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**PLAN DESIGN AND BENEFITS - AK Gold PPO Matsu 750 70/50 (2024)**

**AK Group Business 1-50 Employees**

| PLAN FEATURES | NETWORK CARE | OUT-OF-NETWORK CARE |
|---|---|---|
| **Primary Care Physician Selection** | Not applicable | Not applicable |
| **Deductible** (per calendar year) | $750 Individual<br>$1,500 Family | $750 Individual<br>$1,500 Family |
| Unless otherwise indicated, the deductible must be met before benefits can be paid. | | |
| Claims from in-network and out-of-network providers do cross-accumulate to satisfy the deductible. | | |
| As indicated in the plan, member cost sharing for certain services are excluded from the charges to meet the deductible. | | |
| No one family member may contribute more than the individual deductible amount to the family deductible. Once the family deductible is met, all family members will be considered as having met their deductible for the remainder of the year. | | |
| **Member Coinsurance**<br>(applies to all expenses unless otherwise stated) | 30% | 50% |
| **Out-of-Pocket (OOP) Maximum**<br>(per calendar year, includes deductible) | $6,500 Individual<br>$13,000 Family | Unlimited Individual<br>Unlimited Family |
| Claims from in-network and out-of-network providers do cross-accumulate to satisfy the out-of-pocket maximums. | | |
| Only those out-of-pocket expenses resulting from the application of coinsurance percentage, deductibles, and copays (except any penalty amounts) may be used to satisfy the Out-of-Pocket Maximum. | | |
| No one family member may contribute more than the individual out-of-pocket maximum amount to the family out-of-pocket maximum. Once the family out-of-pocket maximum is met, all family members will be considered as having met their out-of-pocket maximum for the remainder of the year. | | |
| **Payment for Out-of-Network Care*** | Not applicable | Professional: Fair Health 80%<br>Facility: Billed Charges |
| **Precertification Requirements** | | |
| Some out-of-network services need approval by us in advance (precertification). Without this approval, a benefit reduction of $400 per occurrence applies separately to each type of covered service. Refer to your plan documents for a full list of services that need this approval. | | |
| **Referral Requirement** | Not applicable | Not applicable |
| **PHYSICIAN SERVICES** | **NETWORK CARE** | **OUT-OF-NETWORK CARE** |
| **Office Visits to Non-Specialist** | $35 copay deductible waived | 50% after deductible |
| Includes services of an internist, general physician, family practitioner or pediatrician for diagnosis and treatment of an illness or injury. | | |
| **Telemedicine Consultations to Non-Specialist** | $35 copay deductible waived | 50% after deductible |
| **Virtual Primary Care Telemedicine Provider Consultations**<br>Includes basic medical and preventive health care services for persons 18 years of age or older. Telemedicine preventive screening and counseling services are subject to the preventive care benefit. | Covered in full | Not Covered |
| **Non-Specialist Telemedicine Provider Consultations** | Covered in full | Not Covered |
| **Specialist Office Visits** | $60 copay deductible waived | 50% after deductible |
| **Telemedicine Consultations to Specialist** | $60 copay deductible waived | 50% after deductible |
| **Specialist Telemedicine Provider Consultations** | Covered in full | Not Covered |
| **Walk-in Clinics** | $35 copay deductible waived | 50% after deductible |
| Walk-in clinics are freestanding health care facilities that (a) may be located in or with a pharmacy, drug store, supermarket or other retail store; and (b) provide limited medical care and services on a scheduled or unscheduled basis. Urgent care centers, emergency rooms, the outpatient department of a hospital, ambulatory surgical centers, and physician offices are not considered to be walk-in clinics. | | |
| **Maternity - Delivery and Post-Partum Care** | 30% after deductible | 50% after deductible |
| Your cost sharing applies to all covered benefits incurred during your inpatient stay. | | |
| **Allergy Testing** | Cost-sharing is based on type of service and where it is received. | 50% after deductible |

