

**AETNA MANAGED CHOICE OPEN ACCESS PLAN OPTIONS\***

PLAN OPTIONS	Managed Choice Open Access 27-09 (Limited Benefits Plan)		Managed Choice Open Access 29-09	
	Network	Out-of-Network	Network	Out-of-Network
<b>MEMBER BENEFITS</b>	Network	Out-of-Network	Network	Out-of-Network
<b>Plan Coinsurance</b>	30% after deductible	50% after deductible	Not Applicable	20% after deductible
<b>Calendar Year Deductible**</b>	\$3,000 Individual \$6,000 Family	\$3,000 Individual \$6,000 Family	Not Applicable	\$1,000 Individual \$3,000 Family
<b>Calendar Year Maximum Out-of-Pocket Limit**</b>	\$9,000 Individual \$18,000 Family	\$9,000 Individual \$18,000 Family	Not Applicable	\$3,000 Individual \$9,000 Family
<b>Lifetime Maximum</b>	\$2,000,000 Network and Out-of-Network combined		Unlimited	\$2,000,000
<b>Primary Care Physician Office Visit</b>	\$30 copay, deductible waived Limited to 6 Office Visits per calendar year; Network and Out-of-Network combined***	50%, deductible waived	\$25 copay	20% after deductible
<b>Specialist Office Visit</b>	\$50 copay, deductible waived Limited to 6 Office Visits per calendar year; Network and Out-of-Network combined***	50%, deductible waived	\$25 copay	20% after deductible
<b>Preventive Care</b>				
<b>Well-Child Exams</b> (Age/Frequency Schedules Apply)	\$0 copay, deductible waived	0%, deductible waived	\$0 copay	0%; deductible waived
<b>Immunizations</b>	\$0 copay, deductible waived	0%; deductible waived	\$0 copay	0%; deductible waived
<b>Adult Physicals</b> (Age/Frequency Schedules Apply)	\$30 copay, deductible waived	50% after deductible	\$25 copay	20% after deductible
<b>Routine GYN Exams and Routine Mammograms</b> (Age/Frequency Schedules Apply)	\$50 copay, deductible waived	50% after deductible	\$25 copay	20% after deductible
<b>Routine Vision Exams</b> One exam every 24 months; Network and Out-of-Network combined	\$50 copay, deductible waived	50% after deductible	\$25 copay	20% after deductible
<b>Outpatient Services</b> Lab, X-ray and Complex Imaging Services	30% after deductible	50% after deductible	\$25 copay	20% after deductible
<b>Inpatient Hospital</b>	30% after deductible	50% after deductible	\$500 copay per admission	20% after deductible
<b>Outpatient Surgery</b>	30% after deductible	50% after deductible	\$0 copay	20% after deductible
<b>Emergency Room</b> Copay waived if admitted (Does Not Apply to MC OA 27-09)	30% after deductible	Paid as Network	\$50 copay	Paid as Network
<b>Urgent Care</b>	Not Covered	Not Covered	\$35 copay	20% after deductible
<b>Inpatient Mental Health</b>	30% after deductible	50% after deductible Maximum of 30 combined days per calendar year for Biologically Based/Children with Serious Emotional Disturbances and Other than Biologically Based/Children with Serious Emotional Disturbances; Network and Out-of-Network combined	\$500 copay per admission	20% after deductible <b>Plan F:</b> Biologically Based/Children with Serious Emotional Disturbances: Unlimited days per calendar year, Network and Out-of-Network combined <b>Other than Biologically Based/Children with Serious Emotional Disturbances:</b> Maximum of 30 days per calendar year, Network and Out-of-Network combined <b>Plan E and G:</b> Maximum of 30 combined days per calendar year for Biologically Based/Children with Serious Emotional Disturbances and Other than Biologically Based/Children with Serious Emotional Disturbances; 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	30% after deductible	50% after deductible	\$500 copay per admission	20% after deductible
<b>Chiropractic Services</b>	See Specialist Office Visit		\$25 copay	20% after deductible
<b>Outpatient Physical, Occupational and Speech Therapy</b> Limited to 60 combined visits per calendar year; Network and Out-of-Network combined (Does Not Apply to MC OA 27-09)	See Specialist Office Visit		\$0 copay	20% after deductible
<b>Durable Medical Equipment</b> \$2,500 calendar year maximum; Network and Out-of-Network combined (Does Not Apply to MC OA 27-09)	Not Covered	Not Covered	50%	50% after deductible
<b>Glasses and Contact Lens Reimbursement</b> Network and Out-of-Network combined	Not Covered		\$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	Generics Only - \$15	Generics Only - \$15 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	Generics Only - \$30	Not Covered	Plan E: Generics Only - \$30 Plan F: \$0 / \$60 / \$100 Plan G: \$30 / \$70 / \$140	Not Covered

For footnotes, see page 15.