

Member benefits

Plan name	WA Gold PPO 500 80/50		WA Gold PPO 1000 80/50		WA Silver PPO 2000 80/50	
	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network
<b>Deductible (Individual/Family)</b>	\$500/\$1,000	\$5,000/\$10,000	\$1,000/\$2,000	\$5,000/\$10,000	\$2,000/\$4,000	\$6,000/\$12,000
<b>Out-of-pocket limit (Individual/Family)</b>	\$6,200/\$12,400	Unlimited/Unlimited	\$6,000/\$12,000	Unlimited/Unlimited	\$8,200/\$16,400	Unlimited/Unlimited
<b>Deductible/out-of-pocket limit accumulation</b>	Embedded <sup>1</sup>		Embedded <sup>1</sup>		Embedded <sup>1</sup>	
<b>Primary care physician office visit</b>	\$35 DW	50% AD	\$35 DW	50% AD	\$65 DW	50% AD
<b>Specialist office visit</b>	\$90 DW	50% AD	\$90 DW	50% AD	\$110 DW	50% AD
<b>Walk-in clinics <sup>5</sup></b>	\$35 DW	50% AD	\$35 DW	50% AD	\$65 DW	50% AD
<b>Diagnostic testing: Lab</b>	20% AD	50% AD	20% AD	50% AD	20% AD	50% AD
<b>Diagnostic testing: X-ray</b>	20% AD	50% AD	20% AD	50% AD	20% AD	50% AD
<b>Imaging CT/PET scans MRIs</b>	20% AD	50% AD	20% AD	50% AD	20% AD	50% AD
<b>Inpatient hospital facility</b>	20% AD	50% AD	20% AD	50% AD	20% AD	50% AD
<b>Outpatient surgery</b>	20% AD	50% AD	20% AD	50% AD	20% AD	50% AD
<b>Emergency room</b>	\$500 plus 20% AD	Paid as In-Network	\$500 plus 20% AD	Paid as In-Network	\$500 plus 20% AD	Paid as In-Network
<b>Urgent care</b>	\$70 DW	50% AD	\$70 DW	50% AD	\$110 DW	50% AD
<b>Rehabilitation services (PT/OT/ST) <sup>3</sup></b>	\$90 DW	50% AD	\$90 DW	50% AD	\$110 DW	50% AD
<b>Chiropractic <sup>4</sup></b>	\$90 DW	50% AD	\$90 DW	50% AD	\$110 DW	50% AD
<b>Pediatric Dental and Vision <sup>6</sup></b>	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network
<b>Dental check-up (aka preventive/diagnostic)</b>	Covered in full AD	30% AD	Covered in full AD	30% AD	Covered in full AD	30% AD
<b>Dental basic</b>	30% AD	50% AD	30% AD	50% AD	30% AD	50% AD
<b>Dental major</b>	50% AD	50% AD	50% AD	50% AD	50% AD	50% AD
<b>Dental ortho</b>	50% AD	50% AD	50% AD	50% AD	50% AD	50% AD
<b>Vision exam (1 exam per 12 months)</b>	Covered in full DW	Not Covered	Covered in full DW	Not Covered	Covered in full DW	Not Covered
<b>Vision hardware</b>	Covered in full DW	Not covered	Covered in full DW	Not covered	Covered in full DW	Not covered
<b>Pharmacy <sup>7</sup></b>	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network
<b>Pharmacy deductible</b>	None	None	None	None	\$150 per Member	None
<b>Preferred generic drugs</b>	\$10	Not Covered	\$10	Not Covered	\$20 AD	Not Covered
<b>Preferred brand drugs</b>	\$45	Not Covered	\$45	Not Covered	\$85 AD	Not Covered
<b>Non-preferred drugs</b>	\$85	Not Covered	\$85	Not Covered	\$150 AD	Not Covered
<b>Specialty drugs</b>	Preferred Specialty: 30% up to \$300 Non-Preferred Specialty: 40% up to \$500	Preferred Specialty: Not Covered Non-Preferred Specialty: Not Covered	Preferred Specialty: 30% up to \$300 Non-Preferred Specialty: 40% up to \$500	Preferred Specialty: Not Covered Non-Preferred Specialty: Not Covered	Preferred Specialty: 40% up to \$500 AD Non-Preferred Specialty: 50% up to \$750 AD	Preferred Specialty: Not Covered Non-Preferred Specialty: Not Covered

Health insurance plans are offered and/or underwritten by Aetna Life Insurance Company (Aetna).



