# Schedule of benefits

**Prepared for:**

| | |
|---|---|
| Employer: | Port of Seattle |
| Contract number: | MSA-285742 |
| Plan name: | Choice POS II – High Deductible Health Plan 80%/ 60% Plan |
| Schedule of benefits: | 1A |
| Plan effective date: | January 1, 2025 |
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**Third Party Administrative Services provided by Aetna Life Insurance Company**

# Schedule of benefits

This schedule of benefits (schedule) lists the **deductibles**, **copayments** or **payment percentage**, if any apply to the **covered services** you receive under the plan. You should review this schedule to become aware of these and any limits that apply to these services.

## How your cost share works

- The **deductibles** and **copayments**, if any, listed in the schedule below are the amounts that you pay for **covered services**.
  - For the **covered services** under your medical plan, you will be responsible for the dollar amount
  - For pharmacy benefits where a percentage cost share acts like a **copayment**, you will be responsible for the percentage amount
- **Payment percentage** amounts, if any, listed in the schedule below are what the plan will pay for **covered services**.
- Sometimes your cost share shows a combination of your dollar amount **copayment** that you will be responsible for and the **payment percentage** that your plan will pay.
- You are responsible to pay any **deductibles**, **copayments** and remaining **payment percentage**, if they apply and before the plan will pay for any **covered services**.
- This plan doesn't cover every health care service. You pay the full amount of any health care service you get that is not a **covered service**.
- This plan has limits for some **covered services**. For example, these could be visit, day or dollar limits. They may be:
  - Combined limits between in-network and **out-of-network providers**
  - Separate limits for in-network and **out-of-network providers**
  - Based on a rolling, 12 month period starting with the date of your most recent visit under this plan

  See the schedule for more information about limits.
- Your cost share may vary if the **covered service** is preventive or not. Ask your **physician** or contact us if you have a question about what your cost share will be.

For examples of how cost share and **deductible** work, go to the *Using your Aetna benefits* section under Individuals & Families at https://www.aetna.com/

**Important note:**
**Covered services** are subject to the **deductible**, maximum out-of-pocket, limits, **copayment** or **payment percentage** unless otherwise stated in this schedule. The *Surprise bill* section in the booklet explains your protections from a surprise bill.

### How your deductible works

The **deductible** is the amount you pay for **covered services** each year before the plan starts to pay. This is in addition to any **copayment** or **payment percentage** you pay when you get **covered services** from an in-network, **out-of-network provider**. This schedule shows the **deductible** amounts that apply to your plan. Once you have met your **deductible**, we will start sharing the cost when you get **covered services**. You will continue to pay **copayments** or **payment percentage**, if any, for **covered services** after you meet your **deductible**.

### How your PCP or physician office visit cost share works

You will pay the **PCP** cost share when you get **covered services** from any **PCP**.

### How your maximum out-of-pocket works

This schedule shows the **maximum out-of-pocket limits** that apply to your plan. Once you reach your **maximum out-of-pocket limit**, your plan will pay for **covered services** for the remainder of that year.

## Contact us

We are here to answer questions. See the *Contact us* section in your booklet.

This schedule replaces any schedule of benefits previously in use. Keep it with your booklet.

## Plan features

### Precertification covered services reduction

This only applies to out-of-network **covered services**:
Your booklet contains a complete description of the **precertification** process. You will find details in the *Medical necessity and precertification* section.

If **precertification** for **covered services** isn't completed, when required, it results in the following benefit reduction:

- A 50% **payment percentage** reduction applied separately to the benefit provided for each **covered service**

You may have to pay an additional portion of the **recognized charge** because you didn't get **precertification**. This portion is not a **covered service** and doesn't apply to your **deductible** or **maximum out-of-pocket limit**, if you have one.

### Deductible

You have to meet your **deductible** before this plan pays for benefits.

| Deductible type | In-network | Out-of-network |
|---|---|---|
| Individual | $1,700 per year | $2,550 per year |
| Family | $3,400 per year | $5,100 per year |

### Deductible waiver provisions for preventive prescription drugs

No **deductible** will apply to preventive covered **prescription** drug expenses:

**Preventive:**
Preventive drugs as defined in guidance issued by the U.S. Department of the Treasury and Internal Revenue Service (IRS) for Health Savings Accounts (HSAs) and qualified High Deductible Health Plans (HDHPs). This list will be reviewed periodically and is subject to change as federal guidelines change.

