



DISTRICT OF COLUMBIA HMO PLAN 1

| PLAN FEATURES | PARTICIPATING PROVIDERS | NON-PARTICIPATING PROVIDERS |
|---|--|------------------------------------|
| Deductible (per calendar year) | None | Not Applicable |
| Member Coinsurance | Not Applicable | Not Applicable |
| Out-of-Pocket Maximum (per calendar year) | \$2,000 Individual \$4,000 Family | Not Applicable |
| Member cost sharing for prescription drug benefits and DME does not apply toward the Out-of-Pocket Maximum. Once the Family Out-of-Pocket Maximum is met, all family members will be considered as having met their Out-of-Pocket Maximum for the remainder of the calendar year. | | |
| Lifetime Maximum | Unlimited | Not Applicable |
| Primary Care Physician Selection | Required | Not Applicable |
| Referral Requirement * | Required for all non-emergency, non-urgent and non-Primary Care Physician services, except direct access services. | Not Applicable |

| PREVENTIVE CARE | PARTICIPATING PROVIDERS | NON-PARTICIPATING PROVIDERS |
|---|---|------------------------------------|
| Routine Adult Physical Exams / Immunizations (Age and Frequency schedules apply.) | \$10 Copay | Not Covered |
| Well Child Exams / Immunizations (Limited to Children ages 0 through 17. Unlimited visits for preventive and primary care.) | \$10 Copay | Not Covered |
| Routine Gynecological Care Exams (Limited to 1 routine exam and pap smear every 365 days.) | \$20 Copay | Not Covered |
| Routine Mammograms (Limited to one mammogram per calendar year. No age limit.) | \$0 Copay | Not Covered |
| Routine Digital Rectal Exams / Prostate Specific Antigen Test (For males age 40 and over) | Member cost sharing is based on the type of service performed and the where it is rendered. | Not Covered |
| Colorectal Cancer Screening (For members age 50 and over) | Member cost sharing is based on the type of service performed and the place where it is rendered. | Not Covered |
| Routine Eye Exams (Direct access to participating providers.) | \$20 Copay | Not Covered |
| Routine Hearing Screening (Included as part of physician's office visit.) | Member cost sharing is based on the type of service performed and the place where it is rendered. | Not Covered |

| PHYSICIAN SERVICES | PARTICIPATING PROVIDERS | NON-PARTICIPATING PROVIDERS |
|--------------------------------------|---|------------------------------------|
| Primary Care Physician Visits | \$10 Copay (Office Hours) \$15 Copay (After Hours) | Not Covered |
| Specialist Office Visits | \$20 Copay | Not Covered |
| Maternity OB Visits | \$20 Copay for initial visit only | Not Covered |
| Allergy Treatment | Member cost sharing is based on the type of service performed and the place where it is rendered. | Not Covered |
| Allergy Testing | Member cost sharing is based on the type of service performed and the place where it is rendered. | Not Covered |

| DIAGNOSTIC PROCEDURES | PARTICIPATING PROVIDERS | NON-PARTICIPATING PROVIDERS |
|---|--------------------------------|------------------------------------|
| Diagnostic Laboratory – Outpatient hospital or other outpatient facility | \$20 Copay | Not Covered |
| Diagnostic X-ray – Outpatient hospital or other outpatient facility | \$20 Copay | Not Covered |



