Illustrative Plan Design (2018)

Washington Mid-Market 51-100

***Disclaimer:** The following plan summary is for informational purposes only. A final plan design document will be distributed once the renewal is confirmed and finalized. This document is intended for marketing purposes and is subject to change, the final plan design may include additional coverages added at renewal such as Vision coverage. Please refer to and replace this draft with the group specific plan summary created upon renewal. Please refer to your designated TBS Account Manager with any questions.

Prepared: 11/17/17

PLAN DESIGN & BENEFITS
MEDICAL PLAN PROVIDED BY AETNA LIFE INSURANCE COMPANY

PLAN FEATURES	IN-NETWORK	OUT-OF-NETWORK
Deductible (per calendar year)	$3,000 Individual $6,000 Family	$5,000 Individual $10,000 Family
All covered expenses accumulate simultaneously toward both the preferred and non-preferred Deductible. Unless otherwise indicated, the deductible must be met prior to benefits being payable. Member cost sharing for certain services, as indicated in the plan, are excluded from charges to meet the Deductible. Pharmacy expenses apply towards the Deductible. Once Family Deductible is met, all family members will be considered as having met their Deductible. There is no Individual Deductible to satisfy within the Family Deductible.		
Member Coinsurance Applies to all expenses unless otherwise stated.	10%	30%
Payment Limit (per calendar year)	$6,000 Individual $6,000 Family	$10,000 Individual $10,000 Family
All covered expenses accumulate simultaneously toward both the preferred and non-preferred Payment Limit. Certain member cost sharing elements may not apply toward the Payment Limit. Pharmacy expenses apply towards the Payment Limit. Only those out-of-pocket expenses resulting from the application of coinsurance percentage, copays, and deductibles (except any penalty amounts) may be used to satisfy the Payment Limit. There is no Individual Payment Limit to satisfy within the Family Payment Limit. Once Family Payment Limit is met, all family members will be considered as having met their Payment Limit.		
Lifetime Maximum Unlimited except where otherwise indicated.		
Payment for Non-Preferred Care**	Not Applicable	Professional: 105% of Medicare Facility: 140% of Medicare
Primary Care Physician Selection	Not Applicable	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	**IN-NETWORK**	**OUT-OF-NETWORK**
Routine Adult Physical Exams/ Immunizations 1 exam every 12 months for members age 22 to age 65; 1 exam every 12 months for adults age 65 and older.	Covered 100%; deductible waived	30%; after deductible
Routine Well Child Exams/Immunizations 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 year thereafter to age 22.	Covered 100%; deductible waived	30%; after deductible
Routine Gynecological Care Exams Includes routine tests and related lab fees.	Covered 100%; deductible waived	30%; after deductible
Routine Mammograms	Covered 100%; deductible waived	30%; 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 100%; deductible waived	30%; after deductible
Routine Digital Rectal Exam Recommended: For covered males age 40 and over.	Covered 100%; deductible waived	30%; after deductible

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Prostate-specific Antigen Test Recommended: For covered males age 40 and over.	Covered 100%; deductible waived	30%; after deductible
Colorectal Cancer Screening Recommended: For all members age 50 and over.	Covered 100%; deductible waived	Covered under Routine Adult Exams
Routine Hearing Screening	Covered 100%; deductible waived	30%; after deductible
PHYSICIAN SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Office Visits to non-Specialist Includes services of an internist, general physician, family practitioner or pediatrician.	10%; after deductible	30%; after deductible
Specialist Office Visits Includes visits to a naturopath	10%; after deductible	30%; after deductible
Audiometric Hearing Exam 1 routine exam per 24 months.	Covered 100%; deductible waived	Not Covered
Pre-Natal Maternity	Covered 100%; deductible waived	30%; after deductible
Walk-in Clinics Walk-in Clinics are network, free-standing health care facilities. They are an alternative to a physician's office visit for treatment of unscheduled, non-emergency illnesses and injuries and the administration of certain immunizations. It is not an alternative for emergency room services or the ongoing care provided by a physician. Neither an emergency room, nor the outpatient department of a hospital, shall be considered a Walk-in Clinic.	10%; after deductible	Not Covered
Allergy Testing	Your cost sharing is based on the type of service and where it is performed	Your cost sharing is based on the type of service and where it is performed
Allergy Injections	Your cost sharing is based on the type of service and where it is performed	Your cost sharing is based on the type of service and where it is performed
DIAGNOSTIC PROCEDURES	**IN-NETWORK**	**OUT-OF-NETWORK**
Diagnostic X-ray If performed as a part of a physician office visit and billed by the physician, expenses are covered subject to the applicable physician's office visit member cost sharing.	10%; after deductible	30%; after deductible
Diagnostic Laboratory If performed as a part of a physician office visit and billed by the physician, expenses are covered subject to the applicable physician's office visit member cost sharing.	10%; after deductible	30%; after deductible
Diagnostic Outpatient Complex Imaging	10%; after deductible	30%; after deductible
EMERGENCY MEDICAL CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Urgent Care Provider	10%; after deductible	30%; after deductible
Non-Urgent Use of Urgent Care Provider	Not Covered	Not Covered
Emergency Room	10%; after deductible	Same as in-network care
Non-Emergency Care in an Emergency Room	Not Covered	Not Covered
Emergency Use of Ambulance	10%; after deductible	Same as in-network care
Non-Emergency Use of Ambulance	Not covered unless medically necessary for safe transport	Not covered unless medically necessary for safe transport
HOSPITAL CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient Coverage Your cost sharing applies to all covered benefits incurred during your inpatient stay.	10%; after deductible	30%; after deductible
Inpatient Maternity Coverage (includes delivery and postpartum care) Your cost sharing applies to all covered benefits incurred during your inpatient stay.	10%; after deductible	30%; after deductible