### Maximum out-of-pocket limit

Includes the **deductible**.

| Maximum out-of-pocket type | In-network | Out-of-network |
|---|---|---|
| Individual | $4,000 per year | $9,600 per year |
| Family | $8,000 per year | $19,200 per year |

## General coverage provisions

This section explains the **deductible, maximum out-of-pocket limit** and limitations listed in this schedule.

### Deductible provisions

**Covered services** that are subject to the **deductible** include those provided under the medical plan and the **prescription** drug plan.

**Covered services** apply to the in-network and out-of-network **deductibles.**

The **deductible** may not apply to some **covered services**. You still pay the **copayment** or **payment percentage**, if any, for these **covered services**.

### Individual deductible
You pay for **covered services** each year before the plan begins to pay. After the amount paid for **covered services** reaches this individual **deductible**, this plan starts to pay for **covered services** for the rest of the year. The individual **deductible** applies to a person who is enrolled for self-only coverage with no dependent coverage.

### Family deductible
You and your covered dependents pay for **covered services** each year before the plan begins to pay. After the amount paid for **covered services** reaches this family **deductible**, this plan starts to pay for **covered services** for the rest of the year. The family **deductible** applies to a person enrolled with one or more dependents.

## Copayment
This is the dollar amount you pay for **covered services**. In most plans, you pay this after you meet your **deductible** limit. In **prescription** drug plans, it is the amount you pay for covered drugs.

## Payment Percentage
This is the percentage of the bill you pay after you meet your **deductible**.

## Maximum out-of-pocket limit
The **maximum out-of-pocket limit** is the most you will pay per year in **copayments**, **payment percentage** and **deductible**, if any, for **covered services**. **Covered services** that are subject to the **maximum out-of-pocket limit** include those provided under the medical plan and the outpatient **prescription** drug plan.

**Covered services** apply to the in-network and out-of-network **maximum out-of-pocket limit**.

Certain costs that you have do not apply toward the **maximum out-of-pocket limit**. These include:

- All costs for non-**covered services** which are identified in the booklet and the schedule
- Charges, expenses or costs in excess of the **recognized charge**

## Limit provisions

**Covered services** will apply to the in-network and out-of-network limits.

## Your financial responsibility and decisions regarding benefits

We base your financial responsibility for the cost of **covered services** on when the service or supply is provided, not when payment is made. Benefits will be pro-rated to account for treatment or portions of **stays** that occur in more than one year. Decisions regarding when benefits are covered are subject to the terms and conditions of the booklet.

## Prescription drug – outpatient deductible provisions

**Covered services** that are subject to the **deductible** include **covered services** provided under the medical plan and the **prescription** drug plan.

The **deductible** may not apply to certain **covered services**. You still pay the **copayment** or **payment percentage**, if any, for these **covered services**.

## Prescription drug – outpatient maximum out-of-pocket limit provisions

**Covered services** that are subject to the **maximum out-of-pocket limit** include **covered services** provided under the medical plan and the **prescription** drug plan.

The **maximum out-of-pocket limit** is the most you will pay per year in **copayments**, **payment percentage** and **deductible**, if any, for **covered services**. This plan may have an individual and family **maximum out-of-pocket limit**.

## Covered services

### Abortion

| Description | In-network | Out-of-network |
|---|---|---|
| Abortion | Covered based on type of service and where it is received | Covered based on type of service and where it is received |

### Acupuncture

| Description | In-network | Out-of-network |
|---|---|---|
| Acupuncture | 80% per visit after **deductible** | 60% per visit after **deductible** |
| Visit limit per year | 12 | 12 |

### Ambulance services

| Description | In-network | Out-of-network |
|---|---|---|
| **Emergency services** | 80% per trip after **deductible** | 60% per trip after **deductible** |
| Medical necessary non-**emergency services, such as transport to or from home or another facility, when precertified** | 80% per trip after deductible | 60% per trip after deductible |
| Not medically necessary non-emergency services, such as routine transportation | Not covered | Not covered |

### Applied behavior analysis

| Description | In-network | Out-of-network |
|---|---|---|
| Applied behavior analysis | Covered based on type of service and where it is received | Covered based on type of service and where it is received |

### Autism spectrum disorder

| Description | In-network | Out-of-network |
|---|---|---|
| Diagnosis and testing | Covered based on type of service and where it is received | Covered based on type of service and where it is received |
| Treatment | Covered based on type of service and where it is received | Covered based on type of service and where it is received |
| Occupational (OT), physical (PT) and speech (ST) therapy for autism spectrum disorder | Covered based on type of service and where it is received | Covered based on type of service and where it is received |

