



DISTRICT OF COLUMBIA POS PLAN 1

PLAN FEATURES	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
Deductible (per calendar year) Deductible applies to all covered expenses. Deductible does not apply to the Out-of-Pocket Maximum.	None	\$300 per member
Member Coinsurance	Not Applicable	30%
Out-of-Pocket Maximum (per calendar year) Member cost-sharing for prescription drug benefits and DME does not apply toward the Participating Out-of-Pocket Maximum. All covered expenses accumulate separately toward both the Participating and Non-Participating Out-of-Pocket Maximum.	\$1,000 per member	\$2,000 per member
Lifetime Maximum	Unlimited	\$2,000,000
Payment for Services from a Non-Participating Provider	Not Applicable	Recognized Charge*
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

Pre-certification Requirement - Certain services require pre-certification or benefits will be reduced. Refer to your plan documents for a complete list of services that require pre-certification.

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.)	\$10 Copay; Unlimited visits for preventive and primary care.	30%; Unlimited visits for preventive and primary care for ages 0 – 11; 3 visits per calendar year for ages 12 – 17.
Routine Gynecological Care Exams (Limited to 1 routine exam and pap smear every 365 days.)	\$20 Copay	GYN exam is not covered; 0% for Pap Smear
Routine Mammograms (Limited to one mammogram per calendar year. No age limit.)	\$0 Copay	0%
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.	30%
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.	30%
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)	30%
Specialist Office Visits	\$20 Copay	30%
Maternity OB Visits	\$20 Copay for initial visit only	30%
Allergy Treatment	Member cost sharing is based on the type of service performed and the place where it is rendered.	30%
Allergy Testing	Member cost sharing is based on the type of service performed and the place where it is rendered.	30%



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DIAGNOSTIC PROCEDURES	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
Diagnostic Laboratory – Outpatient hospital or other outpatient facility	\$20 Copay	30%
Diagnostic X-ray – Outpatient hospital or other outpatient facility	\$20 Copay	30%
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%	30%
HOSPITAL CARE	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
Inpatient Coverage (Including maternity)	\$250 Copay per admission	30%
Outpatient Surgery	\$100 Copay	\$100 Copay plus 30%
MENTAL HEALTH SERVICES	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
Inpatient (Limited to 45 days per calendar year. Participating and Non-Participating combined.)	\$250 Copay per admission	30%
Outpatient	\$25 Copay for visits 1 to 40; \$40 Copay for visits 41+	25%
ALCOHOL/DRUG ABUSE SERVICES	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
Inpatient Detoxification (Limited to 12 days per calendar year. Participating and Non-Participating combined.)	\$250 Copay per admission	30%
Outpatient Detoxification (Limited to 30 visits per calendar year combined with Outpatient Rehabilitation. Participating and Non-Participating combined.)	\$20 Copay per visit	30%
Inpatient Rehabilitation (Limited to 28 days per calendar year. Participating and Non-Participating combined.)	\$250 Copay per admission	30%
Outpatient Rehabilitation (Limited to 30 visits per calendar year combined with Outpatient Detoxification. Participating and Non-Participating combined.)	\$20 Copay per visit	30%
OTHER SERVICES	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
Skilled Nursing Facility (Limited to 60 days per calendar year. Participating and Non-Participating combined. Copay waived if transferred from hospital.)	\$250 Copay per admission	30%
Home Health Care	\$0 Copay per visit	30%; 1 visit per day up to 4 hours per visit
Hospice Care – Inpatient (Copay waived if transferred from hospital.)	\$250 Copay per admission	30%
Hospice Care – Outpatient	\$0 Copay per visit	30%
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	30%



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OTHER SERVICES (CONTINUED)	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
Chiropractic Care (Subluxation) (Limited to 20 visits per calendar year. Participating and Non-Participating combined.)	\$20 Copay per visit	30%
Durable Medical Equipment (Limited to \$2,500 calendar year maximum. Participating and Non-Participating combined.)	50%	50% Must pre-certify if over \$1,500.
Diabetic Supplies not obtainable from a pharmacy	Covered the same as any other medical expense.	Covered the same as any other medical expense.
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
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.	30%
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™.		

* Non-Participating Provider payments for facility charges are determined based upon Aetna’s Allowable Fee Schedule. Non-Participating Provider payments for other charges are determined based upon the negotiated charge that would apply if such services or supplies were received from a Participating Provider. These charges are referred to in your plan documents as “recognized” charges.

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.**

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- 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.
- 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.



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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.