aetna

Open Access® Managed Choice® POS - Washington
Qualified High Deductible Health Plan
WA19 AWH OAMC HSA 5000 90/70 EMB RX1

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

| PLAN FEATURES | IN-NETWORK DESIGNATED PROVIDERS | OUT OF NETWORK/NON DESIGNATED PROVIDERS |
|---|---|---|
| **Benefit Limitations** - For any service or supply that is subject to a maximum visit, day, or dollar limitation on a per year basis, the benefit year begins on January 1st unless otherwise mandated. Refer to your plan documents for more information. | | |
| **Deductible** (per calendar year) | $5,000 Individual<br>$10,000 Family | $7,500 Individual<br>$15,000 Family |
| All covered expenses accumulate separately toward the in-network or out-of-network Deductible.<br>Unless otherwise indicated, the deductible must be met prior to benefits being payable.<br>Member cost sharing for certain services, as indicated in the plan, are excluded from charges to meet the Deductible.<br>Pharmacy expenses apply towards the Deductible.<br>The family Deductible is a cumulative Deductible for all family members. The family Deductible can be met by a combination of family members; however, no single individual within the family will be subject to more than the individual Deductible amount. | | |
| **Member Coinsurance**<br>Applies to all expenses unless otherwise stated. | 10% | 30% |
| **Payment Limit** (per calendar year) | $6,750 Individual<br>$13,500 Family | $12,000 Individual<br>$24,000 Family |
| All covered expenses accumulate separately toward the in-network or out-of-network Payment Limit.<br>Certain member cost sharing elements may not apply toward the Payment Limit.<br>Pharmacy expenses apply towards the Payment Limit.<br>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.<br>The family Payment Limit is a cumulative Payment Limit for all family members. The family Payment Limit can be met by a combination of family members; however, no single individual within the family will be subject to more than the individual Payment Limit amount. | | |
| **Lifetime Maximum**<br>Unlimited except where otherwise indicated. | | |
| **Payment for Out-of-Network Care**** | Not Applicable | Professional: 105% of Medicare<br>Facility: 140% of Medicare |
| **Primary Care Physician Selection** | Optional | Not Applicable |
| **Certification Requirements -**<br>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, 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 |
| **Network Designations**- In order to be covered at the preferred in-network benefit level you must use a designated provider for care. If you receive care from a non-designated provider your care may be paid at the out-of-network benefit level or may not be covered at all. | | |



47.35.300.1 (08/18)

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| PREVENTIVE CARE | IN-NETWORK DESIGNATED PROVIDERS | OUT OF NETWORK/NON DESIGNATED PROVIDERS |
|---|---|---|
| **Routine Adult Physical Exams/ Immunizations** | Covered 100%; deductible waived | 30%; after deductible |
| 1 exam every 12 months up to age 65, 1 exam every 12 months age 65 and older | | |
| **Routine Well Child Exams/Immunizations** | Covered 100%; deductible waived | 30%; after deductible |
| 7 exams first 12 months, 3 exams 13th - 24th months, 3 exams 25th - 36th months, 1 exam per 12 months thereafter to age 22. | | |
| **Routine Gynecological Care Exams** | Covered 100%; deductible waived | 30%; after deductible |
| 1 obgyn exam and pap smear per year<br>Covered females may access care for covered "women's health care services" without PCP referral. Physician charges in connection with "women's health care services" include maternity care, reproductive health services, gynecological care, general examination and preventive care and follow-up visits for these services. The member must self-refer to a network provider in order to receive preferred benefits. | | |
| **Routine Mammograms** | Covered 100%; deductible waived | 30%; after deductible |
| **Women's Health** | Covered 100%; deductible waived | 30%; after deductible |
| 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.<br>Contraceptive methods, sterilization procedures, patient education and counseling. Limitations may apply. | | |
| **Routine Digital Rectal Exam** | Covered 100%; deductible waived | 30%; after deductible |
| Recommended: For covered males age 40 and over. | | |
| **Prostate-specific Antigen Test** | Covered 100%; deductible waived | 30%; after deductible |
| Recommended: For covered males age 40 and over. | | |
| **Colorectal Cancer Screening** | Covered 100%; deductible waived | Covered under Routine Adult Exams |
| Recommended: For all members age 45 and over and members under the age of 50 who are considered high risk. | | |
| **Routine Hearing Screening** | Covered 100%; deductible waived | 30%; after deductible |
| **PHYSICIAN SERVICES** | **IN-NETWORK DESIGNATED PROVIDERS** | **OUT OF NETWORK/NON DESIGNATED PROVIDERS** |
| **Office Visits to PCP** | 10%; after deductible | 30%; after deductible |
| Includes services of an internist, general physician, family practitioner or pediatrician. | | |
| **Specialist Office Visits** | 10%; after deductible | 30%; after deductible |
| Includes visits to a naturopath | | |
| **Hearing Exams** | Covered 100%; deductible waived | Not Covered |
| 1 routine exam per 24 months. | | |
| **Pre-Natal Maternity** | Covered 100%; deductible waived | 30%; after deductible |
| **Walk-in Clinics** | 10%; after deductible | Not Covered |
| Walk-in Clinics are free-standing 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. | | |
| **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 |

