

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

PLAN OPTIONS	Managed Choice Open Access 34-07 (HSA Compatible)*		Managed Choice Open Access 35-09 (HSA Compatible)*	
	Network	Out-of-Network	Network	Out-of-Network
<b>MEMBER BENEFITS</b>	Network	Out-of-Network	Network	Out-of-Network
<b>Plan Coinsurance</b>	0% after deductible	30% after deductible	0% after deductible	30% after deductible
<b>Calendar Year Deductible**</b>	\$3,000 Individual \$6,000 Family		\$1,500 Individual \$3,000 Family	
<b>Calendar Year Maximum Out-of-Pocket Limit**</b>	\$5,000 Individual \$10,000 Family		\$5,000 Individual \$10,000 Family	
<b>Lifetime Maximum</b>	Unlimited	\$2,000,000	Unlimited	\$2,000,000
<b>Primary Care Physician Office Visit</b>	0% after deductible	30% after deductible	0% after deductible	30% after deductible
<b>Specialist Office Visit</b>	0% after deductible	30% after deductible	0% after deductible	30% after deductible
<b>Preventive Care</b>				
<b>Well-Child Exams</b> <i>(Age/Frequency Schedules Apply)</i>	\$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 Physicals</b> <i>(Age/Frequency Schedules Apply)</i>	\$10 copay; deductible waived	30%; deductible waived	\$10 copay; deductible waived	30%; deductible waived
<b>Routine GYN Exams and Routine Mammograms</b> <i>(Age/Frequency Schedules Apply)</i>	\$20 copay; deductible waived	30%; deductible waived	\$20 copay; deductible waived	30%; deductible waived
<b>Routine Vision Exams</b> <i>One exam every 24 months; Network and Out-of-Network combined</i>	0% after deductible	30% after deductible	0% after deductible	30% after deductible
<b>Outpatient Services</b> <i>Lab, X-ray and Complex Imaging Services</i>	0% after deductible	30% after deductible	0% after deductible	30% after deductible
<b>Inpatient Hospital</b>	0% after deductible	30% after deductible	0% after deductible	30% after deductible
<b>Outpatient Surgery</b>	0% after deductible	30% after deductible	0% after deductible	30% after deductible
<b>Emergency Room</b>	0% after deductible	Paid as Network	0% after deductible	Paid as Network
<b>Urgent Care</b>	0% after deductible	30% after deductible	0% after deductible	30% after deductible
<b>Inpatient Mental Health</b>	0% after deductible	30% after deductible	0% after deductible	30% 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		<i>Biologically Based/Children with Serious Emotional Disturbances:</i> Unlimited days per calendar year; Network and Out-of-Network combined <i>Other than Biologically Based/Children with Serious Emotional Disturbances:</i> Maximum of 30 days per calendar year; Network and Out-of-Network combined	
<b>Inpatient Substance Abuse</b> <i>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</i>	0% after deductible	30% after deductible	0% after deductible	30% after deductible
<b>Chiropractic Services</b>	0% after deductible	30% after deductible	0% after deductible	30% after deductible
<b>Outpatient Physical, Occupational and Speech Therapy</b> <i>Limited to 60 combined visits per calendar year; Network and Out-of-Network combined</i>	0% after deductible	30% after deductible	0% after deductible	30% after deductible
<b>Durable Medical Equipment</b> <i>\$2,500 calendar year maximum; Network and Out-of-Network combined</i>	50% after deductible	50% after deductible	50% after deductible	50% after deductible
<b>Glasses and Contact Lens Reimbursement</b> <i>Network and Out-of-Network combined</i>	Not Covered		Not Covered	
<b>Aetna Vision Discounts Program</b>	Included	Not Covered	Included	Not Covered
<b>PRESCRIPTION DRUGS**</b>				
<b>Retail:</b> <i>Up to a 30 day supply</i>	After plan deductible is met, \$15 / \$35 / \$50	After plan deductible is met, \$15 / \$35 / \$50 plus 30%	After plan deductible is met, \$0 / \$30 / \$50	After plan deductible is met, \$0 / \$30 / \$50 plus 30%
<b>Mail Order:</b> <i>31 - 90 day supply</i>	After plan deductible is met, \$30 / \$70 / \$100	Not Covered	After plan deductible is met, \$0 / \$60 / \$100	Not Covered

For footnotes, see page 15.