## Behavioral health

### Mental health treatment

Coverage provided is the same as for any other illness

| Description | In-network | Out-of-network |
|---|---|---|
| Inpatient services-**room and board** including **residential treatment facility** | 80% per admission after **deductible** | 60% per admission after **deductible** |
| Other inpatient services and supplies<br>Other **residential treatment facility** services and supplies | 80% per admission after **deductible** | 60% per admission after **deductible** |

| Description | In-network | Out-of-network |
|---|---|---|
| Outpatient office visit to a **physician** or **behavioral health provider** | 80% per visit after **deductible** | 80% per visit after **deductible** |
| **Physician** or **behavioral health provider telemedicine** consultation | 80% per visit after **deductible** | 80% per visit after **deductible** |
| Outpatient **mental health disorders telemedicine** cognitive therapy consultations by a **physician** or **behavioral health provider** | Covered based on type of service and **provider** from which it is received | Covered based on type of service and **provider** from which it is received |

| Description | In-network | Out-of-network |
|---|---|---|
| Other outpatient services including:<br>• Behavioral health services in the home<br>• Partial hospitalization treatment<br>• Intensive outpatient program<br><br>The cost share doesn't apply to in-network peer counseling support services after you meet your **deductible** | 80% per visit after **deductible** | 80% per visit after **deductible** |

| Description | In-network | Out-of-network |
|---|---|---|
| **Telemedicine provider mental health disorders** consultation | Covered based on type of service and **provider** from which it is received | Not covered |
| **Telemedicine** cognitive therapy **mental health disorders** consultation by a **telemedicine provider** | Covered based on type of service and **provider** from which it is received | Not covered |

### Substance related disorders treatment

Includes **detoxification**, rehabilitation and **residential treatment facility**
Coverage provided is the same as for any other illness

| Description | In-network | Out-of-network |
|---|---|---|
| Inpatient services-**room and board** during a **hospital stay** | 80% per admission after **deductible** | 60% per admission after **deductible** |
| Other inpatient services and supplies during a **hospital stay** | 80% per admission after **deductible** | 60% per admission after **deductible** |

| Description | In-network | Out-of-network |
|---|---|---|
| Outpatient office visit to a **physician** or **behavioral health provider** | 80% per visit after **deductible** | 80% per visit after **deductible** |

| | | |
|---|---|---|
| **Physician** or **behavioral health provider telemedicine** consultation | 80% per visit after **deductible** | 80% per visit after **deductible** |
| Outpatient **telemedicine** cognitive therapy consultations by a **physician** or **behavioral health provider** | Covered based on type of service and **provider** from which it is received | Covered based on type of service and **provider** from which it is received |

| Description | In-network | Out-of-network |
|---|---|---|
| Other outpatient services including:<br>• Behavioral health services in the home<br>• Partial hospitalization treatment<br>• Intensive outpatient program<br><br>The cost share doesn't apply to in-network peer counseling support services after you meet your **deductible** | 80% per visit after **deductible** | 80% per visit after **deductible** |

| Description | In-network | Out-of-network |
|---|---|---|
| **Telemedicine provider substance related disorders** consultation | Covered based on type of service and **provider** from which it is received | Not covered |
| **Telemedicine** cognitive therapy **substance related disorders** consultation by a **telemedicine provider** | Covered based on type of service and **provider** from which it is received | Not covered |

## Clinical trials

| Description | In-network | Out-of-network |
|---|---|---|
| **Experimental or investigational** therapies | Covered based on type of service and where it is received | Covered based on type of service and where it is received |
| Routine patient costs | Covered based on type of service and where it is received | Covered based on type of service and where it is received |

## Diabetic services, supplies, equipment, and self-care programs

| Description | In-network | Out-of-network |
|---|---|---|
| Diabetic services | Covered based on type of service and where it is received | Covered based on type of service and where it is received |
| Diabetic supplies | Covered based on type of service and where it is received | Covered based on type of service and where it is received |
| Diabetic equipment | Covered based on type of service and where it is received | Covered based on type of service and where it is received |
| Diabetic self-care programs | Covered based on type of service and where it is received | Covered based on type of service and where it is received |

## Durable medical equipment (DME)

| Description | In-network | Out-of-network |
|---|---|---|
| DME | 80% per item after **deductible** | 80% per item after **deductible** |

## Emergency services

| Description | In-network | Out-of-network |
|---|---|---|
| Emergency room | 80% per visit after **deductible** | Paid same as in-network |
| Non-emergency care in a **hospital** emergency room | 80% per visit after **deductible** | 80% per visit after **deductible** |

**Emergency services important note: Out-of-network providers** do not have a contract with us. However, for out of network emergencies the federal No Surprises Act applies. If the **provider** bills you for an amount above your cost share, you are not responsible for payment of that amount. You should send the bill to the address on your ID card and we will resolve any payment issue with the **provider**. Make sure the member ID is on the bill. If you are admitted to the **hospital** for an inpatient **stay** right after you visit the emergency room, you will not pay your emergency room cost share if you have one. You will pay the inpatient **hospital** cost share, if any.

