

## KANSAS AETNA ADVANTAGE PLAN OPTIONS

	PPO 5000 with maternity	
MEMBER BENEFITS	In-Network	Out-of-Network <sup>+</sup>
Deductible Individual Family	\$5,000/\$10,000	\$10,000/\$20,000
Coinsurance (Member's responsibility)	20% after deductible	50% after deductible
Coinsurance Maximum Individual Family (includes deductible)	\$2,500/\$5,000	\$2,500/\$5,000
Out-of-Pocket Maximum Individual Family	\$7,500/\$15,000	\$12,500/\$25,000
Lifetime Maximum* per insured	\$5,000,000	\$5,000,000
Non-Specialist Office Visit (General Physician, Family Practitioner Pediatrician or Internist)	\$40 copay ded. waived	50% after deductible
Specialist Visit	\$50 copay ded. waived	50% after deductible
Hospital Admission	20% after deductible	50% after deductible
Outpatient Surgery	20% after deductible	50% after deductible
Urgent Care Facility	\$50 copay ded. waived	50% after deductible
Emergency Room (after deductible)	\$100 copay** (waived if admitted) 20% coinsurance after deductible	
Annual Routine Gyn Exam (Annual Pap/Mammogram)	0% ded. waived	50% after deductible
Maternity Obstetrician Visits	\$50 copay ded. waived	50% after deductible
Maternity Hospital	20% after deductible	50% after deductible
Preventative Health (Routine Physical) (\$200 maximum*)	\$40 copay ded. waived	50% after deductible
Lab/X-Ray	20% after deductible	50% after deductible
Skilled Nursing (in lieu of hospital) (30 days per calendar year*)	20% after deductible	50% after deductible
Physical/Occupational Therapy (\$25 Max- 24 visits per calendar year*)	20% after deductible	50% after deductible
Home Health Care (30 visits per calendar year*)	20% after deductible	50% after deductible
Durable Medical Equipment (\$2,000 per calendar year*)	20% after deductible	50% after deductible
<b>PHARMACY</b>		
Pharmacy Deductible	\$500	\$500
Generic (Oral Contraceptives Included)	\$15 copay ded. waived	\$15 copay plus 50% ded. waived
Preferred Brand (Oral Contraceptives Included)	\$25 copay after deductible	\$25 copay plus 50% after deductible
Non-Preferred Brand (Oral Contraceptives Included)	\$40 copay after deductible	\$40 copay plus 50% after deductible
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.

+ Payment for out-of-network facility care is determined based upon Aetna's Allowable Fee Schedule. Payment for other out-of-network facility care is determined based upon the negotiated charge that would apply if such services or supplies were received from a Preferred Provider.

A summary of exclusions is listed on page 13 of the Aetna Advantage brochure. For a full list of benefit coverage and exclusions refer to the plan documents.

**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.**

Plans may be subject to medical underwriting or other restrictions. 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.

We want you to know<sup>®</sup>



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