

| | POS Open Access First Dollar 35 | |
|---|--|--|
| MEMBER BENEFITS | In-Network | Out-of-Network ⁺ |
| Deductible Individual Family | \$0 \$0 | \$7,000 \$14,000 |
| Coinsurance (Member's Responsibility) | 35% | 50% after deductible |
| Coinsurance Maximum Individual Family | \$5,000 \$10,000 | \$5,500 \$11,000 |
| Out-of-Pocket Maximum Individual Family (deductible included) | \$5,000 \$10,000 | \$12,500 \$25,000 |
| Lifetime Maximum* | \$5,000,000 | |
| Non-Specialist Office Visit (General Physician, Family Practitioner, Pediatrician or Internist) | \$35 copay | 50% after deductible |
| Specialist Visit | \$45 copay | 50% after deductible |
| Hospital Admission | 35% | 50% after deductible |
| Outpatient Surgery | 35% | 50% after deductible |
| Urgent Care Facility | \$50 copay | 50% after deductible |
| Emergency Room | \$150 copay** (waived if admitted) 35% coinsurance | |
| Annual Routine Gyn Exam (Annual Pap/Mammogram) | \$0 copay | 50% after deductible |
| Maternity | Not covered (except for preg. complications) | Not covered (except for preg. complications) |
| Preventive Health (Routine Physical) (\$200 per exam) | \$35 copay | 50% after deductible |
| Lab/X-ray | 35% | 50% after deductible |
| Skilled Nursing (In lieu of Hospital) (30 days per calendar year*) | 35% | 50% after deductible |
| Physical/Occupational Therapy & Chiropractic Care (\$25 Max – 24 visits per calendar year*) | 35% | 50% after deductible |
| Home Health Care (In lieu of Hospital) (30 visits per calendar year*) | 35% | 50% after deductible |
| Durable Medical Equipment (\$2,000 per calendar year*) | 35% | 50% after deductible |
| PHARMACY | | |
| Pharmacy Deductible per Individual (does not apply to generic)* | \$500 | \$500 |
| Generic (Oral Contraceptives included) | \$15 copay deductible waived | 50% deductible waived |
| Preferred Brand Name | \$35 copay after deductible | 50% after deductible |
| Non-Preferred Brand (Oral Contraceptives included) | \$50 copay after deductible | 50% after deductible |
| Calendar Year Maximum per Individual* | Unlimited | Unlimited |

* Maximum applies to combined in- 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.

Aetna Advantage Plans for individuals, families and the self-employed are underwritten by Aetna Life Insurance Company (Aetna) directly and/or through an out of state blanket trust and Aetna Health Inc. In some states, individuals may qualify as a business group one and may be eligible for guaranteed issue, small group health 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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