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| EMERGENCY MEDICAL CARE | PARTICIPATING PROVIDERS | NON-PARTICIPATING PROVIDERS |
|---|---|------------------------------------|
| Urgent Care Provider | \$50 Copay | Paid as Participating |
| Non-Urgent Use of Urgent Care Provider | Covered same as Urgent Care | Covered same as Urgent Care |
| Emergency Room (Waived if admitted) | \$100 Copay | Paid as Participating |
| Non-Emergency Care in an Emergency Room | Covered same as Emergency | Covered same as Emergency |
| Ambulance | 0% | 0% |
| HOSPITAL CARE | PARTICIPATING PROVIDERS | NON-PARTICIPATING PROVIDERS |
| Inpatient Coverage (Including maternity) | \$250 Copay per admission | Not Covered |
| Outpatient Surgery | \$100 Copay | Not Covered |
| MENTAL HEALTH SERVICES | PARTICIPATING PROVIDERS | NON-PARTICIPATING PROVIDERS |
| Inpatient (Limited to 45 days per calendar year.) | \$250 Copay per admission | Not Covered |
| Outpatient | \$25 Copay for visits 1 to 40; \$40 Copay for visits 41+ | Not Covered |
| ALCOHOL/DRUG ABUSE SERVICES | PARTICIPATING PROVIDERS | NON-PARTICIPATING PROVIDERS |
| Inpatient Detoxification (Limited to 12 days per calendar year.) | \$250 Copay per admission | Not Covered |
| Outpatient Detoxification (Limited to 30 visits per calendar year combined with Outpatient Rehabilitation.) | \$20 Copay per visit | Not Covered |
| Inpatient Rehabilitation (Limited to 28 days per calendar year.) | \$250 Copay per admission | Not Covered |
| Outpatient Rehabilitation (Limited to 30 visits per calendar year combined with Outpatient Detoxification.) | \$20 Copay per visit | Not Covered |
| OTHER SERVICES | PARTICIPATING PROVIDERS | NON-PARTICIPATING PROVIDERS |
| Skilled Nursing Facility (Limited to 60 days per calendar year. Copay waived if transferred from hospital.) | \$250 Copay per admission | Not Covered |
| Home Health Care | \$0 Copay per visit | Not Covered |
| Hospice Care – Inpatient (Copay waived if transferred from hospital.) | \$250 Copay per admission | Not Covered |
| Hospice Care – Outpatient | \$0 Copay per visit | Not Covered |
| Private Duty Nursing | Not Covered | Not Covered |
| Outpatient Rehabilitation Therapy (Includes speech, physical and occupational therapy. Treatment over a 60-day consecutive period per incident of illness or injury beginning with the first day of treatment.) | \$20 Copay per visit | Not Covered |
| Chiropractic Care (Subluxation) (Limited to 20 visits per calendar year.) | \$20 Copay per visit | Not Covered |
| Durable Medical Equipment (Limited to \$2,500 calendar year maximum.) | 50% | Not Covered |
| Diabetic Supplies not obtainable from a pharmacy | Covered the same as any other medical expense. | Not Covered |
| Transplants (Coverage is provided at an IOE contracted facility only.) | Member cost sharing is based on the type of service performed and the place where it is rendered. | Not Covered |



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| FAMILY PLANNING | PARTICIPATING PROVIDERS | NON-PARTICIPATING PROVIDERS |
|---|--|------------------------------------|
| Infertility Treatment (Limited to diagnosis and underlying medical condition only and specifically excludes artificial insemination, in-vitro fertilization, embryo transfer & infertility drugs.) | Member cost sharing is based on the type of service performed and the place where it is rendered. | Not Covered |
| Voluntary Sterilization (Including tubal ligation and vasectomy.) | Member cost sharing is based on the type of service performed and the place where it is rendered. | Not Covered |
| PHARMACY – PRESCRIPTION DRUG BENEFITS | PARTICIPATING PROVIDERS | NON-PARTICIPATING PROVIDERS |
| Retail Up to 30 day supply | \$10 Copay for generic drugs, \$20 Copay for formulary brand-name drugs, and \$35 Copay for non-formulary brand-name drugs | Not Covered |
| Mail Order 31 - 60 day supply | \$20 Copay for generic drugs, \$40 Copay for formulary brand-name drugs, and \$70 Copay for non-formulary brand-name drugs | Not Covered |
| Plan includes: Diabetic supplies, contraceptive drugs and devices obtainable from a pharmacy. | | |
| Prescription Drug Deductible (per calendar year) | None | Not Covered |
| Pre-certification included. | | |
| No Mandatory Generic (No MG) – Member is responsible to pay the applicable copay only. | | |
| ADDITIONAL PLAN OPTIONS | PARTICIPATING PROVIDERS | NON-PARTICIPATING PROVIDERS |
| No Referral Requirement * | Not Required | Not Applicable |
| Basic Dental Rider – Option 1 | \$ 2 Copay | Not Covered |
| SPECIAL PROGRAMS | | |
| Certain special programs may be included in your plan: Aetna Navigator™, Fitness, Healthy Outlook, Moms-to-Babies Maternity Management™, National Advantage, National Medical Excellence, Natural Alternatives, Natural Products, Vision One® and Vitamin Advantage™. | | |

