COST OF COVERAGE AND PLAN HIGHLIGHTS

COST OF COVERAGE (MONTHLY)

-	AETNA MEDICAL CDHP WITH HSA OR HRA	AETNA MEDICAL PPO	DENTAL/VISION
Employee Only	$75.00	$160.00	$55.00
Employee + Spouse	$150.00	$200.00	$55.00
Employee + Child(ren)	$100.00	$190.00	$55.00
Employee + Family	$180.00	$225.00	$55.00

MEDICAL HIGHLIGHTS (PPO)

Benefit Features	In-Network	Out-of-Network
Annual Deductible	$1,500/individual; $4,500/family	
Out-of-Pocket Maximum	$5,300/individual; $12,900/family	
Lifetime Max Benefit	Unlimited	
-	**Plan Pays**	
Preventive Services	100%	100%
Office Visit	100% after $50 copay	100% of allowed amount after $50 copay
Specialist Visit	100% after $125 copay	100% of allowed amount after $125 copay

MEDICAL HIGHLIGHTS (CDHP)

Benefit Features	In-Network	Out-of-Network
Annual Deductible	$1,500/individual; $3,000/family (aggregate)	
HSA/HRA Funding (offsets deductible)	$750/individual; $1,500/family	
Out-of-Pocket Maximum	$5,300/individual; $10,600/family (aggregate) $6,850/embedded individual maximum	
Lifetime Max Benefit	Unlimited	
-	**Plan Pays**	
Preventive Services	100%	100%
Office Visit	80% after deductible	60% of allowed amount after deductible
Specialist Visit	80% after deductible	60% of allowed amount after deductible

VERA WHOLE HEALTH CLINIC

Vera Whole Health is an independent primary care health clinic, and an additional benefit available to Anchorage School District employees and their families on the District sponsored health plan.

Benefit Features	PPO	CDHP
Preventative Care	100%	100%
Primary Care	100%	$75 initial patient visit / $50
Acute Care	100%	$75 initial patient visit / $50

PHARMACY HIGHLIGHTS

-	AETNA E PPO PLAN		AETNA CONSUMER DRIVEN HEALTH PLAN	
Benefit Features	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible	N/A		Subject to medical plan deductible	
Retail Pharmacy	**You Pay**		**You Pay**	
Generic	$15 copay	$15 copay then 40%	$15 copay	$15 copay then 40%
Preferred Brand	20% (up to $120 cap)	20% (up to $120 cap) then 40%	20% (up to $120 cap)	20% (up to $120 cap) then 40%
Non-preferred Brand	20% (up to $240 cap)	20% (up to $240 cap) then 40%	20% (up to $240 cap)	20% (up to $240 cap) then 40%
Supply Limit	Up to 90 days	Up to 90 days	Up to 90 days	Up to 90 days
Mail Order	**You Pay**		**You Pay**	
Generic	$30 copay	Not covered	$30 copay	Not covered
Preferred Brand	20% (up to $80 cap)		20% (up to $80 cap)	
Non-preferred Brand	20% (up to $160 cap)		20% (up to $160 cap)	
Supply Limit	31-90 days		31-90 days	

DENTAL HIGHLIGHTS

Benefit Features	In-Network	Out-of-Network
Calendar Year Deductible	$50/individual; $150/family	
Annual Plan Maximum	$2,000	
Reimbursement Level	Negotiated Fee	90th Percentile of Reasonable and Customary
Diagnostic and Preventive Services	**Plan Pays**	**Plan Pays**
Exams, Cleanings, X-rays	100%	100%
Basic Services	**Plan Pays**	**Plan Pays**
Fillings, Periodontics, Endodontics	80% after deductible	80% after deductible
Major Services	**Plan Pays**	**Plan Pays**
Crowns, Bridges, Dentures	50% after deductible	50% after deductible

VISION HIGHLIGHTS

Benefit Features	In-Network	Out-of-Network
Vision Benefits	**Plan Pays**	**Plan Pays**
Eye Exam Once every 12 months	100%	100% up to $50
Materials	100%	100% up to benefit limits listed below
Contact Lens Fitting/Exam	100% after up to $60 copay	See Contact Lenses Below
Eyeglass Lenses Once every 12 months Single Vision Lens Bifocal Lens Trifocal Lens	100% for basic lens 100% for basic lens 100% for basic lens	100% up to $50 100% up to $65 100% up to $100
Frames Once every 24 months	100% up to $180	100% up to $70
Contact Lenses (in lieu of eyeglasses) Once every 12 months	100% up to $170	100% up to $105