Aetna 1-50
PPOMedical | WA 01/01/2018

Member benefits

Plan Name	WA Gold PPO 500 80/50		WA Gold PPO 1000 80/50		WA Silver PPO 1500 70/50		WA Silver PPO 2000 70/50	
	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network
Deductible (Individual/Family)	$500/$1,000	$5,000/10,000	$1,000/$2,000	$5,000/$10,000	$1,500/$3,000	$5,000/$10,000	$2,000/$4,000	$6,000/$12,000
Out-of-pocket limit (Individual/Family)	$6,000/$12,000	Unlimited/Unlimited	$6,000/$12,000	Unlimited/Unlimited	$7,350/$14,700	Unlimited/Unlimited	$7,350/$14,700	Unlimited/Unlimited
Deductible/out-of-pocket limit accumulation	Embedded [1]		Embedded [1]		Embedded [1]		Embedded [1]	
Primary care physician office visit	$35 DW	50% AD	$30 DW	50% AD	$50 DW	50% AD	$45 DW	50% AD
Specialist office visit	$90 DW	50% AD	$75 DW	50% AD	$125 DW	50% AD	$115 DW	50% AD
Walk-in clinics	$35 DW	Not Covered	$30 DW	Not Covered	$50 DW	Not Covered	$45 DW	Not Covered
Diagnostic testing: Lab	20% AD	50% AD	20% AD	50% AD	30% AD	50% AD	30% AD	50% AD
Diagnostic testing: X-ray	20% AD	50% AD	20% AD	50% AD	30% AD	50% AD	30% AD	50% AD
Imaging CT/PET scans MRIs	20% AD	50% AD	20% AD	50% AD	30% AD	50% AD	30% AD	50% AD
Inpatient hospital facility	20% AD	50% AD	20% AD	50% AD	30% AD	50% AD	30% AD	50% AD
Outpatient surgery	20% AD	50% AD	20% AD	50% AD	30% AD	50% AD	30% AD	50% AD
Emergency room	$500 plus 20% AD	Paid as In-Network	$500 plus 20% AD	Paid as In-Network	$500 plus 30% AD	Paid as In-Network	$500 plus 30% AD	Paid as In-Network
Urgent care	$70 DW	50% AD	$60 DW	50% AD	$100 DW	50% AD	$90 DW	50% AD
Rehabilitation services (PT/OT/ST) [3]	$90 DW	50% AD	$75 DW	50% AD	$125 DW	50% AD	$115 DW	50% AD
Chiropractic [4]	$90 DW	50% AD	$75 DW	50% AD	$125 DW	50% AD	$115 DW	50% AD
Pediatric Dental and Vision [5]	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network
Dental Check-Up (aka preventive/diagnostic)	Covered in full AD	30% AD	Covered in full AD	30% AD	Covered in full AD	30% AD	Covered in full AD	30% AD
Dental Basic	30% AD	50% AD	30% AD	50% AD	30% AD	50% AD	30% AD	50% AD
Dental Major	50% AD	50% AD	50% AD	50% AD	50% AD	50% AD	50% AD	50% AD
Dental Ortho	50% AD	50% AD	50% AD	50% AD	50% AD	50% AD	50% AD	50% AD
Vision exam (1 exam per 12 months)	Covered in full DW	Not Covered	Covered in full DW	Not Covered	Covered in full DW	Not Covered	Covered in full DW	Not Covered
Vision Hardware	Covered in full DW	Not covered	Covered in full DW	Not covered	Covered in full DW	Not covered	Covered in full DW	Not covered
Pharmacy [6]	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network
Pharmacy Deductible	None	None	None	None	$200 per Member	None	None	None
Preferred generic drugs	$10	Not Covered	$10	Not Covered	$12 DW	Not Covered	$12	Not Covered
Preferred brand drugs	$45	Not Covered	$45	Not Covered	$55 AD	Not Covered	$55	Not Covered
Non-preferred drugs	$85	Not Covered	$85	Not Covered	$95 AD	Not Covered	$95	Not Covered
Specialty drugs	Preferred Specialty: 30% up to $300 Non-Preferred Specialty: 40% up to $500	Not Covered	Preferred Specialty: 30% up to $300 Non-Preferred Specialty: 40% up to $500	Not Covered	Preferred Specialty: 40% up to $500 AD Non-Preferred Specialty: 50% up to $750 AD	Not Covered	Preferred Specialty: 40% up to $500 Non-Preferred Specialty: 50% up to $750	Not Covered

