Aetna

Washington PPO

Plan Effective Date: 1/1/2014

WA Bronze PPO Saver 4000 70/50 (1/14)

PLAN FEATURES	IN-NETWORK	OUT-OF-NETWORK
Deductible (per calendar year)	$4,000 Individual $8,000 Family	$12,000 Individual $24,000 Family
Unless otherwise indicated, the Deductible must be met prior to benefits being payable. Member cost sharing for certain services, including member cost sharing for prescription drugs, as indicated in the plan, are excluded from charges to meet the Deductible. All covered expenses accumulate separately toward the In Network and Out-of-Network Deductible. Once the amount of covered expenses for you or your covered dependents reach the family deductible amount, this Plan will begin to pay benefits for covered expenses for all covered family members for the remainder of the calendar year.		
Member Coinsurance (applies to all expenses unless otherwise stated)	30%	50%
Payment Limit (per calendar year)	$6,350 Individual $12,700 Family	$19,050 Individual $38,100 Family
All covered expenses accumulate separately toward the In Network and Out-of-Network Payment Limit. Certain member cost sharing elements may not apply toward the Payment Limit. Premiums, balance-billed charges, penalties for failure to obtain pre-authorization for services and health care do not apply to the Payment Limit and continue to be payable after the Payment Limit is reached. Once the amount of covered expenses you or your covered dependents have paid during the calendar year reach the family payment limit, this Plan will pay 100% of covered expenses that apply toward the limit for all covered family members for the remainder of the calendar year.		
Lifetime Maximum (per member lifetime)	Unlimited	
Payment for Out-of-Network Care	Not Applicable	Recognized Charge*
Primary Care Physician Selection	Not Applicable	Not Applicable
Referral Requirement	None	None
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, Complex Imaging Services, and Hospice Care is required. Benefits will be reduced by $400 per occurrence if Certification is not obtained.		
PHYSICIAN SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Office Visits to Non-Specialist Physicians	$45 copay; deductible waived	50% after deductible
Office Visits to Specialist Physicians	$45 copay after deductible	50% after deductible
E-Visits to Physicians	$10 copay; deductible waived	Not Covered
An E-visit is an online internet consultation between a physician and an established patient about a non-emergency healthcare matter. This visit must be conducted through an Aetna authorized internet E-visit service vendor. Register at www.relayhealth.com.		
Pre-Natal Maternity	$0 copay; deductible waived	50% after deductible

Maternity - Delivery and Post-Partum Care	30% after deductible	50% after deductible
Walk-in Clinics	$45 copay; deductible waived	Not Covered
Walk-in Clinics are free-standing healthcare 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 an outpatient department of a hospital, shall be considered a Walk-in Clinic.		
Surgery (in physician's office)	30% after deductible	50% after deductible
Allergy Testing (given by a physician)	30% after deductible	50% after deductible
Allergy Treatment/Injections (not given by a physician)	30% after deductible	50% after deductible
PREVENTIVE CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Routine Adult Physical Exams / Immunizations Age and frequency schedules may apply.	$0 copay; deductible waived	50% after deductible
Well Child Exams / Immunizations Age and frequency schedules may apply	$0 copay; deductible waived	50% after deductible
Routine Gynecological Exams Includes Pap smear and related lab fees. Frequency schedule applies.	$0 copay; deductible waived	50% after deductible
Routine Mammograms For covered females age 40 and over or as recommended by provider. Frequency schedule applies.	$0 copay; deductible waived	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; and contraceptive methods and counseling. Limitations may apply.	$0 copay; deductible waived	Member cost sharing is based on the type of service performed and the place of service where it is rendered
Routine Digital Rectal Exam	Included in Adult Routine Physical Exam	Included in Adult Routine Physical Exam
Prostate-Specific Antigen Test For covered males age 40 and over or as recommended by provider. Frequency schedule applies.	$0 copay; deductible waived	50% after deductible

Colorectal Cancer Screening For all members age 40 and over. Fecal Occult Blood Test (one per 12-month period), Sigmoidoscopy (one test per consecutive five year period), Double Contrast Barium Enema (one test per consecutive five year period). In-Network and Out-of-Network combined.	0%; deductible waived	50% after deductible
Colonoscopy for Members Age 50 and Over Limited to one colonoscopy every 10 consecutive year period. In-Network and Out-of-Network combined.	0%; deductible waived	50% after deductible
Routine Eye and Hearing Exams Covered only as a part of a routine physical.	Paid as part of a routine physical.	Paid as part of a routine physical.
DIAGNOSTIC PROCEDURES	**IN-NETWORK**	**OUT-OF-NETWORK**
Outpatient Diagnostic Laboratory and X-ray [except for Complex Imaging Services]	30% after deductible	50% after deductible
Outpatient Complex Imaging Services Precertification required. Including, but not limited to, MRI, MRA, PET and CT Scans	30% after deductible	50% after deductible
EMERGENCY MEDICAL CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Urgent Care Provider	$50 copay; deductible waived	$50 copay; deductible waived
Non-Urgent Use of Urgent Care Provider	Not Covered	Not Covered
Emergency Room	30% after deductible	Paid as Preferred Care
Non-Emergency care in an Emergency Room	Not Covered	Not Covered
Emergency Ambulance	30% after deductible	Paid as Preferred Care
HOSPITAL CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient Coverage Including maternity	30% after deductible	50% after deductible
Transplants Precertification required.	30% after deductible	Not Covered
Outpatient Surgery Provided in an outpatient hospital department or a freestanding surgical facility.	30% after deductible	50% after deductible

