aetna®

Choice PPO – Pennsylvania Employees Benefit Trust Fund
Active Members

	Network Providers	Out-of-Network Providers *
DEDUCTIBLE (per calendar year) Annual in-network deductible must be paid first for the following services: imaging, hospital expenses (inpatient and outpatient) and medical/surgical expenses including physician services (except office visits), skilled nursing facility care and home health care.	$400 single $800 family	$800 single $1,600 family
MEDICAL OUT-OF-POCKET MAXIMUM (per calendar year)	$400 single $800 family Plus copayments	Deductible $800 single / $1,600 family 30% coinsurance of the next $14,045 single/ $28,090 family after which the plan pays at 100%
COMBINED OUT-OF-POCKET MAXIMUM (per calendar year) When the Out-of-Pocket Maximum is reached, the PPO pays at 100% until the end of the benefit period.	$9,100 single $18,200 family ***Includes costs for medical, mental health and substance abuse benefits and prescription drug costs (cost difference between brand and generic does not apply).*** Includes deductibles, coinsurance, copayments and any other expenditure required of an individual which is a qualified medical expense for the essential health benefits.	$9,100 single $18,200 family ***Includes costs for medical, mental health and substance abuse benefits and prescription drug costs (cost difference between brand and generic does not apply).*** Includes deductibles, coinsurance and any other expenditure required of an individual which is a qualified medical expense for the essential health benefits. This does not include balance billing amounts for out-of-network providers but it does include out-of-network cost sharing.

	Network Providers	Out-of-Network Providers *
PREVENTIVE CARE		
• See the PEBTF Summary Plan Description (SPD) for a list of preventive benefits	Covered 100%	70% plan payment; Member pays 30% If not available in-network, full cost shall be covered without any cost sharing
MATERNITY SERVICES		
• Office visits	Covered 100% including first prenatal visit	70% plan payment; Member pays 30%
• Hospital and newborn care	Covered 100% after Deductible	70% plan payment; Member pays 30%
PHYSICIAN VISITS		
• Office visits (family practice, general practice, internal medicine and pediatrics)	$20 Copayment per office visit	70% plan payment; Member pays 30%
• Specialist office visits	$45 Copayment per office visit	70% plan payment; Member pays 30%
• Diagnostic tests (imaging, X-ray, MRI, etc.), inpatient visits, surgery and anesthesia	Covered 100% after Deductible	70% plan payment; Member pays 30%
• Diagnostic tests (lab)	Covered 100% at Quest Diagnostics or LabCorp; $30 Copayment elsewhere	70% plan payment; Member pays 30%
OUTPATIENT THERAPIES		
• Outpatient physical & occupational therapy • Speech therapy (due to a medical diagnosis or for the diagnosis of Autism Spectrum Disorders, not for developmental) • Cardiac rehabilitation (18 visits per year) • Pulmonary rehabilitation (12 visits per year) • Respiratory therapy • Manipulation therapy (restorative, chiropractic – 6 Medically Necessary visits, then Treatment Plan submitted; not for maintenance of a condition)	$20 Copayment per visit	70% plan payment; Member pays 30%
OTHER PROVIDER SERVICES		
• Radiation therapy, chemotherapy, kidney dialysis (not covered at a Non-Network freestanding dialysis center) • Home Health Care • Outpatient Private Duty Nursing (240 hours per year/8 hours per day) • Skilled Nursing Facility (240 days per year)	Covered 100% after Deductible	70% plan payment; Member pays 30%
• Hospice	Covered 100%	70% plan payment; Member pays 30%
OUTPATIENT HOSPITAL FACILITIES		
• Professional fees & facility services, including: X-rays, pre-admission tests, radiation therapy, chemotherapy, kidney dialysis (not covered if provided in a Non-Network freestanding dialysis center – is covered at a Non-Network rate if it is a Non-Network hospital), anesthesia & surgery	Covered 100% after Deductible	70% plan payment; Member pays 30%
• Outpatient Diabetic Education	Covered 100%	Not covered

	Network Providers	Out-of-Network Providers *
INPATIENT HOSPITAL SERVICES		
• Professional fees & facility services including: room & board & other Covered Services (preauthorization is required for most services)	Covered 100% after Deductible (365 days per benefit period)	70% plan payment; Member pays 30% Non-Network: 70 days per calendar year
EMERGENCY CARE		
• Urgent care	$50 Copayment	70% plan payment; Member pays 30%
• Emergency treatment for accident or medical emergency	$200 emergency room Copayment (waived if the visit leads to an inpatient admission to the hospital); Deductible waived	
• Ambulance services for emergency care	Covered 100%; Deductible waived	Covered 100%; Deductible waived
INVISIBLE PROVIDERS AT A NETWORK FACILITY		
• Includes radiologists, anesthesiologists, pathologists and emergency room physicians operating in a Network facility	Covered same as Network Provider; Covered 100% after Deductible	
DURABLE MEDICAL EQUIPMENT		
• Rental or purchase of durable medical equipment, supplies, prosthetics & orthotics, in accordance with the medical plan's DME policy	Covered 100% if obtained by a Network supplier; Deductible waived **NOTE**: Equipment or supplies dispensed in a physician's office or emergency room setting, provided as part of Home Health Care, Skilled Nursing Facility care or Hospice services; or as part of covered dialysis and home dialysis will be paid by your PPO at 100% after Deductible, if it is billed by the Provider and not by a DME supplier. Your Provider may dispense the equipment and will bill your PPO. For example, if you receive a knee brace or crutches at the emergency room, it is paid at 100% after Deductible. If your doctor writes a prescription for a DME item, you should obtain it from a Network supplier to get the highest level of benefits.	70% plan payment; Member pays 30%; Deductible waived if obtained by an out-of-network supplier
LIFETIME MAXIMUM BENEFIT	Unlimited	Unlimited

* Participating providers agree to accept the PPO plan allowance as payment in full, often less than their normal charge. If you visit a non-participating provider, you are responsible for paying the deductible, coinsurance and the difference between the provider's charges and the plan allowance.