Member benefits

Plan name	WA Silver PPO 2400 70/50		WA Silver PPO 3000 80/50		WA Silver PPO 4000 80/50	
	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network
<b>Deductible (Individual/Family)</b>	\$2,400/\$4,800	\$8,000/\$16,000	\$3,000/\$6,000	\$9,000/\$18,000	\$4,000/\$8,000	\$12,000/\$24,000
<b>Out-of-pocket limit (Individual/Family)</b>	\$8,100/\$16,200	Unlimited/Unlimited	\$8,100/\$16,200	Unlimited/Unlimited	\$7,900/\$15,800	Unlimited/Unlimited
<b>Deductible/out-of-pocket limit accumulation</b>	Embedded <sup>1</sup>		Embedded <sup>1</sup>		Embedded <sup>1</sup>	
<b>Primary care physician office visit</b>	\$40 DW	50% AD	\$50 DW	50% AD	\$50 DW	50% AD
<b>Specialist office visit</b>	\$110 DW	50% AD	\$125 DW	50% AD	\$125 DW	50% AD
<b>Walk-in clinics <sup>5</sup></b>	\$40 DW	50% AD	\$50 DW	50% AD	\$50 DW	50% AD
<b>Diagnostic testing: Lab</b>	30% AD	50% AD	20% AD	50% AD	20% AD	50% AD
<b>Diagnostic testing: X-ray</b>	30% AD	50% AD	20% AD	50% AD	20% AD	50% AD
<b>Imaging CT/PET scans MRIs</b>	30% AD	50% AD	20% AD	50% AD	20% AD	50% AD
<b>Inpatient hospital facility</b>	30% AD	50% AD	20% AD	50% AD	20% AD	50% AD
<b>Outpatient surgery</b>	30% AD	50% AD	20% AD	50% AD	20% AD	50% AD
<b>Emergency room</b>	\$500 plus 30% AD	Paid as In-Network	\$500 plus 20% AD	Paid as In-Network	\$500 plus 20% AD	Paid as In-Network
<b>Urgent care</b>	\$80 DW	50% AD	\$100 DW	50% AD	\$100 DW	50% AD
<b>Rehabilitation services (PT/OT/ST) <sup>3</sup></b>	\$110 DW	50% AD	\$125 DW	50% AD	\$125 DW	50% AD
<b>Chiropractic <sup>4</sup></b>	\$110 DW	50% AD	\$125 DW	50% AD	\$125 DW	50% AD
<b>Pediatric Dental and Vision <sup>6</sup></b>	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network
<b>Dental check-up (aka preventive/diagnostic)</b>	Covered in full AD	30% AD	Covered in full AD	30% AD	Covered in full AD	30% AD
<b>Dental basic</b>	30% AD	50% AD	30% AD	50% AD	30% AD	50% AD
<b>Dental major</b>	50% AD	50% AD	50% AD	50% AD	50% AD	50% AD
<b>Dental ortho</b>	50% AD	50% AD	50% AD	50% AD	50% AD	50% AD
<b>Vision exam (1 exam per 12 months)</b>	Covered in full DW	Not Covered	Covered in full DW	Not Covered	Covered in full DW	Not Covered
<b>Vision hardware</b>	Covered in full DW	Not covered	Covered in full DW	Not covered	Covered in full DW	Not covered
<b>Pharmacy <sup>7</sup></b>	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network
<b>Pharmacy deductible</b>	None	None	None	None	None	None
<b>Preferred generic drugs</b>	\$15	Not Covered	\$15	Not Covered	\$15	Not Covered
<b>Preferred brand drugs</b>	\$60	Not Covered	\$60	Not Covered	\$60	Not Covered
<b>Non-preferred drugs</b>	\$100	Not Covered	\$100	Not Covered	\$100	Not Covered
<b>Specialty drugs</b>	Preferred Specialty: 40% up to \$500 Non-Preferred Specialty: 50% up to \$750	Preferred Specialty: Not Covered Non-Preferred Specialty: Not Covered	Preferred Specialty: 40% up to \$500 Non-Preferred Specialty: 50% up to \$750	Preferred Specialty: Not Covered Non-Preferred Specialty: Not Covered	Preferred Specialty: 40% up to \$500 Non-Preferred Specialty: 50% up to \$750	Preferred Specialty: Not Covered Non-Preferred Specialty: Not Covered

