Aetna Life Insurance Company (Aetna)
BASIC PPO Plan
SCHEDULE of BENEFITS
Plan 2

INDIVIDUAL LIFETIME MAXIMUM BENEFIT — $2 Million Dollars

DEDUCTIBLE — $2,500 Single / $7,500 Family

COINSURANCE PERCENTAGE

Participating Providers	60% of Allowance (Aetna Pays) 40% of Allowance (Covered Person Pays)
Non-Participating Providers	50% of Allowance (Aetna Pays) 50% of Allowance (Covered Person Pays)

OUT-OF-POCKET MAXIMUM EXPENSE LIMITS — $7,500 Single / $15,000 Family

PRIOR AUTHORIZATION PENALTY — 20%
(Penalty for failure to obtain authorization for specified Covered Services)

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

Hospital Services (including Maternity Care) *All Hospital care must be authorized by the Member's Participating Physician and Aetna*.	**Member Responsibility** *Coinsurance payment after satisfaction of the [Calendar] [Contract] Year Deductible*.
Inpatient Hospital Care	
Participating Providers	40% of Allowance
Non-Participating Providers	50% of Allowance
Outpatient Surgical Care	
Participating Providers	40% of Allowance
Non-Participating Providers	50% of Allowance

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Emergency Services and Care	**Member Responsibility** *Coinsurance payment after satisfaction of the [Calendar] [Contract] Year Deductible. Copayments must be paid at time of service.*
Emergency Room Visit At Hospital	
Participating Providers	40% of Allowance
Non-Participating Providers	40% of Allowance
Ambulance	
Participating Providers	40% of Allowance
Non-Participating Providers	50% of Allowance
Urgent Care	
Participating Providers	40% of Allowance
Non-Participating Providers	50% of Allowance

Outpatient Medical Treatment and Services *must be authorized by the Covered Person's Participating Physician and Aetna.*	**Member Responsibility** *Coinsurance payment after satisfaction of the [Calendar] [Contract] Year Deductible. Copayments must paid at time of service.*
Participating Physician Office Visit	
Participating Providers	$25 Copayment per visit
Non-Participating Providers	50% of Allowance
Specialist Office Visit	
Participating Providers	$75 Copayment per visit
Non-Participating Providers	50% of Allowance
Surgical Care in Ambulatory Surgical Center or other Outpatient Medical Treatment Facility	
Participating Providers	40% of Allowance
Non-Participating Providers	50% of Allowance
Diagnostic Procedures (including EKG, lab tests, traditional x-ray exams)	
Participating Providers	40% of Allowance
Non-Participating Providers	50% of Allowance
Imagery Services (including MRI, PET and CT scans)	
Participating Providers	40% of Allowance
Non-Participating Providers	50% of Allowance
Outpatient Rehabilitative Services (limited to 10 visits per [Calendar] [Contract] Year)	
Participating Providers	40% of Allowance
Non-Participating Providers	50% of Allowance
Non-surgical Spine and Back Disorder Treatment (limited to 10 visits per [Calendar] [Contract] Year)	
Participating Providers	40% of Allowance
Non-Participating Providers	50% of Allowance
Durable Medical Equipment, Prosthetics and Orthotics	
Participating Providers	40% of Allowance
Non-Participating Providers	50% of Allowance

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Prescription Drugs * *Prescription Drugs and Oral Contraceptives filled or refilled at a Participating or Non-Participating Pharmacy*.	**Member Responsibility** *Coinsurance payment after satisfaction of the [Calendar] [Contract] Year Deductible. Copayments must be paid at time of service*
Preferred Generic Prescription Drug	
Participating Providers	$10 Copayment per prescription
Non-Participating Providers	40% of Allowance
Preferred Brand Prescription Drug	
Participating Providers	$50 Copayment per prescription
Non-Participating Providers	40% of Allowance
Non- Preferred Prescription Drug	
Participating Providers	$100 Copayment per prescription
Non-Participating Providers	40% of Allowance

Mental And Nervous Disorders Services *must be authorized by the Covered Person's Participating Physician and Aetna.*	**Member Responsibility** *Coinsurance payment after satisfaction of the [Calendar] [Contract] Year Deductible. Copayments must be paid at time of service.*
Inpatient Services in a Hospital or Psychiatric Treatment Facility. Maximum inpatient coverage of 5 days per [Calendar] [Contract] Year	
Participating Providers	40% of Allowance
Non-Participating Providers	50% of Allowance
Outpatient Services. Maximum outpatient coverage of 10 visits per [Calendar] [Contract] Year, with a Maximum Reimbursement of $50 per visit.	
Participating Providers	40% of Allowance
Non-Participating Providers	50% of Allowance

Alcohol and Substance Abuse Treatment Services *must be authorized by the Covered Person's 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** *Coinsurance payment after satisfaction of the [Calendar] [Contract] Year Deductible. Copayments must be paid at time of service.*
Inpatient Services in a Hospital or Psychiatric Treatment Facility	
Participating Providers	40% of Allowance
Non-Participating Providers	50% of Allowance
Outpatient Services. Maximum outpatient coverage of 44 office visits, with a Maximum Reimbursement of $35 per visit.	
Participating Providers	40% of Allowance
Non-Participating Providers	50% of Allowance

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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** *Coinsurance payment after satisfaction of the [Calendar] [Contract] Year Deductible. Copayments must be paid at time of service. The Preventive Medical Services benefit is not subject to the [Calendar] [Contract] Year Deductible.*
Preventive Medical Services The following services are covered, subject to the Copayments and Coinsurance percentage and the [Calendar] [Contract] Year Maximum stated below. After the [Calendar] [Contract] 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] [Contract] Year.	
Periodic Health Assessment Exam	
Participating Providers	$25 Copayment per visit
Non-Participating Providers	50% of Allowance
PREVENTIVE MEDICAL SERVICES [CALENDAR] [CONTRACT] YEAR MAXIMUM IS $250	
Home Health Care (limited to 60 visits per [Calendar][Contract] Year)	
Participating Providers	40% of Allowance
Non-Participating Providers	50% of Allowance
Hospice (in lieu of hospitalization)	
Participating Providers	No Copayment
Non-Participating Providers	50% of Allowance
Skilled Nursing Facility (in lieu of hospitalization) Lifetime Benefit Maximum is 100 days.	
Participating Providers	40% of Allowance
Non-Participating Providers	50% of Allowance

**Prescription Drug Coinsurance Percentages and/or Copayments do not contribute towards the Out-of-Pocket Maximum Expense Limit.*