APPENDIX V

(Following are some of the co-pay, deductible, and coverage features of the POS/PPO Plan) The POS/PPO Plan is only available to those employee hired on or before June 30, 2016

aetna

East Lyme Town and Board of Education - Tchrs / Cert (FD 120 & 122)
Effective Date: 07-01-2016
Aetna Choice™ POS II - ASC

PLAN DESIGN AND BENEFITS
ADMINISTERED BY AETNA LIFE INSURANCE COMPANY

PLAN FEATURES	PREFERRED CARE		NON-PREFERRED CARE	
Deductible (per plan year)	None	Individual	$600	Individual
	None	2 Person/Family	$1,200	2 Person/Family
Unless otherwise indicated, the out of network Deductible must be met prior to benefits being payable. Once the 2 Person/Family Deductible is met, all family members will be considered as having met their Deductible for the remainder of the plan year. An individual is considered as having met their deductible when they reach the individual deductible/payment limit and that amount will accrue toward the 2 Person/Family deductible total.				
Member Coinsurance Applies to all expenses unless otherwise stated.	Covered 100%		30%	
Payment Limit (per plan year)	$6,350	Individual	$2,000	Individual
	$12,700	2 Person/Family	$4,000	2 Person/Family
Certain member cost sharing elements may not apply toward the Payment Limit. 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. Once the 2 Person/Family Payment Limit is met, all family members will be considered as having met their Payment Limit for the remainder of the plan year.				
Lifetime Maximum	Unlimited except where otherwise indicated.			
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, 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 1 exam every calendar year age 22 and over.	Covered 100%		30%; after deductible	
Routine Well Child Exams/Immunizations 7 exams in the first calendar year of life, 3 exams in the second calendar year of life, 3 exams in the third calendar year of life, 1 exam per calendar year thereafter through age 21.	Covered 100%		30%; after deductible	
Routine Gynecological Care Exams 1 routine exam every calendar year, includes routine tests and related lab fees	Covered 100%		30%; after deductible	
Routine Mammograms Recommended one baseline mammogram for covered females age 35 to 40. One mammogram per calendar year for covered females age 40 and older.	Covered 100%		30%; after deductible	
Women's Health	Covered 100%		30%; after deductible	
Routine Digital Rectal Exam / Prostate-specific Antigen Test Recommended for covered males age 40 and over	Covered 100%		30%; after deductible	
Colorectal Cancer Screening For all members age 50 and over.	Covered 100%		30%; after deductible	
Routine Eye Exams 1 routine exam per 24 months	$30 copay		30%; after deductible	
Routine Hearing Exams 1 routine exam per 24 months	$30 copay		30%; after deductible	
PHYSICIAN SERVICES	**PREFERRED CARE**		**NON-PREFERRED CARE**	
Office Visits to Non-Specialist	$30 copay		30% after deductible	

Includes services of an internist, general physician, family practitioner or pediatrician.		
Specialist Office Visits	$30 copay	30% after deductible
Pre-Natal Maternity	Covered 100%	30% after deductible
Allergy Testing and Therapy	$30 copay	30% after deductible
Allergy Injections (serum)	Covered 100%	30% after deductible
DIAGNOSTIC PROCEDURES	**PREFERRED CARE**	**NON-PREFERRED CARE**
Diagnostic X-Ray and Laboratory	Covered 100%	30% after deductible
Complex Imaging Services	$75 copay	30% after deductible
EMERGENCY MEDICAL CARE	**PREFERRED CARE**	**NON-PREFERRED CARE**
Urgent Care Provider (benefit availability may vary by location)	$150 copay	30% after deductible
Emergency Room	$150 copay	Covered 100%
Ambulance	Covered 100%	30% after deductible
HOSPITAL CARE	**PREFERRED CARE**	**NON-PREFERRED CARE**
Inpatient Coverage	$500 per confinement copay	30% after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay		
Inpatient Maternity Coverage	$500 per confinement copay	30% after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay		
Outpatient Hospital Expenses and Surgery	$200 copay	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 per confinement copay	30% after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay		
Outpatient	$30 copay	30% after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit		
ALCOHOL/DRUG ABUSE SERVICES	**PREFERRED CARE**	**NON-PREFERRED CARE**
Inpatient	$500 per confinement copay	30% after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay		
Outpatient	$30 copay	30% after deductible
The member cost sharing applies to all Covered Benefits incurred during a member's outpatient visit		
OTHER SERVICES	**PREFERRED CARE**	**NON-PREFERRED CARE**
Convalescent Facility Limited to 180 days per plan year. The member cost sharing applies to all covered benefits incurring during a member's inpatient stay	Covered 100%	30% after deductible
Home Health Care Limited to 200 visits per plan year.	Covered 100%	30% after deductible
Hospice Care - Inpatient The member cost sharing applies to all covered benefits incurred during a member's inpatient stay	Covered 100%	30% after deductible
Hospice Care - Outpatient The member cost sharing applies to all covered benefits incurred during a member's outpatient visit	Covered 100%	30% after deductible
Outpatient Short-Term Rehabilitation Includes Chiro, Physical/ Occupational Therapy and Speech Therapy. Combined 50 visits max. per member per plan year.	Covered 100%	30% after deductible

