



DISTRICT OF COLUMBIA PPO PLAN 2

PLAN FEATURES	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
<b>Deductible</b> (per calendar year) Deductible applies to all covered expenses except member cost-sharing for routine mammograms. Deductible does not apply to the Out-of-Pocket Maximum.	None	\$1,000 Individual \$2,000 Family
<b>Member Coinsurance</b>	0%	30%
<b>Out-of-Pocket Maximum</b> (per calendar year) Copays do not apply toward the Out-of-Pocket Maximum.	Not Applicable	\$2,000 Individual \$4,000 Family
<b>Lifetime Maximum</b>	Unlimited	\$2,000,000
<b>Payment for Services from a Non-Participating Provider</b>	Not Applicable	Usual and Customary *
<b>Primary Care Physician Selection</b>	Not Applicable	Not Applicable
<b>Referral Requirement</b>	Not Applicable	Not Applicable
<b>Pre-certification Requirement</b> - 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
<b>Routine Adult Physical Exams / Immunizations</b> (Age and Frequency schedules apply.)	\$15 Copay	Not Covered
<b>Well Child Exams / Immunizations</b> (Limited to Children ages 0 through 17.)	\$15 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.
<b>Routine Gynecological Care Exams</b> (Limited to 1 routine exam and pap smear per calendar year.)	\$35 Copay	GYN exam not covered; 0% for Pap Smear
<b>Routine Mammograms</b> (Limited to one mammogram per calendar year. No age limit.)	\$0 Copay	0%
<b>Routine Digital Rectal Exams / Prostate Specific Antigen Test</b> (For males age 40 and over)	Member cost sharing is based on the type of service performed and the place where it is rendered.	30%
<b>Colorectal Cancer Screening</b> (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%
<b>Routine Eye Exams</b> (Direct access to participating providers.)	\$35 Copay	Not Covered
<b>Routine Hearing Screening</b> (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
<b>Primary Care Physician Visits</b>	\$15 Copay	30%
<b>Specialist Office Visits</b>	\$35 Copay	30%
<b>Maternity OB Visits</b>	\$35 Copay for initial visit only	30%
<b>Allergy Treatment</b>	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
<b>Diagnostic Laboratory</b> – Outpatient hospital or other outpatient facility	\$35 Copay	30%
<b>Diagnostic X-ray</b> – Outpatient hospital or other outpatient facility	\$35 Copay	30%



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EMERGENCY MEDICAL CARE	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
<b>Urgent Care Provider</b>	\$50 Copay	\$50 Copay
<b>Non-Urgent Use of Urgent Care Provider</b>	Not Covered	Not Covered
<b>Emergency Room</b> (Waived if admitted)	\$100 Copay	\$100 Copay
<b>Non-Emergency Care in an Emergency Room</b>	Not Covered	Not Covered
<b>Ambulance</b>	0%	30%
HOSPITAL CARE	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
<b>Inpatient Coverage</b> (Including maternity)	\$250 Copay per admission	30%
<b>Outpatient Surgery</b>	\$0 Copay	30%
MENTAL HEALTH SERVICES	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
<b>Inpatient</b> (Limited to 45 days per calendar year. Participating and Non-Participating combined.)	\$250 Copay per admission	30%
<b>Outpatient</b>	\$25 Copay for visits 1 to 40; \$40 Copay for visits 41+	25%
ALCOHOL/DRUG ABUSE SERVICES	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
<b>Inpatient Detoxification</b>	\$250 Copay per admission	30%
<b>Outpatient Detoxification</b> (Limited to 30 visits per calendar year combined with Outpatient Rehabilitation. Participating and Non-Participating combined.)	\$35 Copay per visit	30%
<b>Inpatient Rehabilitation</b> (Limited to 28 days per calendar year. Participating and Non-Participating combined.)	\$250 Copay per admission	30%
<b>Outpatient Rehabilitation</b> (Limited to 30 visits per calendar year combined with Outpatient Detoxification. Participating and Non-Participating combined.)	\$35 Copay per visit	30%
OTHER SERVICES	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
<b>Skilled Nursing Facility</b> (Limited to 60 days per calendar year. Participating and Non-Participating combined.)	\$0 Copay per admission	30%
<b>Home Health Care</b>	\$0 Copay per visit	30%; 1 visit per day up to 4 hours per visit
<b>Hospice Care – Inpatient</b> (Limited to 30 days per lifetime. Participating and Non-Participating combined.)	\$0 Copay per admission	30%
<b>Hospice Care – Outpatient</b> (Limited to \$5,000 lifetime maximum. Participating and Non-Participating combined.)	\$0 Copay per visit	30%
<b>Private Duty Nursing</b>	Not Covered	Not Covered
<b>Outpatient Rehabilitation Therapy</b> (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.)	\$35 Copay per visit	30%



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OTHER SERVICES (CONTINUED)	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
<b>Chiropractic Care (Subluxation)</b> (Limited to 20 visits per calendar year. Participating and Non-Participating combined.)	\$35 Copay per visit	30%
<b>Durable Medical Equipment</b>	0%	50% Must pre-certify if over \$1,500.
<b>Diabetic Supplies</b> not obtainable at a pharmacy	Covered the same as any other medical expense.	Covered the same as any other medical expense.
<b>Transplants</b> (Coverage provided at an IOE contracted facility, subject to Participating cost-sharing. Coverage provided at a non-IOE facility, subject to Non-Participating cost-sharing.)	Member cost sharing is based on the type of service performed and the place where it is rendered.	Member cost sharing is based on the type of service performed and the place where it is rendered.
FAMILY PLANNING	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
<b>Infertility Treatment</b> (Limited to diagnosis and treatment for 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
<b>Voluntary Sterilization</b> (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
<b>Retail</b> 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	\$10 Copay plus 20% for generic drugs, \$20 Copay plus 20% for formulary brand-name drugs, and \$35 Copay plus 20% for non-formulary brand-name drugs
<b>Mail Order</b> 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.		
<b>Prescription Drug Deductible</b> (per calendar year)	None	None
<b>Pre-certification included.</b>		
<b>No Mandatory Generic</b> (No MG) – Member is responsible to pay the applicable copay only.		
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 are determined based upon current statistical samplings of charges for services or supplies made within a geographic or comparable area. These charges are referred to in your plan documents as “reasonable” 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 by your employer.



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- 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;
- Dental care and X-rays;
- Donor egg retrieval;
- Experimental and investigational procedures;
- Hearing aids;
- 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;
- Nonmedically necessary services or supplies;
- Orthotics;
- Over-the-counter medications and supplies;
- Reversal of sterilization;
- Services for the treatment of sexual dysfunction or inadequacies, including therapy, supplies, or counseling; and
- Special duty nursing.

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. Booklet, Booklet-Certificate and/or Group Policy) 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 without notice.

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. Some of the benefits requiring precertification may include, but are not limited to, inpatient hospital, inpatient mental health, inpatient skilled nursing, outpatient surgery, substance abuse (detoxification, inpatient and outpatient rehabilitation). When the Member's preferred provider is coordinating care, the preferred provider will obtain the precertification. When the member utilizes a nonpreferred provider, Member must obtain the precertification. Precertification requirements may vary.

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 Life Insurance Company. While this material is believed to be accurate as of the print date, it is subject to change.