aetna

PLAN DESIGN AND BENEFITS - AK PPO Plus 1500 80/60/50 (2018)

AK Group Business 51-100 Employees

PLAN FEATURES	NETWORK CARE DESIGNATED PROVIDER	NETWORK CARE NON-DESIGNATED PROVIDER	OUT-OF-NETWORK CARE
Primary Care Physician Selection	Not applicable	Not applicable	Not applicable
Deductible (per calendar year)	$1,500 Individual $3,000 Family	$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 not 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.			
Member Coinsurance (applies to all expenses unless otherwise stated)	20%	40%	50%
Out-of-Pocket (OOP) Maximum (per calendar year, includes deductible)	$5,000 Individual $10,000 Family	$5,000 Individual $10,000 Family	$10,000 Individual $20,000 Family
Y (Tier1/2 only)			
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.			
No one family member may contribute more than the individual out-of-pocket maximum amount to the family out-of-pocket maximum.			
Payment for Out-of-Network Care*	Not applicable	Not applicable	Professional: Fair Health 80% Facility: Fair Health 80%
Certification Requirements			
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			
Referral Requirement	Not applicable	Not applicable	Not applicable
Benefit Limitations -- 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 DESIGNATED PROVIDER	NETWORK CARE NON-DESIGNATED PROVIDER	OUT-OF-NETWORK CARE
Office Visits to Non-Specialist	$30 copay deductible waived	$50 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.			
Specialist Office Visits	$40 copay deductible waived	$60 copay deductible waived	50% after deductible
Walk-in Clinics	$30 copay deductible waived	Paid at the designated level	50% 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.			
Maternity - Delivery and Post-Partum Care	20% after deductible	40% after deductible	50% after deductible
Allergy Testing (given by a physician)	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.	50% after deductible
Allergy Injections (not given by a physician)	20% after deductible	40% after deductible	50% after deductible
PREVENTIVE CARE	NETWORK CARE DESIGNATED PROVIDER	NETWORK CARE NON-DESIGNATED PROVIDER	OUT-OF-NETWORK CARE

Preventive care services are covered in accordance with Health Care Reform.			
Routine Adult Physical Exams and Immunizations Coverage is limited to 1 exam every 12 months.	Covered in full	Covered in full	50% after deductible
Well Child Exams and Immunizations 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	50% after deductible
Routine Gynecological Exams Includes Pap smear, HPV screening and related lab fees. Coverage is limited to 1 exam every 12 months.	Covered in full	Covered in full	50% after deductible
Routine Mammograms For covered females age 40 and over. Frequency schedule applies.	Covered in full	Covered in full	50% 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; Limitations may apply.	Covered in full	Covered in full	Member cost sharing is based on the type of service performed and the place of service where it is rendered.
Prenatal Maternity	Covered in full	Covered in full	50% after deductible
Routine Digital Rectal Exam / Prostate-Specific Antigen Test For covered males age 40 and over. Frequency schedule applies.	Covered in full	Covered in full	50% after deductible
Colorectal Cancer Screening 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	50% after deductible
Routine Eye and Hearing Screenings	Paid as part of routine physical exam.	Paid as part of routine physical exam.	Paid as part of routine physical exam.
HEARING SERVICES	NETWORK CARE DESIGNATED PROVIDER	NETWORK CARE NON-DESIGNATED PROVIDER	OUT-OF-NETWORK CARE
Hearing Exam (by Specialist) Coverage is limited to 1 exam every 36 months.	20% deductible waived	20% deductible waived	20% deductible waived
Hearing Aid Coverage is limited to 1 every 36 months up to a $1,000 maxiumum.	20% deductible waived	20% deductible waived	20% deductible waived
VISION SERVICES	NETWORK CARE DESIGNATED PROVIDER	NETWORK CARE NON-DESIGNATED PROVIDER	OUT-OF-NETWORK CARE
Adult Routine Eye Exams (Refraction) Coverage is limited to 1 exam per calendar year.	10% deductible waived	10% deductible waived	10% deductible waived
Pediatric Routine Eye Exams (Refraction) Coverage is limited to 1 exam per calendar year.	10% deductible waived	10% deductible waived	10% deductible waived
Adult Vision Hardware Coverage for vision supplies (eyeglass frames, prescription and contact lenses) is limited to $350 per year.	Covered in full	Covered in full	Covered in full