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Durable Medical Equipment	Covered 100%	30% after deductible
Diabetic Supplies -- (if not covered under Pharmacy benefit)	Covered 100%	30% after deductible
Contraceptive drugs and devices not obtainable at a pharmacy (includes coverage for contraceptive visits)	Covered 100%	30% after deductible
Transplants	Covered 100%.	30% after deductible.
Bariatric Surgery	$500 per confinement copay	30% after deductible
FAMILY PLANNING	**PREFERRED CARE**	**NON-PREFERRED CARE**
Infertility Treatment Diagnosis and treatment of the underlying medical condition.	Member cost sharing is based on the type of service performed and the place of service where it is rendered	30% after deductible
Voluntary Sterilization Including tubal ligation and vasectomy	Member cost sharing is based on the type of service performed and the place of service where it is rendered	30% after deductible
PHARMACY	**PREFERRED CARE**	**NON-PREFERRED CARE**
Retail	$5 copay for generic drugs, $35 copay for formulary brand-name drugs, and $60 copay for non-formulary brand-name drugs up to a 30 day supply at participating pharmacies.	30% coinsurance for up to a 30 day supply at non-participating pharmacies.
Mail Order	$10 copay for generic drugs, $70 copay for formulary brand-name drugs, and $120 copay for non-formulary brand-name drugs up to a 31-100 day supply from Aetna Rx Home Delivery®.	Not applicable
Annual Benefit Maximum (per calendar year) - $3,000		
Mandatory Generic (MG) - If the member requests brand when generic is available, the member pays the applicable copay plus the difference between the generic price and the brand price.		
Plan Includes: Contraceptive drugs and devices obtainable from a pharmacy, Oral fertility drugs, Diabetic supplies.		
Formulary Generic FDA-approved Women's Contraceptives covered 100% in network		
Precert for growth hormones included		
GENERAL PROVISIONS		
Dependents Eligibility	Spouse, children from birth to age 26	
Pre-existing Conditions Exclusion	On effective date: Waived After effective date: Full Postponement	

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;
- Non-accident related Dental care and X-rays;
- Donor egg retrieval;
- Experimental and investigational procedures;

- Hearing aids; except as state mandated
- Non-medically necessary services or supplies;
- Non-medical condition Orthotics;
- Over-the-counter medications and supplies;
- Services for the treatment of sexual dysfunction or inadequacies, including therapy, supplies, or counseling;
- Weight control services including 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 limitation 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.

Plans are administered by Aetna Life Insurance Company.

APPENDIX VI
HIGH DEDUCTIBLE HEALTH CARE PLAN

(Following are some of the co-pay, deductible, and coverage features of the HDHP Plan)
The HDHP Plan is the sole plan available to employees hired on or after July 1, 2016

This insurance matrix appendix contains a summary and description of the HDHP Plan. It is agreed and understood by the parties that the insurance description contained in this matrix are descriptive only and is not the insurance policy. All questions or issues concerning insurance coverage and related matters shall be determined by reference to the actual insurance policy documents issued or possessed by the insurers and/or plan administrators.

