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PLAN DESIGN AND BENEFITS - WA Bronze PPO 6350 70/50 HSA-E (2024)

WA Group Business 1-50 Employees

PLAN FEATURES	NETWORK CARE	OUT-OF-NETWORK CARE
Primary Care Physician Selection	Not applicable	Not applicable
Deductible (per calendar year)	$6,350 Individual $12,700 Family	$17,150 Individual $34,300 Family
Unless otherwise indicated, the deductible must be met before benefits can be paid.		
Claims from in-network and out-of-network providers do not cross-accumulate to satisfy the 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)	30%	50%
Out-of-Pocket (OOP) Maximum (per calendar year, includes deductible)	$7,150 Individual $14,300 Family	Unlimited Individual Unlimited Family
Claims from in-network and out-of-network providers do not cross-accumulate to satisfy the out-of-pocket maximums.		
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: 90% of Medicare Facility: 90% of Medicare
Precertification Requirements		
Some out-of-network services need approval by us in advance (precertification). Without this approval, a benefit reduction of 50% up to $400 per service or supply. 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	30% after deductible	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 to Non-Specialist	30% after deductible	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 after deductible	Not Covered
Non-Specialist Telemedicine Provider Consultations	Covered in full after deductible	Not Covered
Specialist Office Visits	30% after deductible	50% after deductible
Telemedicine Consultations to Specialist	30% after deductible	50% after deductible
Specialist Telemedicine Provider Consultations	Covered in full after deductible	Not Covered
Walk-in Clinics	Covered in full after deductible	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	30% after deductible	50% after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Allergy Testing	30% after deductible	50% after deductible

Allergy Injections	30% 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
Routine 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 Pap smear, HPV screening 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; Limitations may apply.	Covered in full	Cost-sharing is based on type of service and where it is received.
Prenatal Maternity Coverage for dependent daughters is included. Coverage is included for homebirth by a midwife for low risk pregnancy.	Covered in full	50% after deductible
Routine Digital Rectal Exam / Prostate-Specific Antigen Test Recommended: For covered males age 40 and over. Frequency schedule applies.	Covered in full	50% after deductible
Colorectal Cancer Screening Recommended: For all members age 45 and over. Frequency schedule applies.	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 cochlear implants.	30% after deductible	50% after deductible
VISION SERVICES	NETWORK CARE	OUT-OF-NETWORK CARE
Adult Routine Eye Exams (Refraction)	Not covered	Not covered
Pediatric Routine Eye Exams (Refraction) Coverage is limited to 1 exam per calendar year. Includes fitting of eyeglass frames, prescription lenses, low vision devices and contact lenses, age 0-19.	Covered in full	Not covered
Adult Vision Hardware	Not covered	Not covered
Pediatric Vision Hardware Coverage is limited to 1 set of frames and a 12 month supply of contact lenses or eyeglass lenses per year, age 0-19.	Covered in full	Not covered
DIAGNOSTIC PROCEDURES	NETWORK CARE	OUT-OF-NETWORK CARE
Outpatient Diagnostic Laboratory Includes blood, blood products and blood storage, including the services and supplies of a blood bank at ded/coins.	30% after deductible	50% after deductible

Outpatient Diagnostic X-ray (except for Complex Imaging Services)	30% after deductible	50% after deductible
Outpatient Diagnostic X-ray for Complex Imaging Services Including, but not limited to, MRI, MRA, PET and CT scans. Precertification required.	30% after deductible	50% after deductible
Outpatient Diagnostic Laboratory Performed in a PCP Office Visit Includes blood, blood products and blood storage, including the services and supplies of a blood bank at ded/coins.	30% after deductible	50% after deductible
Outpatient Diagnostic X-ray Performed in a PCP Office Visit (except for Complex Imaging Services)	30% after deductible	50% after deductible
Outpatient Diagnostic X-ray for Complex Imaging Services Performed in a PCP Office Visit Including, but not limited to, MRI, MRA, PET and CT scans. Precertification required.	30% after deductible	50% after deductible
Outpatient Diagnostic Laboratory Performed in a Specialist Offic Visit Includes blood, blood products and blood storage, including the services and supplies of a blood bank at ded/coins.	30% after deductible	50% after deductible
Outpatient Diagnostic X-ray Performed in a Specialist Offic Visit (except for Complex Imaging Services)	30% after deductible	50% after deductible
Outpatient Diagnostic X-ray for Complex Imaging Services Performed in a Specialist Offic Visit Including, but not limited to, MRI, MRA, PET and CT scans. Precertification required.	30% after deductible	50% after deductible
EMERGENCY MEDICAL CARE	NETWORK CARE	OUT-OF-NETWORK CARE
Urgent Care Provider	30% after deductible	50% after deductible
Non-Urgent Use of Urgent Care Provider	Not covered	Not covered
Emergency Room	30% after deductible	Paid as in-network
Non-Emergency Care in an Emergency Room	Not covered	Not covered
Emergency Use of Ambulance	30% after deductible	Paid as in-network
Non-Emergency Use of Ambulance	30% after deductible	Paid as in-network
HOSPITAL CARE	NETWORK CARE	OUT-OF-NETWORK CARE
Inpatient Coverage Including maternity (prenatal, delivery and postpartum) and transplants.	30% after deductible	50% after deductible
Outpatient Surgery Provided in an outpatient hospital department or freestanding surgical facility.	30% 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.	30% after deductible	Not covered

