

3 exams from age 13 through 24 months3 exams from age 25 through 36 months

Routine gynecological care exams

• 1 exam every 12 months from age 3 until age 22 years

1 exam and pap smear per year, including related fees

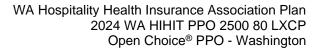
WA Hospitality Health Insurance Association Plan 2024 WA HIHIT PPO 2500 80 LXCP Open Choice® PPO - Washington

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

PLAN FEATURES	IN-NETWORK	OUT-OF-NETWORK
		There might be a maximum number of
		s on January 1 (unless otherwise noted).
Refer to your plan documents to learn		
Deductible (per calendar year)	\$2,500 per Individual	\$5,000 per Individual
	\$5,000 per Family	\$10,000 per Family
	th your in-network and out-of-network d	
	fore the plan begins paying benefits, ur	
	r some medical services does not coun	
	eductible. Refer to your plan documents	
	You will meet it when the expenses of s	
	have to pay more than the individual de	
Member coinsurance	You pay 20%	You pay 50%
Applies to all expenses except as not		***
Out-of-pocket limit (per calendar	\$6,000 per Individual	\$12,000 per Individual
year)	**************************************	*
	\$12,000 per Family	\$24,000 per Family
	th your in-network and out-of-network o	ut-of-pocket limit at the same time.
Some of your cost sharing may not co		
Your pharmacy expenses count towa		
In-network expenses include coinsura		
	nsurance and deductibles. Penalty amo	
Your family will have one out-of-pock	et limit. You will meet it when the expen	ses of several family members add up to
Your family will have one out-of-pocket the family out-of-pocket limit. No one		ses of several family members add up to
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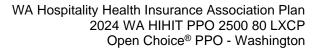
Covered 100%; no deductible

50%; after deductible





Virtual primary care (VPC)	Covered 100%; no deductible	Not Covered
preventive care consultations	2313134 10078, 113 deddollaid	1101 0010100
Includes screening and counseling ser	vices for members age 18 and older	
Routine mammogram	Covered 100%; no deductible	50%; after deductible
Recommended: One per year for mem		,
Women's health	Covered 100%; no deductible	50%; after deductible
Includes: Screening for gestational dia	betes, HPV (Human-Papillomavirus) DN	A testing, counseling for sexually
transmitted infections, counseling and	screening for human immunodeficiency v	virus, screening and counseling for
interpersonal and domestic violence, b	reastfeeding support, supplies and couns	seling.
	(ACA mandated contraceptives, including	
	dures (including tubal ligation), patient ed	ucation and counseling. Limits may
apply.		
Pre-natal maternity	Covered 100%; no deductible	50%; after deductible
Routine digital rectal exam	Covered 100%; no deductible	50%; after deductible
Recommended: For members age 40		
Prostate-specific antigen test	Covered 100%; no deductible	50%; after deductible
Recommended: For members age 40		500/ - f(l- l- 1")
Colorectal cancer screening	Covered 100%; no deductible	50%; after deductible
Recommended: For members age 45		Not Covered
Routine eye exams	Not Covered	
Routine hearing screening	Covered 100%; no deductible IN-NETWORK	50%; after deductible
PHYSICIAN SERVICES		OUT-OF-NETWORK
Office visits to non-specialist	\$30 office visit copay; no deductible ral physician, family practitioner or pediate	50%; after deductible
Virtual primary care (VPC)	Covered 100%; no deductible	Not Covered
consultations	Covered 100%, no deductible	Not Covered
Includes basic medical service consult	ations for members age 18 and older	
Telehealth consultation with non-	\$30 office visit copay; no deductible	50%; after deductible
specialist	too onice view depay, no deductions	5070, artor adaddibio
Specialist office visits	\$45 office visit copay; no deductible	50%; after deductible
	+ · · · · · · · · · · · · · · · · · · ·	
Includes visits to a naturopath	\$45 office visit copay; no deductible	50%; after deductible
	\$45 office visit copay; no deductible	50%; after deductible
Includes visits to a naturopath Telehealth consultation with	\$45 office visit copay; no deductible Covered 100%; no deductible	50%; after deductible Not Covered
Includes visits to a naturopath Telehealth consultation with specialist Hearing exams 1 routine exam per 24 months.	Covered 100%; no deductible	
Includes visits to a naturopath Telehealth consultation with specialist Hearing exams		
Includes visits to a naturopath Telehealth consultation with specialist Hearing exams 1 routine exam per 24 months. Walk-in clinics Walk-in clinics are free-standing health	Covered 100%; no deductible \$30 copay; no deductible care facilities. Sometimes they may be	Not Covered 50%; after deductible within a pharmacy, drug store,
Includes visits to a naturopath Telehealth consultation with specialist Hearing exams 1 routine exam per 24 months. Walk-in clinics Walk-in clinics are free-standing health supermarket, or other retail store. The	Covered 100%; no deductible \$30 copay; no deductible care facilities. Sometimes they may be a company offer some limited medical care and ser	Not Covered 50%; after deductible within a pharmacy, drug store, vices.
Includes visits to a naturopath Telehealth consultation with specialist Hearing exams 1 routine exam per 24 months. Walk-in clinics Walk-in clinics are free-standing health supermarket, or other retail store. The Not walk-in clinics: Urgent care center	Covered 100%; no deductible \$30 copay; no deductible a care facilities. Sometimes they may be a by offer some limited medical care and ser s, emergency rooms, the outpatient depa	Not Covered 50%; after deductible within a pharmacy, drug store, vices.
Includes visits to a naturopath Telehealth consultation with specialist Hearing exams 1 routine exam per 24 months. Walk-in clinics Walk-in clinics are free-standing health supermarket, or other retail store. The Not walk-in clinics: Urgent care center surgical centers, and physician offices	Covered 100%; no deductible \$30 copay; no deductible a care facilities. Sometimes they may be a y offer some limited medical care and ser s, emergency rooms, the outpatient depa	Not Covered 50%; after deductible within a pharmacy, drug store, vices. rtment of a hospital, ambulatory
Includes visits to a naturopath Telehealth consultation with specialist Hearing exams 1 routine exam per 24 months. Walk-in clinics Walk-in clinics are free-standing health supermarket, or other retail store. The Not walk-in clinics: Urgent care center	Covered 100%; no deductible \$30 copay; no deductible care facilities. Sometimes they may be a y offer some limited medical care and ser s, emergency rooms, the outpatient depa	Not Covered 50%; after deductible within a pharmacy, drug store, vices. rtment of a hospital, ambulatory Your cost sharing amount depends
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you receive.