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Outpatient Hospital Expenses	10%; after deductible	30%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Outpatient Surgery - Hospital	10%; after deductible	30%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Outpatient Surgery - Freestanding Facility	10%; after deductible	30%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
MENTAL HEALTH SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient	10%; after deductible	30%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Mental Health Office Visits	10%; after deductible	30%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Other Mental Health Services	10%; after deductible	30%; after deductible
SUBSTANCE ABUSE	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient	10%; after deductible	30%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Residential Treatment Facility	10%; after deductible	30%; after deductible
Substance Abuse Office Visits	10%; after deductible	30%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Other Substance Abuse Services	10%; after deductible	30%; after deductible
OTHER SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Skilled Nursing Facility	10%; after deductible	30%; after deductible
Limited to 120 days per calendar year. Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Home Health Care	10%; after deductible	30%; after deductible
Home health care services include private duty nursing		
Hospice Care - Inpatient	10%; after deductible	30%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Hospice Care - Outpatient	10%; after deductible	30%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Spinal Manipulation Therapy	10%; after deductible	30%; after deductible
Limited to 20 visits per calendar year.		
Outpatient Short-Term Rehabilitation	10%; after deductible	30%; after deductible
Limited to 25 visits per calendar year. Includes speech, physical, occupational and massage therapy		
Habilitative Services	10%; after deductible	30%; after deductible
Covers physical, occupational, and speech therapies.		
Neurodevelopmental Therapy	10%; after deductible	30%; after deductible
Autism Behavioral Therapy	10%; after deductible	30%; after deductible
Covered same as any other Outpatient Mental Health benefit		

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Autism Applied Behavior Analysis	10%; after deductible	30%; after deductible
Covered same as any other Outpatient Mental Health Other Services benefit		
Autism Physical Therapy	10%; after deductible	30%; after deductible
Autism Occupational Therapy	10%; after deductible	30%; after deductible
Autism Speech Therapy	10%; after deductible	30%; after deductible
Durable Medical Equipment	10%; after deductible	30%; after deductible
Diabetic Supplies -- (if not covered under Pharmacy benefit)	Covered same as any other medical expense.	Covered same as any other medical expense.
Affordable Care Act mandated Women's Contraceptives	Covered 100%; deductible waived	Covered same as any other expense.
Women's Contraceptive drugs and devices not obtainable at a pharmacy	Covered 100%; deductible waived	Covered same as any other medical expense.
Infusion Therapy Administered in the home or physician's office	10%; after deductible	30%; after deductible
Infusion Therapy Administered in an outpatient hospital department or freestanding facility	10%; after deductible	30%; after deductible
Transplants	10%; after deductible Preferred coverage is provided at an IOE contracted facility only.	30%; after deductible Non-Preferred coverage is provided at a Non-IOE facility.
Bariatric Surgery	Not Covered	Not Covered
Acupuncture Limited to 20 visits per calendar year.	10%; after deductible	30%; after deductible
Temporomandibular Joint Disorder (TMJ)	10%; after deductible	30%; after deductible
Includes coverage for TMJ surgery. Non-surgical treatment limited to $1,000 calendar year maximum and $5,000 lifetime maximum, in-network or out-of-network combined.		
Other Licensed Providers (including alternative care)	Your cost sharing is based on the type of service and where it is performed	Your cost sharing is based on the type of service and where it is performed
FAMILY PLANNING	**IN-NETWORK**	**OUT-OF-NETWORK**
Infertility Treatment	Your cost sharing is based on the type of service and where it is performed	Your cost sharing is based on the type of service and where it is performed
Diagnosis and treatment of the underlying medical condition only.		
Comprehensive Infertility Services	Not Covered	Not Covered
Advanced Reproductive Technology (ART)	Not Covered	Not Covered
In-vitro fertilization (IVF), zygote intrafallopian transfer (ZIFT), gamete intrafallopian transfer (GIFT), cryopreserved embryo transfers, intracytoplasmic sperm injection (ICSI), or ovum microsurgery		