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Member benefits

Plan name	WA Silver PPO 3000 80/50		WA Bronze PPO Saver 5250 70/50		WA Bronze PPO 6500 Copay Plan	
	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network
Deductible (Individual/Family)	$3,000/$6,000	$9,000/$18,000	$5,250/$10,500	$15,750/$31,500	$6,500/$13,000	$19,500/$39,000
Out-of-pocket limit (Individual/Family)	$7,350/$14,700	Unlimited/Unlimited	$7,350/$14,700	Unlimited/Unlimited	$7,350/$14,700	Unlimited/Unlimited
Deductible/out-of-pocket limit accumulation	Embedded [1]		Embedded [1]		Embedded [1]	
Primary care physician office visit	$45 DW	50% AD	$50 DW	50% AD	$50 DW	50% AD
Specialist office visit	$115 DW	50% AD	$125 DW	50% AD	$125 DW	50% AD
Walk-in clinics	$45 DW	Not Covered	$50 DW	Not Covered	$50 DW	Not Covered
Diagnostic testing: Lab	20% AD	50% AD	30% AD	50% AD	Covered in full AD	50% AD
Diagnostic testing: X-ray	20% AD	50% AD	30% AD	50% AD	Covered in full AD	50% AD
Imaging CT/PET scans MRIs	20% AD	50% AD	30% AD	50% AD	$500 AD	50% AD
Inpatient hospital facility	20% AD	50% AD	30% AD	50% AD	$1,000 per admission AD	50% AD
Outpatient surgery	20% AD	50% AD	30% AD	50% AD	$500 AD	50% AD
Emergency room	$500 plus 20% AD	Paid as In-Network	$500 plus 30% AD	Paid as In-Network	$500 AD	Paid as In-Network
Urgent care	$90 DW	50% AD	$100 DW	50% AD	$100 DW	50% AD
Rehabilitation services (PT/OT/ST) [3]	$115 DW	50% AD	$125 DW	50% AD	$125 DW	50% AD
Chiropractic [4]	$115 DW	50% AD	$125 DW	50% AD	$125 DW	50% AD
Pediatric Dental and Vision [5]	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network
Dental Check-Up (aka preventive/diagnostic)	Covered in full AD	30% AD	Covered in full AD	30% AD	Covered in full AD	30% AD
Dental Basic	30% AD	50% AD	30% AD	50% AD	30% AD	50% AD
Dental Major	50% AD	50% AD	50% AD	50% AD	50% AD	50% AD
Dental Ortho	50% AD	50% AD	50% AD	50% AD	50% AD	50% AD
Vision exam (1 exam per 12 months)	Covered in full DW	Not Covered	Covered in full DW	Not Covered	Covered in full DW	Not Covered
Vision Hardware	Covered in full DW	Not covered	Covered in full DW	Not covered	Covered in full DW	Not covered
Pharmacy [6]	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network
Pharmacy Deductible	None	None	$250 per Member	None	None	None
Preferred generic drugs	$12	Not Covered	$15 DW	Not Covered	$15	Not Covered
Preferred brand drugs	$55	Not Covered	$65 AD	Not Covered	$65	Not Covered
Non-preferred drugs	$95	Not Covered	$100 AD	Not Covered	$100	Not Covered
Specialty drugs	Preferred Specialty: 40% up to $500 Non-Preferred Specialty: 50% up to $750	Not Covered	Preferred Specialty: 40% up to $500 AD Non-Preferred Specialty: 50% up to $750 AD	Not Covered	Preferred Specialty: 40% up to $500 Non-Preferred Specialty: 50% up to $750	Not Covered

