ARIZONA AETNA ADVANTAGE PLAN OPTIONS

HIGH DEDUCTIBLE PPO 1 (H.S.A. COMPATIBLE)		
MEMBER BENEFITS	In-Network	Out-of-Network+
Deductible Individual/Fam	$2,750 Ind/$5,500 Fam	$5,500 Ind/$11,000 Fam
Coinsurance	20%	50%
Out-of-Pocket Maximum Individual/Family	$5,000 Ind/$10,000 Family	$10,000 Ind/$20,000 Family
Lifetime Maximum	$5,000,000 per member lifetime	
Non-specialist Office Visit (General Physician, Family Practitioner, Pediatrician or Internist)	20%	50%
Specialist Visit	20%	50%
Hospital Admission	20%	50%
Outpatient Surgery	20%	50%
Emergency Room	20% after $100 copay Waived if admitted	50% after $100 copay Waived if admitted
Annual Routine Ob/Gyn Exam (Annual Pap/Mammogram)	0% Not Subject to deductible	50%
Preventive Health (Annual Physical) ($200 per calendar year*)	$20 copay Not Subject to deductible	50%
Lab/X-Ray	20%	50%
Skilled Nursing (in lieu of hospital (30 days per calendar year*)	20%	50%
Physical/Occupational Therapy Chiropractic Care** (24 visits per calendar year*)	20%	50%
Home Health (30 visits per calendar year*)	20%	50%
Durable Medical Equipment ($2,000 per calendar year*)	20%	50%
Urgent Care	20%	50%
PHARMACY		
Generic (Contraceptives Included)	$15 copay	$15 copay plus 50%
Brand Name (Calendar Year Deductible per Individual)	Integrated Medical/RX deductible	Integrated Medical/RX deductible
Preferred Brand/Non-Preferred Brand (Contraceptives Included)	$25/$40 copay	$25/$40 copay plus 50%
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.

Note: Payment for out-of-network facility 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.

Aetna®