

ARIZONA AETNA ADVANTAGE PLAN OPTIONS

PPO 500		
MEMBER BENEFITS	In-Network	Out-of-Network*
Deductible Individual/Family	\$500/\$1,000	\$1,000/\$2,000
Coinsurance	20% after deductible	50% after deductible
Out-of-Pocket Maximum Individual/Family	\$2,000/\$4,000	\$2,500/\$5,000
Lifetime Maximum*	\$5,000,000 per insured	\$5,000,000 per insured
Non-specialist Office Visit (General Physician, Family Practitioner, Pediatrician or Internist)	\$20 Copay	50% after deductible
Specialist Visit	\$35 Copay	50% after deductible
Hospital Admission	20% after deductible	50% after deductible
Outpatient Surgery	20% after deductible	50% after deductible
Emergency Room	\$100 Copay (waived if admitted) 20% after deductible	\$100 Copay (waived if admitted) 50% after deductible
Annual Routine Gyn Exam (Annual Pap/Mammogram)	\$35 Copay	50% after deductible
Preventive Health (Annual Physical) (\$200 per calendar year*)	\$20 Copay	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 and Chiropractic Care** (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
Urgent Care	\$50 Copay	50% after deductible
PHARMACY		
Generic (Contraceptives Included)	\$15 Copay	\$15 Copay plus 50%
Brand Name (Calendar Year Deductible per Individual)	\$250 (does not apply to generic)	\$250 (does not apply to generic)
Preferred Brand/Non-Preferred Brand (Contraceptives Included)	\$25/\$40 Copay after deductible	\$25/\$40 Copay plus 50% after deductible
Calendar Year Maximum per Individual*	\$5,000	\$5,000

*Maximum applies to combined in and out of network benefits

**Aetna will pay a maximum of \$25 per visit.

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

Maternity and pregnancy related expenses are not covered.

For a full list of benefit coverage and exclusions refer to the plan documents.