

**PLAN DESIGN & BENEFITS**

Provided by Aetna Public Employees Plan of Washington

PLAN FEATURES	IN-NETWORK COVERAGE
Deductible	None
Out of Pocket Maximum (per calendar year) Out of pocket expenses include office visits and inpatient copays. ER and prescription drug copays do not apply to the out of pocket maximum.	\$750 Individual \$1,500 Family
Lifetime Maximum	No lifetime maximum
Member Coinsurance	20% for durable medical equipment
Primary Care Physician Selection	No requirement to select a PCP. Must use network providers to receive benefits.
PHYSICIAN SERVICES	IN-NETWORK COVERAGE
Office and Clinic Visits	\$10 copay per office/clinic visit
Maternity OB Visits	Covered in full after \$10 copay for first visit
Routine Eye Exams 1 routine exam per calendar year	\$10 office visit copay
Vision Eyewear Applies to eyeglass lenses, frames, contacts, and fitting fees combined	Maximum plan payment of \$150 every 24 months
Hearing Aids For hearing aids and rental/repair combined	Maximum plan payment of \$800 every 3 calendar years
PREVENTIVE CARE	IN-NETWORK COVERAGE
Routine Adult Physical Exams and Preventive Immunizations 1 exam per calendar year for all members age 2 and up	Covered at 100%, not subject to copay
Routine Well-Baby Exams and Preventive Immunizations 8 exams during the first 24 months of life	Covered at 100%, not subject to copay
Routine Gynecological Care Exams 1 exam per year	Covered at 100%, not subject to copay
Routine Mammograms Once per calendar year beginning at age 40, as recommended by your doctor.	Covered at 100%, not subject to copay
Colorectal Cancer Screenings for All Members Ages 50+ Fecal occult blood test every year, sigmoidoscopy (1 every 48 months), colonoscopy (1 every 10 years, but not within 48 months of sigmoidoscopy), double contrast barium enema (1 every 5 years)	Covered at 100%, not subject to copay
Bone Density Screening for Women Ages 65+ Every two years. May be covered at 60 if your provider determines that you are at risk	Covered at 100%, not subject to copay
Routine Hearing Exams 1 routine exam per calendar year	Covered at 100%, not subject to copay

DIAGNOSTIC PROCEDURES	IN-NETWORK COVERAGE
Diagnostic Laboratory and X-ray When performed as part of a physician office visit and billed by physician	When performed during an office visit, included in the \$10 office visit copay.
Diagnostic Laboratory and X-ray Performed in an outpatient facility, hospital or other outpatient facility setting, including an independent lab	\$10 copay
EMERGENCY MEDICAL CARE	IN-NETWORK COVERAGE
Emergency Room	\$75 copay, waived if admitted to hospital
Non-Emergency Care in an Emergency Room	Not covered
Ambulance - air	\$100 copay
Ambulance - ground	\$75 copay
Urgent Care Provider Benefit availability may vary by location	\$10 copay
HOSPITAL CARE	IN-NETWORK COVERAGE
Inpatient Coverage	Covered 100% after \$200 copay per day / \$600 max per member/per calendar year. Must be precertified.
Inpatient Maternity Coverage	Member pays inpatient hospital copay for mother only
Outpatient Surgical & Ambulatory Surgical Center Facility Charges	Covered 100% after \$100 copay. Must be precertified.
MENTAL HEALTH SERVICES	IN-NETWORK COVERAGE
Inpatient	Covered 100%. Subject to inpatient hospital copay. Must be precertified.
Outpatient Limited to 50 visits per calendar year	\$10 copay
ALCOHOL/CHEMICAL DEPENDENCY TREATMENT	IN-NETWORK COVERAGE
Inpatient	*Covered 100%. Subject to inpatient hospital copay. Must be precertified.
Outpatient	*\$10 copay
*Chemical Dependency Maximum \$14,500 maximum plan payment per 24 months, inpatient and outpatient combined. Plan payment limit excludes detox unless you have been admitted to a chemical dependency program where you receive those services.	
OTHER SERVICES	IN-NETWORK COVERAGE
Skilled Nursing Facility Semi-private room rate. Must meet Medicare's requirements for skilled nursing. Must be precertified. Maximum of 150 days per year.	Covered 100%. Subject to inpatient hospital copay. Must be precertified.
Home Health Care	Covered 100%. Must be precertified.
Hospice Care – Inpatient / Outpatient Includes respice care. Maximum of 5 days per 3 months of hospice care.	Covered 100%. Must be precertified.
Outpatient Short-Term Rehabilitation Includes speech, physical, occupational, and neurodevelopmental therapy. Limited to 60 visits per calendar year for all therapies combined.	\$10 office visit copay

OTHER SERVICES	IN-NETWORK COVERAGE
Bariatric Surgery	Very limited coverage, call member services for details.
Durable Medical Equipment Includes rental of wheelchair, walker, cane, insulin pump, glucometer. May cover purchase if more cost-effective than rental.	20% coinsurance May need to be precertified.
Wig or hairpiece to replace hair loss due to radiation or chemotherapy.	20% coinsurance \$100 lifetime maximum
Massage Therapy Covered only to treat injury or exacerbation of existing injury. Not covered for maintenance therapy. Limited to 16 visits per calendar year. Must be prescribed by diagnosing provider.	\$10 copay
Spinal Disorders Spinal and extremity manipulations performed by a medical doctor, doctor of osteopathy, chiropractor or therapist. Limited to 10 visits per calendar year.	\$10 copay
Temporomandibular Joint Dysfunction (TMJ)	Covers surgical treatment only if precertified (no coverage for non-surgical treatment).
FAMILY PLANNING	IN-NETWORK COVERAGE
Infertility Treatment and Services	Not covered
Voluntary Sterilization Including tubal ligation and vasectomy. Excludes reversals.	\$10 office visit copay for outpatient. Inpatient subject to inpatient hospital copay.
PHARMACY	IN-NETWORK COVERAGE
Retail	Washington State Rx Services 1-888-361-1612
Mail Order	Wellpartner 1-800-815-3539

This plan does not cover all health care expenses; some expenses are excluded from coverage or have limits. 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 by your employer.

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; 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, ICSI and other related services, unless specifically listed as covered in your plan documents; Nonmedically necessary services or supplies; Over-the-counter medications and supplies; Reversal of sterilization; Services for the treatment of sexual dysfunction or inadequacies, including therapy, supplies, or counseling; and special duty nursing.

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. All preferred providers and vendors are independent contractors in private practice and are neither employees nor agents of Aetna or its affiliates.

Some benefits are subject to limitations or visit maximums. 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. Services provided by non-network providers are not covered, except for emergency care. Precertification requirements may vary.

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