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

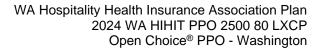
When your physician performs and bills for this service at their office, you pay your office visit cost share amount.

Diagnostic complex imaging 20%; after deductible 50%; after deductible

When your physician performs and bills for this service at their office, you pay your office visit cost share amount.

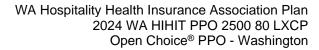
EMERGENCY MEDICAL CARE	IN-NETWORK	OUT-OF-NETWORK
Jrgent care provider	\$60 office visit copay; no deductible	50%; after deductible
Non-urgent use of urgent care provider	Not Covered	Not Covered
Emergency room	20% after \$300 copay; after deductible	Same as in-network care
Copay waived if admitted		
Non-emergency care in an emergency room	Not Covered	Not Covered
Emergency use of ambulance	20%; after deductible	Same as in-network care
Non-emergency use of ambulance	Not Covered	Not Covered
HOSPITAL CARE	IN-NETWORK	OUT-OF-NETWORK
npatient coverage	20%; after deductible	50%; after deductible
When you're admitted into a hospital fo benefits you receive.	or the care you need, your cost sharing a	amount counts toward all covered
Inpatient maternity coverage (includes delivery and postpartum care)	20%; after deductible	50%; after deductible
	or the care you need, your cost sharing a	amount counts toward all covered
Outpatient hospital	20%; after deductible	50%; after deductible
When you receive outpatient care at a covered benefits during your visit.	hospital but don't stay overnight, your co	ost sharing amount counts toward all
Outpatient surgery - hospital	20%; after deductible	50%; after deductible
When you receive outpatient care at a covered benefits during your visit.	hospital but don't stay overnight, your co	ost sharing amount counts toward all
Outpatient surgery - freestanding facility	20%; after deductible	50%; after deductible
When you receive outpatient care at a covered benefits during your visit.	hospital but don't stay overnight, your co	ost sharing amount counts toward all
MENTAL HEALTH SERVICES	IN-NETWORK	OUT-OF-NETWORK
Inpatient	20%; after deductible	50%; after deductible
When you're admitted into a hospital fo benefits you receive.	or the care you need, your cost sharing a	amount counts toward all covered
Mental health office visits	\$30 copay; no deductible	50%; after deductible
Mental health telehealth	\$30 office visit copay; no deductible	50%; after deductible
consultations	<u> </u>	
Other mental health services	Covered 100%; no deductible	50%; after deductible
When you receive outpatient care at a covered benefits during your visit.	facility but don't stay overnight, your cos	
SUBSTANCE ABUSE	IN-NETWORK	OUT-OF-NETWORK
Inpatient	20%; after deductible	50%; after deductible
When you're admitted into a hospital for benefits you receive.	or the care you need, your cost sharing a	amount counts toward all covered
Residential treatment facility	20%; after deductible	50%; after deductible
1		, , , , , , , , , , , , , , , , , , , ,

When you're admitted into a facility for the care you need, your cost sharing amount counts toward all covered benefits





