



PLAN DESIGN AND BENEFITS - WA Silver PPO 2450 80/50 HSA-T (2023)

WA Group Business 1-50 Employees

PLAN FEATURES	NETWORK CARE	OUT-OF-NETWORK CARE
<b>Primary Care Physician Selection</b>	Not applicable	Not applicable
<b>Deductible</b> (per calendar year)	\$2,450 Individual \$4,900 Family	\$6,000 Individual \$12,000 Family
Unless otherwise indicated, the deductible must be met before benefits can be paid.		
Claims from in-network and out-of-network providers do not cross-accumulate to satisfy the deductible.		
As indicated in the plan, member cost sharing for certain services are excluded from the charges to meet the deductible.		
Once the family deductible is met, all family members will be considered as having met their deductible for the remainder of the calendar year.		
<b>Member Coinsurance</b> (applies to all expenses unless otherwise stated)	20%	50%
<b>Out-of-Pocket (OOP) Maximum</b> (per calendar year, includes deductible)	\$6,750 Individual \$8,700 Family	Unlimited Individual Unlimited Family
Claims from in-network and out-of-network providers do not cross-accumulate to satisfy the out-of-pocket maximums.		
Only those out-of-pocket expenses resulting from the application of coinsurance percentage, deductibles, and copays (except any penalty amounts) may be used to satisfy the Out-of-Pocket Maximum.		
Once the family payment limit is met, all family members will be considered as having met their payment limit for the remainder of the calendar year.		
<b>Payment for Out-of-Network Care*</b>	Not applicable	Professional: 90% of Medicare Facility: 90% of Medicare
<b>Certification Requirements</b>		
Certification for certain types of non-preferred 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, home health care, and hospice care is required. If the necessary certification is not received, payment for services will be reduced by 50% up to \$400 per service or supply.		
<b>Referral Requirement</b>	Not applicable	Not applicable
PHYSICIAN SERVICES	NETWORK CARE	OUT-OF-NETWORK CARE
<b>Office Visits to Non-Specialist</b>	20% after deductible	50% after deductible
Includes services of an internist, general physician, family practitioner or pediatrician for diagnosis and treatment of an illness or injury.		
<b>Telemedicine Consultations to Non-Specialist</b>	20% after deductible	50% after deductible
<b>Non-Specialist Telemedicine Provider Consultations</b>	20% after deductible	Not Covered
<b>Specialist Office Visits</b>	20% after deductible	50% after deductible
<b>Telemedicine Consultations to Specialist</b>	20% after deductible	50% after deductible
<b>Specialist Telemedicine Provider Consultations</b>	20% after deductible	Not Covered
<b>Walk-in Clinics</b>	Covered in full after deductible	50% after deductible
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.		
<b>Maternity - Delivery and Post-Partum Care</b>	20% after deductible	50% after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
<b>Allergy Testing</b>	20% after deductible	50% after deductible
<b>Allergy Injections</b>	20% after deductible	50% after deductible
PREVENTIVE CARE	NETWORK CARE	OUT-OF-NETWORK CARE
Preventive care services are covered in accordance with Health Care Reform.		
<b>Routine Adult Physical Exams and Immunizations</b> Coverage is limited to 1 exam every 12 months.	Covered in full	50% after deductible

<b>Routine Well Child Exams and Immunizations</b> Coverage is limited 7 exams in the first 12 months of life; 3 exams in the second 12 months of life; 3 exams in the third 12 months of life; 1 exam every 12 months thereafter to age 22.	Covered in full	50% after deductible
<b>Routine Gynecological Exams</b> Includes Pap smear, HPV screening and related lab fees. Coverage is limited to 1 exam every 12 months.	Covered in full	50% after deductible
<b>Routine Mammograms</b> For covered females age 40 and over. Frequency schedule applies.	Covered in full	50% after deductible
<b>Women's Health</b> 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; Limitations may apply.	Covered in full	Member cost sharing is based on the type of service performed and the place of service where it is rendered.
<b>Prenatal Maternity</b> Coverage for dependent daughters is included. Coverage is included for homebirth by a midwife for low risk pregnancy.	Covered in full	50% after deductible
<b>Routine Digital Rectal Exam / Prostate-Specific Antigen Test</b> Recommended: For covered males age 40 and over. Frequency schedule applies.	Covered in full	50% after deductible
<b>Colorectal Cancer Screening</b> Recommended: For all members age 45 and over. Frequency schedule applies.	Covered in full	50% after deductible
<b>Routine Eye and Hearing Screenings</b>	Paid as part of routine physical exam.	Paid as part of routine physical exam.
<b>HEARING SERVICES</b>	<b>NETWORK CARE</b>	<b>OUT-OF-NETWORK CARE</b>
<b>Hearing Exam</b> (by Specialist)	Not covered	Not covered
<b>Hearing Aid</b> Coverage is limited to cochlear implants.	20% after deductible	50% after deductible
<b>VISION SERVICES</b>	<b>NETWORK CARE</b>	<b>OUT-OF-NETWORK CARE</b>
<b>Adult Routine Eye Exams (Refraction)</b>	Not covered	Not covered
<b>Pediatric Routine Eye Exams (Refraction)</b> Coverage is limited to 1 exam per calendar year. Includes fitting of eyeglass frames, prescription lenses, low vision devices and contact lenses, age 0-19.	Covered in full	Not covered
<b>Adult Vision Hardware</b>	Not covered	Not covered
<b>Pediatric Vision Hardware</b> Coverage is limited to 1 set of frames and a 12 month supply of contact lenses or eyeglass lenses per year, age 0-19.	Covered in full	Not covered
<b>DIAGNOSTIC PROCEDURES</b>	<b>NETWORK CARE</b>	<b>OUT-OF-NETWORK CARE</b>
<b>Outpatient Diagnostic Laboratory</b> Includes blood, blood products and blood storage, including the services and supplies of a blood bank at ded/coins.	20% after deductible	50% after deductible
<b>Outpatient Diagnostic X-ray (except for Complex Imaging Services)</b>	20% after deductible	50% after deductible
<b>Outpatient Diagnostic X-ray for Complex Imaging Services</b> Including, but not limited to, MRI, MRA, PET and CT scans. Precertification required.	20% after deductible	50% after deductible

