



PLAN DESIGN AND BENEFITS - AK Silver PPO 3000 80/50 (2019)

AK Group Business 1-50 Employees

| PLAN FEATURES | NETWORK CARE | OUT-OF-NETWORK CARE |
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| Primary Care Physician Selection | Not applicable | Not applicable |
| Deductible (per calendar year) | \$3,000 Individual \$6,000 Family | \$3,000 Individual \$6,000 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. | | |
| 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% | 50% |
| Payment Limit (per calendar year, includes deductible) | \$7,900 Individual \$15,800 Family | Unlimited Individual 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 Payment Limit. | | |
| No one family member may contribute more than the individual out-of-pocket maximum amount to the family out-of-pocket maximum. | | |
| Payment for Non-Preferred Care* | Not applicable | Professional: Fair Health 80% Facility: Billed Charges |
| Certification Requirements | | |
| Certification for certain types of non-preferred care must be obtained to avoid a reduction in benefits paid for that care. Certification for hospital admissions, treatment facility admissions, 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 \$400 per occurrence. | | |
| Referral Requirement | Not applicable | Not applicable |
| PHYSICIAN SERVICES | NETWORK CARE | OUT-OF-NETWORK CARE |
| Office Visits to Non-Specialist | \$55 copay deductible waived | \$55 copay deductible waived |
| Includes services of an internist, general physician, family practitioner or pediatrician for diagnosis and treatment of an illness or injury. | | |
| Specialist Office Visits | \$110 copay deductible waived | \$110 copay deductible waived |
| Walk-in Clinics | \$55 copay deductible waived | \$55 copay deductible waived |
| 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 | 20% after deductible |
| Your cost sharing applies to all covered benefits incurred during your inpatient stay. | | |
| Allergy Testing | 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. |
| Allergy Injections | 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. | | |
| Routine Adult Physical Exams and Immunizations Coverage is limited to 1 exam every 12 months. | Covered in full | Covered in full |
| Routine 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 |
| 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 |

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| Routine Mammograms For covered females age 40 and over. Frequency schedule applies. | Covered in full | Covered in full |
| 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 | 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 |
| Routine Digital Rectal Exam / Prostate-Specific Antigen Test For covered males age 40 and over. Frequency schedule applies. | Covered in full | Covered in full |
| 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 |
| 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) Coverage is limited to 1 exam every 36 months. | 20% deductible waived | 20% deductible waived |
| Hearing Aid Coverage is limited to 1 every 36 months up to a \$3,000 maximum. | 20% deductible waived | 20% deductible waived |
| VISION SERVICES | NETWORK CARE | OUT-OF-NETWORK CARE |
| Adult Routine Eye Exams (Refraction) Coverage is limited to 1 exam per calendar year. | 10% deductible waived | 10% deductible waived |
| Pediatric Routine Eye Exams (Refraction) Coverage is limited to 1 exam per calendar year age 0-19. | 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 |
| Pediatric Vision Hardware 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 | 50% after deductible |
| DIAGNOSTIC PROCEDURES | NETWORK CARE | OUT-OF-NETWORK CARE |
| Outpatient Diagnostic Laboratory | 20% after deductible | 50% after deductible |
| Outpatient Diagnostic X-ray (except for Complex Imaging Services) | 20% 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 | 50% after deductible |
| Outpatient Diagnostic Laboratory Performed in a PCP Office Visit | 20% after deductible | 20% after deductible |
| Outpatient Diagnostic X-ray Performed in a PCP Office Visit (except for Complex Imaging Services) | 20% after deductible | 20% after deductible |

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| Outpatient Diagnostic X-ray for Complex Imaging Services Performed in a PCP Office Visit Including, but not limited to, MRI, MRA, PET and CT scans. Precertification required. | 20% after deductible | 20% after deductible |
| Outpatient Diagnostic Laboratory Performed in a Specialist Office Visit | 20% after deductible | 20% after deductible |
| Outpatient Diagnostic X-ray Performed in a Specialist Office Visit (except for Complex Imaging Services) | 20% after deductible | 20% after deductible |
| Outpatient Diagnostic X-ray for Complex Imaging Services Performed in a Specialist Office Visit Including, but not limited to, MRI, MRA, PET and CT scans. Precertification required. | 20% after deductible | 20% after deductible |
| EMERGENCY MEDICAL CARE | NETWORK CARE | OUT-OF-NETWORK CARE |
| Urgent Care Provider (Benefit Availability may vary by location.) | \$110 copay deductible waived | \$110 copay deductible waived |
| Non-Urgent Use of Urgent Care Provider | \$110 copay deductible waived | \$110 copay deductible waived |
| Emergency Room Copay waived if admitted. | \$350 copayment after deductible, then 20% | Paid as in-network |
| Non-Emergency care in an Emergency Room | \$350 copayment after deductible, then 20% | 50% after deductible |
| Emergency Ambulance | 20% after deductible | Paid as in-network |
| Non-Emergency Ambulance | 20% after deductible | Paid as in-network |
| HOSPITAL CARE | NETWORK CARE | OUT-OF-NETWORK CARE |
| Inpatient Coverage Including maternity (prenatal, delivery and postpartum) and transplants. | 20% after deductible | 50% after deductible |
| Outpatient Surgery Provided in an outpatient hospital department or freestanding surgical facility. | 20% 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. |
| 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 | 50% after deductible |
| MENTAL HEALTH and SUBSTANCE USE SERVICES | NETWORK CARE | OUT-OF-NETWORK CARE |
| Inpatient Mental Health & Substance Use Services | 20% after deductible | 50% after deductible |
| Outpatient Office Visit Mental Health & Substance Use Services | \$110 copay deductible waived | \$110 copay deductible waived |
| Outpatient Other Mental Health & Substance Use Services (e.g.:partial hospitalization programs, intensive outpatient programs, applied behavior analysis) | 20% after deductible | 20% after deductible |
| OTHER SERVICES AND PLAN DETAILS | NETWORK CARE | OUT-OF-NETWORK CARE |
| Skilled Nursing Facility Coverage is limited to 60 days per calendar year. | 20% 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 | 50% after deductible |
| Infusion Therapy Provided in the home or physician's office. | 20% after deductible | 50% after deductible |