## Foot orthotic devices

| Description | In-network | Out-of-network |
|---|---|---|
| Orthotic devices | 80% per item after **deductible** | 60% per item after **deductible** |

## Habilitation therapy services

### Outpatient physical (PT), occupational (OT) therapies

| Description | In-network | Out-of-network |
|---|---|---|
| PT, OT therapies | Covered based on type of service and where it is received | Covered based on type of service and where it is received |

### Outpatient speech therapy (ST)

| Description | In-network | Out-of-network |
|---|---|---|
| ST therapy | Covered based on type of service and where it is received | Covered based on type of service and where it is received |

## Hearing aids

| Description | In-network | Out-of-network |
|---|---|---|

| | | |
|---|---|---|
| Hearing aids | 80% per item, no **deductible** applies | 80% per item no **deductible applies** |

| | | |
|---|---|---|
| Limit | $3,000 every 36 months | $3,000 every 36 months |

## Hearing exams

| Description | In-network | Out-of-network |
|---|---|---|
| Hearing exams | Covered based on type of service and where it is received | Covered based on type of service and where it is received |
| Visit limit | 1 visit every 12 months | 1 visit every 12 months |

## Home health care

A visit is a period of 4 hours or less

| Description | In-network | Out-of-network |
|---|---|---|
| Home health care | 80% per visit after **deductible** | 60% per visit after **deductible** |

| | | |
|---|---|---|
| Visit limit per year | 520 | 520 |

**Home health care important note:**
Intermittent visits are periodic and recurring visits that skilled nurses make to ensure your proper care. The intermittent requirement may be waived to allow for coverage for up to 12 hours with a daily maximum of 3 visits.

## Hospice care

| Description | In-network | Out-of-network |
|---|---|---|
| Inpatient services - **room and board** | 80% after **deductible** | 60% after **deductible** |

| | | |
|---|---|---|
| Other inpatient services and supplies | 80% per admission after **deductible** | 60% after **deductible** |

| Description | In-network | Out-of-network |
|---|---|---|
| Outpatient services | 80% per visit after **deductible** | 60% per visit after **deductible** |

| | | |
|---|---|---|
| Limit per lifetime | unlimited | unlimited |

**Hospice important note:**
This includes part-time or infrequent nursing care by an R.N. or L.P.N. to care for you up to 8 hours a day. It also includes part-time or infrequent home health aide services to care for you up to 8 hours a day.

## Hospital care

| Description | In-network | Out-of-network |
|---|---|---|
| Inpatient services – **room and board** | 80% after **deductible** | 60% after **deductible** |

| Description | In-network | Out-of-network |
|---|---|---|
| Other inpatient services and supplies | 80% per admission after **deductible** | 60% after **deductible** |

## Infertility services

### Basic infertility

| Description | In-network | Out-of-network |
|---|---|---|
| Treatment of basic **infertility** | Covered based on type of service and where it is received | Covered based on type of service and where it is received |

### Advanced reproductive technology (ART)

| Description | In-network | Out-of-network |
|---|---|---|
| Outpatient services performed at ART **specialist** office | Covered based on type of service and where it is received | Covered based on type of service and where it is received |
| Services performed at **hospital** outpatient department | Covered based on type of service and where it is received | Covered based on type of service and where it is received |
| Services performed at a facility other than a **hospital** outpatient department | Covered based on type of service and where it is received | Covered based on type of service and where it is received |
| Fertility preservation | Covered based on type of service and where it is received | Covered based on type of service and where it is received |

### Limits

| Description | In-network | Out-of-network |
|---|---|---|
| Limit per lifetime | $20,000<br><br>Combined for in-network and out-of-network benefits | $20,000<br><br>Combined for in-network and out-of-network benefits |

## Maternity and related newborn care

Includes complications

| Description | In-network | Out-of-network |
|---|---|---|
| Inpatient services – **room and board** | 80% per admission after **deductible** | 60% per admission after **deductible** |
| Other inpatient services and supplies | 80% per admission after **deductible** | 60% per admission after **deductible** |
| Services performed in **physician** or **specialist** office or a facility | 80% per visit after **deductible** | 60% per visit after **deductible** |
| Other services and supplies | 80% per visit after **deductible** | 60% per visit after **deductible** |

**Maternity and related newborn care important note:**
Any cost share collected applies only to the delivery and postpartum care services provided by an OB, GYN or OB/GYN. Review the *Maternity* section of the booklet. It will give you more information about coverage for maternity care under this plan.

