Aetna Health, Inc.
BASIC HMO COPAY PLAN 1
SCHEDULE OF BENEFITS

INDIVIDUAL LIFETIME MAXIMUM BENEFIT $2 Million Dollars

OUT-OF-POCKET MAXIMUM EXPENSE LIMITS $5,000 Single
$10,000 Family

The Covered Services set forth in this Schedule must be provided by and/or authorized by the Member's [Primary Care][Participating] Physician. Some services are subject to authorization by [Aetna]. Please consult the Certificate of Coverage for complete details regarding benefits, exclusions and limitations.

Hospital Services (including Maternity Care) *All Hospital care must be authorized by the Member's [Primary Care][Participating] Physician [and] [AETNA].*	**Member Responsibility** *Copayment paid at time of service*
Inpatient Hospital Care	$750 Copayment per day of an authorized Hospital Confinement
Outpatient Surgical Care	$500 Copayment per surgical procedure

Emergency Services and Care	**Member Responsibility** *Copayment paid at time of service*
Emergency Room Visit At Hospital	$250 Copayment per visit (waived if admitted)
Ambulance	$100 Copayment per transport
Urgent Care	$75 Copayment per visit
If the use of a Participating or Non-Participating Hospital Emergency Room is not due to an Emergency Medical Condition for a Condition covered by this Group Plan, the only payment made will be for the determination of whether an Emergency Medical Condition existed. If an Emergency Medical Condition did not exist, no further benefits will be paid.	

Outpatient Medical Treatment and Services *must be provided by and/or authorized by the Member's [Primary Care][Participating] Physician.*	**Member Responsibility** *Copayment paid at time of service*
[Primary Care] [Participating] Physician Office Visit	$25 Copayment per visit
Specialist Office Visit	$75 Copayment per visit
Surgical Care in Ambulatory Surgical Center or other Outpatient Medical Treatment Facility	$250 Copayment per surgical procedure
Diagnostic Procedures (including EKG, lab tests, traditional x-ray exams)	No Copayment
Imagery Services (including MRI, PET and CT scans)	$200 Copayment per service
Outpatient Rehabilitative Services (limited to 10 visits per [Calendar][Contract] Year)	$25 Copayment per visit
Non-surgical Spine and Back Disorder Treatment (limited to 10 visits per [Calendar][Contract] Year)	$25 Copayment per visit
Durable Medical Equipment, Prosthetics and Orthotics	No Copayment

Aetna Health, Inc.
BASIC HMO COPAY PLAN 1
SCHEDULE OF BENEFITS

Prescription Drugs * *Prescription Drugs and Oral Contraceptives filled or refilled at a Participating Pharmacy.*	**Member Responsibility** *Copayment paid at time of service.*
Preferred Generic Prescription Drug	$10 Copayment per prescription
Preferred Brand Prescription Drug	$50 Copayment per prescription
Non-Preferred Prescription Drug	$100 Copayment per prescription

Mental And Nervous Disorders Services *must be authorized by the Covered Person's [Primary Care][Participating] Physician [and] [Aetna]*	**Member Responsibility** *Copayment paid at time of service*
Inpatient Services in a Hospital or Psychiatric Treatment Facility. Maximum inpatient coverage of 5 days per Calendar Year	$750 Copayment per day for an authorized confinement
Outpatient Services Maximum outpatient coverage of 10 visits per Calendar Year, with a Maximum Reimbursement of $50 per visit.	$25 Copayment per visit

Alcohol and Substance Abuse Treatment Services *must be authorized by the Covered Person's [Primary Care][Participating] Physician [and] [Aetna]. Inpatient or outpatient treatment or any combination of the two is limited to a Lifetime Maximum Benefit of $2,000*	**Member Responsibility** *Copayment paid at time of service*
Inpatient Services in a Hospital or Psychiatric Treatment Facility	$750 Copayment per day for an authorized confinement
Outpatient Services Maximum outpatient coverage of 44 office visits, with a Maximum Reimbursement of $35 per visit.	$25 Copayment per visit

Special Services *All special services, as described in the Covered Services section, are subject to special conditions and limitations as stated below or as noted in the Certificate of Coverage.*	**Member Responsibility** *Copayment paid at time of service*
<u>Preventive Medical Care Services</u> The following services are covered, subject to the Copayments and the Calendar Year Maximum stated below. After the Calendar Year Maximum for these services has been reached, all Preventive Medical services are no longer covered under this Plan for the remainder of the Calendar Year. *Note: Aetna may waive cost sharing for these services or use an alternative cost sharing mechanism that does not exceed the level of a [Primary Care][Participating] Physician Office Visit.*	
CALENDAR YEAR MAXIMUM IS $250	
Periodic Health Assessment Exam	See Note
Home Health Care (limited to 60 visits per [Calendar][Contract] Year)	$25 Copayment per visit
Hospice (in lieu of hospitalization)	No Copayment
Skilled Nursing Facility (in lieu of hospitalization) Lifetime Benefit Maximum is 100 days.	No Copayment

**Prescription Drug Copayments do not contribute towards the Out-of-Pocket Maximum Expense Limit.*