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| **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 DESIGNATED PROVIDERS** | **OUT OF NETWORK/NON DESIGNATED PROVIDERS** |
| **Diagnostic X-ray** | 10%; after deductible | 30%; after deductible |
| 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. | | |
| **Diagnostic Laboratory** | 10%; after deductible | 30%; after deductible |
| 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. | | |
| **Diagnostic Outpatient Complex Imaging** | 10%; after deductible | 30%; after deductible |
| 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. | | |
| **EMERGENCY MEDICAL CARE** | **IN-NETWORK DESIGNATED PROVIDERS** | **OUT OF NETWORK/NON DESIGNATED PROVIDERS** |
| **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 DESIGNATED PROVIDERS** | **OUT OF NETWORK/NON DESIGNATED PROVIDERS** |
| **Inpatient Coverage** | 10%; after deductible | 30%; after deductible |
| Your cost sharing applies to all covered benefits incurred during your inpatient stay. | | |
| **Inpatient Maternity Coverage** (includes delivery and postpartum care) | 10%; after deductible | 30%; after deductible |
| Your cost sharing applies to all covered benefits incurred during your inpatient stay. | | |
| **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 DESIGNATED PROVIDERS** | **OUT OF NETWORK/NON DESIGNATED PROVIDERS** |
| **Inpatient** | 10%; after deductible | 30%; after deductible |
| Your cost sharing applies to all covered benefits incurred during your inpatient stay. | | |

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| **Mental Health Office Visits**<br>Your cost sharing applies to all covered benefits incurred during your outpatient visit. | 10%; after deductible | 30%; after deductible |
| **Other Mental Health Services** | 10%; after deductible | 30%; after deductible |
| **SUBSTANCE ABUSE** | **IN-NETWORK DESIGNATED PROVIDERS** | **OUT OF NETWORK/NON DESIGNATED PROVIDERS** |
| **Inpatient**<br>Your cost sharing applies to all covered benefits incurred during your inpatient stay. | 10%; after deductible | 30%; after deductible |
| **Residential Treatment Facility** | 10%; after deductible | 30%; after deductible |
| **Substance Abuse Office Visits**<br>Your cost sharing applies to all covered benefits incurred during your outpatient visit. | 10%; after deductible | 30%; after deductible |
| **Other Substance Abuse Services** | 10%; after deductible | 30%; after deductible |
| **OTHER SERVICES** | **IN-NETWORK DESIGNATED PROVIDERS** | **OUT OF NETWORK/NON DESIGNATED PROVIDERS** |
| **Skilled Nursing Facility**<br>Limited to 120 days per year<br>Your cost sharing applies to all covered benefits incurred during your inpatient stay. | 10%; after deductible | 30%; after deductible |
| **Home Health Care**<br>Home health care services include private duty nursing | 10%; after deductible | 30%; after deductible |
| **Hospice Care - Inpatient**<br>Your cost sharing applies to all covered benefits incurred during your inpatient stay. | 10%; after deductible | 30%; after deductible |
| **Hospice Care - Outpatient**<br>Your cost sharing applies to all covered benefits incurred during your outpatient visit. | 10%; after deductible | 30%; after deductible |
| **Spinal Manipulation Therapy**<br>Limited to 20 visits per year | 10%; after deductible | 30%; after deductible |
| **Outpatient Short-Term Rehabilitation**<br>Limited to 25 visits per calendar year.<br>Includes speech, physical, occupational and massage therapy | 10%; after deductible | 30%; after deductible |
| **Habilitative Services (Physical/Occupational/Speech Therapy)** | Cost sharing same as any other physical, occupational, speech therapy expense. | Cost sharing same as any other physical, occupational, speech therapy expense. |
| **Neurodevelopmental Therapy** | 10%; after deductible | 30%; after deductible |
| **Autism Behavioral Therapy**<br>Covered same as any other Outpatient Mental Health benefit | 10%; after deductible | 30%; after deductible |
| **Autism Applied Behavior Analysis**<br>Covered same as any other Outpatient Mental Health Other Services benefit | 10%; after deductible | 30%; after deductible |
| **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. |
| **Women's Contraceptive drugs and devices not obtainable at a pharmacy** | Covered 100%; deductible waived | Covered same as any other expense. |