Health insurance plans are offered and/or underwritten by Aetna Life Insurance Company (Aetna).



Member benefits

Plan name	WA Bronze PPO 6200 70/50		WA Bronze PPO 6850 100/50 Copay Plan		WA Silver PPO 2450 80/50 HSA-T	
	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network
<b>Deductible (Individual/Family)</b>	\$6,200/\$12,400	\$20,000/\$40,000	\$6,850/\$13,700	\$20,000/\$40,000	\$2,450/\$4,900	\$6,000/\$12,000
<b>Out-of-pocket limit (Individual/Family)</b>	\$8,550/\$17,100	Unlimited/Unlimited	\$8,550/\$17,100	Unlimited/Unlimited	\$6,850/\$6,850	Unlimited/Unlimited
<b>Deductible/out-of-pocket limit accumulation</b>	Embedded <sup>1</sup>		Embedded <sup>1</sup>		TIF <sup>2</sup>	
<b>Primary care physician office visit</b>	\$70 DW	50% AD	\$90 DW	50% AD	20% AD	50% AD
<b>Specialist office visit</b>	\$160 DW	50% AD	\$160 DW	50% AD	20% AD	50% AD
<b>Walk-in clinics <sup>5</sup></b>	\$70 DW	50% AD	\$65 DW	50% AD	20% AD	50% AD
<b>Diagnostic testing: Lab</b>	30% AD	50% AD	Covered in full AD	50% AD	20% AD	50% AD
<b>Diagnostic testing: X-ray</b>	30% AD	50% AD	Covered in full AD	50% AD	20% AD	50% AD
<b>Imaging CT/PET scans MRIs</b>	30% AD	50% AD	\$750 AD	50% AD	20% AD	50% AD
<b>Inpatient hospital facility</b>	30% AD	50% AD	\$1,500 per admission AD	50% AD	20% AD	50% AD
<b>Outpatient surgery</b>	30% AD	50% AD	\$750 AD	50% AD	20% AD	50% AD
<b>Emergency room</b>	\$750 plus 30% AD	Paid as In-Network	\$750 AD	Paid as In-Network	20% AD	Paid as In-Network
<b>Urgent care</b>	\$100 DW	50% AD	\$120 DW	50% AD	20% AD	50% AD
<b>Rehabilitation services (PT/OT/ST) <sup>3</sup></b>	\$160 DW	50% AD	\$160 DW	50% AD	20% AD	50% AD
<b>Chiropractic <sup>4</sup></b>	\$160 DW	50% AD	\$160 DW	50% AD	20% AD	50% AD
<b>Pediatric Dental and Vision <sup>6</sup></b>	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network
<b>Dental check-up (aka preventive/diagnostic)</b>	Covered in full AD	30% AD	Covered in full AD	30% AD	Covered in full AD	30% AD
<b>Dental basic</b>	30% AD	50% AD	30% AD	50% AD	30% AD	50% AD
<b>Dental major</b>	50% AD	50% AD	50% AD	50% AD	50% AD	50% AD
<b>Dental ortho</b>	50% AD	50% AD	50% AD	50% AD	50% AD	50% AD
<b>Vision exam (1 exam per 12 months)</b>	Covered in full DW	Not Covered	Covered in full DW	Not Covered	Covered in full DW	Not Covered
<b>Vision hardware</b>	Covered in full DW	Not covered	Covered in full DW	Not covered	Covered in full DW	Not covered
<b>Pharmacy <sup>7</sup></b>	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network
<b>Pharmacy deductible</b>	\$400 per Member	None	\$450 per Member	None	Integrated with Medical Deductible	None
<b>Preferred generic drugs</b>	\$20 AD	Not Covered	\$20 AD	Not Covered	\$15 AD	Not Covered
<b>Preferred brand drugs</b>	\$85 AD	Not Covered	\$85 AD	Not Covered	\$65 AD	Not Covered
<b>Non-preferred drugs</b>	\$150 AD	Not Covered	\$150 AD	Not Covered	\$100 AD	Not Covered
<b>Specialty drugs</b>	Preferred Specialty: 40% up to \$500 AD Non-Preferred Specialty: 50% up to \$750 AD	Preferred Specialty: Not Covered Non-Preferred Specialty: Not Covered	Preferred Specialty: 40% up to \$500 AD Non-Preferred Specialty: 50% up to \$750 AD	Preferred Specialty: Not Covered Non-Preferred Specialty: Not Covered	Preferred Specialty: 40% up to \$500 AD Non-Preferred Specialty: 50% up to \$750 AD	Preferred Specialty: Not Covered Non-Preferred Specialty: Not Covered

