



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

<b>PLAN FEATURES</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Deductible</b> (per calendar year)	\$750 Individual \$1,500 Family	\$1,500 Individual \$3,000 Family
<p>All covered expenses, accumulate simultaneously toward the preferred or non-preferred Deductible. Unless otherwise indicated, the deductible must be met prior to benefits being payable. Member cost sharing for certain services, as indicated in the plan, are excluded from charges to meet the Deductible. Pharmacy expenses do not apply towards the Deductible. 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.</p>		
<b>Member Coinsurance</b>	15%	25%
<p>Applies to all expenses unless otherwise stated.</p>		
<b>Payment Limit</b> (per calendar year)	\$1,500 Individual \$3,000 Family	\$3,000 Individual \$6,000 Family
<p>All covered expenses accumulate simultaneously toward the preferred or non-preferred Payment Limit. Certain member cost sharing elements may not apply toward the Payment Limit. Pharmacy expenses do not apply towards the Out-of-Pocket-Maximum. 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. 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.</p>		
<b>Lifetime Maximum</b>	Unlimited except where otherwise indicated.	
<b>Payment for Non-Preferred Care**</b>	Not Applicable	Professional: Prevailing Charges Facility: Facility Fee Schedule
<b>Primary Care Physician Selection</b>	Not Applicable	Not Applicable
<b>Certification Requirements -</b>	<p>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, 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.</p>	
<b>Referral Requirement</b>	None	None
<b>PREVENTIVE CARE</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Routine Adult Physical Exams/ Immunizations</b>	Covered 100%; deductible waived	25%; after deductible
<p>1 exam every 12 months for members age 22 to age 65; 1 exam every 12 months for adults age 65 and older.</p>		
<b>Routine Well Child Exams/Immunizations</b>	Covered 100%; deductible waived	25%; after deductible
<p>Unlimited exams for child to age 12, 3 exams per year for child age 12 to 21, 1 exam per year for child age 21 to 22.</p>		



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<b>Routine Gynecological Care Exams</b> Limited to 1 exam per calendar year	Covered 100%; deductible waived	25%; deductible waived
<b>Pap Smear and related lab fees</b>	Covered 100%; deductible waived	25%; deductible waived
<b>Routine Mammograms</b> Limited to 1 mammogram per calendar year	Covered 100%; deductible waived	Covered 100%; deductible waived
<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. Contraceptive methods, sterilization procedures, patient education and counseling. Limitations may apply.	Covered 100%; deductible waived	25%; after deductible
<b>Routine Digital Rectal Exam</b> Recommended: For covered males age 40 and over.	Covered 100%; deductible waived	Covered 100%; deductible waived
<b>Prostate-specific Antigen Test</b> Recommended: For covered males age 40 and over.	Covered 100%; deductible waived	Covered 100%; deductible waived
<b>Colorectal Cancer Screening</b> Recommended: For all members age 50 and over.	Covered 100%; deductible waived	Covered under Routine Adult Exams
<b>Routine Eye Exams</b> 1 routine exam per 12 months.	Covered 100%; deductible waived	Not Covered
<b>Routine Hearing Screening</b>	Covered 100%; deductible waived	25%; after deductible
<b>PHYSICIAN SERVICES</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Office Visits to non-Specialist</b> Includes services of an internist, general physician, family practitioner or pediatrician.	\$15 copay; deductible waived	25%; after deductible
<b>Specialist Office Visits</b>	\$30 copay; deductible waived	25%; after deductible
<b>Audiometric Hearing Exam</b> 1 routine exam per 24 months.	\$30 copay; deductible waived	Not Covered
<b>Pre-Natal Maternity</b>	Covered 100%; deductible waived	25%; after deductible
<b>Walk-in Clinics</b> Walk-in Clinics are network, free-standing health care 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 the outpatient department of a hospital, shall be considered a Walk-in Clinic.	\$15 copay; deductible waived	25%; after deductible
<b>Allergy Testing</b>	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
<b>Allergy Injections</b>	Your cost sharing is based on the type of service and where it is performed. Covered 100% when an office visit charge is not applicable.	Your cost sharing is based on the type of service and where it is performed
<b>DIAGNOSTIC PROCEDURES</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Diagnostic X-ray</b> 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.	15%; after deductible	25%; after deductible
<b>Diagnostic Laboratory</b> 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.	15%; after deductible	25%; after deductible