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 or rider(s) purchased.**

- All medical and hospital services not specifically covered in, or which are limited or excluded by your plan documents, including costs of services before coverage begins and after coverage terminates.
- Cosmetic surgery.
- 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.
- Immunizations for travel or work.
- 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.
- Non-medically necessary services or supplies.
- Orthotics.
- Over-the-counter medications and supplies.
- Radial keratotomy or related procedures.

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- Reversal of sterilization.
- Services for the treatment of sexual dysfunction or inadequacies including therapy, supplies or counseling.
- Special duty nursing.
- Therapy or rehabilitation other than those listed as covered in the plan documents.
- Treatment of behavioral disorders.

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 any results or outcomes. Consult the plan documents (i.e. Schedule of Benefits, Certificate/Evidence of Coverage, and/or Group Agreement) to determine governing contractual provisions, including procedures, exclusions and limitations relating to the plan. The availability of a plan or program may vary by geographic service area. With the exception of Aetna Rx Home Delivery, LLC, participating providers and vendors are independent contractors in private practice and are neither employees nor agents of Aetna or its affiliates. Aetna Rx Home Delivery, LLC is a subsidiary of Aetna Inc. The availability of any particular provider cannot be guaranteed, and provider network composition is subject to change. Notice of the change shall be provided in accordance with applicable state law. Certain primary care providers are affiliated with integrated delivery systems or other provider groups (such as independent practice associations and physician-hospital organizations), and members who select these providers will generally be referred to specialists and hospitals within those systems or groups. However, if a system or group does not include a provider qualified to meet member's medical needs, member may request to have services provided by non-system or non-group providers. Member's request will be reviewed and will require prior authorization from the system or group and/or Aetna to be a covered benefit.

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. Members or Providers may be required to precertify for certain services such as non-emergency inpatient hospital care.

Depending on the plan selected, new prescription drugs not yet reviewed by our medication review committee are either available at the highest copay under plans with an open formulary, or excluded from coverage unless a medical exception is obtained under plans that use a closed formulary. They may also be subject to precertification or step-therapy. Non-prescription drugs and drugs in the Limitations and Exclusions section of the plan documents (received after enrollment) are not covered, and medical exceptions are not available for them. Aetna Rx Home Delivery, LLC, is a licensed pharmacy providing mail-order pharmacy services. Aetna's negotiated reimbursement rates with Aetna Rx Home Delivery may be higher than Aetna Rx Home Delivery's cost of purchasing drugs and providing mail-order pharmacy services. In prescription plans with copayment or coinsurance tiers, use of formulary drugs generally will result in lower costs to members. However, where the prescription plan utilizes copayments or coinsurance calculated on a percentage basis, there could be some circumstances in which a formulary drug would cost the member more than a non-formulary drug because (i) the negotiated pharmacy payment rate for the formulary drug may be more than the negotiated pharmacy payment rate for the non-formulary drug, and (ii) rebates received by Aetna from drug manufacturers are not reflected in the cost of a prescription drug obtained by a member.

Plans are offered by: Aetna Health Inc. While this material is believed to be accurate as of the print date, it is subject to change.