

| | PPO 1500 | |
|---|---|--|
| MEMBER BENEFITS | In-Network | Out-of-Network ⁺ |
| Deductible Individual Family | \$1,500 \$3,000 | \$3,000 \$6,000 |
| Coinsurance (Member's Responsibility) | 20% after deductible | 50% after deductible |
| Coinsurance Maximum Individual Family | \$1,500 \$3,000 | \$1,500 \$3,000 |
| Out-of-Pocket Maximum Individual Family (deductible included) | \$3,000 \$6,000 | \$4,500 \$9,000 |
| Lifetime Maximum* | \$5,000,000 | |
| Non-Specialist Office Visit (General Physician, Family Practitioner, Pediatrician or Internist) | \$20 copay deductible waived | 50% after deductible |
| Specialist Visit | \$35 copay deductible 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 deductible waived | 50% after deductible |
| Emergency Room | \$100 copay** (waived if admitted) 20% coinsurance after deductible | |
| Annual Routine Gyn Exam (Annual Pap/Mammogram) | \$35 copay deductible waived | 50% after deductible |
| Maternity | Not covered (except for preg. complications) | Not covered (except for preg. complications) |
| Preventive Health (Routine Physical) (\$200 per exam) | \$20 copay deductible 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 & Chiropractic Care (\$25 Max – 24 visits per calendar year*) | 20% after deductible | 50% after deductible |
| Home Health Care (In lieu of Hospital) (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 |
| PHARMACY | | |
| Pharmacy Deductible per Individual (does not apply to generic)* | \$250 | \$250 |
| Generic (Oral Contraceptives Included) | \$15 copay deductible waived | \$15 copay plus 50% deductible waived |
| Preferred Brand Name (Oral Contraceptive 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* | \$5,000 | \$5,000 |

* Maximum applies to combined in-of-network 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 max.

+ 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.

The Aetna Advantage Plans for Individuals, Families and the Self Employed are offered, underwritten or administered by Aetna Life Insurance Company (Aetna). In some states, Sole Proprietors may be eligible for Small Group Healthcare Plans.

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

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Materials subject to change.

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