

# Alaska HSA Rx 20 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: \$1,250 Family: \$2,500	
<b>Annual Coinsurance Maximum</b> PCY (once met, in-network providers covered in full)	Individual: \$3,750 Family: \$7,500	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)	No deductible applies, you pay 20%	
<b>Immunizations</b> (unlimited)	Covered in full	
<b>Preventive Screenings</b> (includes PAP smear, PSA testing, home colon cancer screening, cholesterol screening and bone density test)	Covered in full	
<b>PROFESSIONAL CARE</b>		
<b>Office Visit and Urgent Care</b> (visits shared with Naturopathy)	Deductible applies first, then you pay 20%	
<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 you pay 20%	
<b>Acupuncture</b> 12 visits PCY (visits shared with Spinal and Other Manipulations)	Deductible applies first, then you pay 20%	
<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 you pay 20%	
<b>Mammography</b>	No deductible applies, you pay 20%	
<b>PHARMACY</b>		
<b>Retail and Mail Order</b>	Deductible applies first, then you pay 20% 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 you pay 20%	
<b>Ambulance Transportation</b> Air and Ground (unlimited)		
<b>FACILITY CARE</b>		
<b>Inpatient Facility Care</b>		
<b>Outpatient Facility Care</b>	Deductible applies first, then you pay 20%	You pay 50% for out-of-network hospital
<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 you pay 20%	
<b>OTHER SERVICES</b>		
<b>Supplies, Equipment and Prosthetics</b> \$5,000 PCY		
<b>Home Health Care</b> 130 visits PCY		
<b>Hospice Care</b> Inpatient: 10 days, Respite: 240 hours PCY	Deductible applies first, then you pay 20%	
<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 you pay 20%	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.*