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| Infusion Therapy Provided in the outpatient hospital department or freestanding facility. | 20% after deductible | 50% after deductible |
| Hospice Care - Inpatient | 20% after deductible | 50% after deductible |
| Hospice Care Outpatient | 20% after deductible | 50% after deductible |
| Private Duty Nursing -Outpatient | Not covered | Not covered |
| Outpatient Short-Term Rehabilitation - Physical Therapy If provided in the outpatient hospital department, paid under outpatient hospital benefit. 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. | \$110 copay deductible waived | \$110 copay deductible waived |
| Outpatient Short-Term Rehabilitation - Occupational Therapy If provided in the outpatient hospital department, paid under outpatient hospital benefit. 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. | \$110 copay deductible waived | \$110 copay deductible waived |
| Outpatient Short-Term Rehabilitation - Speech Therapy If provided in the outpatient hospital department, paid under outpatient hospital benefit. 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. | \$110 copay deductible waived | \$110 copay deductible waived |
| Outpatient Chiropractic If provided in the outpatient hospital department, paid under outpatient hospital benefit. 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. | \$110 copay deductible waived | \$110 copay deductible waived |
| Acupuncture Coverage is limited to 12 visits per calendar year. | 20% after deductible | 20% after deductible |
| 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. |
| FAMILY PLANNING | NETWORK CARE | 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. | \$110 copay deductible waived |
| 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 |
| Voluntary Sterilization - Vasectomy | 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 |
| PEDIATRIC DENTAL SERVICES | NETWORK CARE | OUT-OF-NETWORK CARE |

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| Preventive & Diagnostic (includes exams, cleanings, x-rays, fluoride, sealants) Coverage is limited to 2 exams every 12 months age 0-19. | Covered in full after deductible | Covered in full after deductible |
| Basic (includes space maintainers, fillings, anesthesia, denture adjustments) Coverage is limited to age 0-19. | 30% after deductible | 30% after deductible |
| Major (includes crowns, endodontics, periodontics, oral surgery, dentures, bridges) Coverage is limited to age 0-19. | 50% after deductible | 50% after deductible |
| Orthodontia (limited to medically necessary orthodontia) 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 | Per Member: N/A | Per Member: N/A |
| PHARMACY - PRESCRIPTION DRUG BENEFITS | NETWORK CARE | OUT-OF-NETWORK CARE |
| Retail Up to a 90 day supply | | |
| Generic Drugs | \$12 copay deductible waived | 20% deductible waived |
| Preferred Brand Drugs | \$55 copayment after deductible | 20% after deductible |
| Non-Preferred Drugs Deductible waived for generics on all tiers | Generic & Brand: \$95 copayment after deductible | Generic & Brand: 20% after deductible |
| Specialty Drugs Includes self-injectable, infused and oral specialty drugs (retail and mail order up to a 30-day supply, excludes insulin). | Specialty Preferred: 40% up to \$500 after deductible Specialty Nonpreferred: 50% up to \$750 after deductible | Specialty Preferred: 20% after deductible Specialty Nonpreferred: 20% after deductible |
| Mail Order Delivery | When you fill your prescription by mail order, you may save money 31-90 days – excludes specialty drugs when compared to the cost to purchase your prescriptions at your local retail pharmacy. | |
| Generic Drugs | \$30 copay deductible waived | 20% deductible waived |
| Preferred Brand Drugs | \$137.50 copayment after deductible | 20% after deductible |
| Non-Preferred Drugs Deductible waived for generics on all tiers | Generic & Brand: \$237.50 copayment after deductible | Generic & Brand: 20% after deductible |
| Specialty Drugs Includes self-injectable, infused and oral specialty drugs | Not covered Not covered | Not covered Not covered |
| Specialty CareRxSM - For more information, please go to www.aetnaspecialtycarerx.com | | |

Choose Generic - Included. See Aetna Formulary for details.

Full Choose Generics - Penalty does not apply to medical deductible and integrated MOOP but DOES APPLY to pharmacy deductible

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).

Performance Enhancing Drugs - Not Covered

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 may 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**.

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