BENEFIT	
COST SHARES	
	In-Network services and Out-of-Network services subject to deductible and coinsurance.
	No Referrals Required
Deductible	$2,000/$4,000
Coinsurance	In = 100% Out = 80%/20%
Coinsurance Max	In-Net = $1,000/$2,000 Out-Net = $3,000/$6,000
Out of Pocket Max	In-Net = $3,000/$6,000 Out-Net = $5,000/$10,000
	Only In-Network Benefits Illustrated Below
PREVENTIVE CARE	Annual
Pediatric	Covered 100% - Not Subject to Deductible
Adult	Covered 100% - Not subject to Deductible
Vision Exam	Covered 100% - Not Subject to Deductible
Hearing	Covered 100% - Not Subject to Deductible
Routine Gynecological	Covered 100% - Not Subject to Deductible
MEDICAL SERVICES	
Medical Office Visit	100% after deductible
Outpatient - PT/OT/Chiro	100% after deductible; 50 visits per calendar year
Allergy Services	100% after deductible
Diagnostic Lab & X-ray	100% after deductible
Surgery Fees	100% after deductible

BENEFIT	
COST SHARES	
Office Surgery	100% after deductible
Outpatient MH/SA	100% after deductible
EMERGENCY SERVICES	
Emergency Room	100% after deductible
Urgent Care Facility	100% after deductible
Ambulance	100% after deductible
INPATIENT HOSPITAL	Note: All hospital admissions require pre-cert
General/Medical & Surgical	100% after deductible
Ancillary Services (Medication, Supplies)	100% after deductible
Psychiatric	100% after deductible
Substance Abuse/Detox	100% after deductible
Rehabilitative	100% after deductible
	Covered up to 100 days per calendar year.
Skilled Nursing Facility	100% after deductible
	120 days per calendar year
Hospice	100% after deductible
OUTPATIENT HOSPITAL	
Outpatient Surgery	100% after deductible
Facility Charges	
Diagnostic Lab & X-ray	100% after deductible
Pre-Admission Testing	100% after deductible
OTHER SERVICES	
Durable Medical Equipment	100% after deductible
Prosthetics	100% after deductible
Home Health Care	100% after deductible 200 visits per calendar year.
Infertility Services	100% after deductible
Prescription Drugs	After deductible is met: 2x retail for mail order / $10 generic, $25 preferred brand, $40 non- preferred brand; Unlimited max.

In the 2016-2017 year only, the Board's full contribution to the HSA account shall be made on or around July 1st, at sixty-five (65%) percent of the applicable deductible.

Thereafter, the Board will contribute fifty percent (50%) of the applicable HDHP deductible amount. The Board's contribution toward the HDHP deductible will be deposited into a Health Savings Account (HSA) in two (2) equal payments, with the first payment with the first September payroll and the second with the first January payroll. Should a member demonstrate extraordinary need, the Superintendent shall have the discretionary authority to have the Board's HSA contribution deposited prior to September 1st. Employees who are not eligible for an HSA can participate in a Health Reimbursement Account (HRA) with the Board providing the same contributions towards reimbursement as in the HSA. The parties acknowledge that the Board's contribution toward the contributions to the HSA and/or HRA plans is not an element of the underlying insurance plan, but rather relates to the manner in which the deductible shall be funded for active employees. The Board shall have no obligation to fund any portion of the HDHP deductible for individuals upon their separation from employment.

This insurance matrix appendix contains a summary and description of the HDHP Plan. It is agreed and understood by the parties that the insurance description contained in this matrix are descriptive only and is not the insurance policy. All questions or issues concerning insurance coverage and related matters shall be determined by reference to the actual insurance policy documents issued or possessed by the insurers and/or plan administrators.

APPENDIX VII

PREVENTIVE SERVICES SCHEDULES FOR WELLNESS INCENTIVE

These preventive schedules will change as per the carrier recommendations, without the need for further negotiations. Required wellness screenings are provided at no cost to the member.

Preventative Screening Requirements	*Birth to 19	Ages 20 to 29	Ages 30 to 39	Ages 40 to 49	Ages 50 Plus
Preventive Physical Exam including:	NA	1 exam every 3 years	1 exam every 3 years	1 exam every 3 years	1 exam every 3 years
Cholesterol Screening	NA	1 screening every 5 years	1 screening every 5 years	1 screening every 5 years	1 screening every 5 years
Colorectal Screening	NA	NA	NA	NA	Colonoscopy every 10 years
Routine OB/GYN Exam including: Clinical breast exam and cervical cancer screening	NA	1 exam every 2 years	1 exam every 2 years	1 exam every 2 years	1 exam every 2 years
Mammogram	NA	NA	NA	1 exam every year	1 exam every year

*Birth to Age 1 requires visits at Months 1, 2,4,6,9, and 12 per the American Academy of Pediatrics