Outpatient Hospital Services other than Surgery Including but not limited to lab, x-ray, physical therapy, speech therapy, occupational therapy, spinal manipulation, dialysis and radiation therapy.	30% after deductible	50% after deductible
MENTAL HEALTH SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient Mental Health	30% after deductible	50% after deductible
Outpatient Mental Health	$45 copay after deductible	50% after deductible
Residential Treatment Centers	30% after deductible	50% after deductible
Autism Behavioral Therapy	$45 copay after deductible	50% after deductible
Autism OT/PT/ST Includes Neurodevelopmental Therapy Mandate to age 6.	30% after deductible	50% after deductible
ALCOHOL / DRUG ABUSE SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient Detoxification	30% after deductible	50% after deductible
Outpatient Detoxification	$45 copay after deductible	50% after deductible
Inpatient Rehabilitation	30% after deductible	50% after deductible
Outpatient Rehabilitation	$45 copay after deductible	50% after deductible
OTHER SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Skilled Nursing Facility Limited to 60 days per member per calendar year. In-Network and Out-of-Network combined.	30% after deductible	50% after deductible
Pediatric Vision Frequency schedule applies	Eye exam: 0%; deductible waived Glasses: 0%; deductible waived	Eye exam: not covered Glasses: not covered
Pediatric Dental Frequency schedule applies	Check-up: 0%; deductible waived	Check-up: 30% deductible waived
Home Health Care Limited to 130 visits per member per calendar year. In-Network and Out-of-Network combined. 1 visit equals a period of 4 hours or less.	30% after deductible	50% after deductible

Infusion Therapy Provided in the home or physician's office	30% after deductible	50% after deductible
Infusion Therapy Provided in an outpatient hospital department or freestanding facility	30% after deductible	50% after deductible
Inpatient & Outpatient Hospice Care	30% after deductible	50% after deductible
Outpatient Physical, Occupational, Speech and Massage Therapy Limited to 25 visits per member per calendar year. In-Network and Out-of-Network combined.	30% after deductible	50% after deductible
Outpatient Chiropractic Therapy Limited to 12 visits per member per calendar year. In-Network and Out-of-Network combined	30% after deductible	50% after deductible
Acupuncture Limited to 12 visits per member per calendar year. In-Network and Out-of-Network combined.	$45 copay; deductible waived	50% after deductible
Jaw Joint Disorder Treatment (TMJ)	30% after deductible	50% after deductible
Durable Medical Equipment	30% 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	**IN-NETWORK**	**OUT-OF-NETWORK**
Infertility Treatment Covered only for the diagnosis and surgical treatment of the underlying medical condition	Member cost sharing is based on the type of service performed and the place rendered	50% after deductible
Voluntary Sterilization - Vasectomy	30% after deductible	50% after deductible

Voluntary Sterilization - Tubal Ligation	0%; deductible waived	50% after deductible
PHARMACY - PRESCRIPTION DRUG BENEFITS	**PARTICIPATING PHARMACIES**	**NON-PARTICIPATING PHARMACIES**
Deductible (per calendar year)	$500 per member (waived for preferred generic)	Not Covered
Retail Up to a 30-day supply	$20 copay for generic drugs, $80 copay for brand name formulary drugs, 50% up to $500 for non formulary drugs and 30% up to $300 for preferred specialty drugs.	Not Covered
Mail Order Delivery 31-90 day supply	$40 copay for generic drugs, $160 copay for brand name formulary drugs and 50% up to $500 for non formulary drugs.	Not Covered
Self-Injectables	Included in Pharmacy Plan. Must use Aetna Specialty Pharmacy Network.	Not Covered
Plan includes: Contraceptive drugs and devices obtainable from a pharmacy and diabetic supplies obtainable from a pharmacy.		
Plan excludes: Lifestyle/performance drugs		
Precertification included.		
Formulary generic FDA-approved Women’s Contraceptives covered 100% in network.		

*Members may choose providers in our network (physicians and facilities) or may visit an out-of-network provider. Typically, members will pay substantially more money out of their own pocket if they choose to use an out-of-network doctor. The out-of-network provider will be paid based on Aetna's "recognized" charge". This is not the same as the billed charge from the doctor.

Aetna pays a percentage of the recognized charge, as defined in the member's plan. The member may have to pay the difference between the out-of-network provider's billed charge and Aetna's recognized charge, plus any coinsurance and deductibles due under the plan. Note that any amount the doctor bills the member above Aetna's recognized charge does not count toward the member's deductible or out-of-pocket maximums.

For out-of-network providers (physicians and facility), the recognized charge is based on 100% of the Medicare rate.

This benefit applies when members choose to get care out-of-network. When members have no choice in the doctors they see (for example, an emergency room visit after a car accident), their deductible and coinsurance for the in-network level of benefits will be applied, and they should contact Aetna if their doctor asks them to pay more.

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 or rider(s) 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;

Dental care and X-rays for adults age 19 and over;

Donor egg retrieval;

Experimental and investigational procedures;

Hearing aids;

Immunizations for travel or work;

Infertility services, including, but not limited to, artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSA and other related services, unless specifically listed as covered in your plan documents;

Nonmedically necessary services or supplies;

Orthotics;

Over-the-counter medications and supplies;

Reversal of sterilization;

Services for the treatment of sexual dysfunction or inadequacies, including therapy, supplies, or counseling;

Special duty and/or private nursing; and

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, excursive 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.

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 and substance abuse, inpatient skilled nursing, complex imaging and hospice care. When the Member’s In-Network provider is coordinating care, the In-Network provider will obtain the precertification. Precertification requirements may vary.

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

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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 contain exclusions and limitations. Plan features and availability may vary by location and group size. 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.

Plans are provided by Aetna Life Insurance Company.