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Vasectomy	Your cost sharing is based on the type of service and where it is performed	30%; after deductible
Tubal Ligation	Covered 100%; deductible waived	30%; after deductible
PHARMACY	**IN-NETWORK**	**OUT-OF-NETWORK**
The full cost of the drug is applied to the deductible before any benefits are considered for payment under the pharmacy plan.		
Pharmacy Plan Type	Aetna Value Plus Open Formulary	
Generic Drugs		
Retail	$10 copay	40% of submitted cost; after applicable copay
Mail Order	$20 copay	Not Applicable
Preferred Brand-Name Drugs		
Retail	$35 copay	40% of submitted cost; after applicable copay
Mail Order	$70 copay	Not Applicable
Non-Preferred Generic and Brand-Name Drugs		
Retail	$60 copay	40% of submitted cost; after applicable copay
Mail Order	$120 copay	Not Applicable
Pharmacy Day Supply and Requirements		
Retail	Up to a 30 day supply from Aetna Standard National Network	
Mail Order	Up to a 31-90 day supply from Aetna Rx Home Delivery®.	
Value Plus Specialty	Up to a 30 day supply from Aetna Specialty Pharmacy Network. First prescription fill at any retail or specialty pharmacy. Subsequent fills must be through our preferred specialty pharmacy network.	
Preventive Medications - Deductible is waived for certain preventive medications. A full list of these drugs is available on Navigator or from your employer.		
Plan Includes: Diabetic supplies and Contraceptive drugs and devices obtainable from a pharmacy. Oral fertility drugs included. A limited list of over-the-counter medications are covered when filled with a prescription. Oral chemotherapy drugs covered 100% Value Plus Pre-certification included Value Plus Step Therapy included One transition fill allowed within 90 days of member's effective date Affordable Care Act mandated female contraceptives and preventive medications covered 100% in-network.		
GENERAL PROVISIONS		
Dependents Eligibility	Spouse, children from birth to age 26 regardless of student status.	

**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 we pay 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 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, we limit the amount it will pay. This limit is called the "recognized" or "allowed" amount.

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• For doctors and other professionals the amount is based on what Medicare pays for these services. The government sets the Medicare rate. Exactly how much we "recognize" depends on the plan you or your employer picks.

• For hospitals and other facilities, the amount is based on what Medicare pays for these services. The government sets the Medicare rate. Exactly how much we "recognize" depends on the plan you or your employer picks.

Your doctor sets his or her own rate to charge you. It may be higher -- sometimes much higher -- than what your plan "recognizes." Your doctor may bill you for the dollar amount that we don'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 our website.

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 Navigator 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 network. You pay cost sharing and deductibles for your in-network level of benefits. Contact us 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.

This way of paying out-of-network doctors and hospitals applies when you choose to get care out of network. When you have no choice (for example: emergency room visit after a car accident), we will pay the bill as if you got care in network. You pay your plan's copayments, coinsurance and deductibles for your in-network level of benefits. Contact us 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 copayments, coinsurance and deductibles.

Plans are provided by: Aetna Life Insurance Company. While this material is believed to be accurate as of the production date, it is subject to change.

Health benefits and health insurance plans contain exclusions and limitations. Not all health services are covered.

See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by location and are subject to change. You may be responsible for the health care provider's full charges for any non-covered services, including circumstances where you have exceeded a benefit limit contained in the plan. 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.

The following is a 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.

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• All medical and hospital services not specifically covered in, or which are limited or excluded by your plan documents.
• Cosmetic surgery, including breast reduction.
• Custodial care.
• Dental care and dental X-rays.
• Donor egg retrieval
• Experimental and investigational procedures, except for coverage for medically necessary routine patient care costs for members participating in a cancer clinical trial.
• Hearing aids
• Home births
• Immunizations for travel or work, except where medically necessary or indicated.
• Implantable drugs and certain injectable drugs including injectable infertility drugs.
• Infertility services, including 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.
• Long-term rehabilitation therapy.
• Non-medically necessary services or supplies.
• Outpatient prescription drugs (except for treatment of diabetes), unless covered by a prescription plan rider and over-the-counter medications (except as provided in a hospital) and supplies.
• Radial keratotomy or related procedures.
• Reversal of sterilization.
• Services for the treatment of sexual dysfunction/enhancement, including therapy, supplies or counseling or prescription drugs.
• Special duty nursing.
• Therapy or rehabilitation other than those listed as covered.
• 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.

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. Aetna Rx Home Delivery refers to Aetna Rx Home Delivery, LLC, a licensed pharmacy subsidiary of Aetna Inc., that operates through mail order. The charges that Aetna negotiates with Aetna Rx Home Delivery may be higher than the cost they pay for the drugs and the cost of the mail order pharmacy services they provide. For these purposes, the pharmacy's cost of purchasing drugs takes into account discounts, credits and other amounts that they may receive from wholesalers, manufacturers, suppliers and distributors.

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