

AETNA MANAGED CHOICE OPEN ACCESS PLAN OPTIONS*

PLAN OPTIONS	Managed Choice Open Access 24-09		Managed Choice Open Access 26-09	
MEMBER BENEFITS	Network	Out-of-Network	Network	Out-of-Network
Plan Coinsurance	20% after deductible	40% after deductible	Not Applicable	30% after deductible
Calendar Year Deductible**	\$2,000 Individual \$6,000 Family	\$2,000 Individual \$6,000 Family	Not Applicable	\$2,000 Individual \$6,000 Family
Calendar Year Maximum Out-of-Pocket Limit**	\$2,000 Individual \$6,000 Family	\$4,000 Individual \$12,000 Family	Not Applicable	\$3,000 Individual \$9,000 Family
Lifetime Maximum	Unlimited	\$2,000,000	Unlimited	\$2,000,000
Primary Care Physician Office Visit	\$25 copay; deductible waived	40% after deductible	\$25 copay	30% after deductible
Specialist Office Visit	\$50 copay; deductible waived	40% after deductible	\$40 copay	30% after deductible
Preventive Care				
Well-Child Exams (Age/Frequency Schedules Apply)	\$0 copay; deductible waived	0%; deductible waived	\$0 copay	0%; deductible waived
Immunizations	\$0 copay; deductible waived	0%; deductible waived	\$0 copay	0%; deductible waived
Adult Physicals (Age/Frequency Schedules Apply)	\$25 copay; deductible waived	40% after deductible	\$25 copay	30% after deductible
Routine GYN Exams and Routine Mammograms (Age/Frequency Schedules Apply)	\$50 copay; deductible waived	40% after deductible	\$40 copay	30% after deductible
Routine Vision Exams One exam every 24 months; Network and Out-of-Network combined	\$50 copay; deductible waived	40% after deductible	\$40 copay	30% after deductible
Outpatient Services Lab, X-ray and Complex Imaging Services	\$50 copay; deductible waived	40% after deductible	\$40 copay	30% after deductible
Inpatient Hospital	20% after deductible	40% after deductible	\$500 copay per admission	30% after deductible
Outpatient Surgery	20% after deductible	40% after deductible	\$250 copay	30% after deductible
Emergency Room Copay waived if admitted	\$100 copay; deductible waived	Paid as Network	\$100 copay	Paid as Network
Urgent Care	\$75 copay; deductible waived	40% after deductible	\$75 copay	30% after deductible
Inpatient Mental Health	20% after deductible	40% after deductible	\$500 copay per admission	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	
Inpatient Substance Abuse	20% after deductible	40% after deductible	\$500 copay per admission	30% after deductible
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				
Chiropractic Services	\$50 copay; deductible waived	40% after deductible	\$40 copay	30% after deductible
Outpatient Physical, Occupational and Speech Therapy Limited to 60 combined visits per calendar year; Network and Out-of-Network combined	20% after deductible	40% after deductible	\$0 copay	30% after deductible
Durable Medical Equipment \$2,500 calendar year maximum; Network and Out-of-Network combined	50% after deductible	50% after deductible	50%	50% after deductible
Glasses and Contact Lens Reimbursement Network and Out-of-Network combined	\$200 every 24 months		\$200 every 24 months	
Aetna Vision Discounts Program	Included	Not Covered	Included	Not Covered
PRESCRIPTION DRUGS**				
Retail: 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%
Mail Order: 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.