NOTE: All benefits are limited to covered services that are determined by the PPO to be medically necessary.

This chart is intended as an easy-to-read summary. Benefits, limitations, and exclusions are provided in accordance with the PEBTF Summary Plan Description.

Pre-certification List

Under the PEBTF Choice PPO plan, pre-certification is required for certain types of care. Pre-certification is a review of certain doctor-recommended inpatient admissions and other services. This review is done before the care is provided. Its purpose is to ensure that the care is necessary and appropriate for the medical condition or problem involved.

Services that require pre-certification, regardless of whether they are performed as inpatient or outpatient:

- All non-emergency inpatient admissions, including acute care, long-term acute care, skilled nursing facilities, and rehabilitation hospitals. Emergency admissions require notification within 48 hours.
- Non-emergency air and ground ambulance transports.
- Any reconstructive surgery for the treatment of a medical disease, injury, accident or congenital anomaly.
- Outpatient rehabilitation therapies including physical therapy, occupational therapy, speech therapy, respiratory therapy and manipulation therapy. The completion of a treatment plan is required for manipulation therapies to be covered beyond the initial six (6) visits.
- Home Health Care – a treatment plan must be submitted for review
- Home Infusion Therapy – requires preauthorization.
- Transplant evaluation and services – preauthorization will include referral assistance by the National Medical Excellence program to the Institutes of Excellence for Transplant network, if appropriate.
- Non-emergency high technology radiology services, including without limitation magnetic resonance imaging (MRI), magnetic resonance angiography (MRA), computed tomography (CT) scanning, position emission tomography (PET) scanning, and cardiac nuclear imaging.

A health insurance plan built for the way you live

With Choice PPO, you can visit any doctor you'd like – without a referral.

You also get access to tools, tips and services to help you manage your health, find network doctors and more.

The Aetna Open Choice PPO Plan has no *Primary Care Physician* (PCP) requirement; however, choosing a PCP to help manage your care is encouraged.

When you need routine or basic care, your PCP should be your first stop. He or she can help you find the right specialist when you need one, or you can use the network specialist of your

choice without the need of a referral — and there are many to choose from. We have one of the largest, fully integrated networks in the country.

No claim forms are necessary.
When you visit a network doctor there's no need to complete a claim form — your doctor will submit the claim for you.

The right tools to help you find network doctors and more

It's easy to find a network doctor
You can find doctors by name, specialty or location. You'll also find maps, directions and more. You can even look for doctors who speak your language. Check it out at www.aetna.com/dse/custom/pebtf.

Tools to manage your health and your money
To be an active and informed member of your care team, you need to be in the know. And we can help get you there.

Our secure member website is a one-stop shop
Sign up for our members-only website to get tools and tips to help you manage your health and your benefits. You'll find all your plan information and cost-saving tools in one place. Members can register for the Aetna® member website at myaetnawebsite.com.

Your secure Aetna member website provides information and self-service convenience to help you manage your health — and your health benefits. Register once and then log on anytime to review benefits information, link to a customized Provider Search site, and use cost-of-care** tools to compare average costs for medical procedures, tests and other services. You can even email Member Services — all from your Aetna member website home page.

We're just a phone call away

Member Services – 1-800-991-9222, 8 a.m. to 6 p.m. Monday through Friday

When you need help or information, Aetna Member Services is just a toll-free call away. Customer Service Representatives can help with:

- Information about network doctors, hospitals and other care providers
- Choosing or changing a PCP
- Requests for additional or replacement ID cards
- Answers to your questions about plan benefits and coverage

Additional tools and services at your finger tips:

24-Hour Nurse Line

Talk to a registered nurse anytime. With the 24-Hour Nurse Line, you can speak to a registered nurse about health issues whenever you need to.* The 24-Hour Nurse Line can provide helpful information and possibly prevent an unneeded trip to the doctor's office. That can be a money-saver. Plus, you'll be able to make smarter health decisions. You'll have reliable information you can trust — and it's only a phone call or click away. Just call 1-800-556-1555 (TTY: 711)* or go to **Aetna.com** to log in.

Our app helps when you're on the go

Sometimes, you need benefits or health info when you're out and about. Our app is available at no cost.

The Aetna Health℠ app puts our most popular online features at your fingertips. Text "AETNA" to 90156 to receive a download link. Message and data rate may apply.*

With the Aetna Health app:

- Search for an in-network doctor or health care facility
- Just download the app and . . .
    - View your ID card
    - Check on claims
    - View your Personal Health Record
    - Access Teladoc® virtual medical visits or
    - Contact Aetna Member Services

** Estimated costs are not available in all markets or for all services. We provide an estimate for the amount you would owe for a particular service based on your plan at that very point in time. It is not a guarantee. Actual costs may differ from an estimate for various reasons including claims processing times for other services, providers joining or leaving our network or changes to your plan. Health maintenance organization (HMO) members can only get estimated costs for doctor and outpatient facility services.

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