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PLAN DESIGN AND BENEFITS - AK Silver Indemnity 2000 80 (2017)

AK Group Business 1-50 Employees

PLAN FEATURES	MEMBER COST
Primary Care Physician Selection	Not applicable
Deductible (per calendar year)	$2,000 Individual $4,000 Family
Unless otherwise indicated, the deductible must be met before benefits can be paid.	
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%
Out-of-Pocket (OOP) Maximum (per calendar year, includes deductible)	$6,850 Individual $13,700 Family
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*	Professional: Fair Health 90% Facility: Billed Charges
Certification Requirements	
Certification for certain types of must be obtained to avoid a reduction in benefits paid for that care. Certification for hospital admissions, treatment facility admissions, convalescent 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 service or supply.	
Referral Requirement	Not applicable
PHYSICIAN SERVICES	**MEMBER COST**
Office Visits to Non-Specialist	20% 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	20% after deductible
Walk-in Clinics	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.	
Maternity - Delivery and Post-Partum Care	20% after deductible
Allergy Testing (given by a physician)	20% after deductible
Allergy Injections (not given by a physician)	20% after deductible
PREVENTIVE CARE	**MEMBER COST**
Preventive care services are covered in accordance with Health Care Reform.	
Routine Adult Physical Exams and Immunizations Limited to 1 exam every 12 months.	Covered in full
Well Child Exams and Immunizations Provides coverage for 7 exams in the first year of life; 3 exams in the second year; 3 exams in the third year; and 1 exam per 12 months from age 3 to age 22.	Covered in full
Routine Gynecological Exams Includes Pap smear, HPV screening and related lab fees. Limited to 1 exam every 12 months.	Covered in full
Routine Mammograms For covered females age 40 and over. Frequency schedule applies.	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
Prenatal Maternity	Covered in full
Routine Digital Rectal Exam / Prostate-Specific Antigen Test For covered males age 40 and over. Frequency schedule applies.	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
Routine Eye and Hearing Screenings	Paid as part of routine physical exam.
HEARING SERVICES	MEMBER COST
Hearing Exam (by Specialist)	20% deductible waived Coverage is limited to 1 exam every 36 months.
Hearing Aid	20% deductible waived Coverage is limited to 1 every 36 months up to a $1,000 maxiumum.
VISION SERVICES	MEMBER COST
Adult Routine Eye Exams (Refraction)	10% deductible waived Coverage is limited to 1 exam per calendar year.
Pediatric Routine Eye Exams (Refraction)	20% after deductible Coverage is limited to 1 exam per calendar year age 0-19.
Adult Vision Hardware	Covered in full Coverage for vision supplies (eyeglass frames, prescription and contact lenses) is limited to $350 per year.
Pediatric Vision Hardware	Covered in full after deductible Coverage is limited to 1 set of frames and 1 set of contact lenses or eyeglass lenses per calendar year age 0-19.
DIAGNOSTIC PROCEDURES	MEMBER COST
Outpatient Diagnostic Laboratory	20% after deductible
Outpatient Diagnostic X-ray (except for Complex Imaging Services)	20% 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
EMERGENCY MEDICAL CARE	MEMBER COST
Urgent Care Provider (Benefit Availability may vary by location.)	20% after deductible
Non-Urgent Use of Urgent Care Provider	20% after deductible
Emergency Room	20% after deductible
Non-Emergency care in an Emergency Room	20% after deductible
Emergency Ambulance	20% after deductible

Non-Emergency Ambulance	20% after deductible
HOSPITAL CARE	MEMBER COST
Inpatient Coverage Including maternity (prenatal, delivery and postpartum) and transplants.	20% after deductible
Outpatient Surgery Provided in an outpatient hospital department or freestanding surgical facility.	20% after deductible
Colonoscopy (non-preventive)	Member cost sharing is based on the type of service performed and the place rendered.
Transplants	20% after deductible
MENTAL HEALTH and ALCOHOL/DRUG ABUSE SERVICES	MEMBER COST
Inpatient Mental Health	20% after deductible
Outpatient Mental Health	20% after deductible MHP compliant.
Inpatient Detoxification	20% after deductible
Outpatient Detoxification	20% after deductible MHP compliant.
Inpatient Rehabilitation	20% after deductible
Outpatient Rehabilitation	20% after deductible MHP compliant.
OTHER SERVICES AND PLAN DETAILS	MEMBER COST
Skilled Nursing Facility Coverage is limited to 60 days per calendar year.	20% after deductible
Home Health Care Coverage is limited to 130 visits per calendar year.	20% after deductible
Infusion Therapy Provided in the home or physician's office, outpatient hospital department of freestanding facility.	20% after deductible
Infusion Therapy Provided in the outpatient hospital department of freestanding facility.	20% after deductible
Inpatient Hospice Care	20% after deductible
Outpatient Hospice Care	20% after deductible
Private Duty Nursing - Outpatient	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.	20% 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.	20% 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.	20% 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.	20% after deductible	
Acupuncture	20% after deductible Coverage is limited to 12 visits per calendar year.	
Durable Medical Equipment	50% after deductible	
Diabetic Supplies not obtainable at a pharmacy	Covered same as any other medical expense	
FAMILY PLANNING	MEMBER COST	
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.	
Infertility Treatment - Artificial Insemination or Ovulation Induction	Not covered	
Advanced Reproductive Technology. Including, but not limited to, GIFT, ZIFT, IVF, ICSI, ovum microsurgery and cryopreserved embryo transfers.	Not covered	
Voluntary Sterilization - Vasectomy	20% after deductible	
Voluntary Sterilization - Tubal Ligation	Covered in full	
PEDIATRIC DENTAL SERVICES	MEMBER COST	
Preventive & Diagnostic (includes exams, cleanings, x-rays, fluoride, sealants)	Covered in full	
Basic (includes space maintainers, fillings, anesthesia, denture adjustments)	30% after deductible	
Major (includes crowns, endodontics, periodontics, oral surgery, dentures, bridges)	50% after deductible	
Orthodontia (limited to medically necessary orthodontia) Coverage is limited to age 0-19.	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
Retail Up to a 30-day supply		
Generic Drugs	Generic: $15 copayment	Generic: $15 copayment
Preferred Brand Drugs	$50 copayment	$50 copayment
Non-Preferred Drugs	Generic & Brand: $150 copayment	Generic & Brand: $150 copayment
Specialty Drugs Includes self-injectable, infused and oral specialty drugs (retail and mail order up to a 30-day supply, excludes insulin).	40%	40%
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	Generic: $30 copayment	Generic: $30 copayment
Preferred Brand Drugs	$100 copayment	$100 copayment
Non-Preferred Drugs	Generic & Brand: $300 copayment	Generic & Brand: $300 copayment
Specialty Drugs Includes self-injectable, infused and oral specialty drugs	Not covered	Not covered

Specialty CareRx℠ -
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.

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**.