PLAN DESIGN & BENEFITS
WA Group Business 51-100 Employees

PLAN FEATURES	NETWORK CARE	OUT-OF-NETWORK CARE
Primary Care Physician Selection	Not applicable	Not applicable
Deductible (per calendar year)	$1,000 Individual $2,000 Family	$2,000 Individual $6,000 Family
Unless otherwise indicated, the deductible must be met before benefits can be paid.		
All covered expenses accumulate separately toward the network and out-of-network Deductible.		
As indicated in the plan, member cost sharing for certain services are excluded from the charges to meet the deductible.		
No one family member may contribute more than the individual deductible amount to the family deductible. Once the family deductible is met, all family members will be considered as having met their deductible for the remainder of the year.		
Member Coinsurance (applies to all expenses unless otherwise stated)	0%	50%
Out-of-Pocket (OOP) Maximum (per calendar year, includes deductible)	$4,500 Individual $9,000 Family	$12,000 Individual $36,000 Family
All covered expenses accumulate separately toward the network and out-of-network Out of Pocket Limit.		
Pharmacy expenses apply towards the Out-of-Pocket Maximum. Only 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 out-of-pocket maximum.		
No one family member may contribute more than the individual out-of-pocket maximum amount to the family out-of-pocket maximum. Once the family out-of-pocket maximum is met, all family members will be considered as having met their out-of-pocket maximum for the remainder of the year.		
Payment for Out-of-Network Care*	Not applicable	Professional: 105% of Medicare Facility: 140% of Medicare
Precertification Requirements		
Some out-of-network services need approval by us in advance (precertification). Without this approval, a benefit reduction of $400 per occurrence applies separately to each type of covered service. Refer to your plan documents for a full list of services that need this approval.		
Referral Requirement	Not applicable	Not applicable
PHYSICIAN SERVICES	**NETWORK CARE**	**OUT-OF-NETWORK CARE**
Office Visits to Non-Specialist	$25 copay deductible waived	50% after deductible
Includes services of an internist, general physician, family practitioner or pediatrician for diagnosis and treatment of an illness or injury.		
Telemedicine Consultations with Non-Specialist	$25 copay deductible waived	50% after deductible
Virtual Primary Care Telemedicine Provider Consultations Includes basic medical and preventive health care services for persons 18 years of age or older. Telemedicine preventive screening and counseling services are subject to the preventive care benefit.	Covered in full	Not Covered
Non-Specialist Telemedicine Provider Consultations	Covered in full	Not Covered
Specialist Office Visits	$75 copay deductible waived	50% after deductible
Telemedicine Consultations with Specialist	$75 copay deductible waived	50% after deductible
Specialist Telemedicine Provider Consultations	Covered in full	Not Covered
Non-Specialist and Specialist Surgical Services	Covered in full after deductible	50% after deductible
Walk-in Clinics	$25 copay deductible waived	50% after deductible
Walk-in clinics are freestanding 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.		
Maternity - Delivery and Post-Partum Care	Covered in full after deductible	50% after deductible

