Group Insurance Plan of Benefits for Reformed Benefits Association (540089) administered by Aetna International® Renewal Effective Date: January 1, 2014

Eligibility Provision			
Employee	Regular full-time employees of Reformed Benefits Association participating in this plan working a minimum of 25 hours per week.		
Dependent	Spouse; children up to age 26, regardless of student status.		
PPO			
		In the U.S.	
PLAN FEATURES	**OUTSIDE THE U.S.**	**Preferred Benefits (In-Network)**	**Non-Preferred Benefits (Out-of-Network)**
Individual Deductible	$500 per calendar year	$1,000 per calendar year	$1,000 per calendar year
Family Deductible	$1,000 per calendar year	$2,000 per calendar year	$2,000 per calendar year
Prior Plan Credit	Prior plan credit accrued within the last calendar year from previous carrier applies to the current year		
Individual Coinsurance Limit	$3,000 per calendar year	$3,000 per calendar year	$5,000 per calendar year
(Does not include precertification penalties. Includes Outpatient Prescription Drugs when outside the US)			
Family Coinsurance Limit	$6,000 per calendar year	$6,000 per calendar year	$10,000 per calendar year
(Does not include precertification penalties. Includes Outpatient Prescription Drugs when outside the US)			
Lifetime Maximum	Unlimited		
Inpatient Per Confinement Deductible *(Maximum of 3 per calendar year)*	None	None	$250
Member Payment Percentages			
Hospital Services			
Inpatient	10% after deductible	10% after deductible	30% after deductible and $250 inpatient per confinement deductible
Outpatient	10% after deductible	10% after deductible	30% after deductible
Private Room Limit	The institution's semiprivate rate.		
Pre-certification Penalty	No Penalty	No Penalty	$400
To avoid penalties and/or benefit reductions for non-preferred benefits received in the U.S., contact the service center to determine if precertification is needed for a procedure.			
Non-Emergency Use of the Emergency Room	10% after deductible	50% after deductible	50% after deductible
Emergency Room	10% after deductible	No charge after $150 copay	No charge after $150 copay
Non-Urgent Use of Urgent Care Provider	10% after deductible	Not Covered	Not Covered
Urgent Care	10% after deductible	No charge after $40 copay	30% after deductible
Physician Services			
Physician Office Visit	No charge	No charge after $20 copay	30% after deductible
Specialist Office Visit	10%	No charge after $40 copay	30% after deductible

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PPO			
		In the U.S.	
PLAN FEATURES	OUTSIDE THE U.S.	Preferred Benefits (In-Network)	Non-Preferred Benefits (Out-of-Network)
Mental Health Services			
Mental Health Inpatient Coverage *Unlimited days per calendar year*	10% after deductible	10% after deductible	30% after deductible and $250 inpatient per confinement deductible
Mental Health Outpatient Coverage *Unlimited visits per calendar year*	No charge	No charge after $40 copay	30% after deductible
Alcohol/Drug Abuse Services			
Substance Abuse Inpatient Coverage *Unlimited days per calendar year*	10% after deductible	10% after deductible	30% after deductible and $250 inpatient per confinement deductible
Substance Abuse Outpatient Coverage *Unlimited visits per calendar year*	No charge	No charge after $40 copay	30% after deductible
Prescription Drug Coverage			
Generic Drugs *(365 day maximum supply)*	10% after deductible	$15 copay per month supply (includes Mail Order Drugs)	30% after deductible
Formulary Brand Name Drugs *(365 day maximum supply)*	10% after deductible	$30 copay per month supply (includes Mail Order Drugs)	30% after deductible
Non Formulary Brand Name Drugs *(365 day maximum supply)*	10% after deductible	$60 copay per month supply (includes Mail Order Drugs)	30% after deductible
Other Services			
Global Emergency Assistance Program *($500,000 calendar year maximum)*	No Charge	No Charge	No Charge
International Employee Assistance Program (IEAP)	Included	Included	Included
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.			

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PPO			
		In the U.S.	
PLAN FEATURES	OUTSIDE THE U.S.	Preferred Benefits (In-Network)	Non-Preferred Benefits (Out-of-Network)
Wellness Benefits			
Routine Children Physical Exams	No charge	No charge	30% after deductible
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)			
Routine Adult Physical Exams	No charge	No charge	30% after deductible
Adults age 22+: 1 exam/12 months (includes immunizations)			
Routine Gynecological Exams	No charge	No charge	30% after deductible
Includes 1 exam and pap smear per calendar year			
Mammograms *(Unlimited visits per calendar year)*	No charge	No charge	30% after deductible
Prostate Specific Antigen (PSA)	No charge	No charge	30% after deductible
Includes 1 PSA per calendar year for males 40+			
Digital Rectal Exam (DRE)	No charge	No charge	30% after deductible
Includes 1 DRE per calendar year for males 40+			
Cancer Screening	No charge	No charge	30% after deductible
Includes 1 flex sigmoid and double barium contrast every 5 years; and at age 50+ 1 colonoscopy every 10 years			
Routine Hearing Exam	No charge	No charge	30% after deductible
Includes one routine exam every 24 months.			
Hearing Aids	10% after deductible	10% after deductible	30% after deductible
1 hearing aid per ear to $1,000 maximum per ear every 3 years for child to age 24			
Vision Care			
Routine Eye Exam	No charge	No charge	30% after deductible
(Covered under medical) Includes one routine exam every 12 months			