Substance abuse office visits	\$30 copay; no deductible	50%; after deductible
Substance abuse telehealth	\$30 office visit copay; no deductible	50%; after deductible
consultations	too omee their copaly, no academic	0070, 0.110. 000001010
Other substance abuse services	Covered 100%; no deductible	50%; after deductible
	facility but don't stay overnight, your cos	
covered benefits during your visit.	,	
THERAPY SERVICES	IN-NETWORK	OUT-OF-NETWORK
Spinal manipulation therapy	\$45 copay; no deductible	50%; after deductible
Limited to 20 visits per year		
Outpatient short-term	\$45 copay; no deductible	50%; after deductible
rehabilitation		
Limited to 25 visits per year		
Includes speech, physical, occupation	al and massage therapy	
Habilitative physical therapy	Covered 100%; no deductible	50%; after deductible
Habilitative occupational therapy	Covered 100%; no deductible	50%; after deductible
Habilitative speech therapy	Covered 100%; no deductible	50%; after deductible
Autism related physical therapy	Covered 100%; no deductible	50%; after deductible
Autism related occupational	Covered 100%; no deductible	50%; after deductible
therapy		
Autism related speech therapy	Covered 100%; no deductible	50%; after deductible
Autism related behavioral therapy	\$30 copay; no deductible	50%; after deductible
These benefits are combined with outp		
Autism related applied behavior	Covered 100%; no deductible	50%; after deductible
analysis		
Vour honofite for these consisce and the	a cama as any other systestiant mantal h	a altha athan a amila a a han afit
Your benefits for these services are the		
OTHER SERVICES	IN-NETWORK	OUT-OF-NETWORK
OTHER SERVICES Skilled nursing facility		
OTHER SERVICES Skilled nursing facility Limited to 120 days per year	IN-NETWORK 20%; after deductible	OUT-OF-NETWORK 50%; after deductible
OTHER SERVICES Skilled nursing facility Limited to 120 days per year When you're admitted into a facility for	IN-NETWORK 20%; after deductible	OUT-OF-NETWORK
OTHER SERVICES Skilled nursing facility Limited to 120 days per year When you're admitted into a facility for you receive.	IN-NETWORK 20%; after deductible the care you need, your cost sharing an	OUT-OF-NETWORK 50%; after deductible nount counts toward all covered benefits
OTHER SERVICES Skilled nursing facility Limited to 120 days per year When you're admitted into a facility for you receive. Home health care	IN-NETWORK 20%; after deductible the care you need, your cost sharing an 20%; after deductible	OUT-OF-NETWORK 50%; after deductible
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Infusion therapy - outpatient hospital/freestanding facility	Your cost sharing amount depends on the type of service and where you receive it.	Your cost sharing amount depends on the type of service and where you receive it.
Transplants	20%; after deductible	50%; after deductible
	In-network coverage is only available at Institutes of Excellence (IOE) contracted facility.	Out-of-network coverage applies when you use a non-IOE facility. You will pay more out of pocket when using a non-IOE facility.
Bariatric surgery	Not Covered	Not Covered
Acupuncture Limited to 20 visits per year	\$30 copay; no deductible	50%; after deductible
Temporomandibular joint disorder (TMJ) Includes coverage for surgical and non-surgical TMJ treatment	20%; after deductible	50%; after deductible
Other licensed providers (including	Your cost sharing depends on the	Your cost sharing depends on the
alternative care)	type of service and where you	type of service and where you
	receive it.	receive it.
FAMILY PLANNING	IN-NETWORK	OUT-OF-NETWORK
FAMILY PLANNING Infertility treatment		OUT-OF-NETWORK Your cost sharing amount depends on the type of service and where you receive it.
Infertility treatment	IN-NETWORK Your cost sharing amount depends on the type of service and where you	Your cost sharing amount depends on the type of service and where you receive it.
You have coverage for the diagnosis a Comprehensive infertility services	IN-NETWORK Your cost sharing amount depends on the type of service and where you receive it. and treatment of the underlying cause of it. Not Covered	Your cost sharing amount depends on the type of service and where you receive it.
Infertility treatment You have coverage for the diagnosis a	IN-NETWORK Your cost sharing amount depends on the type of service and where you receive it. and treatment of the underlying cause of it. Not Covered	Your cost sharing amount depends on the type of service and where you receive it. nfertility. Not Covered
You have coverage for the diagnosis a Comprehensive infertility services Artificial insemination and ovulation inc Advanced Reproductive	IN-NETWORK Your cost sharing amount depends on the type of service and where you receive it. and treatment of the underlying cause of it. Not Covered	Your cost sharing amount depends on the type of service and where you receive it. nfertility.
You have coverage for the diagnosis a Comprehensive infertility services Artificial insemination and ovulation inc Advanced Reproductive Technology (ART)	IN-NETWORK Your cost sharing amount depends on the type of service and where you receive it. and treatment of the underlying cause of it. Not Covered duction Not Covered	Your cost sharing amount depends on the type of service and where you receive it. nfertility. Not Covered Not Covered
You have coverage for the diagnosis at Comprehensive infertility services Artificial insemination and ovulation incomplete Advanced Reproductive Technology (ART) In-vitro fertilization (IVF), zygote intrafation	IN-NETWORK Your cost sharing amount depends on the type of service and where you receive it. Ind treatment of the underlying cause of it. Not Covered duction Not Covered Allopian transfer (ZIFT), gamete intrafallor	Your cost sharing amount depends on the type of service and where you receive it. Infertility. Not Covered Not Covered Dian transfer (GIFT), cryopreserved
You have coverage for the diagnosis at Comprehensive infertility services Artificial insemination and ovulation incompleted Advanced Reproductive Technology (ART) In-vitro fertilization (IVF), zygote intrafatembryo transfers, intracytoplasmic specification.	IN-NETWORK Your cost sharing amount depends on the type of service and where you receive it. and treatment of the underlying cause of in Not Covered duction Not Covered Allopian transfer (ZIFT), gamete intrafallogerm injection (ICSI), or ovum microsurger	Your cost sharing amount depends on the type of service and where you receive it. nfertility. Not Covered Not Covered Dian transfer (GIFT), cryopreserved
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Generic drugs		
Retail	\$15 copay	40% of submitted cost; after
		applicable in-network cost share
Mail order	\$30 copay	Not Applicable
Preferred brand-name drugs		
Retail	\$45 copay	40% of submitted cost; after
		applicable in-network cost share
Mail order	\$90 copay	Not Applicable
Non-preferred generic and brand-na	me drugs	
Retail	\$70 copay	40% of submitted cost; after
		applicable in-network cost share
Mail order	\$140 copay	Not Applicable
Specialty drugs		
Preferred specialty	30%	40% of submitted cost; after
		applicable in-network cost share
	Maximum \$150	
Non-preferred specialty	30%	40% of submitted cost; after
		applicable in-network cost share
	Maximum \$150	
Pharmacy day supply and requirement	ents	
Retail	You can get up to a 30-day supply from Aetna National Network	
Mail order	er You can get a 31-90-day supply from CVS Caremark® Mail Service	
	Pharmacy.1	
Specialty	You can get up to a 30-day supply of specialty drugs	
	You may fill your first prescription at any retail or specialty pharmacy. After	
	that, all other fills must be through o	ur preferred specialty pharmacy network

