AETNA MANAGED CHOICE OPEN ACCESS PLAN OPTIONS*

PLAN OPTIONS	Managed Choice Open Access 31-07 (HSA Compatible†)*		Managed Choice Open Access 33-09	
MEMBER BENEFITS	Network	Out-of-Network	Network	Out-of-Network
Plan Coinsurance	20% after deductible	40% after deductible	10% after deductible	30% after deductible
Calendar Year Deductible**	$3,000 Individual $6,000 Family		$1,500 Individual $4,500 Family	$2,000 Individual $6,000 Family
Calendar Year Maximum Out-of-Pocket Limit**	$5,000 Individual $10,000 Family		$1,500 Individual $4,500 Family	$3,000 Individual $9,000 Family
Lifetime Maximum	Unlimited	$2,000,000	Unlimited	$2,000,000
Primary Care Physician Office Visit	20% after deductible	40% after deductible	$25 copay; deductible waived	30% after deductible
Specialist Office Visit	20% after deductible	40% after deductible	$40 copay; deductible waived	30% after deductible
Preventive Care				
Well-Child Exams (Age/Frequency Schedules Apply)	$0 copay; deductible waived	0%; deductible waived	$0 copay; deductible waived	0%; deductible waived
Immunizations	$0 copay; deductible waived	0%; deductible waived	$0 copay; deductible waived	0%; deductible waived
Adult Physicals (Age/Frequency Schedules Apply)	$10 copay; deductible waived	40%; deductible waived	$25 copay; deductible waived	30% after deductible
Routine GYN Exams and Routine Mammograms (Age/Frequency Schedules Apply)	$20 copay; deductible waived	40%; deductible waived	$40 copay; deductible waived	30% after deductible
Routine Vision Exams One exam every 24 months; Network and Out-of-Network combined	20% after deductible	40% after deductible	$40 copay; deductible waived	30% after deductible
Outpatient Services Lab, X-ray and Complex Imaging Services	20% after deductible	40% after deductible	$40 copay; deductible waived	30% after deductible
Inpatient Hospital	20% after deductible	40% after deductible	10% after deductible	30% after deductible
Outpatient Surgery	20% after deductible	40% after deductible	10% after deductible	30% after deductible
Emergency Room Copay waived if admitted (Does Not Apply to MC OA 31-07)	20% after deductible	Paid as Network	$100 copay; deductible waived	Paid as Network
Urgent Care	20% after deductible	40% after deductible	$75 copay; deductible waived	30% after deductible
Inpatient Mental Health	20% 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	40% after deductible	10% after deductible **Plan F:** *Biologically Based/Children with Serious Emotional Disturbances:* Unlimited days per calendar year; Network and Out-of-Network combined *Other than Biologically Based/Children with Serious Emotional Disturbances:* 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 Biologically Based/Children with Serious Emotional Disturbances and Other than Biologically Based/Children with Serious Emotional Disturbances, Network and Out-of-Network combined	30% after deductible
Inpatient Substance Abuse 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	20% after deductible	40% after deductible	10% after deductible	30% after deductible
Chiropractic Services	20% after deductible	40% after deductible	$40 copay; deductible waived	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	10% after deductible	30% after deductible
Durable Medical Equipment $2,500 calendar year maximum; Network and Out-of-Network combined	50% after deductible	50% after deductible	50% after deductible	50% after deductible
Glasses and Contact Lens Reimbursement Network and Out-of-Network combined	Not Covered		$200 every 24 months	
Aetna Vision Discounts Program	Included	Not Covered	Included	Not Covered
PRESCRIPTION DRUGS††				
Retail: Up to a 30 day supply	After plan deductible is met, $15 / $35 / $50	After plan deductible is met, $15 / $35 / $50 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	After plan deductible is met, $30 / $70 / $100	Not Covered	Plan E: Generics Only - $30 Plan F: $0 / $60 / $100 Plan G: $30 / $70 / $140	Not Covered

For footnotes, see page 15