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| **Allergy Injections** | 30% after deductible | 50% after deductible |
| PREVENTIVE CARE | NETWORK CARE | OUT-OF-NETWORK CARE |
| Preventive care services are covered in accordance with Health Care Reform. | | |
| **Routine Adult Physical Exams and Immunizations**<br>Coverage is limited to 1 exam every 12 months. | Covered in full | 50% after deductible |
| **Routine Well Child Exams and Immunizations**<br>Coverage is limited 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 every 12 months thereafter to age 22. | Covered in full | 50% after deductible |
| **Routine Gynecological Exams**<br>Includes Pap smear, HPV screening and related lab fees. Coverage is limited to 1 exam every 12 months. | Covered in full | 50% after deductible |
| **Routine Mammograms** | Covered in full | 50% after deductible |
| **Women's Health**<br>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; Limitations may apply. | Covered in full | Cost-sharing is based on type of service and where it is received. |
| **Prenatal Maternity** | Covered in full | 50% after deductible |
| **Routine Digital Rectal Exam / Prostate-Specific Antigen Test**<br>Recommended: For covered males age 40 and over. Frequency schedule applies. | Covered in full | 50% after deductible |
| **Colorectal Cancer Screening**<br>Recommended: For all members age 45 and over. Frequency schedule applies. | Covered in full | 50% after deductible |
| **Routine Eye and Hearing Screenings** | Paid as part of routine physical exam. | Paid as part of routine physical exam. |
| HEARING SERVICES | NETWORK CARE | OUT-OF-NETWORK CARE |
| **Hearing Exam** (by Specialist)<br>Coverage is limited to 1 exam every 24 months. | $60 copay deductible waived | 50% after deductible |
| **Hearing Aid**<br>Coverage is limited to 1 every 36 months up to a $3,000 maximum. | 20% deductible waived | 50% deductible waived |
| VISION SERVICES | NETWORK CARE | OUT-OF-NETWORK CARE |
| **Adult Routine Eye Exams (Refraction)**<br>Coverage is limited to 1 exam per calendar year. | 10% deductible waived | 50% after deductible |
| **Pediatric Routine Eye Exams (Refraction)**<br>Coverage is limited to 1 exam per calendar year age 0-19. | 10% deductible waived | Paid as in-network |
| **Adult Vision Hardware**<br>Coverage for vision supplies (eyeglass frames, prescription and contact lenses) is limited to $350 per year. | Covered in full | Paid as in-network |
| **Pediatric Vision Hardware**<br>Coverage is limited to 1 set of frames and 1 set of contact lenses or eyeglass lenses per calendar year age 0-19. | Covered in full | Paid as in-network |
| DIAGNOSTIC PROCEDURES | NETWORK CARE | OUT-OF-NETWORK CARE |
| **Outpatient Diagnostic Laboratory** | 30% after deductible | 50% after deductible |
| **Outpatient Diagnostic X-ray (except for Complex Imaging Services)** | 30% after deductible | 50% after deductible |

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| **Outpatient Diagnostic X-ray for Complex Imaging Services**<br>Including, but not limited to, MRI, MRA, PET and CT scans. Precertification required. | 30% after deductible | 80% after deductible |
| **Outpatient Diagnostic Laboratory Performed in a PCP Office Visit** | 30% after deductible | 50% after deductible |
| **Outpatient Diagnostic X-ray Performed in a PCP Office Visit (except for Complex Imaging Services)** | 30% after deductible | 50% after deductible |
| **Outpatient Diagnostic X-ray for Complex Imaging Services Performed in a PCP Office Visit**<br>Including, but not limited to, MRI, MRA, PET and CT scans. Precertification required. | 30% after deductible | 50% after deductible |
| **Outpatient Diagnostic Laboratory Performed in a Specialist Offic Visit** | 30% after deductible | 50% after deductible |
| **Outpatient Diagnostic X-ray Performed in a Specialist Offic Visit (except for Complex Imaging Services)** | 30% after deductible | 50% after deductible |
| **Outpatient Diagnostic X-ray for Complex Imaging Services Performed in a Specialist Offic Visit**<br>Including, but not limited to, MRI, MRA, PET and CT scans. Precertification required. | 30% after deductible | 50% after deductible |
| EMERGENCY MEDICAL CARE | NETWORK CARE | OUT-OF-NETWORK CARE |
| **Urgent Care Provider** | $60 copay deductible waived | 50% after deductible |
| **Non-Urgent Use of Urgent Care Provider** | Not covered | Not covered |
| **Emergency Room**<br>Copay waived if admitted. | $200 copayment after deductible, then 30% | Paid as in-network |
| **Non-Emergency Care in an Emergency Room** | Not covered | Not covered |
| **Emergency Use of Ambulance** | 30% after deductible | Paid as in-network |
| **Non-Emergency Use of Ambulance** | 30% after deductible | Paid as in-network |
| HOSPITAL CARE | NETWORK CARE | OUT-OF-NETWORK CARE |
| **Inpatient Coverage**<br>Including maternity (prenatal, delivery and postpartum) and transplants. | 30% after deductible | 80% after deductible |
| **Outpatient Surgery**<br>Provided in an outpatient hospital department or freestanding surgical facility. | 30% after deductible | 80% after deductible |
| **Colonoscopy**<br>(non-preventive) | Cost-sharing is based on type of service and where it is received. | Cost-sharing is based on type of service and where it is received. |
| **Transplants**<br>Coverage at the in-network cost share is limited to IOE only. Non-IOE par facilities and out-of-network facilities are covered at out-of-network cost sharing. | 30% after deductible | 80% after deductible |
| BEHAVIORAL HEALTH SERVICES (MENTAL HEALTH and SUBSTANCE RELATED DISORDERS) | NETWORK CARE | OUT-OF-NETWORK CARE |
| **Inpatient Services** | 30% after deductible | 80% after deductible |
| **Outpatient Office Visits** | Covered in full | 50% after deductible |