Health insurance plans are offered and/or underwritten by Aetna Life Insurance Company (Aetna).



Member benefits

Plan name	WA Silver PPO 3000 80/50 HSA-E		WA Silver PPO 5000 80/50 HSA-E		WA Bronze PPO 6250 70/50 HSA-E	
	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network
<b>Deductible (Individual/Family)</b>	\$3,000/\$6,000	\$8,100/\$16,200	\$5,000/\$10,000	\$20,000/\$40,000	\$6,250/\$12,500	\$17,150/\$34,300
<b>Out-of-pocket limit (Individual/Family)</b>	\$6,650/\$13,300	Unlimited/Unlimited	\$6,650/\$13,300	Unlimited/Unlimited	\$6,900/\$13,800	Unlimited/Unlimited
<b>Deductible/out-of-pocket limit accumulation</b>	Embedded <sup>1</sup>		Embedded <sup>1</sup>		Embedded <sup>1</sup>	
<b>Primary care physician office visit</b>	20% AD	50% AD	20% AD	50% AD	30% AD	50% AD
<b>Specialist office visit</b>	20% AD	50% AD	20% AD	50% AD	30% AD	50% AD
<b>Walk-in clinics <sup>5</sup></b>	20% AD	50% AD	20% AD	50% AD	30% AD	50% AD
<b>Diagnostic testing: Lab</b>	20% AD	50% AD	20% AD	50% AD	30% AD	50% AD
<b>Diagnostic testing: X-ray</b>	20% AD	50% AD	20% AD	50% AD	30% AD	50% AD
<b>Imaging CT/PET scans MRIs</b>	20% AD	50% AD	20% AD	50% AD	30% AD	50% AD
<b>Inpatient hospital facility</b>	20% AD	50% AD	20% AD	50% AD	30% AD	50% AD
<b>Outpatient surgery</b>	20% AD	50% AD	20% AD	50% AD	30% AD	50% AD
<b>Emergency room</b>	20% AD	Paid as In-Network	20% AD	Paid as In-Network	30% AD	Paid as In-Network
<b>Urgent care</b>	20% AD	50% AD	20% AD	50% AD	30% AD	50% AD
<b>Rehabilitation services (PT/OT/ST) <sup>3</sup></b>	20% AD	50% AD	20% AD	50% AD	30% AD	50% AD
<b>Chiropractic <sup>4</sup></b>	20% AD	50% AD	20% AD	50% AD	30% AD	50% AD
<b>Pediatric Dental and Vision <sup>6</sup></b>	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network
<b>Dental check-up (aka preventive/diagnostic)</b>	Covered in full AD	30% AD	Covered in full AD	30% AD	Covered in full AD	30% AD
<b>Dental basic</b>	30% AD	50% AD	30% AD	50% AD	30% AD	50% AD
<b>Dental major</b>	50% AD	50% AD	50% AD	50% AD	50% AD	50% AD
<b>Dental ortho</b>	50% AD	50% AD	50% AD	50% AD	50% AD	50% AD
<b>Vision exam (1 exam per 12 months)</b>	Covered in full DW	Not Covered	Covered in full DW	Not Covered	Covered in full DW	Not Covered
<b>Vision hardware</b>	Covered in full DW	Not covered	Covered in full DW	Not covered	Covered in full DW	Not covered
<b>Pharmacy <sup>7</sup></b>	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network
<b>Pharmacy deductible</b>	Integrated with Medical Deductible	None	Integrated with Medical Deductible	None	Integrated with Medical Deductible	None
<b>Preferred generic drugs</b>	\$15 AD	Not Covered	\$12 AD	Not Covered	\$20 AD	Not Covered
<b>Preferred brand drugs</b>	\$65 AD	Not Covered	\$55 AD	Not Covered	\$80 AD	Not Covered
<b>Non-preferred drugs</b>	\$100 AD	Not Covered	\$95 AD	Not Covered	\$120 AD	Not Covered
<b>Specialty drugs</b>	Preferred Specialty: 40% up to \$500 AD Non-Preferred Specialty: 50% up to \$750 AD	Preferred Specialty: Not Covered Non-Preferred Specialty: Not Covered	Preferred Specialty: 40% up to \$500 AD Non-Preferred Specialty: 50% up to \$750 AD	Preferred Specialty: Not Covered Non-Preferred Specialty: Not Covered	Preferred Specialty: 40% up to \$500 AD Non-Preferred Specialty: 50% up to \$750 AD	Preferred Specialty: Not Covered Non-Preferred Specialty: Not Covered