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| **Affordable Care Act mandated Women's Contraceptives** | Covered 100%; deductible waived | Covered same as any other expense. |
| **Infusion Therapy**<br>Administered in the home or physician's office | 10%; after deductible | 30%; after deductible |
| **Infusion Therapy**<br>Administered in an outpatient hospital department or freestanding facility | 10%; after deductible | 30%; after deductible |
| **Transplants** | 10%; after deductible<br>Preferred coverage is provided at an IOE contracted facility only. | 30%; after deductible<br>Non-Preferred coverage is provided at a Non-IOE facility. |
| **Bariatric Surgery** | Not Covered | Not Covered |
| **Acupuncture**<br>Limited to 20 visits per 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 per 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 |
| **Out of Area Dependents** | Coverage provided at the non-preferred benefit level of the plan if in-network provider is not available. | |
| **FAMILY PLANNING** | **IN-NETWORK DESIGNATED PROVIDERS** | **OUT OF NETWORK/NON DESIGNATED PROVIDERS** |
| **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**<br>Artificial insemination and ovulation induction | Not Covered | Not Covered |
| **Advanced Reproductive Technology (ART)** | Not Covered | Not Covered |
| ART coverage includes: In vitro fertilization (IVF), zygote intrafallopian transfer (ZIFT), gamete intrafallopian transfer (GIFT), cryopreserved embryo transfers, intracytoplasmic sperm injection (ICSI) or ovum microsurgery. | | |
| **Vasectomy** | Covered 100%; after deductible | 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** | Advanced Control Plan | |
| **Value Drugs Tier 1A** | | |
| **Retail** | $3 copay | 40% of submitted cost; after applicable copay |
| **Mail Order** | $6 copay | Not Applicable |

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| **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 |
| **Specialty Drugs** | | |
| **Preferred Specialty** | 30%<br>Maximum $150 | Not Covered |
| **Non-Preferred Specialty** | 30%<br>Maximum $150 | Not Covered |
| **Pharmacy Day Supply and Requirements** | | |
| **Retail** | Up to a 30 day supply from Aetna National Network | |
| **Mail Order** | A 31-90 day supply from CVS Caremark® Mail Service Pharmacy | |
| **Specialty** | Up to a 30 day supply<br>First prescription fill at any retail or specialty pharmacy. Subsequent fills must be through our preferred specialty pharmacy network.<br>Advanced Control Formulary Aetna Insured List | |

**Preventive Medications** - Deductible is waived for certain preventive medications. A full list of these drugs is available on your secure member site or from your employer.

**Choose Generics with Dispense as Written (DAW) override** - The member pays the applicable copay only, if the physician requires brand-name. If the member requests brand-name when a generic is available, the member pays the applicable copay plus the difference between the generic price and the brand-name price.

**Plan Includes:** Diabetic supplies and Contraceptive drugs and devices obtainable from a pharmacy.
Contraceptives covered up to a 12 month supply.
A limited list of over-the-counter medications are covered when filled with a prescription.
Oral chemotherapy drugs covered 100%
Precertification and quantity limits included
Step Therapy included
Seasonal Vaccinations covered 100% in-network
Preventive Vaccinations covered 100% in-network
Affordable Care Act mandated female contraceptives and preventive medications covered 100% in-network. Also includes male condoms.

| **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.

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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.

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, or its affiliate(s), receives rebates from drug manufacturers that may be taken into account in determining Aetna's Preferred Drug List. Rebates may 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.

Translation of the material into another language may be available. Please call Member Services at **1-888-982-3862.**

Puede estar disponible la traduccion de este material en otro idioma. Por favor llame a Servicios al Miembro al **1-888-982-3862.**
Plan features and availability may vary by location and group size.
For more information about Aetna plans, refer to **www.aetna.com.**

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Aetna and MinuteClinic, LLC (which either operates or provides certain management support services to MinuteClinic-branded walk-in clinics) are both within the CVS Health family.