



**PLAN DESIGN AND BENEFITS - AK PPO 1500 80/60 HSA TIF (2018)**

**AK Group Business 51-100 Employees**

PLAN FEATURES	NETWORK CARE	OUT-OF-NETWORK CARE
<b>Primary Care Physician Selection</b>	Not applicable	Not applicable
<b>Deductible</b> (per calendar year)	\$1,500 Individual \$3,000 Family	\$1,500 Individual \$3,000 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.		
Once the family deductible is met, all family members will be considered as having met their deductible for the remainder of the calendar year.		
<b>Member Coinsurance</b> (applies to all expenses unless otherwise stated)	20%	40%
<b>Out-of-Pocket (OOP) Maximum</b> (per calendar year, includes deductible)	\$2,500 Individual \$5,000 Family	\$4,000 Individual \$8,000 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 may be used to satisfy the out of pocket maximum.		
Once the family payment limit is met, all family members will be considered as having met their payment limit for the remainder of the calendar year.		
<b>Payment for Out-of-Network Care*</b>	Not applicable	Professional: Fair Health 80% Facility: Fair Health 80%
<b>Certification Requirements</b>		
Certification for certain types of out-of-network care must be obtained to avoid a reduction in benefits paid for that care. Certification for hospital admissions, treatment facility admissions, skilled nursing facility admissions, home health care, and hospice care is required. If the necessary certification is not received, payment for services will be reduced by 50% up to \$400 per occurrence		
<b>Referral Requirement</b>	Not applicable	Not applicable
<b>Benefit Limitations --</b> For any service or supply that is subject to a maximum visit, day, or dollar limitation, such services or supplies accumulate toward both the participating provider and non-participating provider benefit limits under this plan.		
PHYSICIAN SERVICES	NETWORK CARE	OUT-OF-NETWORK CARE
<b>Office Visits to Non-Specialist</b>	20% after deductible	20% after deductible
Includes services of an internist, general physician, family practitioner or pediatrician for diagnosis and treatment of an illness or injury.		
<b>Specialist Office Visits</b>	20% after deductible	20% after deductible
<b>Walk-in Clinics</b>	20% after deductible	20% after deductible
Walk-in clinics are network, free-standing health care facilities. They are an alternative to a doctor'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 an outpatient department of a hospital, is considered a walk-in clinic.		
<b>Maternity - Delivery and Post-Partum Care</b>	20% after deductible	20% after deductible
<b>Allergy Testing</b> (given by a physician)	20% after deductible	20% after deductible
<b>Allergy Injections</b> (not given by a physician)	20% after deductible	20% after deductible
PREVENTIVE CARE	NETWORK CARE	OUT-OF-NETWORK CARE
Preventive care services are covered in accordance with Health Care Reform.		
<b>Routine Adult Physical Exams and Immunizations</b> Coverage is limited to 1 exam every 12 months.	Covered in full	Covered in full
<b>Well Child Exams and Immunizations</b> 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	Covered in full
<b>Routine Gynecological Exams</b> Includes Pap smear, HPV screening and related lab fees. Coverage is limited to 1 exam every 12 months.	Covered in full	Covered in full

