30% after deductible
<b>Spinal Disorder Treatment</b> <i>(Unlimited visits per calendar year)</i>	No charge	No charge after \$10 copay	25% after deductible
<b>Short-Term Rehabilitation</b> <i>(Includes coverage for Occupational and Physical Therapies; Unlimited visits per plan year)</i>	No charge	No charge after \$10 copay	25% after deductible
<b>Speech Therapy</b> <i>(60 visits per plan year)</i>	No charge	No charge after \$35 copay	30% after deductible
<b>Diagnostic Outpatient X-ray</b>	No charge	No charge	30% after deductible
<b>Diagnostic Outpatient Lab</b>	No charge	No charge	30% after deductible
<b>Complex Imaging</b>	No charge after \$50 copay	No charge after \$50 copay	No charge after \$50 copay
<b>Bariatric Surgery</b> <i>(Unlimited per lifetime)</i>	No charge	No charge after \$500 copay	30% after deductible
<b>Base Infertility Services</b> <i>(Base plan coverage includes coverage limited to the testing and treatment of underlying condition)</i>	No charge	No charge	30% after deductible
<b>Comprehensive Infertility Services</b> <i>(6 cycles of Comprehensive plan coverage includes coverage of Artificial Insemination and Ovulation Induction)</i>	No charge	No charge	30% after deductible
<b>ART Infertility Services</b> <i>(6 cycles per lifetime for Advanced Reproductive Technology (ART) coverage with cryopreservation, storage and unlimited embryo transfers).</i>	No charge	No charge	30% after deductible
<b>Autism</b>	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		
<b>Payment for Non-Preferred Providers**</b>	Not Applicable	Not Applicable	Professional: 105% of Medicare Facility: 140% of Medicare

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PPO Dental			
PLAN FEATURES	OUTSIDE THE U.S.	In the U.S.	
		Preferred Benefits (In-Network)	Non-Preferred Benefits (Out-of-Network)
<b>Individual Deductible</b>	None	None	None
<b>Family Deductible</b>	None	None	None
<b>Type A Expense</b> <i>(Diagnostic &amp; Preventive)</i>	20%	20%	30%
<b>Type B Expense</b> <i>(Basic Restorative)</i>	40%	40%	55%
<b>Type C Expense</b> <i>(Major Restorative)</i>	50%	50%	65%
<b>Calendar Year Maximum</b>	\$2,000	\$2,000	\$2,000
<b>Orthodontic Treatment</b> <i>Coverage for Adults and Dependents</i>	50%	50%	60%
<b>Orthodontic Lifetime Maximum</b>	\$2,000	\$2,000	\$2,000
<i>Please refer to your Plan documents which shows coverage for Types A, B and C</i>			

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**Services and Programs included in Quote**

**Informed Health Line (24-hour nurse line)  
International Disease Management  
International Maternity Management Program  
Simple Steps To A Healthier Life®**

**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.*

*Payment limits apply per individual on a plan year basis. Only those out-of-pocket expenses resulting from the application of a payment percentage may be used to satisfy the payment limit. Deductibles, copays, benefit penalties and 50% items are excluded from the payment 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. Pregnancy benefits do not continue to be payable after coverage ends except in the event of total disability.*

*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.*

*Copayments and coinsurance for chiropractic visits are capped at 25% of the amount due to the chiropractor*

*Benefit maximums per Plan year are calculated between 01/01/2020 and 12/31/2020.*

*\*This plan includes coverage under the extent required in accordance with the Federal Mental Health Parity and Addiction Equity Act (MHPAEA) beginning with plan years starting on or after January 1, 2018.*

**\*\* 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.*

*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.*

*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.*

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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](http://Aetna.com). Type "how Aetna pays" in the search box.

You can avoid these extra costs by getting your care from Aetna's broad network of health care providers. Go to [www.aetna.com](http://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.

Pre-Existing Conditions:

- Option: (No Restriction)

**Dental Plan Caveats**

- Refer to your plan document for information how services are covered

The proposed plan of benefits is underwritten by Aetna Life Insurance Company (Delaware).

This is only a brief summary of the PPO Medical Pharmacy and Dental 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.

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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](mailto: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

<b>English</b>	<b>To access language services at no cost to you, call the number on your ID card.</b>
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.

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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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