

	PPO 2500	
MEMBER BENEFITS	In-Network	Out-of-Network ⁺
Deductible Individual Family	\$2,500 \$5,000	\$5,000 \$10,000
Coinsurance (Member's Responsibility)	20% after deductible	50% after deductible
Coinsurance Maximum Individual Family	\$2,500 \$5,000	\$2,500 \$5,000
Out-of-Pocket Maximum Individual Family (deductible included)	\$5,000 \$10,000	\$7,500 \$15,000
Lifetime Maximum*	\$5,000,000	
Non-Specialist Office Visit (General Physician, Family Practitioner, Pediatrician or Internist)	\$25 copay deductible waived	50% after deductible
Specialist Visit	\$40 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)	\$40 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)	\$25 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)*	\$500	\$500
Generic (Oral Contraceptives included)	\$15 copay deductible waived	\$15 copay plus 50% deductible waived
Preferred Brand Name (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*	\$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 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.
Materials subject to change.

AZ PPO 2500 10/07)

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