Allergy Testing	Cost-sharing is based on type of service and where it is received.	50% after deductible
Allergy Injections	Covered in full after deductible	50% after deductible
PREVENTIVE CARE	NETWORK CARE	OUT-OF-NETWORK CARE
Preventive care services are covered in accordance with Health Care Reform.		
Routine Adult Physical Exams and Immunizations Coverage is limited to 1 exam every 12 months.	Covered in full	50% after deductible
Well Child Exams and Immunizations Coverage is limited 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 every 12 months thereafter to age 22.	Covered in full	50% after deductible
Routine Gynecological Exams Includes routine tests and related lab fees. Coverage is limited to 1 exam every 12 months.	Covered in full	50% after deductible
Routine Mammograms	Covered in full	50% after deductible
Women's Health Includes: Screening for gestational diabetes, HPV (Human Papillomavirus) DNA testing, counseling for sexually transmitted infections, counseling and screening for Human Immunodeficiency Virus, screening and counseling for interpersonal and domestic violence, breastfeeding support, supplies, and counseling. Contraceptive methods, sterilization procedures, patient education and counseling. Limitations may apply.	Covered in full	50% after deductible
Prenatal Maternity	Covered in full	50% after deductible
Routine Digital Rectal Exam / Prostate-Specific Antigen Test Recommended: For covered males age 40 and over.	Covered in full	50% after deductible
Colorectal Cancer Screening Recommended: For all members age 45 and over.	Covered in full	50% after deductible
Routine Eye and Hearing Screenings	Paid as part of routine physical exam.	Paid as part of routine physical exam.
HEARING SERVICES	NETWORK CARE	OUT-OF-NETWORK CARE
Hearing Exam (by Specialist)	Not covered	Not covered
Hearing Aid Coverage is limited to 1 per ear every 36 months.	Covered in full	50% after deductible
VISION SERVICES	NETWORK CARE	OUT-OF-NETWORK CARE
Adult Routine Eye Exams (Refraction) Coverage is limited to 1 exam every 12 months.	Covered in full	50% after deductible
Pediatric Routine Eye Exams (Refraction) Coverage is limited to 1 exam every 12 months.	Covered in full	50% after deductible
Adult Vision Hardware	Not Covered	Not Covered
Pediatric Vision Hardware	Not Covered	Not Covered
DIAGNOSTIC PROCEDURES	NETWORK CARE	OUT-OF-NETWORK CARE
Diagnostic Laboratory	Covered in full	50% after deductible
Diagnostic X-ray (except for Complex Imaging Services)	Covered in full	50% after deductible

Diagnostic X-ray for Complex Imaging Services (Including, but not limited to, MRI, MRA, PET and CT Scans)	Covered in full after deductible	50% after deductible
EMERGENCY MEDICAL CARE	NETWORK CARE	OUT-OF-NETWORK CARE
Urgent Care Provider	$75 copay deductible waived	50% after deductible
Non-Urgent Use of Urgent Care Provider	Not covered	Not covered
Emergency Room Copay waived if admitted.	$300 copayment after deductible	Paid as in-network
Non-Emergency Care in an Emergency Room	Not covered	Not covered
Emergency Use of Ambulance	Covered in full after deductible	Paid as in-network
Non-Emergency Use of Ambulance	Covered in full after deductible	Paid as in-network
HOSPITAL CARE	NETWORK CARE	OUT-OF-NETWORK CARE
Inpatient Coverage Including maternity (delivery and postpartum care). The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	Covered in full after deductible	50% after deductible
Outpatient Surgery Provided in an outpatient hospital department or freestanding surgical facility.	Covered in full after deductible	50% after deductible
Colonoscopy (non-preventive)	Cost-sharing is based on type of service and where it is received.	Cost-sharing is based on type of service and where it is received.
Transplants Coverage is limited to IOE facilities only.	Covered in full after deductible	Not covered
BEHAVIORAL HEALTH SERVICES (MENTAL HEALTH and SUBSTANCE RELATED DISORDERS)	NETWORK CARE	OUT-OF-NETWORK CARE
Inpatient Services (including inpatient residential treatment facility) The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	Covered in full after deductible	50% after deductible
Outpatient Office Visits The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.	Covered in full	50% after deductible
Physician or Behavioral Health Provider Telemedicine Consultations	Covered in full	50% after deductible
Telemedicine Provider Consultations	Covered in full	Not Covered
Other Outpatient Services (Includes partial hospitalization treatment, intensive outpatient program.)	Covered in full	50% after deductible
THERAPY SERVICES	NETWORK CARE	OUT-OF-NETWORK CARE
Outpatient Chiropractic/Spinal Manipulation Therapy Coverage is limited to 20 visits per calendar year.	$75 copayment after deductible	50% after deductible
Outpatient Short-Term Rehabilitation - Physical Therapy Coverage is limited to 30 visits per calendar year PT/OT/ST combined. Limits do not apply to neurodevelopmental therapies.	$75 copayment after deductible	50% after deductible