<b>Routine Mammograms</b> For covered females age 40 and over. Frequency schedule applies.	Covered in full	Covered in full
<b>Women's Health</b> 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	Member cost sharing is based on the type of service performed and the place of service where it is rendered.
<b>Prenatal Maternity</b>	Covered in full	Covered in full
<b>Routine Digital Rectal Exam / Prostate-Specific Antigen Test</b> For covered males age 40 and over. Frequency schedule applies.	Covered in full	Covered in full
<b>Colorectal Cancer Screening</b> Sigmoidoscopy and Double Contrast Barium Enema - 1 every 5 years for all members age 50 and over. Preventive Colonoscopy - 1 every 10 years for all members age 50 and over. Fecal Occult Blood Testing - 1 every year for all members age 50 and over.	Covered in full	Covered in full
<b>Routine Eye and Hearing Screenings</b>	Paid as part of routine physical exam.	Paid as part of routine physical exam.
<b>HEARING SERVICES</b>	<b>NETWORK CARE</b>	<b>OUT-OF-NETWORK CARE</b>
<b>Hearing Exam</b> (by Specialist) Coverage is limited to 1 exam every 36 months.	20% after deductible	20% after deductible
<b>Hearing Aid</b> Coverage is limited to 1 every 36 months up to a \$1,000 maximum.	20% after deductible	20% after deductible
<b>VISION SERVICES</b>	<b>NETWORK CARE</b>	<b>OUT-OF-NETWORK CARE</b>
<b>Adult Routine Eye Exams (Refraction)</b> Coverage is limited to 1 exam per calendar year.	10% after deductible	10% after deductible
<b>Pediatric Routine Eye Exams (Refraction)</b> Coverage is limited to 1 exam per calendar year.	10% after deductible	10% after deductible
<b>Adult Vision Hardware</b> Coverage for vision supplies (eyeglass frames, prescription and contact lenses) is limited to \$350 per year.	Covered in full after deductible	Covered in full after deductible
<b>Pediatric Vision Hardware</b> Coverage for vision supplies (frames, lenses and contacts) is limited to a \$350 allowance per calendar year.	Covered in full after deductible	Covered in full after deductible
<b>DIAGNOSTIC PROCEDURES</b>	<b>NETWORK CARE</b>	<b>OUT-OF-NETWORK CARE</b>
<b>Outpatient Diagnostic Laboratory</b>	20% after deductible	40% after deductible
<b>Outpatient Diagnostic X-ray (except for Complex Imaging Services)</b>	20% after deductible	40% after deductible
<b>Outpatient Diagnostic X-ray for Complex Imaging Services</b> Including, but not limited to, MRI, MRA, PET and CT scans. Precertification required.	20% after deductible	40% after deductible
<b>EMERGENCY MEDICAL CARE</b>	<b>NETWORK CARE</b>	<b>OUT-OF-NETWORK CARE</b>
<b>Urgent Care Provider</b> (Benefit Availability may vary by location.)	20% after deductible	20% after deductible
<b>Non-Urgent Use of Urgent Care Provider</b>	Not covered	Not covered
<b>Emergency Room</b>	20% after deductible	Paid as in-network

<b>Non-Emergency care in an Emergency Room</b>	Not covered	Not covered
<b>Emergency Ambulance</b>	20% after deductible	Paid as in-network
<b>Non-Emergency Ambulance</b>	20% after deductible	Paid as in-network
<b>HOSPITAL CARE</b>	<b>NETWORK CARE</b>	<b>OUT-OF-NETWORK CARE</b>
<b>Inpatient Coverage</b> Including maternity (prenatal, delivery and postpartum) and transplants.	20% after deductible	40% after deductible
<b>Outpatient Surgery</b> Provided in an outpatient hospital department or freestanding surgical facility.	20% after deductible	40% after deductible
<b>Colonoscopy</b> (non-preventive)	Member cost sharing is based on the type of service performed and the place rendered.	Member cost sharing is based on the type of service performed and the place rendered.
<b>Transplants</b> 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.	20% after deductible	40% after deductible
<b>MENTAL HEALTH and SUBSTANCE USE SERVICES</b>	<b>NETWORK CARE</b>	<b>OUT-OF-NETWORK CARE</b>
<b>Inpatient Mental Health &amp; Substance Use Services</b>	20% after deductible	40% after deductible
<b>Outpatient Office Visit Mental Health &amp; Substance Use Services</b>	20% after deductible	20% after deductible
<b>Outpatient Other Mental Health &amp; Substance Use Services</b> (e.g.:partial hospitalization programs, intensive outpatient programs, applied behavior analysis)	20% after deductible	20% after deductible
<b>OTHER SERVICES AND PLAN DETAILS</b>	<b>NETWORK CARE</b>	<b>OUT-OF-NETWORK CARE</b>
<b>Skilled Nursing Facility</b> Coverage is limited to 60 days per calendar year.	20% after deductible	40% after deductible
<b>Home Health Care</b> Coverage is limited to 130 visits per calendar year. 1 visit equals a period of 4 hours or less.	20% after deductible	40% after deductible
<b>Infusion Therapy</b> Provided in the home or physician's office.	20% after deductible	20% after deductible
<b>Infusion Therapy</b> Provided in the outpatient hospital department of freestanding facility.	20% after deductible	40% after deductible
<b>Inpatient Hospice Care</b>	20% after deductible	40% after deductible
<b>Outpatient Hospice Care</b>	20% after deductible	40% after deductible
<b>Private Duty Nursing -Outpatient</b>	Not covered	Not covered
<b>Outpatient Short-Term Rehabilitation - Physical Therapy</b> If provided in the outpatient hospital department, paid under outpatient hospital benefit.  Coverage is limited to 45 visits per calendar year PT/OT/ST/MT combined, rehabilitation & habilitation separate.	20% after deductible	20% after deductible
<b>Outpatient Short-Term Rehabilitation - Occupational Therapy</b> If provided in the outpatient hospital department, paid under outpatient hospital benefit.  Coverage is limited to 45 visits per calendar year PT/OT/ST/MT combined, rehabilitation & habilitation separate.	20% after deductible	20% after deductible