<b>Outpatient Diagnostic Laboratory Performed in a PCP Office Visit</b> Includes blood, blood products and blood storage, including the services and supplies of a blood bank at ded/coins.	20% after deductible	50% after deductible
<b>Outpatient Diagnostic X-ray Performed in a PCP Office Visit (except for Complex Imaging Services)</b>	20% after deductible	50% after deductible
<b>Outpatient Diagnostic X-ray for Complex Imaging Services Performed in a PCP Office Visit</b> Including, but not limited to, MRI, MRA, PET and CT scans. Precertification required.	20% after deductible	50% after deductible
<b>Outpatient Diagnostic Laboratory Performed in a Specialist Office Visit</b> Includes blood, blood products and blood storage, including the services and supplies of a blood bank at ded/coins.	20% after deductible	50% after deductible
<b>Outpatient Diagnostic X-ray Performed in a Specialist Office Visit (except for Complex Imaging Services)</b>	20% after deductible	50% after deductible
<b>Outpatient Diagnostic X-ray for Complex Imaging Services Performed in a Specialist Office Visit</b> Including, but not limited to, MRI, MRA, PET and CT scans. Precertification required.	20% after deductible	50% after deductible
<b>EMERGENCY MEDICAL CARE</b>	<b>NETWORK CARE</b>	<b>OUT-OF-NETWORK CARE</b>
<b>Urgent Care Provider</b>	20% after deductible	50% after deductible
<b>Non-Urgent Use of Urgent Care Provider</b>	Not covered	Not covered
<b>Emergency Room</b>	20% after deductible	Paid as in-network
<b>Non-Emergency Care in an Emergency Room</b>	Not covered	Not covered
<b>Emergency Use of Ambulance</b>	20% after deductible	Paid as in-network
<b>Non-Emergency Use of Ambulance</b>	20% after deductible	Paid as in-network
<b>HOSPITAL CARE</b>	<b>NETWORK CARE</b>	<b>OUT-OF-NETWORK CARE</b>
<b>Inpatient Coverage</b> Including maternity (prenatal, delivery and postpartum) and transplants.	20% after deductible	50% after deductible
<b>Outpatient Surgery</b> Provided in an outpatient hospital department or freestanding surgical facility.	20% after deductible	50% after deductible
<b>Colonoscopy</b> (non-preventive)	Member cost sharing is based on the type of service performed and the place rendered.	Member cost sharing is based on the type of service performed and the place rendered.
<b>Transplants</b> Coverage is limited to IOE facilities only.	20% after deductible	Not covered
<b>BEHAVIORAL HEALTH SERVICES (MENTAL HEALTH and SUBSTANCE RELATED DISORDERS)</b>	<b>NETWORK CARE</b>	<b>OUT-OF-NETWORK CARE</b>
<b>Inpatient Services</b>	20% after deductible	50% after deductible
<b>Outpatient Office Visits</b>	20% after deductible	50% after deductible
<b>Physician or Behavioral Health Provider Telemedicine Consultations</b>	20% after deductible	50% after deductible
<b>Telemedicine Provider Consultations</b>	20% after deductible	Not Covered

