

Please note that the information contained in this table is a summary only. For more detailed information, please contact the Plan at the number provided. You may also contact your local human resource professional. In the event that the information in this table differs from that contained in the Summary Plan Document (SPD) or otherwise provided by the Plan, the information in the SPD and/or provided by the Plan shall control.

Highlighted Areas Reflect Changes for 2017

	Aetna Open Choice PPO Plan For Information: 1-800-367-6276 www.aetna.com	Group Health Cooperative WA For Information: 1-888-901-4636
Price	Individual \$6,374	Individual \$5,150
General		
Network Benefits Available	Yes. You can see any physician you choose, but you will receive a higher coverage level if you obtain treatment and supplies from in-network providers.	Yes. To receive coverage, you must see an in-network provider.
Primary Care Physician Required	No	Yes. All healthcare services and supplies must be coordinated through your primary care physician.
Deductible		
Individual	\$200.00	None
Family	\$600.00	\$1,800
Out of Pocket Maximum (Out-of-Pocket Maximum - Individual)	\$3,000	\$4,000
Out-of-Pocket Maximum - Family	\$9,000	\$12,000
Lifetime Maximum	Unlimited	Lifetime Maximum \$2,000,000 Maximum
Preventive Care		
Physical Exams	100% coverage, no copay	No coverage
Routine and Well Baby Care, Immunizations	100% coverage, no copay	\$25 copay. Preventive care visits according to GPC's "well-child" schedules when referred by a GP provider.
Routine Gynecological exam	100% coverage, no copay (once per year, including Pap test and related lab fees)	\$25 copay. Preventive care visits according to GPC's "well-child" schedules when referred by a GP provider.
Routine Mammogram	100% coverage, no copay (once per year for women ages 35 and over)	Covered in full. Mammogram screening according to GPC's "well-child" schedules when referred by a GP provider.
Prostate Screening	100% coverage, no deductible (once per year for men ages 55 and over)	Covered in full. Prostate screening according to GPC's "well-child" schedules when referred by a GP provider.
Routine Eye Exam	100% coverage, no copay (one per calendar year)	\$25 copay (Covered once every 12 months)
Lenses, Frames & Contact Lenses	100% coverage (up to a \$150 lifetime maximum benefit per calendar year per person)	100% coverage (up to a \$150 lifetime maximum benefit per calendar year per person)
Routine Hearing Exam	100% coverage, no copay	No coverage
Hearing Aid	100% coverage (up to a \$1,000 lifetime maximum per person)	100% coverage (up to a \$1,000 lifetime maximum per person)
Physician Office Services		
Office Visits	100% coverage after copay (\$15 PCP/\$35 Specialist)	80% after deductible
Maternity	100% coverage after \$15 copay (includes prenatal and postpartum care. Hospital Services - \$500 copay per admission)	80% after deductible
In-office Surgeries, X-ray and Lab Work	100% coverage after copay (\$15 PCP/\$35 Specialist)	80% after deductible
Allergy Treatment and Testing	100% coverage after \$15 copay (otherwise 100%, no copay, no deductible)	80% after deductible
Specialist	100% coverage after \$35 copayment	80% after deductible
Second Surgical Opinion	100% coverage, no copay, no deductible	80% after deductible
Hospital Services		
Room and Board	80% after deductible plus \$200 per confinement fee	80% after deductible plus \$400 per confinement fee
Pre-Admission Testing	80% coverage, no deductible	80% coverage, no deductible
Lab & X-ray	80% coverage, after deductible	80% coverage, after deductible
Surgery	80% coverage, after deductible	80% coverage, after deductible
Physician Visits (in Hospital)	80% coverage, after deductible	80% coverage, after deductible
Anesthesia	80% coverage, after deductible	80% coverage, after deductible
Outpatient Services		
Therapy	80% coverage, after deductible	80% coverage, after deductible
Lab & X-ray	80% coverage, after deductible	80% coverage, after deductible
Emergency Room Care		
Hospital Emergency Room (Emergency Care)	100% coverage after \$150 copay (unless if admitted, no deductible)	100% coverage after \$150 copay (unless if admitted, no deductible)
Hospital Emergency Room (Non-emergency Care)	80% coverage after deductible plus \$100 copay	80% coverage after deductible plus \$100 copay
Ambulance	80% coverage after deductible	80% coverage after deductible
Alternative Care		
Concurrent Family	80% coverage after deductible (up to 30 days per calendar year per person)	80% coverage after deductible (up to 30 days per calendar year per person)
Home Health Care	80% coverage after deductible (up to 30 visits per calendar year per person)	80% coverage after deductible (up to 30 visits per calendar year per person)
Private-Duty Nursing	80% coverage after deductible (up to 70 8-hour shifts per calendar year per person)	80% coverage after deductible (up to 70 8-hour shifts per calendar year per person)
Hospice	100% coverage, no deductible	100% coverage, no deductible
Other Services		
Family Planning (Contraception)	100% coverage after \$10 copay, no deductible	80% coverage, after deductible
Short-term Rehabilitation	80% coverage after deductible (60 day max per course of treatment)	80% coverage after deductible (60 day max per course of treatment)
Durable Medical Equipment	80% coverage after deductible	80% coverage after deductible
Chiropractic Care	100% coverage after a \$10 copay (20 visits per calendar year)	80% coverage, after deductible (20 visits per calendar year)
Behavioral Support	80% after deductible	80% after deductible
Mental Health Care		
Inpatient	80% after deductible plus \$200 per confinement fee, no maximum on number of days	80% after \$400 per confinement fee, no maximum on number of days
Outpatient	100% after \$35 copay per visit (up to 45 visits per calendar year per person)	80% coverage after deductible plus \$400 copayment (up to 45 visits per calendar year per person)
Outpatient Psychiatric	See Outpatient Benefits	See Outpatient Benefits
Partial Hospitalization	See Outpatient Benefits	See Outpatient Benefits
Substance Abuse Treatment		
Inpatient	80% coverage after deductible plus \$200 per confinement fee (up to 45 visits per calendar year per person)	80% coverage after deductible plus \$400 per confinement fee (up to 45 visits per calendar year per person)
Outpatient	100% after \$35 copay per visit (up to 45 visits per calendar year per person)	80% coverage after deductible (up to 45 visits per calendar year per person)
Prescription Drug Coverage		
Maximum	Unlimited	None
Retail		
Generic	100% after \$10 copay (30-day supply)	No coverage
Formulary Brand Name	100% after \$25 copay (30-day supply)	No coverage
Non-Formulary Brand Name	100% after \$35 copay (30-day supply)	No coverage
Smoking Cessation Aids	Covered when prescribed at a valid pharmacy with a valid prescription	No coverage
Mail Order		
Generic	100% after \$20 copay (30-day supply)	No coverage
Formulary Brand Name	100% after \$40 copay (30-day supply)	No coverage
Non-Formulary Brand Name	100% after \$60 copay (30-day supply)	No coverage
Smoking Cessation Aids	Covered when prescribed at a valid pharmacy with a valid prescription	No coverage
Overseas Prescriptions		
Generic	Not Applicable	100% after deductible
Formulary Brand Name	Not Applicable	80% after deductible
Non-Formulary Brand Name	Not Applicable	Not Applicable
Coverage Continuation	Yes. See Benefits Portal	Yes. See Benefits Portal

For information regarding continuation of coverage, you must contact the HMO directly. If you are enrolled in the HMO option, only the continuation of coverage offered by the HMO will apply. The DCO HMO plan's continuation of coverage option will not apply if you are enrolled in the HMO option when your coverage ends.