aetna

Port of Seattle #285742
H.S.A. / HDHP
Effective Date: 01-01-2018
Aetna Choice® POS II – ASC
Qualified High Deductible Health Plan - TIF

PLAN DESIGN & BENEFITS
ADMINISTERED BY AETNA LIFE INSURANCE COMPANY - SELF FUNDED

PLAN FEATURES	IN-NETWORK	OUT-OF-NETWORK
Deductible (per calendar year)	$1,400 Individual $2,800 Family	$2,100 Individual $4,200 Family
All covered expenses accumulate simultaneously toward the preferred or non-preferred Deductible. Unless otherwise indicated, the deductible must be met prior to benefits being payable. Member cost sharing for certain services, as indicated in the plan, are excluded from charges to meet the Deductible. Pharmacy expenses apply towards the Deductible. Once the Family Deductible is met, all family members will be considered as having met their Deductible. There is no Individual Deductible to satisfy within the Family Deductible.		
Member Coinsurance Applies to all expenses unless otherwise stated	20%	40%
Payment Limit (per calendar year)	$3,000 Individual $6,000 Family	$9,000 Individual $18,000 Family
All covered expenses accumulate simultaneously toward the preferred or non-preferred Payment Limit. Only those out-of-pocket expenses resulting from the application of coinsurance percentage, copays, and deductibles (except any penalty amounts) may be used to satisfy the Payment Limit. Pharmacy expenses apply towards the Payment Limit. There is no Individual Payment Limit to satisfy within the Family Payment Limit. Once Family Payment Limit is met, all family members will be considered as having met their Payment Limit.		
Lifetime Maximum Unlimited except where otherwise indicated		
Primary Care Physician Selection	Optional	Not Applicable
Certification Requirements - Certification for certain types of Non-Preferred care must be obtained to avoid a reduction in benefits paid for that care. Certification for Hospital Admissions, Treatment Facility Admissions, Convalescent Facility Admissions, Home Health Care, Hospice Care and Private Duty Nursing is required - excluded amount applied separately to each type of expense is 50% per occurrence.		
Referral Requirement	None	None
PREVENTIVE CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Routine Adult Physical Exams/ Immunizations 1 exam per 12 months for members age 22 to age 65; 1 exam per 12 months for adults age 65 and older.	Covered 100%; deductible waived	Not Covered
Routine Well Child Exams/Immunizations 7 exams in the first 12 months of life, 3 exams in the second 12 months of life, 3 exams in the third 12 months of life, 1 exam per year thereafter to age 22.	Covered 100%; deductible waived	Not Covered
Routine Gynecological Care Exams Recommended: One exam per 12 months. Includes routine tests and related lab fees.	Covered 100%; deductible waived	Not Covered
Routine Mammograms Recommended: For women age 40 and over. One exam per 12 months.	Covered 100%; deductible waived	40%; after deductible
Women's Health Includes: Screening for gestational diabetes, HPV (Human- Papillomavirus) DNA testing, counseling for sexually transmitted infections, counseling and screening for human immunodeficiency virus, screening and counseling for interpersonal and domestic violence, breastfeeding support, supplies and counseling. Contraceptive methods, sterilization procedures, patient education and counseling. Limitations may apply.	Covered 100%; deductible waived	40%; after deductible

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Routine Digital Rectal Exam	Covered 100%; deductible waived	40%; after deductible
Recommended: For covered males age 50 and over. One exam per 12 months.		
Prostate-specific Antigen Test	Covered 100%; deductible waived	40%; after deductible
Recommended: For males age 50 and over. One exam per 12 months.		
Colorectal Cancer Screening	Covered 100%; deductible waived	Not Covered
Recommended: For all members age 50 and over.		
Routine Eye Exams	$30 copay; deductible waived	Not Covered
1 routine exam per 12 months.		
Routine Hearing Screening	Covered 100%; deductible waived	Not Covered
PHYSICIAN SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Office Visits to Non-Specialist	20%; after deductible	40%; after deductible
Includes services of an internist, general physician, family practitioner or pediatrician.		
Specialist Office Visits	20%; after deductible	40%; after deductible
Includes visits to a naturopath		
Hearing Exam	20%; after deductible	40%; after deductible
1 routine exam per 12 months		
Pre-Natal Maternity	Covered 100%; deductible waived	Covered according to standard claim practice.
Walk-in Clinics	20%; after deductible	40%; after deductible
Walk-in Clinics are network, free-standing health care facilities. They are an alternative to a physician's office visit for treatment of unscheduled, non-emergency illnesses and injuries and the administration of certain immunizations. It is not an alternative for emergency room services or the ongoing care provided by a physician. Neither an emergency room, nor the outpatient department of a hospital, shall be considered a Walk-in Clinic.		
Allergy Testing	Your cost sharing is based on the type of service and where it is performed	40%; after deductible
Allergy Injections	Your cost sharing is based on the type of service and where it is performed	40%; after deductible
DIAGNOSTIC PROCEDURES	**IN-NETWORK**	**OUT-OF-NETWORK**
Diagnostic X-ray	20%; after deductible	40%; after deductible
(other than Complex Imaging Services)		
If performed as a part of a physician office visit and billed by the physician, expenses are covered subject to the applicable physician's office visit member cost sharing.		
Diagnostic Laboratory	20%; after deductible	40%; after deductible
If performed as a part of a physician office visit and billed by the physician, expenses are covered subject to the applicable physician's office visit member cost sharing.		
Diagnostic Complex Imaging	20%; after deductible	40%; after deductible
EMERGENCY MEDICAL CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Urgent Care Provider	20%; after deductible	40%; after deductible
Non-Urgent Use of Urgent Care Provider	20%; after deductible	40%; after deductible
Emergency Room	20%; after deductible	Same as in-network care
Copay waived if admitted		
Non-Emergency Care in an Emergency Room	20%; after deductible	20%; after deductible
Emergency Use of Ambulance	20%; after deductible	Same as in-network care