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<b>Diagnostic Outpatient Complex Imaging</b>	15%; after deductible	25%; after deductible
<b>EMERGENCY MEDICAL CARE</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Urgent Care Provider</b>	\$25 copay; deductible waived	25%; after deductible
<b>Non-Urgent Use of Urgent Care Provider</b>	Not Covered	Not Covered
<b>Emergency Room</b> Copay waived if admitted	\$100 copay; deductible waived	Same as in-network care
<b>Non-Emergency Care in an Emergency Room</b>	Not Covered	Not Covered
<b>Emergency Use of Ambulance</b>	Covered 100%; deductible waived	25%; after deductible
<b>Non-Emergency Use of Ambulance</b>	Not Covered	Not Covered
<b>HOSPITAL CARE</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Inpatient Coverage</b> Your cost sharing applies to all covered benefits incurred during your inpatient stay.	Covered 100%; after deductible	25%; after deductible
<b>Inpatient Maternity Coverage</b> (includes delivery and postpartum care) Your cost sharing applies to all covered benefits incurred during your inpatient stay.	Covered 100%; after deductible	25%; after deductible
<b>Outpatient Hospital Expenses</b> Your cost sharing applies to all covered benefits incurred during your outpatient visit.	Covered 100%; after deductible	25%; after deductible
<b>Outpatient Surgery - Hospital</b> Your cost sharing applies to all covered benefits incurred during your outpatient visit.	Covered 100%; after deductible	25%; after deductible
<b>Outpatient Surgery - Freestanding Facility</b> Your cost sharing applies to all covered benefits incurred during your outpatient visit.	Covered 100%; after deductible	25%; after deductible
<b>MENTAL HEALTH SERVICES</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Inpatient</b> Your cost sharing applies to all covered benefits incurred during your inpatient stay.	Covered 100%; after deductible	25%; after deductible
<b>Outpatient</b> Your cost sharing applies to all covered benefits incurred during your outpatient visit.	\$15 copay; deductible waived	20%; after deductible
<b>SUBSTANCE ABUSE</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Inpatient</b> Your cost sharing applies to all covered benefits incurred during your inpatient stay.	Covered 100%; after deductible	25%; after deductible
<b>Residential Treatment Facility</b>	Covered 100%; after deductible	25%; after deductible
<b>Outpatient</b> Your cost sharing applies to all covered benefits incurred during your outpatient visit.	\$15 copay; deductible waived	20%; after deductible
<b>OTHER SERVICES</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Skilled Nursing Facility</b> Limited to 60 days per calendar year. Your cost sharing applies to all covered benefits incurred during your inpatient stay.	Covered 100%; after deductible	25%; after deductible
<b>Home Health Care</b> Limited to 60 visits per calendar year. Each visit by a nurse or therapist is one visit. Each visit up to 4 hours by a home health care aide is one visit.	Covered 100%; after deductible	25%; after deductible
<b>Hospice Care - Inpatient</b> Your cost sharing applies to all covered benefits incurred during your inpatient stay.	Covered 100%; after deductible	25%; after deductible
<b>Hospice Care - Outpatient</b> Your cost sharing applies to all covered benefits incurred during your outpatient visit.	Covered 100%; after deductible	25%; after deductible



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<b>Private Duty Nursing - Outpatient</b> Includes Private Duty Nursing limited to 70 eight hour shifts per calendar year	Covered 100%; after deductible	25%; after deductible
<b>Spinal Manipulation Therapy</b> Limited to 20 visits per calendar year.	15%; after deductible	25%; after deductible
<b>Outpatient Short-Term Rehabilitation</b> Limited to 60 visits per calendar year. Includes speech, physical, occupational therapy	15%; after deductible	25%; after deductible
<b>Habilitative Services</b>  Unlimited treatment for children under age 21 with congenital or genetic birth defects to enhance the child's ability to function.	Your cost sharing is based on the type of service and where it is performed; after deductible	Your cost sharing is based on the type of service and where it is performed
<b>Autism Behavioral Therapy</b> Covered same as any other Outpatient Mental Health benefit	\$15 copay; deductible waived	20%; after deductible
<b>Autism Applied Behavior Analysis</b>	\$15 copay; deductible waived	20%; after deductible
<b>Autism Physical Therapy</b> Visits combined with Short Term Rehabilitation.	15%; after deductible	25%; after deductible
<b>Autism Occupational Therapy</b> Visits combined with Short Term Rehabilitation.	15%; after deductible	25%; after deductible
<b>Autism Speech Therapy</b> Visits combined with Short Term Rehabilitation.	15%; after deductible	25%; after deductible
<b>Durable Medical Equipment</b>	20%; after deductible	25%; after deductible
<b>Diabetic Supplies</b> -- (if not covered under Pharmacy benefit)	Covered same as any other medical expense.	Covered same as any other medical expense.
<b>Generic FDA-approved Women's Contraceptives</b>	Covered 100%; deductible waived	Covered same as any other expense.
<b>Contraceptive drugs and devices not obtainable at a pharmacy</b>	Covered 100%; deductible waived	Covered same as any other medical expense.
<b>Vision Eyewear</b>	Covered 100%; up to \$100 every 24 months	Covered 100%; up to \$100 every 24 months
<b>Transplants</b>	Covered 100%; after deductible Preferred coverage is provided at an IOE contracted facility only.	25%; after deductible Non-Preferred coverage is provided at a Non-IOE facility.
<b>Bariatric Surgery</b> Your cost sharing applies to all covered benefits incurred during your inpatient stay.	Covered 100%; after deductible	Not Covered
<b>"Other" Health Care</b> -- 20% member coinsurance after the preferred (per calendar year) deductible for services that are neither "preferred" nor "non-preferred".		
<b>FAMILY PLANNING</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Infertility Treatment</b>  Diagnosis and treatment of the underlying medical condition only.	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
<b>Comprehensive Infertility Services</b>	50%; after deductible	Your cost sharing is based on the type of service and where it is performed