<b>Outpatient Short-Term Rehabilitation - Speech Therapy</b> If provided in the outpatient hospital department, paid under outpatient hospital benefit.  Coverage is limited to 45 visits per calendar year PT/OT/ST/MT combined, rehabilitation & habilitation separate.	20% after deductible	20% after deductible
<b>Outpatient Chiropractic</b> If provided in the outpatient hospital department, paid under outpatient hospital benefit.  Coverage is limited to 12 visits per calendar year.	20% after deductible	20% after deductible
<b>Acupuncture</b> Coverage is limited to 12 visits per calendar year.	20% after deductible	20% after deductible
<b>Durable Medical Equipment</b>	20% after deductible	40% after deductible
<b>Diabetic Supplies not obtainable at a pharmacy</b>	Covered same as any other medical expense.	Covered same as any other medical expense.
<b>FAMILY PLANNING</b>	<b>NETWORK CARE</b>	<b>OUT-OF-NETWORK CARE</b>
<b>Infertility Treatment - Diagnostic only</b> Covered only for the diagnosis and treatment of the underlying medical condition.	Member cost sharing is based on the type of service performed and the place rendered.	20% after deductible
<b>Infertility Treatment - Artificial Insemination or Ovulation Induction</b>	Not covered	Not covered
<b>Advanced Reproductive Technology.</b> Including, but not limited to, GIFT, ZIFT, IVF, ICSI, ovum microsurgery and cryopreserved embryo transfers.	Not covered	Not covered
<b>Voluntary Sterilization - Vasectomy</b>	20% after deductible	40% after deductible
<b>Voluntary Sterilization - Tubal Ligation</b>	Covered in full	40% after deductible
<b>PEDIATRIC DENTAL SERVICES</b>	<b>NETWORK CARE</b>	<b>OUT-OF-NETWORK CARE</b>
<b>Preventive &amp; Diagnostic</b> (includes exams, cleanings, x-rays, fluoride, sealants)	Not covered	Not covered
<b>Basic</b> (includes space maintainers, fillings, anesthesia, denture adjustments)	Not covered	Not covered
<b>Major</b> (includes crowns, endodontics, periodontics, oral surgery, dentures, bridges)	Not covered	Not covered
<b>Orthodontia</b> (limited to medically necessary orthodontia)	Not covered	Not covered
<b>PHARMACY DEDUCTIBLE</b>	<b>NETWORK CARE</b>	<b>OUT-OF-NETWORK CARE</b>
<b>Prescription drug calendar year deductible</b>	Prescription drugs purchased at a network pharmacy are subject to the in-network medical deductible which must be satisfied before any prescription drug benefits are paid.	Prescription drugs purchased at a non-network pharmacy are subject to the non-network medical deductible which must be satisfied before any prescription drug benefits are paid.
<b>PHARMACY - PRESCRIPTION DRUG BENEFITS</b>	<b>NETWORK CARE</b>	<b>OUT-OF-NETWORK CARE</b>
<b>Retail</b> Up to a 90 day supply		
<b>Generic Drugs</b>	\$15 copayment after deductible	50% after deductible
<b>Preferred Brand Drugs</b>	\$45 copayment after deductible	50% after deductible
<b>Non-Preferred Drugs</b>	Generic & Brand: \$70 copayment after deductible	Generic & Brand: 50% after deductible
<b>Specialty Drugs</b> Includes self-injectable, infused and oral specialty drugs (retail and mail order up to a 30-day supply, excludes insulin).	30% up to \$250 after deductible	50% after deductible