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Member benefits

Plan Name	WA Silver PPO 2000 80/50 HSA-T		WA Silver PPO 2700 80/50 HSA-E		WA Bronze PPO 5500 80/50 HSA-E	
	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network
Deductible (Individual/Family)	$2,000/$4,000	$6,000/$12,000	$2,700/$5,400	$8,100/$16,200	$5,500/$11,000	$16,500/$33,000
Out-of-pocket limit (Individual/Family)	$6,550/$6,550	Unlimited/Unlimited	$6,550/$13,100	Unlimited/Unlimited	$6,550/$13,100	Unlimited/Unlimited
Deductible/out-of-pocket limit accumulation	TIF [2]		Embedded [1]		Embedded [1]	
Primary care physician office visit	20% AD	50% AD	20% AD	50% AD	20% AD	50% AD
Specialist office visit	20% AD	50% AD	20% AD	50% AD	20% AD	50% AD
Walk-in clinics	20% AD	Not Covered	20% AD	Not Covered	20% AD	Not Covered
Diagnostic testing: Lab	20% AD	50% AD	20% AD	50% AD	20% AD	50% AD
Diagnostic testing: X-ray	20% AD	50% AD	20% AD	50% AD	20% AD	50% AD
Imaging CT/PET scans MRIs	20% AD	50% AD	20% AD	50% AD	20% AD	50% AD
Inpatient hospital facility	20% AD	50% AD	20% AD	50% AD	20% AD	50% AD
Outpatient surgery	20% AD	50% AD	20% AD	50% AD	20% AD	50% AD
Emergency room	20% AD	Paid as In-Network	20% AD	Paid as In-Network	20% AD	Paid as In-Network
Urgent care	20% AD	50% AD	20% AD	50% AD	20% AD	50% AD
Rehabilitation services (PT/OT/ST) [3]	20% AD	50% AD	20% AD	50% AD	20% AD	50% AD
Chiropractic [4]	20% AD	50% AD	20% AD	50% AD	20% AD	50% AD
Pediatric Dental and Vision [5]	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network
Dental Check-Up (aka preventive/diagnostic)	Covered in full AD	30% AD	Covered in full AD	30% AD	Covered in full AD	30% AD
Dental Basic	30% AD	50% AD	30% AD	50% AD	30% AD	50% AD
Dental Major	50% AD	50% AD	50% AD	50% AD	50% AD	50% AD
Dental Ortho	50% AD	50% AD	50% AD	50% AD	50% AD	50% AD
Vision exam (1 exam per 12 months)	Covered in full DW	Not Covered	Covered in full DW	Not Covered	Covered in full DW	Not Covered
Vision Hardware	Covered in full DW	Not covered	Covered in full DW	Not covered	Covered in full DW	Not covered
Pharmacy [6]	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network
Pharmacy Deductible	Integrated with Medical Deductible	None	Integrated with Medical Deductible	None	Integrated with Medical Deductible	None
Preferred generic drugs	$15 AD	Not Covered	$15 AD	Not Covered	$15 AD	Not Covered
Preferred brand drugs	$65 AD	Not Covered	$65 AD	Not Covered	$65 AD	Not Covered
Non-preferred drugs	$100 AD	Not Covered	$100 AD	Not Covered	$100 AD	Not Covered
Specialty drugs	Preferred Specialty: 40% up to $500 AD Non-Preferred Specialty: 50% up to $750 AD	Not Covered	Preferred Specialty: 40% up to $500 AD Non-Preferred Specialty: 50% up to $750 AD	Not Covered	Preferred Specialty: 40% up to $500 AD Non-Preferred Specialty: 50% up to $750 AD	Not Covered

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Limitations and Exceptions

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. 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.

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. Precertification requirements may vary.

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. Aetna receives rebates from drug manufacturers that may be taken into account in determining Aetna's Preferred Drug List. Rebates do not reduce the amount a member pays the pharmacy for covered prescriptions. In addition, in circumstances where your prescription plan uses copayments or coinsurance calculated on a percentage basis or a deductible, use of formulary drugs may not necessarily result in lower costs for the member. 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.