BEHAVIORAL HEALTH SERVICES (MENTAL HEALTH and SUBSTANCE RELATED DISORDERS)	NETWORK CARE	OUT-OF-NETWORK CARE
Inpatient Services	30% after deductible	50% after deductible
Outpatient Office Visits	30% after deductible	50% after deductible
Physician or Behavioral Health Provider Telemedicine Consultations	30% after deductible	50% after deductible
Telemedicine Provider Consultations	Covered in full after deductible	Not Covered
Other Outpatient Services (e.g,:partial hospitalization treatment, intensive outpatient programs)	30% after deductible	50% after deductible
THERAPY SERVICES	NETWORK CARE	OUT-OF-NETWORK CARE
Outpatient Chiropractic/Spinal Manipulation Therapy Accumulation and Cost Share- Coverage is limited to 12 visits per calendar year, separate from habilitation and includes all outpatient places of service for Chiro.	30% after deductible	50% after deductible
Outpatient Short-Term Rehabilitation - Physical Therapy Accumulation and Cost Share- Coverage is limited to 25 visits per calendar year PT, OT and ST combined, separate from habilitation and includes all outpatient places of service for PT, OT and ST.	30% after deductible	50% after deductible
Outpatient Short-Term Rehabilitation - Occupational Therapy Accumulation and Cost Share- Coverage is limited to 25 visits per calendar year PT, OT and ST combined, separate from habilitation and includes all outpatient places of service for PT, OT and ST.	30% after deductible	50% after deductible
Outpatient Short-Term Rehabilitation - Speech Therapy Accumulation and Cost Share- Coverage is limited to 25 visits per calendar year PT, OT and ST combined, separate from habilitation and includes all outpatient places of service for PT, OT and ST.	30% after deductible	50% after deductible
Habilitative Physical, Occupational and Speech Therapy	30% after deductible	50% after deductible
Autism Physical, Occupational and Speech Therapy	30% after deductible	50% after deductible
Autism Behavioral Therapy	30% after deductible	50% after deductible
Autism Applied Behavior Analysis	30% after deductible	50% after deductible
OTHER SERVICES AND PLAN DETAILS	NETWORK CARE	OUT-OF-NETWORK CARE
Skilled Nursing Facility	30% after deductible	50% after deductible
Home Health Care Coverage is limited to 130 visits per calendar year.	30% after deductible	50% after deductible
Infusion Therapy Provided in the home or physician's office.	30% after deductible	50% after deductible
Infusion Therapy Provided in the outpatient hospital department or freestanding facility.	30% 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
Hospice Care - Inpatient	30% after deductible	50% after deductible
Hospice Care Outpatient	30% after deductible	50% after deductible

Private Duty Nursing -Outpatient	Not covered	Not covered
Acupuncture Coverage is limited to 12 visits per calendar year except for substance abuse.	30% after deductible	50% after deductible
Durable Medical Equipment	50% 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.
Bariatric Surgery	Not covered	Not covered
FAMILY PLANNING	NETWORK CARE	OUT-OF-NETWORK CARE
Infertility Treatment - Diagnostic only Covered only for the diagnosis and treatment of the underlying medical condition.	Cost-sharing is based on type of service and where it is received.	50% after deductible
Infertility Treatment - Artificial Insemination or Ovulation Induction	Not covered	Not covered
Advanced Reproductive Technology. Including, but not limited to, GIFT, ZIFT, IVF, ICSI, ovum microsurgery and cryopreserved embryo transfers.	Not covered	Not covered
Vasectomy	Covered in full after deductible	50% after deductible
Tubal Ligation	Covered in full	50% after deductible
PEDIATRIC DENTAL SERVICES	NETWORK CARE	OUT-OF-NETWORK CARE
Preventive & Diagnostic (includes exams, cleanings, x-rays, fluoride, sealants) Coverage is limited to 2 exams per calendar year age 0-19.	Covered in full	30% after deductible
Basic (includes space maintainers, fillings, anesthesia, denture adjustments) Coverage is limited to age 0-19.	30% after deductible	50% after deductible
Major (includes crowns, endodontics, periodontics, oral surgery, dentures, bridges) Coverage is limited to age 0-19.	50% after deductible	50% after deductible
Orthodontia (limited to medically necessary orthodontia) Coverage is limited to age 0-19.	50% after deductible	50% after deductible
PHARMACY DEDUCTIBLE	NETWORK CARE	OUT-OF-NETWORK CARE
Prescription drug calendar year deductible	Prescription drugs purchased at a network pharmacy are subject to the in-network medical deductible which must be satisfied before any prescription drug benefits are paid.	Prescription drugs purchased at a non-network pharmacy are subject to the non-network medical deductible which must be satisfied before any prescription drug benefits are paid.
PHARMACY - PRESCRIPTION DRUG BENEFITS	NETWORK CARE	OUT-OF-NETWORK CARE
Generic Drugs		
Retail	$20 copayment after deductible	Not covered
MailOrder	$50 copayment after deductible	Not covered
Preferred Brand Drugs		
Retail	$80 copayment after deductible	Not covered
MailOrder	$200 copayment after deductible	Not covered
Non-Preferred Drugs		
Retail	$120 copayment after deductible	Not covered
MailOrder	$300 copayment after deductible	Not covered
Speciality Drugs		
Preferred Speciality	40% up to $500 after deductible	Not covered
Non-Preferred Speciality	50% up to $750 after deductible	Not covered
Pharmacy Day Supply and Requirements		