<b>Mail Order Delivery</b>	When you fill your prescription by mail order, you may save money (for your refills for up to a 31-90 day supply) when compared to the cost to purchase your prescriptions at your local retail pharmacy.	
<b>Generic Drugs</b>	\$30 copayment after deductible	Not covered
<b>Preferred Brand Drugs</b>	\$90 copayment after deductible	Not covered
<b>Non-Preferred Drugs</b>	Generic & Brand: \$140 copayment after deductible	Not covered
<b>Specialty Drugs</b> <b>Includes self-injectable, infused and oral specialty drugs</b>	30% up to \$250 after deductible	Not covered
<b>Specialty CareRx<sup>SM</sup> -</b> For more information, please go to <a href="http://www.aetnaspecialtycarerx.com">www.aetnaspecialtycarerx.com</a>		

**Choose Generic** - Included. See Aetna Formulary for details.

If the physician prescribes or the member requests a covered brand name prescription drug when a generic prescription drug equivalent is available, the member will pay the difference in cost between the brand name prescription drug and the generic prescription drug equivalent plus the applicable cost-sharing. The cost difference between the generic and brand does not count toward the Out of Pocket Maximum.

**Precertification** - Included. See Aetna Formulary for details.

**Step Therapy** - Included. See Aetna 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).

Coverage is excluded for lifestyle/performance drugs.

Formulary generic FDA-approved Womens Contraceptives 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](http://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](http://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 Navigator 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. With the exception of Aetna Rx Home Delivery, all preferred providers and vendors are independent contractors in private practice and are neither employees nor agents of Aetna or its affiliates. Aetna Rx Home Delivery, LLC, is a subsidiary of Aetna Inc. The availability of any particular provider cannot be guaranteed, and provider network composition is subject to change without notice.

Certain services require precertification, or prior approval of coverage. Failure to precertify for these services may lead to substantially reduced benefits or denial of coverage. Some of the benefits requiring precertification may include, but are not limited to, inpatient hospital, inpatient mental health, inpatient skilled nursing, outpatient surgery, substance abuse (detoxification, inpatient and outpatient rehabilitation). When the Member's preferred provider is coordinating care, the preferred provider will obtain the precertification. Precertification requirements may vary.

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](http://www.aetna.com), or the Aetna Medication Formulary Guide. 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. In addition, in circumstances where your prescription plan uses copayments or coinsurance calculated on a percentage basis or a deductible, use of formulary drugs may not necessarily result in lower costs for the member. 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.

Aetna Rx Home Delivery refers to Aetna Rx Home Delivery, LLC, a subsidiary of Aetna, Inc., that is a licensed pharmacy providing mail-order pharmacy services. Aetna's negotiated charge with Aetna Rx Home Delivery may be higher than Aetna Rx Home Delivery's cost of purchasing drugs and providing mail-order pharmacy services.

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.

Benefits are provided by Aetna Life Insurance Company (ALIC).

For more information about Aetna plans, refer to [www.aetna.com](http://www.aetna.com).