## Nutritional support

| Description | In-network | Out-of-network |
|---|---|---|
| Nutritional support | Covered based on type of service and where it is received | Covered based on type of service and where it is received |

## Obesity surgery

| Description | In-network | Out-of-network |
|---|---|---|
| Inpatient services – **room and board** | 80% per admission after **deductible** | 60% per admission after **deductible** |
| Other inpatient services and supplies | 80% per admission after **deductible** | 60% per admission after **deductible** |

| Description | In-network | Out-of-network |
|---|---|---|
| Outpatient services | 80% per visit after **deductible** | 60% per visit after **deductible** |

| | | |
|---|---|---|
| Limit per lifetime | $10,000 | $10,000 |

## Oral and maxillofacial treatment (mouth, jaws and teeth)

| Description | In-network | Out-of-network |
|---|---|---|
| Treatment of mouth, jaws and teeth | Covered based on type of service and where it is received | Covered based on type of service and where it is received |

## Outpatient surgery

| Description | In-network | Out-of-network |
|---|---|---|
| At **hospital** outpatient department | 80% per visit after **deductible** | 60% per visit after **deductible** |
| At facility that is not a **hospital** | 80% per visit after **deductible** | 60% per visit after **deductible** |
| At the **physician** office | Covered based on type of service and where it is received | Covered based on type of service and where it is received |

## Physician and specialist services

## Physician services-general or family practitioner

Including surgical services

| Description | In-network | Out-of-network |
|---|---|---|
| **Physician** office hours (not-surgical, not preventive) | 80% per visit after **deductible** | 60% per visit after **deductible** |
| **Physician** surgical services | 80% per visit after **deductible** | 60% per visit after **deductible** |

| Description | In-network | Out-of-network |
|---|---|---|
| **Physician** visit during inpatient **stay** | 80% per visit after **deductible** | 60% per visit after **deductible** |

| Description | In-network | Out-of-network |
|---|---|---|
| **Physician telemedicine** consultation | 80% per visit after **deductible** | 60% per visit after **deductible** |

| Description | In-network | Out-of-network |
|---|---|---|
| **Telemedicine provider** consultation<br><br>Basic medical services | Covered based on type of service and **provider** from which it is received | Not covered |

## Specialist

| Description | In-network | Out-of-network |
|---|---|---|
| **Specialist** office hours (not-surgical, not preventive) | 80% per visit after **deductible** | 60% per visit after **deductible** |
| **Specialist** surgical services | 80% per visit after **deductible** | 60% per visit after **deductible** |

| Description | In-network | Out-of-network |
|---|---|---|
| **Specialist telemedicine** consultation | 80% per visit after **deductible** | 60% per visit after **deductible** |

| Description | In-network | Out-of-network |
|---|---|---|
| **Telemedicine provider** consultation<br><br>**Specialist** services | Covered based on type of service and **provider** from which it is received | Not covered |

## All other services not shown above

| Description | In-network | Out-of-network |
|---|---|---|
| All other services | 80% per visit after **deductible** | 60% per visit after **deductible** |

## Prescription drugs - outpatient

### Generic prescription drugs (including specialty drugs*)

| Description | In-network | Out-of-network |
|---|---|---|
| 30 day supply at a **retail pharmacy** | 20% after **deductible** | 20% then the plan pays 40% after **deductible** |
| 90 day supply at a **retail pharmacy** | 20% after **deductible** | 20% then the plan pays 40% after **deductible** |
| 90 day supply at a **mail order pharmacy** | 20% after **deductible** | Not covered |
| *Specialty drugs – each prescription is limited to a maximum of 30-day supply. | | |

**Brand-name prescription drugs (including specialty drugs*)**

| Description | In-network | Out-of-network |
|---|---|---|
| 30 day supply at a **retail pharmacy** | 20% after **deductible** | 20% then the plan pays 40% after **deductible** |
| 90 day supply at a **retail pharmacy** | 20% after **deductible** | 20% then the plan pays 40% after **deductible** |
| 90 day supply at a **mail order pharmacy** | 20% after **deductible** | Not covered |
| *Specialty drugs – each prescription is limited to a maximum of 30-day supply. | | |