Advanced Control Formulary Aetna Insured List

Your prescription drug plan also includes:

- Diabetic supplies
- Insulin up to a \$35 member payment maximum per fill per 30-day supply
- A limited list of over-the-counter medications when filled with a prescription

Family planning

Contraceptives included up to a 12 month supply

The following are covered 100% in-network:

- Oral chemotherapy drugs
- Seasonal vaccinations
- · Preventive vaccinations
- Affordable Care Act (ACA) eligible preventive medications and contraceptives, also includes male condoms Refer to **Aetna.com** for a complete list of eligible prescription drugs.

Precertification requirements

Some covered prescription drugs need approval from us before we will cover the drug. If you are currently taking one of these drugs when you switch to this plan, you may get one fill of your prescription within the first 90 days of starting the plan.

Some covered prescription drugs require step therapy before we cover them. With step therapy, you must first try one or more drugs before we will pay for drugs that require step therapy. If you are currently taking one of these drugs when you switch to this plan. you may get one fill of your prescription within the first 90 days of starting this plan. To get the most up-to-date precertification requirements and a list of drugs that require step therapy, see your plan documents or go online to your member website.



WA Hospitality Health Insurance Association Plan 2024 WA HIHIT PPO 2500 80 LXCP Open Choice® PPO - Washington

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

Choose generics with dispense as written (DAW) override - Sometimes your physician may say you need a brand-name prescription drug even if a generic is available. If so, you will pay the brand-name copay. If you ask for a brand-name prescription drug when a generic is available, you will pay the applicable brand-name copay plus the difference between the generic price and the brand-name price.

GENERAL PROVISIONS

Dependents who are eligible to be on your plan

Spouse, children from birth to age 26. Student status of children does not matter.

**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 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.

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 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 innetwork. You pay your plan's copayments 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 and deductibles.

Plans are provided by: Aetna Health Inc. 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.



WA Hospitality Health Insurance Association Plan 2024 WA HIHIT PPO 2500 80 LXCP Open Choice® PPO - Washington

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

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. 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.

- 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 overthe-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.

In case of emergency, call 911 or your local emergency hotline, or go directly to an emergency care facility.

Translation of this material into another language may be available. Please call Member Services at the number on the back of your ID card.

Puede estar disponible la traduccion 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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