Alabama Aetna Advantage Plan Options

PPO 7500 with Unlimited Primary Care Visits plus Dental

MEMBER BENEFITS	In-Network	Out-of-Network+
Deductible Individual Family	 $7,500 $15,000	 $10,000 $20,000
Coinsurance (Member's responsibility)	20% after deductible up to out-of-pocket max.	50% after deductible up to out-of-pocket max.
	$0 once out-of-pocket max. is satisfied	
Coinsurance Maximum Individual Family	 $2,500 $5,000	 $2,500 $5,000
Out-of-Pocket Maximum Individual Family	 $10,000 $20,000	 $12,500 $25,000
	Includes deductible	
Lifetime Maximum* per insured	$5,000,000	
Non-Specialist Office Visit *Unlimited visits* General Physician, Family Practitioner, Pediatrician or Internist	$30 copay deductible waived	50% after deductible
Specialist Visit *Unlimited visits*	20% after deductible	50% after deductible
Hospital Admission	20% after deductible	50% after deductible
Outpatient Surgery	20% after deductible	50% after deductible
Urgent Care Facility	$50 copay deductible waived	50% after deductible
Emergency Room	$150 copay** (waived if admitted) after deductible	
Annual Routine Gyn Exam *No waiting period, no calendar year max.* Annual Pap/Mammogram	$0 copay deductible waived	50% after deductible
Maternity	Not covered *Except for pregnancy complications*	
Preventive Health — Routine Physical *Aetna will pay up to $200 per exam** *No waiting period*	$30 copay deductible waived	50% after deductible
	Includes lab work and X-rays	
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 and Chiropractic Care *24 visits per calendar year**	20% after deductible	50% after deductible
	*Aetna will pay a max. of $25 per visit***	
Home Health Care — in lieu of hospital *30 visits per calendar year**	20% after deductible	50% after deductible
Durable Medical Equipment *Aetna will pay up to $2000 per calendar year**	20% after deductible	50% after deductible
PHARMACY		
Pharmacy Deductible per individual	Not Applicable	Not Applicable
Generic *Oral Contraceptives Included*	$15 copay deductible waived	$15 copay plus 50% deductible waived
Preferred Brand *Oral Contraceptives Included*	Not covered	Not covered
Non-Preferred Brand *Oral Contraceptives Included*	Not covered	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.

+ 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 in the Aetna Advantage Plan 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 Individuals, 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.

AL PPO 7500 (10/09)

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Alabama Aetna Advantage Plan Options

	Aetna Advantage Plan options Individual Dental PPO Max plan	
MEMBER BENEFITS	Preferred	NonPreferred
Annual Deductible per Member (Does not apply to Diagnostic and Preventive Services)	$25; $75 family maximum	$25; $75 family maximum
Annual Maximum Benefit	Unlimited	Unlimited
DIAGNOSTIC SERVICES		
Oral exams		
Periodic oral exam	100% deductible waived	100% deductible waived
Comprehensive oral exam	100% deductible waived	100% deductible waived
Problem-focused oral exam	100% deductible waived	100% deductible waived
X-rays		
Bitewing — single film	100% deductible waived	100% deductible waived
Complete series	100% deductible waived	100% deductible waived
PREVENTIVE SERVICES		
Adult cleaning	100% deductible waived	100% deductible waived
Child cleaning	100% deductible waived	100% deductible waived
Sealants — per tooth	Discount	Not covered
Fluoride application — with cleaning	100% deductible waived	100% deductible waived
Space maintainers	Discount	Not covered
BASIC SERVICES		
Amalgam fillings — 2 surfaces	100% after deductible	100% after deductible
Resin fillings — 2 surfaces	Discount	Not covered
Oral Surgery		
Extraction — exposed root or erupted tooth	Discount	Not covered
Extraction of impacted tooth — soft tissue	Discount	Not covered
MAJOR SERVICES		
Complete upper denture	Discount	Not covered
Partial upper denture (resin based)	Discount	Not covered
Crown — Porcelain with noble metal	Discount	Not covered
Pontic — Porcelain with noble metal	Discount	Not covered
Inlay — Metallic (3 or more surfaces)	Discount	Not covered
Oral Surgery		
Removal of impacted tooth — partially bony	Discount	Not covered
Endodontic Services		
Bicuspid root canal therapy	Discount	Not covered
Molar root canal therapy	Discount	Not covered
Periodontic Services		
Scaling & root planing — per quadrant	Discount	Not covered
Osseous surgery — per quadrant	Discount	Not covered
ORTHODONTIC SERVICES	Discount	Not covered

Access to negotiated discounts: members are eligible to receive non-covered services, including cosmetic services such as tooth whitening, at the PPO negotiated rate when visiting a participating PPO dentist.

Nonpreferred (Out-of-Network) Coverage is limited to a maximum of the Plan's payment, which is based on the contracted maximum fee for participating providers in the particular geographic area.

Above list of covered services is representative. A summary of exclusions is listed later in this brochure. For a full list of benefit coverage and exclusions refer to the plan documents.

All products not available in all counties.

This material is for informational purposes only and is neither an offer of coverage nor dental advice. It contains only a partial, general description of plan benefits or programs and does not constitute a contract.

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