

HIGH DEDUCTIBLE PPO 1 (HSA COMPATIBLE*)		
MEMBER BENEFITS	In-Network	Out-of-Network
Deductible Individual/Family	\$2,750 Ind/\$5,500 Family	\$5,500 Ind/\$11,000 Family
Coinsurance	20%	50%
Out-of-Pocket Maximum Individual/Family	\$5,000 Ind/\$10,000 Family	\$10,000 Ind/\$20,000 Family
Lifetime Maximum**	\$5,000,000 per member lifetime	
Non-specialist Office Visit (General Physician, Family Practitioner, Pediatrician or Internist)	\$20 copay	50%
Specialist Visit	\$30 copay	50%
Hospital Admission	20%	50%
Outpatient Surgery	20%	50%
Emergency Room	20% after \$100 copay (waived if admitted)	50% after \$100 copay (waived if admitted)
Annual Routine Ob/Gyn Exam (Annual Pap/Mammogram)	0% Not Subject to deductible	50%
Maternity Obstetrician Visits Hospital	\$30 Copay for Initial Visit \$0 thereafter 20%	50% 50%
Preventive Health (Annual Physical) (\$200 per calendar year**)	\$20 copay Not Subject to deductible	50%
Lab/X-Ray	20%	50%
Skilled Nursing (in lieu of hospital (30 days per calendar year**))	20%	50%
Physical/Occupational Therapy Chiropractic Care** (24 visits per calendar year+)	20%	50%
Home Health (30 visits per calendar year**)	20%	50%
Durable Medical Equipment (\$2,000 per calendar year**)	20%	50%
Urgent Care	20%	50%
PHARMACY		
Generic (Oral Contraceptives Included)	\$15 copay	\$15 copay plus 50%
Calendar Year Deductible per Individual	Integrated Medical/RX deductible	Integrated Medical/RX deductible
Preferred Brand/Non-Preferred Brand (Oral Contraceptives Included)	\$25/\$40 copay	\$25/\$40 copay plus 50% after deductible
Calendar Year Maximum per Individual**	\$5,000	\$5,000

*Based upon treasury guidance available as of the print date.

**Maximum applies to combined in and out of network benefits

†Aetna will pay a maximum of \$25 per visit.

Note: Payment for out-of-network facility care is determined based upon Aetna's Allowable Fee Schedule. Payment for other out-of network care is determined based charge that would apply if such services or supplies were received from a Preferred Provider.

For a full list of benefit coverage and exclusions refer to the plan documents.

Note: For DC only, Alcohol/Drug Abuse: 20% In-Network after deductible. Inpatient hospital/non-hospital residential facility - 28 days per year; outpatient - 30 visits per year; detox - 12 days per year. Mental illness: inpatient hospital/residential care non-hospital - 45 days per year at 20% in-network. Outpatient - 40 visits at 25%, additional visits at 40% coverage.

This is intended to be an insert to the Aetna Advantage Brochure and not a standalone piece. Please refer to the brochure for other important information.

