Aetna MedPremier Major Medical

Benefit Overview of plan features for Full-time employees. Some state mandates may impact benefits shown. Please see Plan Summary for detailed information about the benefits and exclusions and shall prevail over the terms of this

	Full-Time Benefits	
Monthly Hours	120+	
Medical Benefits	**In-Network**	**Out-of-Network**
Plan Coinsurance	80%	50%
Individual / Family Deductible	$1,500 / $3,000	$3,000 / $6,000
Individual / Family Coinsurance Limit	$3,000 / $6,000	$6,000 / $12,000
Lifetime Maximum	Unlimited	Unlimited
Doctor's Office Visit		
▪ Non-Specialist	$25 copay	Plan pays 50%; after deductible
▪ Specialist	$45 copay	Plan pays 50%; after deductible
Inpatient Hospital	Plan pays 80%; after deductible	Plan pays 50%; after deductible
Outpatient Hospital	Plan pays 80%; after deductible	Plan pays 50%; after deductible
Emergency Room Benefit	Plan pays 80% after $300 copay	Same as In-Network Care
Pharmacy Benefit	Copay:	
▪ Prescription Drug	Generic: $20 Brand: $60 Non-Formulary: $100 Preferred Specialty*: Plan pays 60% Non-Preferred Specialty*: Plan pays 50%	Plan pays 50% of submitted cost; after applicable in-network cost share
Ancillary Benefits		
Dental Benefit		
Annual Maximum per covered person	$2,000	
Annual Deductible per covered person	$25	
Preventive and Diagnostic Care	100% up to the Annual Maximum	
Basic Care	80% up to the Annual Maximum	
Major Restorative Care	50% up to the Annual Maximum	
Vision Benefits		
Vision Exam (every 12 months)	$85	
Single Lenses (every 24 months)	$95	
Contact Lenses (every 24 months)	$95	
Bi-focal Lenses (every 24 months)	$120	
Frames (every 24 months)	$120	
Transamerica Short Term Disability Benefits (EE Only)*		
Maximum Weekly Benefit+	$400	
Maximum Benefit Period *(number of months)*	3	
Elimination Period (number of days)	14	
+ The actual weekly benefit will be the amount selected or 80% of the employee's salary, whichever is less		
Transamerica Life and AD&D (EE only)		
Life	$10,000	
Accidental Death and Dismemberment	$10,000	
Employee Assistance Program (EAP)	Included	
HealthiestYou Telehealth Services	Included	
Monthly Contribution for Employee Only Coverage:	$633.98	If **Employee Only** coverage is chosen, Employer will pay 50% of the $633.98 as the employer monthly contribution, (unless benefits are declined by employee with valid proof of other acceptable insurance.
Additional Monthly Employee Paid for Dependents:		
Spouse	$768.94	
Child(ren)	$626.10	
Spouse & Child(ren)	$1,335.90	

** Coverage is not available if you reside in California, Hawaii, New Jersey, New York, Rhode Island, and Puerto Rico.*

** 12 month pre-ex provision on Disability income, even for coverage issued on GI basis. Rates include load for Waiver of Premium beginning the next premium due date after satisfaction of the elimination period.*

** Mental Illness Benefit is limited to 50% of the illustrated Maximum Disability Benefit Period. Policy is issued as monthly benefit; if the disability lasts less than one month, the benefits will be pro-rated based on the days of actual disability following the satisfaction of the Elimination Period.*