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| **Physician or Behavioral Health Provider Telemedicine Consultations** | Covered in full | 50% after deductible |
| **Telemedicine Provider Consultations** | Covered in full | Not Covered |
| **Other Outpatient Services** (e.g,:partial hospitalization treatment, intensive outpatient programs) | 30% after deductible | 50% after deductible |
| THERAPY SERVICES | NETWORK CARE | OUT-OF-NETWORK CARE |
| **Outpatient Chiropractic/Spinal Manipulation Therapy** Accumulation and Cost Share- Coverage is limited to 12 visits per calendar year, separate from habilitation and includes all outpatient places of service for Chiro. | $60 copay deductible waived | 50% after deductible |
| **Outpatient Short-Term Rehabilitation - Physical Therapy** Accumulation and Cost Share- Coverage is limited to 45 visits per calendar year PT, OT, ST and MT combined, separate from habilitation and includes all outpatient places of service for PT, OT, ST, and MT. | $60 copay deductible waived | 50% after deductible |
| **Outpatient Short-Term Rehabilitation - Occupational Therapy** Accumulation and Cost Share- Coverage is limited to 45 visits per calendar year PT, OT, ST and MT combined, separate from habilitation and includes all outpatient places of service for PT, OT, ST, and MT. | $60 copay deductible waived | 50% after deductible |
| **Outpatient Short-Term Rehabilitation - Speech Therapy** Accumulation and Cost Share- Coverage is limited to 45 visits per calendar year PT, OT, ST and MT combined, separate from habilitation and includes all outpatient places of service for PT, OT, ST, and MT. | $60 copay deductible waived | 50% after deductible |
| **Habilitative Physical, Occupational and Speech Therapy** | 30% after deductible | 50% after deductible |
| **Autism Physical, Occupational and Speech Therapy** | 30% after deductible | 50% after deductible |
| **Autism Behavioral Therapy** | Covered in full | 50% after deductible |
| **Autism Applied Behavior Analysis** | 30% after deductible | 50% after deductible |
| OTHER SERVICES AND PLAN DETAILS | NETWORK CARE | OUT-OF-NETWORK CARE |
| **Skilled Nursing Facility** | 30% after deductible | 80% after deductible |
| **Home Health Care** Coverage is limited to 130 visits per calendar year. | 30% after deductible | 50% after deductible |
| **Infusion Therapy** Provided in the home or physician's office. | $60 copay deductible waived | 50% after deductible |
| **Infusion Therapy** Provided in the outpatient hospital department or freestanding facility. | 30% after deductible | 50% after deductible |
| **Gene-Based, Cellular and Other Innovative Therapies (GCIT)** Coverage at the in-network cost share is limited to GCIT designated only. Non GCIT designated par facilities and out-of-network facilities are covered at out-of-network cost sharing. | Cost-sharing is based on type of service and where it is received. | Cost-sharing is based on type of service and where it is received. |
| **Hospice Care - Inpatient** | 30% after deductible | 80% after deductible |
| **Hospice Care Outpatient** | 30% after deductible | 50% after deductible |
| **Private Duty Nursing -**Outpatient | Not covered | Not covered |
| **Acupuncture** Coverage is limited to 12 visits per calendar year. | $35 copay deductible waived | 50% after deductible |