**Contraceptives (birth control)**

**Brand-name prescription drugs** and devices are covered at 100% when a generic is not available

| Description | In-network | Out-of-network |
|---|---|---|
| 30 day supply or 12 month supply of generic and OTC drugs and devices | $0, no **deductible** applies | Paid based on the tier of drug in the schedule |
| 30 day supply or 12 month supply of **brand-name prescription drugs** and devices | Paid based on the tier of drug in the schedule | Paid based on the tier of drug in the schedule |

**Infertility drugs**

| Description | In-network | Out-of-network |
|---|---|---|
| **Infertility** drugs | Paid based on the tier of drug in the schedule | Paid based on the tier of drug in the schedule |

**Weight loss drugs**

| Description | In-network | Out-of-network |
|---|---|---|
| 30 day supply at a **retail pharmacy** | Paid based on the tier of drug in the schedule | Paid based on the tier of drug in the schedule |
| 90 day supply at a **mail order pharmacy** | Paid based on the tier of drug in the schedule | Not covered |

**Preventive care drugs and supplements**

| Description | In-network | Out-of-network |
|---|---|---|
| Preventive care drugs and supplements | $0, no **deductible** applies | Paid based on the tier of drug in the schedule |
| Limits | Subject to any sex, age, medical condition, family history and frequency guidelines as recommended by the U.S. Preventive Services Task Force (USPSTF)<br><br>For a current list of covered preventive care drugs and supplements or more information, see the *Contact us* section | Subject to any sex, age, medical condition, family history and frequency guidelines as recommended by the U.S. Preventive Services Task Force (USPSTF)<br><br>For a current list of covered preventive care drugs and supplements or more information, see the *Contact us* section |

**Risk reducing breast cancer prescription drugs**

| Description | In-network | Out-of-network |
|---|---|---|
| Risk reducing breast cancer **prescription** drugs | $0, no **deductible** applies | Paid based on the tier of drug in the schedule |
| Limits | Subject to any sex, age, medical condition, family history and frequency guidelines as recommended by the U.S. Preventive Services Task Force (USPSTF)<br><br>For a current list of risk reducing breast cancer drugs or more information, see the *Contact us* section | Subject to any sex, age, medical condition, family history and frequency guidelines as recommended by the U.S. Preventive Services Task Force (USPSTF)<br><br>For a current list of risk reducing breast cancer drugs or more information, see the *Contact us* section |

**Tobacco cessation prescription and OTC drugs (preventive care)**

| Description | In-network | Out-of-network |
|---|---|---|
| Tobacco cessation **prescription** and OTC drugs | $0, no **deductible** applies<br><br>for the first two 90-day treatment programs.<br><br>Additional treatment programs will be paid based on the tier of drug in the schedule. | Paid based on the tier of drug in the schedule |
| Limits | Subject to any sex, age, medical condition, family history and frequency guidelines in the recommendations of the USPSTF.<br><br>For a current list of covered tobacco cessation drugs or more information, see the *Contact us* section. See the *Other services* section of this schedule for more information. | Subject to any sex, age, medical condition, family history and frequency guidelines in the recommendations of the USPSTF.<br><br>For a current list of covered tobacco cessation drugs or more information, see the *Contact us* section. See the *Other services* section of this schedule for more information. |

**Prescription drug important note:**
If a **provider** prescribes a covered **brand-name prescription drug** when a **generic prescription drug** equivalent is available and specifies "Dispense As Written" (DAW), you will pay the cost share for the brand-name drug. If a **provider** does not specify DAW and you request a covered **brand-name prescription drug**, you will be responsible for the cost share that applies to the brand-name drug plus the cost difference between the generic drug and the brand-name drug. The cost difference related to a **prescription** not specified as DAW does not apply toward your **prescription** drug **deductible** or **maximum out-of-pocket limit**.

