

Aetna Plan PPO Network Overview

In-Network Medical Benefits		
	2026	2027
Annual Deductible	In-Network: \$300 person / \$900 family per calendar year	Tier One: \$400 person / \$1,200 family per calendar year Tier Two: \$600 person / \$1,800 family per calendar year
Coinsurance	In-Network: 20% Max: \$2,000 person / \$4,000 family	Tier One: 10% Max: \$2,000 person / \$4,000 family Tier Two: 25% Max: \$4,000 person / \$8,000 family
Co-pays	In-Network: \$20 Emergency Room: \$100	Tier One: \$20 Emergency Room: \$100 Tier Two: \$40 Emergency Room: \$200
Out-of-Pocket Maximum	In-Network: \$2,000 person / \$4,000 family	Either In-Network Tier \$8,000 person / \$16,000 family



IN-NETWORK TIER ONE Aetna Premier Care Network ACPN Plus	IN-NETWORK TIER TWO Aetna Broad Choice POS II
Providence/Swedish*	MultiCare / Tacoma General Hospital
Rainier Health Network/CHI Franciscan*	Virginia Mason Medical Center
Evergreen*	UW Medical Center
Optum (Polyclinic)*	Western WA Medical Clinics
Seattle Children's Hospital*	Fred Hutchinson Cancer Center
Overlake Hospital and Medical Clinics	Mary Bridge Children's Hospital and Health

*Top Plan providers by number of users

Please note these lists are not comprehensive.
To find a provider by location and specialty, visit www.aetna.com.



OUT-OF-NETWORK providers that are not within the Aetna networks and will incur significantly higher costs in 2027. While out-of-network visits are low for the Trust, members are strongly encouraged to always visit in-network providers and facilities whenever possible.

Out-of-Network Medical Benefits		
	2026	2027
Annual Deductible	Out-of-Network: \$1,000 person / \$3,000 family per calendar year	Out-of-Network: \$2,500 person / \$7,500 family per calendar year
Coinsurance	Out-of-Network: 40% Max: \$4,000 person / \$8,000 family	Out-of-Network: 40% Max: \$5,000 person / \$10,000 family
Co-pays	Out-of-Network: \$40 per visit Emergency Room: \$100 In-patient hospital: \$100	Out-of-Network: \$60 per visit Emergency Room: \$200 In-patient hospital: \$500 + coinsurance
Out-of-Pocket Maximum	Out-of-Network: \$5,000 person / \$10,000 per family	Out-of-Network: No out-of-pocket maximum



If you see an out-of-network provider you may also be responsible for amounts not paid by the Plan.

PPO Prescription Plan Co-Pays

Prescription Benefits		
	2026	2027
In-Network Pharmacy	A 30-day supply: Generic: \$8 Preferred Brand: \$40 Non-preferred brand: \$55	A 30-day supply: Generic: \$20 Preferred Brand: \$60 Non-preferred brand: \$75
Mail Order Pharmacy	A 90-day supply: Generic: \$20 Preferred Brand: \$100 Non-preferred brand: \$137.50	A 90-day supply: Generic: \$50 Preferred Brand: \$150 Non-preferred brand: \$187.50
Specialty	30% coinsurance	30% coinsurance
Deductible	None	None