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Non-Emergency Use of Ambulance	Not covered unless medically necessary for safe transport	Not covered unless medically necessary for safe transport
HOSPITAL CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient Coverage Your cost sharing applies to all covered benefits incurred during your inpatient stay.	20%; after deductible	40%; after deductible
Inpatient Maternity Coverage (includes delivery and postpartum care) Your cost sharing applies to all covered benefits incurred during your inpatient stay.	20%; after deductible	40%; after deductible
Outpatient Hospital Expenses Your cost sharing applies to all covered benefits incurred during your outpatient visit.	20%; after deductible	40%; after deductible
Outpatient Surgery - Hospital Your cost sharing applies to all covered benefits incurred during your outpatient visit.	20%; after deductible	40%; after deductible
Outpatient Surgery - Freestanding Facility Your cost sharing applies to all covered benefits incurred during your outpatient visit.	20%; after deductible	40%; after deductible
MENTAL HEALTH SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient Your cost sharing applies to all covered benefits incurred during your inpatient stay.	20%; after deductible	40%; after deductible
Outpatient Your cost sharing applies to all covered benefits incurred during your outpatient visit.	20%; after deductible	40%; after deductible
Other Mental Health Services	20%; after deductible	40%; after deductible
SUBSTANCE ABUSE	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient Your cost sharing applies to all covered benefits incurred during your inpatient stay.	20%; after deductible	40%; after deductible
Residential Treatment Facility	20%; after deductible	40%; after deductible
Outpatient Your cost sharing applies to all covered benefits incurred during your outpatient visit.	20%; after deductible	40%; after deductible
Other Substance Abuse Services	20%; after deductible	40%; after deductible
OTHER SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Skilled Nursing Facility Limited to 90 days per calendar year. Your cost sharing applies to all covered benefits incurred during your inpatient stay.	20%; after deductible	40%; after deductible
Home Health Care Limited to 130 visits per calendar year. Includes private duty nursing	20%; after deductible	40%; after deductible
Hospice Care - Inpatient Your cost sharing applies to all covered benefits incurred during your inpatient stay.	20%; after deductible	40%; after deductible
Hospice Care - Outpatient Your cost sharing applies to all covered benefits incurred during your outpatient visit.	20%; after deductible	40%; after deductible
Outpatient Short-Term Rehabilitation Includes speech, physical, occupational and massage therapy; limited to 45 visits per calendar year	20%; after deductible	40%; after deductible
Spinal Manipulation Therapy Limited to 12 visits per calendar year.	20%; after deductible	40%; after deductible
Neurodevelopmental Therapy	20%; after deductible	40%; after deductible

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Autism Behavioral Therapy Covered same as any other outpatient mental health benefit	Refer to MBH Outpatient Mental Health	Refer to MBH Outpatient Mental Health
Autism Applied Behavior Analysis Covered same as any other outpatient mental health benefit	Refer to MBH Outpatient Mental Health	Refer to MBH Outpatient Mental Health
Autism Physical Therapy	20%; after deductible	40%; after deductible
Autism Occupational Therapy	20%; after deductible	40%; after deductible
Autism Speech Therapy	20%; after deductible	40%; after deductible
Durable Medical Equipment	20%; after deductible	40%; after deductible
Orthotics Includes foot orthotics and orthopedic shoes	20%; after deductible	40%; after deductible
Hearing Aids Limited to $3,000 maximum every 36 months	20%; after deductible	20%; after deductible
Diabetic Supplies (if not covered under Pharmacy benefit)	Covered same as any other medical expense.	Covered same as any other medical expense.
Affordable Care Act mandated Women's Contraceptives	Covered 100%; deductible waived	Covered same as any other expense.
Women's Contraceptive drugs and devices not obtainable at a pharmacy	Covered 100%; deductible waived	Covered same as any other medical expense.
Infusion Therapy Administered in the home or physician's office	20%; after deductible	40%; after deductible
Infusion Therapy Administered in an outpatient hospital department or freestanding facility	20%; after deductible	40%; after deductible
Vision Eyewear	Covered 100% up to $200 every 12 months	Same as in-network care
Transplants	20%; after deductible Preferred coverage is provided at an IOE contracted facility only.	40%; after deductible Non-Preferred coverage is provided at a Non-IOE facility.
Bariatric Surgery Limited to $10,000 lifetime maximum	20%; after deductible	40%; after deductible
Acupuncture Limited to 12 visits per calendar year. Covered for all conditions.	20%; after deductible	40%; after deductible
Other Licensed Providers (including alternative care)	Your cost sharing is based on the type of services and where it is performed	Your cost sharing is based on the type of services and where it is performed
FAMILY PLANNING	**IN-NETWORK**	**OUT-OF-NETWORK**
Infertility Treatment Diagnosis and treatment of the underlying medical condition only.	Your cost sharing is based on the type of service and where it is performed	Your cost sharing is based on the type of service and where it is performed
Comprehensive Infertility Services Artificial insemination and ovulation induction	Not Covered	Not Covered
Advanced Reproductive Technology (ART) In-vitro fertilization (IVF), zygote intrafallopian transfer (ZIFT), gamete intrafallopian transfer (GIFT), cryopreserved embryo transfers, intracytoplasmic sperm injection (ICSI), or ovum microsurgery	Not Covered	Not Covered
Vasectomy	Your cost sharing is based on the type of service and where it is performed	Your cost sharing is based on the type of service and where it is performed