Aetna Rx Home Delivery refers to Aetna Rx Home Delivery, LLC, a subsidiary of Aetna, Inc., that is a licensed pharmacy providing mail-order pharmacy services. Aetna's negotiated charge with Aetna Rx Home Delivery may be higher than Aetna Rx Home Delivery's cost of purchasing drugs and providing mail-order pharmacy services.

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Footnotes

"AD" indicates after deductible and "DW" indicates Deductible waived

All services are subject to the deductible unless noted otherwise. Some benefits are subject to age and frequency schedules, limitations or visit maximums. Members or Providers may be required to precertify or obtain approval for certain services.

Note: Please refer to Aetna's Producer World® web site at **www.aetna.com** for specific Summary of Benefits and Coverage documents. Or for more information, please contact your licensed agent or Aetna Sales Representative.

Deductibles, copays and coinsurance apply to the out-of-pocket maximum (OOP). After the out of pocket maximum is met, members continue to be responsible for any applicable premiums, penalties for failure to precertify (where applicable) and services not covered by Aetna.

[1] **Embedded** – No one family member may contribute more than the individual deductible/out-of-pocket limit amount to the family deductible/out-of-pocket limit. Once the family deductible/out-of-pocket limit is met, all family members will be considered as having met their deductible/out-of-pocket limit for the remainder of the calendar year.

[2] **TIF (Non-Embedded) -** The individual deductible/out-of-pocket limit can only be met when a member is enrolled for self only coverage with no dependent coverage. The family deductible/out-of-pocket limit can be met by a combination of family members or by any single individual within the family. Once the family deductible/out-of-pocket limit is met, all family members will be considered as having met their deductible/out-of-pocket limit for the remainder of the calendar year.

[3] **Rehabilitation services -** Coverage is limited to **25** visits for PT/OT/ST combined per calendar year. Benefit limits are not shared between rehabilitation and habilitation services.

[4] **Chiropractic/subluxation** services have a limit of **12** visits per calendar year.

[5] **Vision and Dental services -** These plans do not cover all dental and vision expenses and have exclusions and limitations. Members should refer to their plan documents to determine which services are covered and to what extent.– Important Notes: This plan will cover **1** set of frames and a **12** month supply of contact lenses or eyeglass lenses per year.

[6] **Pharmacy**

Choose Generics applies - If the physician prescribes or the member requests a covered brand name prescription drug when a generic prescription drug equivalent is available, the member will pay the difference in cost between the brand name prescription drug and the generic prescription drug equivalent plus the applicable cost-sharing. The cost difference between the generic and brand does not count toward the Out of Pocket Limit. Not all drugs are covered. It is important to look at the Drug List (SG ACA Open) to understand which drugs are covered.

Network

How your 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 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 doctor who is out of network, your Aetna health plan may pay some of that doctor'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. When you choose out-of-network care, Aetna limits the amount it will pay. This limit is called the "recognized" or "allowed" amount.

Professional Services/Facility Services: 90% of Medicare

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 doctor may bill you for the dollar amount that your plan 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 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 Navigator member site.

This applies when you choose to get care out of network. When you have no choice (usually, for emergency services), some of our plans pay the bill as if you got care in network. For those plans, you pay cost sharing and deductibles based on your in-network level of benefits. You do not have to pay anything else. Other plans pay the bill differently. And, under those plans, you may be responsible for more than your in-network cost sharing. The additional amounts could be very large. Look at your plan or contact us to find out more about how your plan pays for emergency services.

This material is for information only and is not an offer or invitation to contract. An application must be completed to obtain coverage. Rates and benefits may vary by location. Health/dental insurance plans contain exclusions and limitations. Plan features and availability may vary by location and group size. Investment services are independently offered through PayFlex. Providers are independent contractors and not agents of Aetna. Provider participation may change without notice. Aetna does not provide care or guarantee access to health services. Not all health and dental services are covered. See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Plan features are subject to change. Aetna receives rebates from drug manufacturers that may be taken into account in determining Aetna's Preferred Drug List. Rebates do not reduce the amount a member pays the pharmacy for covered prescriptions. Information is believed to be accurate as of the production date; however, it is subject to change. For more information about Aetna plans, refer to **www.aetna.com**.

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