## Preventive care

| Description | In-network | Out-of-network |
|---|---|---|
| Preventive care services | 100% per visit, no **deductible** applies | Not Covered |
| Breast feeding counseling and support | 100% per visit, no **deductible** applies | 60% per visit after **deductible** |
| Breast feeding counseling and support limit | 6 visits in a group or individual setting<br><br>Visits that exceed the limit are covered under the **physician** services office visit | 6 visits in a group or individual setting<br><br>Visits that exceed the limit are covered under the **physician** services office visit |
| Breast pump, accessories and supplies limit | Electric pump: 1 every 12 months<br><br>Manual pump: 1 per pregnancy<br><br>Pump supplies and accessories: 1 purchase per pregnancy if not eligible to purchase a new pump | Electric pump: 1 every 12 months<br><br>Manual pump: 1 per pregnancy<br><br>Pump supplies and accessories: 1 purchase per pregnancy if not eligible to purchase a new pump |
| Breast pump waiting period | Electric pump: 12 months to replace an existing electric pump | Electric pump: 12 months to replace an existing electric pump |
| Counseling for alcohol or drug misuse | 100% per visit, no **deductible** applies | Not covered |
| Counseling for alcohol or drug misuse visit limit | 5 visits/12 months | Not covered |
| Counseling for obesity, healthy diet | 100% per visit, no **deductible** applies | Not covered |
| Counseling for obesity, healthy diet visit limit | Age 22 and older: 26 visits per 12 months, of which up to 10 visits may be used for healthy diet counseling. | Not covered |
| Counseling for sexually transmitted infection | 100% per visit, no **deductible** applies | Not covered |
| Counseling for sexually transmitted infection visit limit | 2 visits/12 months | Not covered |
| Counseling for tobacco cessation | 100% per visit, no **deductible** applies | Not covered |
| Counseling for tobacco cessation visit limit | 8 visits/12 months | Not covered |
| Family planning services (female contraception counseling) | 100% per visit, no **deductible** applies | 60% per visit after **deductible** |
| Family planning services (female contraception counseling) limit | Contraceptive counseling limited to 2 visits/12 months in a group or individual setting<br><br>Counseling that exceeds this limit covered as a **physician** services office visit | Contraceptive counseling limited to 2 visits/12 months in a group or individual setting<br><br>Counseling that exceeds this limit are covered as a **physician** services office visit |
| Immunizations | 100%, no **deductible** applies | Not covered |
| Immunizations limit | Subject to any age limits provided for in the comprehensive guidelines | Not covered |

| | | |
|---|---|---|
| | supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention<br><br>For details, contact your **physician** | |
| Routine cancer screenings other than colonoscopies | 100% per visit, no **deductible** applies | 60% per visit after **deductible** |
| Colonoscopies | 100% per visit, no **deductible** applies | Not covered |
| Routine cancer screening limits | Subject to any age, family history and frequency guidelines as set forth in the most current:<br>Evidence-based items that have a rating of A or B in the current recommendations of the USPSTF<br><br>The comprehensive guidelines supported by the Health Resources and Services Administration<br><br>For more information contact your **physician** or see the *Contact us* section | Subject to any age, family history and frequency guidelines as set forth in the most current:<br>Evidence-based items that have a rating of A or B in the current recommendations of the USPSTF<br><br>The com<br>prehensive guidelines supported by the Health Resources and Services Administration<br><br>For more information contact your **physician** or see the *Contact us* section |
| Routine lung cancer screening | 100% per visit, no **deductible** applies | 60% per visit after **deductible** |
| Routine lung cancer screening limit | 1 screening every 12 months<br><br>Screenings that exceed this limit are covered as outpatient diagnostic testing | 1 screening every 12 months<br><br>Screenings that exceed this limit are covered as outpatient diagnostic testing |
| Routine physical exam | 100% per visit, no **deductible** applies | Not covered |
| Routine physical exam limits | Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration for children and adolescents<br><br>Limited to 7 exams from age 0-1 year; 3 exams every 12 months age 1-2; 3 exams every 12 months age 2-3; and 1 exam every per year after that age, up to age 22; 1 exam every 12 months after age 22<br><br>High risk Human Papillomavirus (HPV) DNA testing for woman age 30 and older limited to 1 every 36 months | Not covered |
| Well woman GYN exam | 100% per visit, no **deductible** applies | Not covered |

| | | |
|---|---|---|
| Well woman GYN exam limit | Subject to any age and visit limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration | Not covered |

## Prosthetic devices

| Description | In-network | Out-of-network |
|---|---|---|
| Prosthetic devices | Covered based on type of service and where it is received | Covered based on type of service and where it is received |

## Reconstructive surgery and supplies

Including breast **surgery**

| Description | In-network | Out-of-network |
|---|---|---|
| **Surgery** and supplies | Covered based on type of service and where it is received | Covered based on type of service and where it is received |

## Short-term rehabilitation services

A visit is equal to no more than 1 hour of therapy.