Outpatient Short-Term Rehabilitation - Occupational Therapy Coverage is limited to 30 visits per calendar year PT/OT/ST combined. Limits do not apply to neurodevelopmental therapies.	$75 copayment after deductible	50% after deductible
Outpatient Short-Term Rehabilitation - Speech Therapy Coverage is limited to 30 visits per calendar year PT/OT/ST combined. Limits do not apply to neurodevelopmental therapies.	$75 copayment after deductible	50% after deductible
Habilitative Physical, Occupational and Speech Therapy	Covered in full	50% after deductible
Autism Physical, Occupational and Speech Therapy	Covered in full	50% after deductible
Autism Behavioral Therapy	Covered in full	50% after deductible
Autism Applied Behavior Analysis	Covered in full	50% after deductible
OTHER SERVICES	NETWORK CARE	OUT-OF-NETWORK CARE
Skilled Nursing Facility Coverage is limited to 60 days per calendar year. The member cost sharing applies to all covered benefits incurring during a member's inpatient stay.	Covered in full after deductible	50% after deductible
Home Health Care Coverage is limited to 60 visits per calendar year. 1 visit equals a period of 4 hours or less.	Covered in full after deductible	50% after deductible
Infusion Therapy Provided in the home or physician's office.	Covered in full after deductible	50% after deductible
Infusion Therapy Provided in the outpatient hospital department of freestanding facility.	Covered in full after deductible	50% after deductible
Gene-Based, Cellular and Other Innovative Therapies (GCIT) Coverage is limited to GCIT designated facilities only.	Cost-sharing is based on type of service and where it is received.	Not covered
Inpatient Hospice Care The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	Covered in full after deductible	50% after deductible
Outpatient Hospice Care The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.	Covered in full after deductible	50% after deductible
Private Duty Nursing - Outpatient	Not covered	Not covered
Acupuncture Coverage is limited to 10 visits per calendar year.	$25 copay deductible waived	50% after deductible
Durable Medical Equipment	Covered in full after deductible	50% after deductible
Prosthetics	Covered in full after deductible	50% after deductible
Diabetic Supplies not obtainable at a pharmacy	Covered same as any other medical expense.	Covered same as any other medical expense.
Mouth, Jaws and Teeth Coverage for medical in nature oral surgery only. No coverage for dental in nature oral surgery or for removal of impacted teeth.	Cost-sharing is based on type of service and where it is received.	50% after deductible
Bariatric Surgery	Not covered	Not covered
FAMILY PLANNING	NETWORK CARE	OUT-OF-NETWORK CARE

Basic Infertility Coverage is limited to the diagnosis and treatment of the underlying medical condition, including artificial insemination.	Cost-sharing is based on type of service and where it is received.	Cost-sharing is based on type of service and where it is received.
Advanced Reproductive Technology (ART) In-vitro fertilization (IVF), zygote intrafallopian transfer (ZIFT), gamete intrafallopian transfer (GIFT), cryopreserved embryo transfers, intracytoplasmic sperm injection (ICSI), or ovum microsurgery and ovulation induction	Not covered	Not covered
Fertility preservation	Not covered	Not covered
Vasectomy	Covered in full	50% after deductible
Tubal Ligation	Covered in full	50% after deductible
PHARMACY DEDUCTIBLE	NETWORK CARE	OUT-OF-NETWORK CARE
Prescription drug calendar year deductible	Not Applicable under both the network care and out-of-network columns.	Not Applicable under both the network care and out-of-network columns.
PHARMACY - PRESCRIPTION DRUG BENEFITS	NETWORK CARE	OUT-OF-NETWORK CARE
Generic Drugs		
Retail	Generic - T1A: $3 copayment Generic - T1: $10 copayment	50%
Mail Order	Generic - T1A: $6 copayment Generic - T1: $20 copayment	Not covered
Preferred Brand Drugs		
Retail	$45 copayment	50%
Mail Order	$90 copayment	Not covered
Non-Preferred Generic and Brand Drugs		
Retail	$75 copayment	50%
Mail Order	$150 copayment	Not covered
Specialty Drugs		
Preferred Specialty	$250 copayment	Not covered
Non-Preferred Specialty	$250 copayment	Not covered
Pharmacy Day Supply and Requirements		
Retail Up to 90 days supply. 30 day supply= retail cost share; 31-90 day supply= mail order cost share from the Aetna National Pharmacy Network		
Mail Order 31-90 day supply from CVS Caremark Mail Service Pharmacy™		

Specialty- Up to a 30 day supply.

