

## AETNA MANAGED CHOICE OPEN ACCESS PLAN OPTIONS\*

PLAN OPTIONS	Managed Choice Open Access 21-09		Managed Choice Open Access 22-09	
MEMBER BENEFITS	Network	Out-of-Network	Network	Out-of-Network
<b>Plan Coinsurance</b>	10% after deductible	30% after deductible	0% after deductible	30% after deductible
<b>Calendar Year Deductible**</b>	\$500 Individual \$1,500 Family	\$1,000 Individual \$3,000 Family	\$1,000 Individual \$3,000 Family	\$2,000 Individual \$6,000 Family
<b>Calendar Year Maximum Out-of-Pocket Limit**</b>	\$1,000 Individual \$3,000 Family	\$2,000 Individual \$6,000 Family	Not Applicable	\$3,000 Individual \$9,000 Family
<b>Lifetime Maximum</b>	Unlimited	\$2,000,000	Unlimited	\$2,000,000
<b>Primary Care Physician Office Visit</b>	\$25 copay, deductible waived	30% after deductible	\$25 copay, deductible waived	30% after deductible
<b>Specialist Office Visit</b>	\$25 copay, deductible waived	30% after deductible	\$50 copay, deductible waived	30% after deductible
<b>Preventive Care</b>				
<b>Well-Child Exams</b> (Age/Frequency Schedules Apply)	\$0 copay, deductible waived	0%, deductible waived	\$0 copay, deductible waived	0%, deductible waived
<b>Immunizations</b>	\$0 copay, deductible waived	0%, deductible waived	\$0 copay, deductible waived	0%, deductible waived
<b>Adult Rhysicals</b> (Age/Frequency Schedules Apply)	\$25 copay, deductible waived	30% after deductible	\$25 copay, deductible waived	30% after deductible
<b>Routine GYN Exams and Routine Mammograms</b> (Age/Frequency Schedules Apply)	\$25 copay, deductible waived	30% after deductible	\$50 copay, deductible waived	30% after deductible
<b>Routine Vision Exams</b> One exam every 24 months; Network and Out-of-Network combined	\$25 copay, deductible waived	30% after deductible	\$50 copay, deductible waived	30% after deductible
<b>Outpatient Services</b> Lab, X-ray and Complex Imaging Services	\$25 copay, deductible waived	30% after deductible	\$50 copay, deductible waived	30% after deductible
<b>Inpatient Hospital</b>	10% after deductible	30% after deductible	0% after deductible	30% after deductible
<b>Outpatient Surgery</b>	10% after deductible	30% after deductible	0% after deductible	30% after deductible
<b>Emergency Room</b> Copay waived if admitted	\$100 copay, deductible waived	Paid as Network	\$100 copay, deductible waived	Paid as Network
<b>Urgent Care</b>	\$75 copay, deductible waived	30% after deductible	\$75 copay, deductible waived	30% after deductible
<b>Inpatient Mental Health</b>	10% after deductible	30% after deductible	0% after deductible	30% after deductible
	Plan F: <i>Biologically Based/Children with Serious Emotional Disturbances</i> : Unlimited days per calendar year, Network and Out-of-Network combined Other than <i>Biologically Based/Children with Serious Emotional Disturbances</i> : Maximum of 30 days per calendar year, Network and Out-of-Network combined Plan E and G: Maximum of 30 combined days per calendar year for <i>Biologically Based/Children with Serious Emotional Disturbances</i> and Other than <i>Biologically Based/Children with Serious Emotional Disturbances</i> , Network and Out-of-Network combined		Plan F: <i>Biologically Based/Children with Serious Emotional Disturbances</i> : Unlimited days per calendar year, Network and Out-of-Network combined Other than <i>Biologically Based/Children with Serious Emotional Disturbances</i> : Maximum of 30 days per calendar year, Network and Out-of-Network combined Plan E and G: Maximum of 30 combined days per calendar year for <i>Biologically Based/Children with Serious Emotional Disturbances</i> and Other than <i>Biologically Based/Children with Serious Emotional Disturbances</i> , Network and Out-of-Network combined	
<b>Inpatient Substance Abuse</b> Inpatient Detox - Maximum of 30 days per calendar year; Network and Out-of-Network combined Inpatient Rehab - Maximum of 30 days per calendar year; Network and Out-of-Network combined	10% after deductible	30% after deductible	0% after deductible	30% after deductible
<b>Chiropractic Services</b>	\$25 copay, deductible waived	30% after deductible	\$50 copay, deductible waived	30% after deductible
<b>Outpatient Physical, Occupational and Speech Therapy</b> Limited to 60 combined visits per calendar year; Network and Out-of-Network combined	10% after deductible	30% after deductible	0% after deductible	30% after deductible
<b>Durable Medical Equipment</b> \$2,500 calendar year maximum; Network and Out-of-Network combined	50% after deductible	50% after deductible	50% after deductible	50% after deductible
<b>Glasses and Contact Lens Reimbursement</b> Network and Out-of-Network combined	\$200 every 24 months		\$200 every 24 months	
<b>Aetna Vision Discounts Program</b>	Included	Not Covered	Included	Not Covered
<b>PRESCRIPTION DRUGS**</b>				
<b>Retail:</b> Up to a 30 day supply	Plan E: Generics Only - \$15 Plan F: \$0 / \$30 / \$50 Plan G: \$15 / \$35 / \$70	Plan E: Generics Only - \$15 plus 30% Plan F: \$0 / \$30 / \$50 plus 30% Plan G: \$15 / \$35 / \$70 plus 30%	Plan E: Generics Only - \$15 Plan F: \$0 / \$30 / \$50 Plan G: \$15 / \$35 / \$70	Plan E: Generics Only - \$15 plus 30% Plan F: \$0 / \$30 / \$50 plus 30% Plan G: \$15 / \$35 / \$70 plus 30%
<b>Mail Order:</b> 31 - 90 day supply	Plan E: Generics Only - \$30 Plan F: \$0 / \$60 / \$100 Plan G: \$30 / \$70 / \$140	Not Covered	Plan E: Generics Only - \$30 Plan F: \$0 / \$60 / \$100 Plan G: \$30 / \$70 / \$140	Not Covered

For footnotes, see page 15.