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PPO			
		In the U.S.	
PLAN FEATURES	OUTSIDE THE U.S.	Preferred Benefits (In-Network)	Non-Preferred Benefits (Out-of-Network)
Other Services			
Skilled Nursing Facility *(120 Days per calendar year)*	10% after deductible	10% after deductible	30% after deductible and $250 inpatient per confinement deductible
Hospice Care Facility Inpatient *(30 Days lifetime maximum)*	10% after deductible	10% after deductible	30% after deductible and $250 inpatient per confinement deductible
Hospice Care Facility Outpatient *(Unlimited lifetime maximum)*	10% after deductible	10% after deductible	30% after deductible
Home Health Care *(120 visits per calendar year)*	10% after deductible	10% after deductible	30% after deductible
Private Duty Nursing *(70 shifts per calendar year)*	10% after deductible	10% after deductible	30% after deductible
Spinal Disorder Treatment *(Unlimited calendar year maximum)*	10% after deductible	No charge after $30 copay	30% after deductible
Short-Term Rehabilitation	10% after deductible	No charge after $40 copay	30% after deductible
(Includes coverage for Occupational, Physical and Speech Therapies; combined maximum visits per calendar year)			
Diagnostic Outpatient X-ray	10% after deductible	10% after deductible	30% after deductible
Diagnostic Outpatient Lab	10% after deductible	10% after deductible	30% after deductible
Base Infertility Services	10% after deductible	10% after deductible	30% after deductible
(Base plan coverage includes coverage limited to the testing and treatment of underlying condition)			
Allergy Testing	Covered at Specialist Office visit	Covered at Specialist Office visit	Covered at Specialist Office visit
Allergy Serum and Injection and Injectable Drug	Covered at Plan Coin	Covered at Plan Coin	Covered at Plan Coin
DME Calendar Year Maximum	$2,500	$2,500	$2,500

Passive PPO Dental			
Individual Deductible	$50 per calendar year	$50 per calendar year	$50 per calendar year
Family Deductible	$150 per calendar year	$150 per calendar year	$150 per calendar year
Type A Expense *(Diagnostic & Preventive)*	No Charge	No Charge	No Charge
Type B Expense *(Basic Restorative)*	20% after deductible	20% after deductible	20% after deductible
Type C Expense *(Major Restorative)*	50% after deductible	50% after deductible	50% after deductible
Calendar Year Maximum	$1,000	$1,000	$1,000
Orthodontic Treatment Coverage for Adults and Dependents up to age 20	50% - not subject to deductible	50% - not subject to deductible	50% - not subject to deductible
Orthodontic Lifetime Maximum	$2,000	$2,000	$2,000
Please refer to the Dental Plan Caveats below for additional benefit coverages for Types A, B and C			

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Included Services and Programs
Informed Health Line (24-hour nurse line) **International Disease Management** **International Maternity Management Program** **Wellness Checkpoint** **Weight Watchers® Program** **On-Line Global Health and Travel Information through HTH Worldwide (http//www.aetnainternational.com)**

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 calendar year basis. Only those out-of-pocket expenses resulting from the application of a payment percentage may be used to satisfy the payment limit. Precertification penalties are excluded from the payment limit.* *There is cross-application between calendar 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 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).* *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.* *Benefit maximums per calendar year are calculated between 01/01/2014 and 12/31/2014.* Pre-Existing Conditions: ➢ *Option: Option 5 - (No Restriction)* ➢ *On Effective Date: Pre-existing condition limitation is waived on the effective date.* ➢ *After Effective Date: Pre-existing condition limitation is waived after the effective date.* ➢ *Pre-Existing Conditions is waived for dependents under age 19.*

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Dental Plan Caveats
Passive PPO Dental
Type A
Includes Prophylaxis, Bitewing and full mouth series X-rays, Space Maintainers, Oral Exams, Fluoride applications, Sealants, and Periapical X-rays.
Type B
Includes Fillings, Simple Extractions and Oral Surgery.
Type C
Includes Crown Lengthening, Crown Buildup, Inlays/onlays, Bridgework, Osseous surgery, Soft tissue grafts, Partial and full bony impactions, General anesthesia and intravenous sedation, Dentures (benefit includes all relines, rebases and adjustments within 6 months of installation), Molar root canal therapy, Prosthetic repairs, and Occlusal Guards (for bruxism only).

The plan of benefits is underwritten by Aetna Life & Casualty (Bermuda) Ltd.

This is only a brief summary of the PPO Medical and Passive PPO 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 (which will be provided near the time the plan becomes effective).*