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Tubal Ligation	Covered 100%; deductible waived	Your cost sharing is based on the type of service and where it is performed
PHARMACY	**IN-NETWORK**	**OUT-OF-NETWORK**
The full cost of the drug is applied to the deductible before any benefits are considered under the pharmacy plan.		
Pharmacy Plan Type	**Aetna Premier Plus Open Formulary**	
Generic Drugs		
Retail	20%; after deductible	60% of submitted cost; after applicable coinsurance
Mail Order	20%; after deductible	Not Applicable
Preferred Brand-Name Drugs		
Retail	20%; after deductible	60% of submitted cost; after applicable coinsurance
Mail Order	20%; after deductible	Not Applicable
Non-Preferred Brand-Name Drugs		
Retail	20%; after deductible	60% of submitted cost; after applicable coinsurance
Mail Order	20%; after deductible	Not Applicable
Pharmacy Day Supply and Requirements		
Retail	Up to a 90 day supply subject to applicable coinsurance.	
Mail Order	Up to a 31-90 day supply from Aetna Rx Home Delivery® subject to applicable coinsurance.	
Premier Plus Specialty	Up to a 30 day supply from Aetna Specialty Pharmacy Network subject to applicable coinsurance. First prescription fill at any retail or specialty pharmacy. Subsequent fills must be through our preferred Aetna Specialty Pharmacy network.	
Generic Preventive Medications - Deductible is waived for certain preventive medications. A full list of these drugs is available on Navigator or from your employer.		
Choose Generics with Dispense As Written (DAW) – The member pays the applicable copay if physician requires brand. If the member requests brand when generic is available, the member pays the applicable copay plus the difference between the generic price and the brand price.		
Plan Includes: Diabetic supplies and Contraceptive drugs and devices obtainable from a pharmacy. Oral and injectable fertility drugs excluded Oral chemotherapy drugs covered same as any other drug Performance Enhancement Drugs (8 tablets per month) Preventive, Seasonal and Travel Vaccines at a Retail Pharmacy 100% Premier Plus Pre-certification included with 90 day Transition of Care Premier Plus Step Therapy with 90 day Transition of Care Affordable Care Act mandated female contraceptives and preventive medications covered 100% in-network		
GENERAL PROVISIONS		
Dependents Eligibility	Spouse, children from birth to age 26 regardless of student status	

Plans are provided by: Aetna Life Insurance Company. While this material is believed to be accurate as of the production date, it is subject to change.

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Health benefits and health insurance plans contain exclusions and limitations. Not all health services are covered.
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.
- 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 over-the-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.

Aetna receives rebates from drug manufacturers that may be taken into account in determining Aetna's Preferred Drug List. Rebates do not reduce the amount a member pays the pharmacy for covered prescriptions. Aetna Rx Home Delivery refers to Aetna Rx Home Delivery, LLC, a licensed pharmacy subsidiary of Aetna Inc.,that operates through mail order. The charges that Aetna negotiates with Aetna Rx Home Delivery may be higher than the cost they pay for the drugs and the cost of the mail order pharmacy services they provide. For these purposes, the pharmacy's cost of purchasing drugs takes into account discounts, credits and other amounts that they may receive from wholesalers, manufacturers, suppliers and distributors.

In case of emergency, call 911 or your local emergency hotline, or go directly to an emergency care facility.
Translation of the material into another language may be available. Please call Member Services at **1-888-982-3862.**
Puede estar disponible la traduccion de este material en otro idioma. Por favor llame a Servicios al Miembro al **1-888-982-3862.**

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Plan features and availability may vary by location and group size. For more information about Aetna plans, refer to **www.aetna.com**