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PLAN DESIGN AND BENEFITS - WA Bronze PPO 6500 Copay Plan (2018)

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)	$6,500 Individual $13,000 Family	$19,500 Individual $39,000 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.		
Member Coinsurance (applies to all expenses unless otherwise stated)	0%	50%
Out-of-Pocket (OOP) Maximum (per calendar year, includes deductible)	$7,350 Individual $14,700 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 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.		
Payment for Out-of-Network Care*	Not applicable	Professional: 90% of Medicare Facility: 90% of Medicare
Certification Requirements		
Certification for certain types of out-of-network care must be obtained to avoid a reduction in benefits paid for that care. Certification for hospital admissions, treatment facility admissions, skilled nursing facility admissions, home health care, and hospice care is required. If the necessary certification is not received, payment for services will be reduced by 50% up to $400 per service or supply.		
Referral Requirement	Not applicable	Not applicable
Benefit Limitations -- For any service or supply that is subject to a maximum visit, day, or dollar limitation, such services or supplies accumulate toward both the participating provider and non-participating provider benefit limits under this plan.		
PHYSICIAN SERVICES	NETWORK CARE	OUT-OF-NETWORK CARE
Office Visits to Non-Specialist	$50 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.		
Specialist Office Visits	$125 copay deductible waived	50% after deductible
Walk-in Clinics	$50 copay deductible waived	Not covered
Walk-in clinics are network, free-standing health care facilities. They are an alternative to a doctor'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 an outpatient department of a hospital, is considered a walk-in clinic.		
Maternity - Delivery and Post-Partum Care	Covered in full after deductible	50% after deductible
Allergy Testing (given by a physician)	Member cost sharing is based on the type of service performed and the place rendered.	50% after deductible
Allergy Injections (not given by a physician)	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 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 For covered females age 40 and over. Frequency schedule applies.	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	Member cost sharing is based on the type of service performed and the place of service where it is rendered.
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 For covered males age 40 and over. Frequency schedule applies.	Covered in full	50% after deductible
Colorectal Cancer Screening Sigmoidoscopy and Double Contrast Barium Enema - 1 every 5 years for all members age 50 and over. Preventive Colonoscopy - 1 every 10 years for all members age 50 and over. Fecal Occult Blood Testing - 1 every year for all members age 50 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 cochlear implants.	Covered in full after deductible	Not covered
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.	Covered in full after deductible	50% after deductible
Outpatient Diagnostic X-ray (except for Complex Imaging Services)	Covered in full 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.	$500 copayment after deductible	50% after deductible
EMERGENCY MEDICAL CARE	NETWORK CARE	OUT-OF-NETWORK CARE

Urgent Care Provider (Benefit Availability may vary by location.)	$100 copay deductible waived	50% after deductible
Non-Urgent Use of Urgent Care Provider	Not covered	Not covered
Emergency Room Copay waived if admitted.	$500 copayment after deductible	Paid as in-network
Non-Emergency care in an Emergency Room	Not covered	Not covered
Emergency Ambulance	Covered in full after deductible	Paid as in-network
Non-Emergency Ambulance	Covered in full after deductible	Paid as in-network
HOSPITAL CARE	NETWORK CARE	OUT-OF-NETWORK CARE
Inpatient Coverage Including maternity (prenatal, delivery and postpartum) and transplants.	$1,000 copayment per admission after deductible	50% after deductible
Outpatient Surgery Provided in an outpatient hospital department or freestanding surgical facility.	$500 copayment after deductible	50% after deductible
Colonoscopy (non-preventive)	Member cost sharing is based on the type of service performed and the place rendered.	Member cost sharing is based on the type of service performed and the place rendered.
Transplants Coverage is limited to IOE facilities only.	$1,000 copayment per admission after deductible	Not covered
MENTAL HEALTH and SUBSTANCE USE SERVICES	NETWORK CARE	OUT-OF-NETWORK CARE
Inpatient Mental Health & Substance Use Services	$1,000 copayment per admission after deductible	50% after deductible
Outpatient Office Visit Mental Health & Substance Use Services	$125 copay deductible waived	50% after deductible
Outpatient Othert Mental Health & Substance Use Services (e.g,:partial hospitalization programs, intensive outpatient programs, applied behavior analysis)	Covered in full after deductible	50% after deductible
OTHER SERVICES AND PLAN DETAILS	NETWORK CARE	OUT-OF-NETWORK CARE
Skilled Nursing Facility Coverage is limited to 60 days per calendar year.	$1,000 copayment per admission after deductible	50% after deductible
Home Health Care Coverage is limited to 130 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
Inpatient Hospice Care Coverage is limited to 14 days per lifetime IP/OP combined.	$1,000 copayment per admission after deductible	50% after deductible
Outpatient Hospice Care	Covered in full after deductible	50% after deductible
Private Duty Nursing -Outpatient	Not covered	Not covered
Outpatient Short-Term Rehabilitation - Physical Therapy If provided in the outpatient hospital department, paid under outpatient hospital benefit. Coverage is limited to 25 visits per calendar year PT/OT/ST combined, rehabilitation & habilitation separate	$125 copay deductible waived	50% after deductible

