



Aetna Public Employees Plan Summary of Benefits

Member Cost-Sharing

Aetna PEP enrollees share the cost of their health coverage through payments such as deductibles, copays, and coinsurance. Read below to see how and when each of these payments apply.

Medical deductible

What you pay to providers before Aetna PEP pays benefits for most medical services. Once you meet this amount, Aetna PEP pays benefits for the rest of the year.*

\$250 per person; maximum of \$750 for a family of three or more

** Member pays applicable copay at point of service.*

Medical out-of-pocket limit

The most you'll pay per year for coinsurance and copays for covered services. Some costs do not count toward your out-of-pocket limit, so check the *Aetna PEP 2010 Certificate of Coverage* for specific details.

\$2,000 per person; maximum of \$6,000 for a family of three or more

Copay

A set dollar amount you pay for some services and supplies.

Office Visits

\$25

Inpatient hospitalization

\$200 per day, up to \$600 maximum per year

Emergency room

\$75 per visit

Coinsurance

The percentage of the contracted amount you pay when you purchase durable medical equipment.

20% (network providers)

Your 2010 Medical Benefits

Except where otherwise indicated, you must see Aetna network providers for all services, or claims will be denied. **All covered benefits are subject to the medical deductible unless noted.**

Benefits	In-Network Coverage Only
Acupuncture 16 visit max/year; only as an anesthetic or to reduce pain	\$25 copay
Ambulance Ground, Air or Water	<ul style="list-style-type: none"> • Ground: \$75 copay • Air or Water: \$100 copay
Chemical Dependency Treatment	
<ul style="list-style-type: none"> • Inpatient <i>Must be precertified</i> 	\$200 copay per day; \$600 max copay per person, per year
<ul style="list-style-type: none"> • Outpatient 	\$25 copay
Chiropractic Treatment See “Spinal and Extremity Manipulations”	
Diagnostic Tests, Laboratory, and X-Rays	
<ul style="list-style-type: none"> • When performed during an office visit and billed by physician 	Included in \$25 office visit copay (no additional charge)
<ul style="list-style-type: none"> • When performed in an outpatient facility, hospital or other outpatient facility setting including an independent lab 	\$25 copay
<ul style="list-style-type: none"> • High-cost imaging (such as MRIs, CT scans) <i>Must be precertified</i> 	\$25 copay
Durable Medical Equipment, Supplies, and Prostheses	20% coinsurance
Emergency Room (ER) You do not have to pay the ER copay if admitted to the hospital directly from the ER. Non-emergency care provided in an emergency setting is not covered	\$75 copay
Hearing	
<ul style="list-style-type: none"> • Hearing exams (routine) One exam per calendar year 	\$25 copay No deductible
<ul style="list-style-type: none"> • Hearing hardware (aids) 	\$800 maximum plan payment every three calendar years No deductible

Benefits	In-Network Coverage Only
Hospice Care <i>Must be precertified</i>	Covered 100%
<ul style="list-style-type: none"> • Respite care \$5,000 lifetime max 	Covered 100%
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Hospital Services	
<ul style="list-style-type: none"> • Inpatient <i>Must be precertified</i> 	\$200 copay per day; \$600 max copay per person, per year
<ul style="list-style-type: none"> • Outpatient Surgical & Ambulatory Surgical Center Facility Charges <i>Must be precertified</i> 	\$100 copay
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Mammograms	
<ul style="list-style-type: none"> • Screening mammograms Beginning at age 40, once per calendar year 	Covered 100%, no copay No deductible
<ul style="list-style-type: none"> • Diagnostic mammograms 	\$25 copay
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Massage Therapy 16-visit max per calendar year; must be prescribed for a medical condition	\$25 copay
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Mental Health Treatment	
<ul style="list-style-type: none"> • Inpatient <i>Must be precertified</i> 	\$200 copay per day; \$600 max copay per person, per year
<ul style="list-style-type: none"> • Outpatient 	\$25 copay
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Naturopathic Physician Services	\$25 copay
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Obstetric and Newborn Care	
<ul style="list-style-type: none"> • Inpatient 	\$200 copay per day; \$600 max copay per person, per year
<ul style="list-style-type: none"> • Outpatient 	Covered 100% after \$25 copay for first prenatal visit
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Office Visits	\$25 copay
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Physical, Occupational, Speech, and Neurodevelopmental Therapy	
<ul style="list-style-type: none"> • Inpatient <i>60-visit max per calendar year for all types of therapy combined</i> 	Included in inpatient hospital copay (see above)
<ul style="list-style-type: none"> • Outpatient <i>60-visit max per calendar year for all types of therapy combined</i> 	\$25 copay

Benefits	In-Network Coverage Only
Preventive Care <i>Including immunizations</i> Only the services listed in the <i>Aetna PEP 2010 Certificate of Coverage</i> are covered under this benefit	Covered 100% No deductible
Spinal and Extremity Manipulations 10-visit max per calendar year	\$25 copay
Surgery <ul style="list-style-type: none"> • Inpatient <i>Must be precertified</i> • Outpatient 	\$200 copay per day; \$600 max copay per person, per year \$100 copay
Tobacco Cessation Program <i>Free & Clear</i> program only	Covered 100% No deductible
Vision Care <ul style="list-style-type: none"> • Eye exams (routine) One exam per calendar year • Vision hardware 	\$25 copay No deductible \$150 max plan payment every 24 consecutive calendar months No deductible
Well-Baby Preventive Care Services See the <i>Aetna PEP 2010 Certificate of Coverage</i> for specific services covered	Covered 100% No deductible

Prescription Drugs

The prescription drug benefit is administered by Washington State Rx Services. Deductible doesn't apply.

Tier	Network Retail Pharmacy <i>(up to a 30-day supply)</i>	Wellpartner Mail-Order Pharmacy <i>(up to a 90-day supply)</i>
Tier 1 Generic drugs	\$20 copay	\$40 copay
Tier 2 Preferred brand-name drugs	\$40 copay	\$80 copay
Tier 3 Nonpreferred brand-name drugs	\$60 copay	\$120 copay