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| **Durable Medical Equipment** | 50% after deductible | 50% after deductible |
| **Diabetic Supplies not obtainable at a pharmacy** | Covered same as any other medical expense. | Covered same as any other medical expense. |
| **Bariatric Surgery** | Not covered | Not covered |
| FAMILY PLANNING | NETWORK CARE | OUT-OF-NETWORK CARE |
| **Infertility Treatment - Diagnostic only**<br>Covered only for the diagnosis and treatment of the underlying medical condition. | Cost-sharing is based on type of service and where it is received. | 50% after deductible |
| **Infertility Treatment - Artificial Insemination or Ovulation Induction** | Not covered | Not covered |
| **Advanced Reproductive Technology.** Including, but not limited to, GIFT, ZIFT, IVF, ICSI, ovum microsurgery and cryopreserved embryo transfers. | Not covered | Not covered |
| **Vasectomy** | Cost-sharing is based on type of service and where it is received. | 50% after deductible |
| **Tubal Ligation** | Covered in full | 50% after deductible |
| PEDIATRIC DENTAL SERVICES | NETWORK CARE | OUT-OF-NETWORK CARE |
| **Preventive & Diagnostic** (includes exams, cleanings, x-rays, fluoride, sealants)<br>Coverage is limited to 2 exams every 12 months age 0-19. | Covered in full after deductible | 30% after deductible |
| **Basic** (includes space maintainers, fillings, anesthesia, denture adjustments)<br>Coverage is limited to age 0-19. | 30% after deductible | 50% after deductible |
| **Major** (includes crowns, endodontics, periodontics, oral surgery, dentures, bridges)<br>Coverage is limited to age 0-19. | 50% after deductible | 50% after deductible |
| **Orthodontia** (limited to medically necessary orthodontia)<br>Coverage is limited to age 0-19. | 50% after deductible | 50% after deductible |
| PHARMACY DEDUCTIBLE | NETWORK CARE | OUT-OF-NETWORK CARE |
| **Prescription drug calendar year deductible** | Not applicable | Not applicable |
| PHARMACY - PRESCRIPTION DRUG BENEFITS | NETWORK CARE | OUT-OF-NETWORK CARE |
| **Generic Drugs** | | |
| **Retail** | $10 copayment | Generic: 20% |
| **MailOrder** | Generic: $25 copayment | Generic: 20% |
| **Preferred Brand Drugs** | | |
| **Retail** | $45 copayment | 20% |
| **MailOrder** | $112.50 copayment | 20% |
| **Non-Preferred Drugs** | | |
| **Retail** | $85 copayment | 20% |
| **MailOrder** | $212.50 copayment | 20% |
| **Speciality Drugs** | | |
| **Preferred Speciality** | 30% up to $300 | 20% |
| **Non-Preferred Speciality** | 40% up to $500 | 20% |
| **Pharmacy Day Supply and Requirements** | | |
| **Retail :**<br>Up to a 90 day supply<br>For a 30 day supply you will be responsible for the Retail Drug copay.<br>For a 31-90 day supply you will be responsible for the Mail Order Drug copay. | | |
| **Mail Order :**<br>A 31-90 day supply from CVS Caremark Mail Service PharmacyTM at the Mail Order Drug copay. | | |
| **Specialty :**<br>Up to a 30 day supply | | |

**Full Choose Generics -** If the member or the physician requests brand when generic is available, the member pays the applicable cost-sharing plus the cost difference between the generic and brand. Penalty does not apply to integrated MOOP.

**Precertification -** Included. See formulary for details.

**Step Therapy -** Included. See formulary for details.

**Pharmacy Plan includes:**

Diabetic supplies obtainable from a pharmacy (Including: needles, syringes, test strips, lancets and alcohol swabs - available at retail or mail order).

**Performance Enhancing Drugs -** Not Covered

Affordable Care Act mandated female contraceptives and preventive medications covered 100% in-network.