<b>Other Outpatient Services</b> (e.g.:partial hospitalization treatment, intensive outpatient programs)	20% after deductible	50% after deductible
<b>OTHER SERVICES AND PLAN DETAILS</b>	<b>NETWORK CARE</b>	<b>OUT-OF-NETWORK CARE</b>
<b>Skilled Nursing Facility</b>	20% after deductible	50% after deductible
<b>Home Health Care</b> Coverage is limited to 130 visits per calendar year. 1 visit equals a period of 4 hours or less.	20% after deductible	50% after deductible
<b>Infusion Therapy</b> Provided in the home or physician's office.	20% after deductible	50% after deductible
<b>Infusion Therapy</b> Provided in the outpatient hospital department or freestanding facility.	20% after deductible	50% after deductible
<b>Gene-Based, Cellular and Other Innovative Therapies (GCIT)</b> Coverage is limited to GCIT designated facilities only.	Member cost sharing is based on the type of service performed and the place rendered.	Not covered
<b>Hospice Care - Inpatient</b>	20% after deductible	50% after deductible
<b>Hospice Care Outpatient</b>	20% after deductible	50% after deductible
<b>Private Duty Nursing -Outpatient</b>	Not covered	Not covered
<b>Outpatient Short-Term Rehabilitation - Physical Therapy</b>  Accumulation and Cost Share- 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.	20% after deductible	50% after deductible
<b>Outpatient Short-Term Rehabilitation - Occupational Therapy</b>  Accumulation and Cost Share- 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.	20% after deductible	50% after deductible
<b>Outpatient Short-Term Rehabilitation - Speech Therapy</b>  Accumulation and Cost Share- 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.	20% after deductible	50% after deductible
<b>Outpatient Chiropractic</b>  Accumulation and Cost Share- Coverage is limited to 12 visits per calendar year, separate from habilitation and includes all outpatient places of service for Chiro.	20% after deductible	50% after deductible
<b>Habilitative Physical, Occupational and Speech Therapy</b>	20% after deductible	50% after deductible
<b>Autism Behavioral Therapy</b>	20% after deductible	50% after deductible
<b>Autism Applied Behavior Analysis</b>	20% after deductible	50% after deductible
<b>Autism Physical, Occupational and Speech Therapy</b>	20% after deductible	50% after deductible
<b>Acupuncture</b> Coverage is limited to 12 visits per calendar year except for substance abuse.	20% after deductible	50% after deductible
<b>Durable Medical Equipment</b>	50% after deductible	50% after deductible



**Full Choose Generics** - If the member or the physician requests brand when generic is available, the member pays the applicable cost-sharing plus the cost difference between the generic and brand. Penalty does not apply to medical deductible and integrated MOOP.

**Precertification** - Included. See formulary for details.

**Step Therapy** - Included. See formulary for details.

**Maintenance Choice® with Opt Out** - After two retail fills, members must choose to fill a 90-day supply of their maintenance drugs at CVS Caremark Mail Service Pharmacy™ or at a CVS retail pharmacy. If the member wants to continue to fill their 30-day supply at any other network pharmacy, they simply need to call us at the number on their member ID card. If they do not notify us that they want to opt out of the 90-day supply at a CVS Pharmacy, they'll be responsible for 100 percent of their medication cost. The member may call us any time, even from the pharmacy, to let us know that they intend to opt out of the benefit.

**Pharmacy Plan includes:**

Diabetic supplies obtainable from a pharmacy (Including: needles, syringes, test strips, lancets and alcohol swabs - available at retail or mail order).

**Performance Enhancing Drugs** - Not Covered

Affordable Care Act mandated female contraceptives and preventive medications covered 100% in-network.

Preventive and seasonal vaccinations covered 100% in-network.

**In-Network and Out-of-Network Providers**

\*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 provider who is out-of-network, your Aetna health plan may pay some of that provider'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.

Your doctor sets his or her own rate to charge you. It may be higher - sometimes much higher - than what your Aetna plan "recognizes". Your non-network doctor may bill you for the dollar amount that Aetna 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 [www.aetna.com](http://www.aetna.com). Type "how Aetna pays" in the search box.

You can avoid these extra costs by getting your care from Aetna's broad network of health care providers. Go to [www.aetna.com](http://www.aetna.com) and click on "Find a Doctor" on the left side of the page. If you are already a member, sign on to your Aetna member site.

This applies when you choose to get care out-of-network. When you have no choice (for example: emergency room visit after a car accident, or for other emergency services), we will pay the bill as if you got care in the network. You pay cost sharing 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 cost sharing and deductibles.

**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 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
- 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 documents
- 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. CVS Caremark® Mail Service Pharmacy and Aetna are part of the CVS Health family of companies. Preferred providers and vendors are independent contractors in private practice and are neither employees nor agents of Aetna or its affiliates. The availability of any particular provider cannot be guaranteed, and provider network composition is subject to change without notice.

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 [www.aetna.com](http://www.aetna.com), or the Aetna Medication Formulary Guide. 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.

While this information is believed to be accurate as of the print date, it is subject to change.

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

Plans are provided by Aetna Health Inc.

For more information about Aetna plans, refer to [www.aetna.com](http://www.aetna.com).

FORM #: 14.35.305.1 E (09/21) © 2021

Print Date:09-30-2022

TPID: 14050949