Choose Generics with Dispense as Written (DAW) override - Choose Generic with DAW Override - Penalty applies to integrated MOOP

Precertification - Included. See formulary for details.

Step Therapy - Included. See formulary for details.

Pharmacy Plan includes:

Contraceptive drugs and devices obtainable from a pharmacy, Oral fertility drugs, Diabetic supplies.

Affordable Care Act mandated female contraceptives and preventive medications covered 100% in-network.

Contraceptives may be dispensed for up to a 12 month supply at one time.

Preventive and seasonal vaccinations covered 100% in-network.

Cost share will not exceed $25 per fill per 30 day supply for formulary insulin, $35 per fill per 30 day supply for non-formulary insulin, $35 per fill per 30 day supply for asthma inhaler; and $17 per device for epinephrine.

Performance Enhancing Drugs - Coverage is excluded for lifestyle/performance drugs.

Not all drugs are covered. It is important to look at the Drug List (Advanced Control Plan - Aetna Formulary) to understand which drugs are covered.

***How out-of-network care is reimbursed:**

We cover the cost of services based on whether doctors are “in network” or “out of network.” We want to help members understand how much Aetna pays for their out-of-network care. At the same time, we want to make it clear how much more members will need to pay for this "out-of-network" care.

Members may choose a provider (doctor or hospital) in our network. Members may choose to visit an out-of-network provider. If a member chooses a doctor who is out of network, their Aetna health plan may pay some of that doctor's bill. Most of the time, members will pay a lot more money out of their own pocket if they choose to use an out-of-network doctor or hospital.

When members choose out-of-network care, Aetna limits the amount it will pay. This limit is called the "recognized" or "allowed" amount.

The members' doctor sets his or her own rate to charge members. These rates may be higher -- sometimes much higher -- than what the members' Aetna plan "recognizes." Members' doctors may bill them for the dollar amount that their plan doesn't "recognize." Members must also pay any copayments, coinsurance and deductibles under their plan. No dollar amount above the "recognized charge" counts toward their deductible or out-of-pocket maximums. To learn more about how we pay out-of-network benefits visit **Aetna.com**. Type "how Aetna pays" in the search box.

Members can avoid these extra costs by getting their care from Aetna's network of health care providers. Go to **www.aetna.com** and click on "Find a Doctor" on the left side of the page. Members can sign on to the Aetna member site.

This applies when members choose to get care out of network. When members have no choice (for example: emergency room visit after a car accident, or for other emergency services), we will pay the bill as if the member got care in network. Members pay cost sharing and deductibles for their in-network level of benefits. Members should contact Aetna if their health care provider asks them to pay more. Members are not responsible for any outstanding balance billed by their providers for emergency services beyond their cost sharing and deductibles.

What's Not Covered

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; Custodial care; Dental services; Donor egg retrieval; Experimental and investigational procedures; Hearing aids; Immunizations for travel or work; Infertility services, including, but not limited to, advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI and other related services, unless specifically listed as covered in your plan documents;
Nonmedically necessary services or supplies; Orthotics, except diabetic orthotics; Over-the-counter medications and supplies; Reversal of sterilization; Services for the treatment of sexual dysfunction or inadequacies, including therapy, supplies, or counseling; and special duty nursing. Weight control services including surgical procedures, medical treatments, 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.

Not all services are covered. See plan documents for a complete description of benefits, exclusions and limitations of coverage. Plan features and availability may vary by location and are subject to change. Providers are independent contractors and are not our agents. Provider participation may change without notice. We do not provide care or guarantee access to health services.

Medications on the Aetna Drug Guide, precertification, step-therapy and quantity limits lists are subject to change.

Aetna, CVS Pharmacy® and MinuteClinic, LLC (which either operates or provides certain management support services to MinuteClinic-branded walk-in clinics) are part of the CVS Health® family of companies.CVS Caremark® Mail Service Pharmacy and Aetna are part of the CVS Health® family of companies.

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In case of emergency, call 911 or your local emergency hotline, or go directly to an emergency care facility.

While this information is believed to be accurate as of the print date, it is subject to change. For more information about Aetna plans, refer to **Aetna.com**.

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