Coverage includes artificial insemination and ovulation induction limited to six courses of treatment combined, per member lifetime. Lifetime maximum applies to all procedures covered by any of our plans except where prohibited by law.



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<b>Advanced Reproductive Technology (ART)</b>	50%; after deductible	Your cost sharing is based on the type of service and where it is performed
In-vitro fertilization (IVF), zygote intrafallopian transfer (ZIFT), gamete intrafallopian transfer (GIFT), cryopreserved embryo transfers, intracytoplasmic sperm injection (ICSI), or ovum microsurgery. Limited to three courses of treatment combined, per member lifetime.		
<b>Vasectomy</b>	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
<b>Tubal Ligation</b>	Covered 100%; deductible waived	25%; after deductible
<b>PHARMACY</b>		
<b>Pharmacy Plan Type</b>	Aetna Premier Plus Open Formulary	
<b>Pharmacy Out-of-Pocket Maximum</b> (per calendar year)	\$5,100 Individual \$10,200 Family	
Pharmacy expenses do not apply towards the Medical Out-of-Pocket-Maximum. The family Out-of-Pocket Maximum is a cumulative Out-of-Pocket Maximum for all family members. The family Out-of-Pocket Maximum can be met by a combination of family members; however no single individual within the family will be subject to more than the individual Out-of-Pocket Maximum amount.		
<b>Generic Drugs</b>	<b>Retail</b> \$10 copay	20% of submitted cost; after applicable copay
	<b>Mail Order</b> \$20 copay	Not Applicable
<b>Preferred Brand-Name Drugs</b>	<b>Retail</b> \$20 copay	20% of submitted cost; after applicable copay
	<b>Mail Order</b> \$40 copay	Not Applicable
<b>Non-Preferred Brand-Name Drugs</b>	<b>Retail</b> \$40 copay	20% of submitted cost; after applicable copay
	<b>Mail Order</b> \$80 copay	Not Applicable
<b>Pharmacy Day Supply and Requirements</b>	<b>Retail</b> Up to a 30 day supply	
	<b>Mail Order</b> Up to a 31-90 day supply from Aetna Rx Home Delivery®.	
	<b>Premier Plus Specialty</b> Up to a 30 day supply from Aetna Specialty Pharmacy Network.	
	First prescription fill at any retail or specialty pharmacy. Subsequent fills must be through our preferred Aetna Specialty Pharmacy network.	
<b>Plan Includes:</b> Diabetic supplies and Contraceptive drugs and devices obtainable from a pharmacy. Oral fertility drugs included. Performance Enhancement Drugs (limited to 6 tablets per month) A limited list of over-the-counter medications are covered when filled with a prescription. Oral chemotherapy drugs covered 100% Premier Plus Pre-certification for Specialty Drugs Formulary Generic FDA-approved Women's Contraceptives and certain over-the-counter preventive medications covered 100% in network.		

**GENERAL PROVISIONS**

**Dependents Eligibility** Spouse, children from birth to age 26 regardless of student status.



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\*\*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.

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 doctor who is out of network, your health plan may pay some of that doctor'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.

When you choose out-of-network care, we limit the amount it will pay. This limit is called the "recognized" or "allowed" amount.

- 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 the Facility Fee Schedule.

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.

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 Navigator 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 network. You pay cost sharing and deductibles for your in-network level of benefits. Contact us 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.

This way of paying out-of-network doctors and hospitals applies when you choose to get care out of network. When you have no choice (for example: emergency room visit after a car accident), we will pay the bill as if you got care in network. You pay your plan's copayments, coinsurance and deductibles for your in-network level of benefits. Contact us 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 copayments, coinsurance and deductibles.

Plans are provided by: Aetna Life Insurance Company, 151 Farmington Avenue, Hartford, CT 06156. 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 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. 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 traducción 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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Government of the District of Columbia  
Proposed Effective Date: 01-01-2017  
Open Choice<sup>®</sup> (PPO) - Washington DC

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