Retail : Up to a 30 day supply.
Mail Order : A 31-90 day supply from CVS Caremark Mail Service PharmacyTM or a CVS Pharmacy at the Mail Order Drug copay.
Specialty : Up to a 30 day supply

Specialty Drugs - First prescription fill at any retail or specialty pharmacy. Subsequent fills must be through our preferred specialty pharmacy network.

Full Choose Generics - If the member or the physician requests brand when generic is available, the member pays the applicable cost-sharing plus the cost difference between the generic and brand. Penalty does not apply to medical deductible and integrated MOOP.

Precertification - Included. See formulary for details.

Step Therapy - Included. See formulary for details.

Maintenance Choice® with Opt Out - After two retail fills, members must choose to fill a 90-day supply of their maintenance drugs at CVS Caremark Mail Service PharmacyTM or at a CVS retail pharmacy. If the member wants to continue to fill their 30-day supply at any other network pharmacy, they simply need to call us at the number on their member ID card. If they do not notify us that they want to opt out of the 90-day supply at a CVS Pharmacy, they'll be responsible for 100 percent of their medication cost. The member may call us any time, even from the pharmacy, to let us know that they intend to opt out of the benefit.

Pharmacy Plan includes:

Diabetic supplies obtainable from a pharmacy (Including: needles, syringes, test strips, lancets and alcohol swabs - available at retail or mail order).

Performance Enhancing Drugs - Not Covered

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

Preventive and seasonal vaccinations covered 100% in-network.

In-Network and Out-of-Network Providers

*We cover the cost of services based on whether doctors 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.

You may choose a provider (doctor or hospital) in our network. You may choose to visit an out-of-network provider. If you choose a provider who is out-of-network, your Aetna health plan may pay some of that provider '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.

Your doctor sets his or her own rate to charge you. It may be higher - sometimes much higher - than what your Aetna plan "recognizes". Your non-network 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 out-of-pocket maximums.

To learn more about how we pay out-of-network benefits visit **www.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** and click on "Find a Doctor" on the left side of the page. If you are already a member, sign on to your Aetna member site.

This applies when you choose to get care out-of-network. When you have no choice (for example: emergency room visit after a car accident, or for other emergency services), we will pay the bill as if you got care in the network. You pay cost sharing 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 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 purchased.

- 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
- Adult dental care and x-rays
- Donor egg retrieval
- Experimental and investigational procedures
- Immunizations for travel or work

- Infertility services, including, but not limited to, artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI and other related services, unless specifically listed as covered in your plan documents
- Non-medically necessary services or supplies
- Orthotics except as specified in the plan
- Over-the-counter medications and supplies
- Reversal of sterilization
- Services for the treatment of sexual dysfunction or inadequacies, including therapy, supplies, counseling and prescription drugs
- Special duty nursing
- Weight reduction programs, or dietary supplements

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. CVS Caremark® Mail Service Pharmacy and Aetna are part of the CVS Health family of companies. Preferred providers and vendors are independent contractors in private practice and are neither employees nor agents of Aetna or its affiliates. The availability of any particular provider cannot be guaranteed, and provider network composition is subject to change without notice.

If your plan covers outpatient prescription drugs, your plan includes a drug formulary (preferred drug list). A formulary is a list of prescription drugs generally covered under your prescription drug benefits plan on a preferred basis subject to applicable limitations and conditions. Your pharmacy benefit is generally limited to the drugs listed on the formulary. The medications listed on the formulary are subject to change in accordance with applicable state law. For information regarding how medications are reviewed and selected for the formulary, formulary information, and information about other pharmacy programs such as precertification and step therapy, please refer to our website at **www.aetna.com**, or the Aetna Medication Formulary Guide. Members should consult with their treating physicians regarding questions about specific medications. Refer to your plan documents or contact Member Services for information regarding the terms and limitations of coverage.

While this information is believed to be accurate as of the print date, it is subject to change.

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

Plans are provided by Aetna Health Inc.

For more information about Aetna plans, refer to **www.aetna.com**.