

ALASKA AETNA ADVANTAGE PLAN OPTIONS

Preventive and Hospital Care 3000 (HSA Compatible)		
MEMBER BENEFITS	In-Network	Out-of-Network
Deductible		
Individual	\$3,000	\$6,000
Family	\$6,000	\$12,000
Coinsurance (Member's Responsibility)	20% after deductible	20% after deductible Non Facility Services 50% after deductible - Facility Services
Coinsurance Maximum		
Individual	\$2,000	\$4,000
Family	\$4,000	\$8,000
Out-of-Pocket Maximum		
Individual	\$5,000	\$10,000
Family	\$10,000	\$20,000
	<i>Includes deductible</i>	
Lifetime Maximum* per insured	\$5,000,000	
Non-specialist Office Visit <i>Unlimited Visits</i> (General Physician, Family Practitioner, Pediatrician or Internist)	Not covered	Not covered
Specialist Visit <i>Unlimited Visits</i>	Not covered	Not covered
Hospital Admission	20% after deductible	50% after deductible
Outpatient Surgery	20% after deductible	50% after deductible
Urgent Care Facility	Not covered	Not covered
Emergency Room	\$100 copay** (waived if admitted) 20% coinsurance after deductible	
Annual Routine Gyn Exam <i>No waiting period, No calendar year max. Annual Pap/Mammogram</i>	\$0 copay deductible waived	\$0 copay deductible waived
Maternity	Not covered (except for pregnancy complications)	
Preventive Health — Routine Physical Aetna will pay up to \$200 per exam	\$35 copay deductible waived	\$35 copay deductible waived
	<i>Includes lab work and X-rays</i>	
Lab/X-Ray	Not covered	Not covered
Skilled Nursing (In lieu of Hospital) 30 days per calendar year*	20% after deductible	20% after deductible
Physical/Occupational Therapy and Chiropractic Care 24 visits per calendar year*	Not covered	Not covered <i>Aetna will pay up to \$25 per visit max.</i>
Home Health Care (In lieu of Hospital) 30 visits per calendar year*	20% after deductible	20% after deductible
Durable Medical Equipment	Not covered†	Not covered†
PHARMACY		
Pharmacy Deductible per Individual	Not applicable	Not applicable
Generic (Oral Contraceptives Included)	Not covered <i>Aetna discount applies</i>	Not covered
Preferred Brand Name (Oral Contraceptives Included)	Not covered <i>Aetna discount applies</i>	Not covered
Non-Preferred Brand (Oral Contraceptives Included)	Not covered <i>Aetna discount applies</i>	Not covered
Calendar Year Maximum per Individual*	Unlimited	Unlimited

* Maximum applies to combined in and out of network benefits.

** Copay is billed separately and not due at time of service. Copay does not count towards coinsurance or out-of-pocket maximum.

† Coverage will be provided for care and treatment of diabetes; this includes coverage for equipment and supplies used exclusively with diabetes management and outpatient self-management training.

A summary of exclusions is listed in the Aetna Advantage brochure. For a full list of benefit coverage and exclusions refer to the plan documents.

Plans may be subject to medical underwriting or other restrictions. Rates and benefits vary by location. 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. Health insurance plans contain exclusions and limitations. Material subject to change.

Aetna Advantage Plans for individual, families and the self employed are underwritten by Aetna Life Insurance Company (Aetna) directly and/or through an out of state blanket trust.

In some states, individuals may qualify as a business group of one and may be eligible for guaranteed issue, small group health plans. These plans are medically underwritten and you may be declined coverage in accordance with your health condition.

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AK PHC 3000 (4/09)

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