Pediatric Vision Hardware Coverage for vision supplies (frames, lenses and contacts) is limited to a $350 allowance per calendar year.	Covered in full	Covered in full	Covered in full
DIAGNOSTIC PROCEDURES	NETWORK CARE DESIGNATED PROVIDER	NETWORK CARE NON-DESIGNATED PROVIDER	OUT-OF-NETWORK CARE
Outpatient Diagnostic Laboratory	20% after deductible	40% after deductible	50% after deductible
Outpatient Diagnostic X-ray (except for Complex Imaging Services)	20% after deductible	40% after deductible	50% after deductible
Outpatient Diagnostic X-ray for Complex Imaging Services Including, but not limited to, MRI, MRA, PET and CT scans. Precertification required.	20% after deductible	40% after deductible	50% after deductible
EMERGENCY MEDICAL CARE	NETWORK CARE DESIGNATED PROVIDER	NETWORK CARE NON-DESIGNATED PROVIDER	OUT-OF-NETWORK CARE
Urgent Care Provider (Benefit Availability may vary by location.)	$50 copay deductible waived	$50 copay deductible waived	50% after deductible
Non-Urgent Use of Urgent Care Provider	Not covered	Not covered	Not covered
Emergency Room Copay waived if admitted.	$150 copayment deductible waived, then 20%	Paid at the designated level	Paid at the designated level
Non-Emergency care in an Emergency Room	Not covered	Not covered	Not covered
Emergency Ambulance	20% after deductible	Paid at the designated level	Paid at the designated level
Non-Emergency Ambulance	20% after deductible	Paid at the designated level	Paid at the designated level
HOSPITAL CARE	NETWORK CARE DESIGNATED PROVIDER	NETWORK CARE NON-DESIGNATED PROVIDER	OUT-OF-NETWORK CARE
Inpatient Coverage Including maternity (prenatal, delivery and postpartum) and transplants.	20% after deductible	40% after deductible	50% after deductible
Outpatient Surgery Provided in an outpatient hospital department or freestanding surgical facility.	20% after deductible	40% after deductible	50% after deductible
Colonoscopy (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.	Member cost sharing is based on the type of service performed and the place rendered.
Transplants 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	50% after deductible
MENTAL HEALTH and SUBSTANCE USE SERVICES	NETWORK CARE DESIGNATED PROVIDER	NETWORK CARE NON-DESIGNATED PROVIDER	OUT-OF-NETWORK CARE
Inpatient Mental Health & Substance Use Services	20% after deductible	40% after deductible	50% after deductible
Outpatient Office Visit Mental Health & Substance Use Services	$40 copay deductible waived	$60 copay deductible waived	50% after deductible

Outpatient Othert Mental Health & Substance Use Services (e.g,:partial hospitalization programs, intensive outpatient programs, applied behavior analysis)	20% after deductible	40% after deductible	50% after deductible
OTHER SERVICES AND PLAN DETAILS	NETWORK CARE DESIGNATED PROVIDER	NETWORK CARE NON-DESIGNATED PROVIDER	OUT-OF-NETWORK CARE
Skilled Nursing Facility Coverage is limited to 60 days per calendar year.	20% after deductible	40% after deductible	50% after deductible
Home Health Care 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	50% after deductible
Infusion Therapy Provided in the home or physician's office.	20% after deductible	40% after deductible	50% after deductible
Infusion Therapy Provided in the outpatient hospital department of freestanding facility.	20% after deductible	40% after deductible	50% after deductible
Inpatient Hospice Care	20% after deductible	40% after deductible	50% after deductible
Outpatient Hospice Care	20% after deductible	40% after deductible	50% after deductible
Private Duty Nursing - Outpatient	Not covered	Not covered	Not covered
Outpatient Short-Term Rehabilitation - Physical Therapy 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.	$40 copay deductible waived	$60 copay deductible waived	50% after deductible
Outpatient Short-Term Rehabilitation - Occupational Therapy 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.	$40 copay deductible waived	$60 copay deductible waived	50% after deductible
Outpatient Short-Term Rehabilitation - Speech Therapy 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.	$40 copay deductible waived	$60 copay deductible waived	50% after deductible
Outpatient Chiropractic If provided in the outpatient hospital department, paid under outpatient hospital benefit. Coverage is limited to 12 visits per calendar year.	$40 copay deductible waived	$60 copay deductible waived	50% after deductible
Acupuncture Coverage is limited to 12 visits per calendar year.	$40 copay deductible waived	$60 copay deductible waived	50% after deductible
Durable Medical Equipment	20% after deductible	40% 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.	Covered same as any other medical expense.

FAMILY PLANNING	NETWORK CARE DESIGNATED PROVIDER	NETWORK CARE NON-DESIGNATED PROVIDER	OUT-OF-NETWORK CARE
Infertility Treatment - Diagnostic only 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.	Member cost sharing is based on the type of service performed and the place rendered.	50% after deductible
Infertility Treatment - Artificial Insemination or Ovulation Induction	Not covered	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	Not covered
Voluntary Sterilization - Vasectomy	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.	50% after deductible
Voluntary Sterilization - Tubal Ligation	Covered in full	Covered in full	50% after deductible
PEDIATRIC DENTAL SERVICES	NETWORK CARE DESIGNATED PROVIDER	NETWORK CARE NON-DESIGNATED PROVIDER	OUT-OF-NETWORK CARE
Preventive & Diagnostic (includes exams, cleanings, x-rays, fluoride, sealants)	Not covered	Not covered	Not covered
Basic (includes space maintainers, fillings, anesthesia, denture adjustments)	Not covered	Not covered	Not covered
Major (includes crowns, endodontics, periodontics, oral surgery, dentures, bridges)	Not covered	Not covered	Not covered
Orthodontia (limited to medically necessary orthodontia)	Not covered	Not covered	Not covered

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
Retail Up to a 90 day supply		
Generic Drugs	$20 copayment	50%
Preferred Brand Drugs	$30 copayment	50%
Non-Preferred Drugs	Generic & Brand: $45 copayment	Generic & Brand: 50%
Specialty Drugs **Includes self-injectable, infused and oral specialty drugs** (retail and mail order up to a 30-day supply, excludes insulin).	30% up to $250	50%
Mail Order Delivery	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.	
Generic Drugs	$40 copayment	Not covered
Preferred Brand Drugs	$60 copayment	Not covered
Non-Preferred Drugs	Generic & Brand: $90 copayment	Not covered
Specialty Drugs **Includes self-injectable, infused and oral specialty drugs**	30% up to $250	Not covered
Specialty CareRx[SM] - For more information, please go to **www.aetnaspecialtycarerx.com**		

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**. 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 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**, 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**.

FORM #: 14.35.305.1A (9/17) Print Date:10-04-2017 TPID: 14039534