Preventive and seasonal vaccinations covered 100% in-network.

**In-Network and Out-of-Network Providers**

*We cover the cost of services based on whether doctors are "in-network" or "out-of-network". We want to help you understand how much Aetna pays for your out-of-network care. At the same time, we want to make it clear how much more you will need to pay for this "out-of-network" care.

You may choose a provider (doctor or hospital) in our network. You may choose to visit an out-of-network provider. If you choose a provider who is out-of-network, your Aetna health plan may pay some of that provider 's bill. Most of the time, you will pay a lot more money out of your own pocket if you choose to use an out-of-network doctor or hospital.

Your doctor sets his or her own rate to charge you. It may be higher - sometimes much higher - than what your Aetna plan "recognizes". Your non-network doctor may bill you for the dollar amount that Aetna doesn't "recognize". You must also pay any copayments, coinsurance and deductibles under your plan. No dollar amount above the "recognized charge" counts toward your deductible or out-of-pocket maximums.

To learn more about how we pay out-of-network benefits visit **www.aetna.com**. Type "how Aetna pays" in the search box.

You can avoid these extra costs by getting your care from Aetna's broad network of health care providers. Go to **www.aetna.com** and click on "Find a Doctor" on the left side of the page. If you are already a member, sign on to your Aetna member site.

This applies when you choose to get care out-of-network. When you have no choice (for example: emergency room visit after a car accident, or for other emergency services), we will pay the bill as if you got care in the network. You pay cost sharing and deductibles for your in-network level of benefits. Contact Aetna if your provider asks you to pay more. You are not responsible for any outstanding balance billed by your providers for emergency services beyond your cost sharing and deductibles.

**What's Not Covered**

This plan does not cover all health care expenses and includes exclusions and limitations. Members should refer to their plan documents to determine which health care services are covered and to what extent. The following is a partial 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 purchased.

- All medical or hospital services not specifically covered in or which are limited or excluded in the plan documents
- Charges related to any eye surgery mainly to correct refractive errors
- Cosmetic surgery, including breast reduction
- Custodial care
- Adult dental care and x-rays
- Donor egg retrieval
- Experimental and investigational procedures
- Immunizations for travel or work
- Infertility services, including, but not limited to, 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
- Non-medically necessary services or supplies
- Orthotics except as specified in the plan
- Over-the-counter medications and supplies
- Reversal of sterilization
- Services for the treatment of sexual dysfunction or inadequacies, including therapy, supplies, counseling and prescription drugs
- Special duty nursing
- Weight reduction programs, or dietary supplements

This material is for informational purposes only and is neither an offer of coverage nor medical advice. It contains only a partial, general description of plan benefits or programs and does not constitute a contract. Aetna does not provide health care services and, therefore, cannot guarantee results or outcomes. Consult the plan documents (i.e. Group Insurance Certificate and/or Group Policy) to determine governing contractual provisions, including procedures, exclusions and limitation relating to the plan. CVS Caremark® Mail Service Pharmacy and Aetna are part of the CVS Health family of companies. Preferred providers and vendors are independent contractors in private practice and are neither employees nor agents of Aetna or its affiliates. The availability of any particular provider cannot be guaranteed, and provider network composition is subject to change without notice.

If your plan covers outpatient prescription drugs, your plan includes a drug formulary (preferred drug list). A formulary is a list of prescription drugs generally covered under your prescription drug benefits plan on a preferred basis subject to applicable limitations and conditions. Your pharmacy benefit is generally limited to the drugs listed on the formulary. The medications listed on the formulary are subject to change in accordance with applicable state law. For information regarding how medications are reviewed and selected for the formulary, formulary information, and information about other pharmacy programs such as precertification and step therapy, please refer to our website at **www.aetna.com**, or the Aetna Medication Formulary Guide. Members should consult with their treating physicians regarding questions about specific medications. Refer to your plan documents or contact Member Services for information regarding the terms and limitations of coverage.

While this information is believed to be accurate as of the print date, it is subject to change.

In case of emergency, call 911 or your local emergency hotline, or go directly to an emergency care facility.

Plans are provided by Aetna Health Inc.

For more information about Aetna plans, refer to **www.aetna.com**.