

# Alaska HSA Rx Plan

For plans effective May 1, 2009

Deductible, coinsurance and copay represent **what you pay**. All coinsurance amounts are based on allowable charges. Benefits apply after calendar year deductible is met, unless otherwise noted as "no deductible," "copay" or "covered in full."

MEDICAL BENEFITS	IN-NETWORK	OUT-OF-NETWORK
<b>Annual Deductible</b> PCY (choose one)	Individual: \$5,000 Family: \$10,000	
<b>Annual Coinsurance Maximum</b> PCY (once met, in-network providers covered in full)	Individual: \$0 Family: \$0	Unlimited for out-of-network hospital
<b>Lifetime Benefit Maximum</b>	\$5 Million	
<b>COVERED SERVICES</b>		
<b>PREVENTIVE CARE</b>		
<b>Preventive Care Exams</b> (routine medical exam, men's and women's health exam, sports physical and well baby exam)	Covered in full	
<b>Immunizations</b> (unlimited)		
<b>Preventive Screenings</b> (includes PAP smear, PSA testing, home colon cancer screening, cholesterol screening and bone density test)		
<b>PROFESSIONAL CARE</b>		
<b>Office Visit and Urgent Care</b> (visits shared with Naturopathy)	Deductible applies first, then covered in full	
<b>Outpatient and Inpatient Professional Services</b>		
<b>ALTERNATIVE CARE</b>		
<b>Spinal and Other Manipulations</b> 12 visits PCY (visits shared with Acupuncture)	Deductible applies first, then covered in full	
<b>Acupuncture</b> 12 visits PCY (visits shared with Spinal and Other Manipulations)		
<b>Naturopathy</b> (visits shared with Office Visits)		
<b>DIAGNOSTIC SERVICES</b>		
<b>Outpatient Diagnostic X-ray and Lab Services</b>	Deductible applies first, then covered in full	
<b>Mammography</b>	Covered in full	
<b>PHARMACY</b>		
<b>Retail and Mail Order</b>	Deductible applies first, then covered in full up to 90 day supply Certain generic preventive drugs covered in full*	
<b>EMERGENCY CARE</b>		
<b>Emergency Care</b> (copay waived if direct admit to an inpatient facility)	Deductible applies first, then covered in full	
<b>Ambulance Transportation</b> Air and Ground (unlimited)		
<b>FACILITY CARE</b>		
<b>Inpatient Facility Care</b>	Deductible applies first, then covered in full	
<b>Outpatient Facility Care</b>		
<b>Skilled Nursing Facility</b> 20 days PCY		
<b>MATERNITY</b>		
<b>Maternity Care</b> (including prenatal care) \$4,000 PCY 12-month benefit exclusion period**	Deductible applies first, then covered in full	
<b>OTHER SERVICES</b>		
<b>Supplies, Equipment and Prosthetics</b> \$5,000 PCY	Deductible applies first, then covered in full	
<b>Home Health Care</b> 130 visits PCY		
<b>Hospice Care</b> Inpatient: 10 days, Respite: 240 hours PCY		
<b>Rehabilitation</b> (includes Physical, Occupational, Speech, Massage Therapy; Chronic Pain; Cardiac & Pulmonary Rehab) Outpatient: 15 visits PCY, Inpatient: 10 days PCY		
<b>Transplants (Organ and Bone Marrow)</b> \$250,000 lifetime benefit max, 12-month benefit exclusion period**	Deductible applies first, then covered in full	Not covered

PCY = Per Calendar Year

\* Benefits provided at 100% of allowable charges; not subject to deductible or coinsurance.

\*\* Benefit exclusion period is a time period during which specified treatment or services are excluded from coverage under this plan. After the benefit exclusion period is satisfied, services may be eligible for benefits, subject to terms of contract.

Note: For services covered in full, benefits are provided at 100% of allowable charges; not subject to deductible or coinsurance.

*This is only a summary of the major benefits provided by our plans. This is not a contract.*