Health insurance plans are offered and/or underwritten by Aetna Life Insurance Company (Aetna).



## Exclusions and Limitations

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 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
- 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. 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 network provider is coordinating care, the network 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 **Aetna.com**, or the Aetna Medication Formulary Guide. Aetna or its affiliate(s) receives rebates from drug manufacturers. Rebates may not reduce the amount a member pays the pharmacy for covered prescriptions. Information is subject to change. For more information about your pharmacy plan, refer to your plan's website. 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.



## 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 [Aetna.com](https://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.

<sup>1</sup> **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.

<sup>2</sup> **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.

<sup>3</sup> **Rehabilitation services** - 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.

<sup>4</sup> **Chiropractic/subluxation** services have a limit of **12** visits per calendar year, separate from habilitation and includes all outpatient places of service for Chiro.

<sup>5</sup> **Walk-in clinics** - 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.

<sup>6</sup> **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, age 0-19.

<sup>7</sup> **Pharmacy** - The drug formulary includes Precertification, Step therapy and Quantity limits. Choose generics applies / Choose generics applies with dispense as written (DAW) override. Members must obtain all specialty medication fills through the Aetna Specialty Pharmacy network. Performance enhancing drugs are excluded. Fertility drugs are excluded. Pharmacy copays stated above are for up to a 30 day supply at Retail. Mail order delivery (MOD) available for 31-90 day supply at 2 times the retail copay.

### 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 our 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:** 90% of Medicare

**Facility Services:** 90% of Medicare

Your provider sets his or her own rate to charge you. It may be higher – sometimes much higher – than what your Aetna plan "recognizes." Your provider 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](https://www.aetna.com). Type "network care" in the search box. You can avoid these extra costs by getting your care from Aetna's broad network of health care providers. Refer to the 'Find a Doctor' link on [Aetna.com](https://www.aetna.com) for a listing of network providers under the heading "Small Group Under 51 Employees". If you are already a member, sign on to your member website.

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 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 copayments, coinsurance and deductibles.

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 or its affiliate(s) receives rebates from drug manufacturers. Rebates may not reduce the amount a member pays the pharmacy for covered prescriptions. Choose Generic: For PPO based plans the cost difference penalty for choose generics does not apply to the members accumulators. For HMO based plans the cost difference penalty does apply to the members accumulators. Information is subject to change. For more information about your pharmacy plan, refer to your plan's website.