Outpatient Short-Term Rehabilitation - Occupational Therapy If provided in the outpatient hospital department, paid under outpatient hospital benefit. Coverage is limited to 25 visits per calendar year PT/OT/ST combined, rehabilitation & habilitation separate	$125 copay deductible waived	50% after deductible
Outpatient Short-Term Rehabilitation - Speech Therapy If provided in the outpatient hospital department, paid under outpatient hospital benefit. Coverage is limited to 25 visits per calendar year PT/OT/ST combined, rehabilitation & habilitation separate	$125 copay deductible waived	50% after deductible
Outpatient Chiropractic If provided in the outpatient hospital department, paid under outpatient hospital benefit. Coverage is limited to 12 visits per calendar year.	$125 copay deductible waived	50% after deductible
Acupuncture Coverage is limited to 12 visits per calendar year except for substance abuse.	$125 copay deductible waived	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.
FAMILY PLANNING	NETWORK CARE	OUT-OF-NETWORK CARE
Infertility Treatment - Diagnostic only Covered only for the diagnosis and treatment of the underlying medical condition.	Member cost sharing is based on the type of service performed and the place rendered.	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
Voluntary Sterilization - Vasectomy	Member cost sharing is based on the type of service performed and the place rendered.	50% after deductible
Voluntary Sterilization - 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 after deductible	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	Not applicable	Not applicable
PHARMACY - PRESCRIPTION DRUG BENEFITS	NETWORK CARE	OUT-OF-NETWORK CARE
Retail Up to a 30 day supply		
Generic Drugs	$15 copayment	Not covered
Preferred Brand Drugs	$65 copayment	Not covered

Non-Preferred Drugs	Generic & Brand: $100 copayment	Not covered
Specialty Drugs **Includes self-injectable, infused and oral specialty drugs** (retail and mail order up to a 30-day supply, excludes insulin).	Specialty Preferred: 40% up to $500 Specialty Nonpreferred: 50% up to $750	Not covered Not covered
Mail Order Delivery	When you fill your prescription by mail order, you may save money 30-90 days when compared to the cost to purchase your prescriptions at your local retail pharmacy.	
Generic Drugs	$37.50 copayment	Not covered
Preferred Brand Drugs	$162.50 copayment	Not covered
Non-Preferred Drugs	Generic & Brand: $250 copayment	Not covered
Specialty Drugs **Includes self-injectable, infused and oral specialty drugs**	Not covered Not covered	Not covered Not covered
Specialty CareRx℠ -First Prescription for a specialty drugs must be filled at a participating retail pharmacy or Aetna Specialty Pharmacy®. Subsequent fills must be through Aetna Specialty Pharmacy®. For more information, please go to **www.aetnaspecialtycarerx.com**		

Choose Generic - Included. See Aetna Formulary for details.
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 Maximum.

Precertification - Included. See Aetna Formulary for details.

Step Therapy - Included. See Aetna Formulary for details.

Pharmacy Plan includes:

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

Coverage is excluded for lifestyle/performance drugs.

Formulary generic FDA-approved Womens Contraceptives 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 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 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. 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.

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.

Benefits are provided by Aetna Life Insurance Company (ALIC).

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

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