### Cardiac rehabilitation

| Description | In-network | Out-of-network |
|---|---|---|
| Cardiac rehabilitation | Covered based on type of service and where it is received | Covered based on type of service and where it is received |

### Pulmonary rehabilitation

| Description | In-network | Out-of-network |
|---|---|---|
| Pulmonary rehabilitation | Covered based on type of service and where it is received | Covered based on type of service and where it is received |

### Cognitive rehabilitation

| Description | In-network | Out-of-network |
|---|---|---|
| Cognitive rehabilitation | Covered based on type of service and where it is received | Covered based on type of service and where it is received |

### Physical, occupational speech and massage therapies

| Description | In-network | Out-of-network |
|---|---|---|
| | 80% per visit after **deductible** | 60% per visit after **deductible** |

## Physical, occupational, speech and massage therapies

| Description | In-network | Out-of-network |
|---|---|---|
| Visit limit per year<br><br>Physical, occupational and speech therapies combined<br>In-network and out-of-network combined | 45 | 45 |

**Spinal manipulation**

| Description | In-network | Out-of-network |
|---|---|---|
| | 80% per visit after **deductible** | 60% per visit after **deductible** |

| | | |
|---|---|---|
| Visit limit per year<br><br>In-network and out-of-network combined | 15 | 15 |

## Skilled nursing facility

| Description | In-network | Out-of-network |
|---|---|---|
| Inpatient services - **room and board** | 80% per admission after **deductible** | 60% per admission after **deductible** |
| Other inpatient services and supplies | 80% per admission after **deductible** | 60% per admission after **deductible** |

| | | |
|---|---|---|
| Day limit per year | 90 | 90 |

## Tests, images and labs – outpatient

**Diagnostic complex imaging services**

| Description | In-network | Out-of-network |
|---|---|---|
| | 80% per visit after **deductible** | 80% per visit after **deductible** |

**Diagnostic lab work**

| Description | In-network | Out-of-network |
|---|---|---|
| | 80% per visit after **deductible** | 60% per visit after **deductible** |

**Diagnostic x-ray and other radiological services**

| Description | In-network | Out-of-network |
|---|---|---|
| | 80% per visit after **deductible** | 60% per visit after **deductible** |

## Therapies

**Chemotherapy**

| Description | In-network | Out-of-network |
|---|---|---|
| Chemotherapy services | Covered based on type of service and where it is received | Covered based on type of service and where it is received |

**Gene-based, cellular and other innovative therapies (GCIT)**

| Description | In-network (GCIT-designated facility/provider) | Out-of-network (Including **providers** who are otherwise part of Aetna's network but are not GCIT-designated facilities/**providers**) |
|---|---|---|
| Services and supplies | Covered based on type of service and where it is received | Not covered |
| Gene therapy products, **prescription** drugs | 80% after **deductible** | Not covered |

**Infusion therapy**

Outpatient services

| Description | In-network | Out-of-network |
|---|---|---|
| In **physician** office | 80% per visit after **deductible** | 60% per visit after **deductible** |
| At an infusion location | Covered based on type of service and where it is received | Covered based on type of service and where it is received |
| In the home | 80% per visit after **deductible** | 60% per visit after **deductible** |
| At **hospital** outpatient department | 80% per visit after **deductible** | 60% per visit after **deductible** |
| At facility that is not a **hospital** | 80% per visit after **deductible** | 60% per visit after **deductible** |

**Radiation therapy**

| Description | In-network | Out-of-network |
|---|---|---|
| Radiation therapy | Covered based on type of service and where it is received | Covered based on type of service and where it is received |

**Respiratory therapy**

| Description | In-network | Out-of-network |
|---|---|---|
| Respiratory therapy | Covered based on type of service and where it is received | Covered based on type of service and where it is received |

## Transplant services

| Description | In-network (IOE facility) | Out-of-network (Includes **providers** who are otherwise part of Aetna's network but are non-IOE **providers**) |
|---|---|---|
| Inpatient services and supplies | 80% per transplant after **deductible** | 60% per transplant after **deductible** |
| **Physician** services | Covered based on type of service and where it is received | Covered based on type of service and where it is received |

## Urgent care services

At a freestanding facility or **provider** that is not a **hospital**

A separate urgent care cost share will apply for each visit to an urgent care facility or **provider**

| Description | In-network | Out-of- network |
|---|---|---|
| Urgent care facility | 80% per visit after **deductible** | 60% per visit after **deductible** |

## Walk-in clinic

Not all preventive care services are available at a **walk-in clinic**. All services are available from a network **physician**.

| Description | In-network | Out-of-network |
|---|---|---|
| Non-**emergency services** | 80% per visit after **deductible** | 60% per visit after **deductible** |
| Preventive care immunizations | 100% per visit, no **deductible** applies | Not covered |
| Preventive care immunization limits | Subject to any age and frequency limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention<br><br>For details, contact your **physician** | Not covered |
| Preventive screening and counseling services | 100% per visit, no **deductible** applies | Not covered |
| Preventive screening and counseling limits | See the *Preventive care* section of the schedule | Not covered |