Plan Details (2004)

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Member Services for Open Choice PPO

Hours	Monday through Friday 8am to 6pm
Phone Number	800 541 6711
Web Address	www.aetna.com
Group Contract Number	880780

Details on this page represent a summary for this plan. For further information, call the carrier directly at the number listed in Member Services.

Plan Provisions

	In Network	Out of Network
Medical Coinsurance/Copay/Deductibles/Benefit Maximum		
Office Visits - Preventive	$15 copay per office visit. Routine Immunizations and related office visits at 100%. Certain preventive services (bone mass density, cholesterol, fecal occult blood, sigmoidscopy, colonscopy) covered within US Preventive Taskforce Guidelines. (SEE NOTE)	Not covered: physical exams, eye and hearing exams, well-child care. 100% coverage for routine immunizations and related office visits.
Office Visits - Diagnostic	$15 copay per office visit. Lab, x-ray covered at 80% (subject to deductibles and out of pocket maximums).	70% coverage, subject to deductibles, and out-of-pocket maximums. Subject to R&C limits--unless POS provider used. (SEE NOTE)
Office Visits - Specialist	$15 copay with PCP referral. (SEE NOTE)	70%, coverage, subject to deductibles and out-of-pocket maximums. Subject to R&C limits--unless POS provider used. (SEE NOTE)
Annual Medical Deductible - Individual	$250	$500
Annual Medical Deductible - Family	$500	$1,000
Annual Out of Pocket Maximum - Individual	$1,000	$2,000
Annual Out of Pocket Maximum - Family	$2,000	$4,000
Lifetime Benefit Maximum	$2 million per individual in- and out-of-network.	$2 million per individual in- and out-of-network.
Note(s)	• **Office Visits - Preventive (In Network)** - Includes OB-GYN exams, physical exams (age 7 and up, 1 per year), eye and hearing exams (1 per 24 months), and well-child care (up to age 6). • **Office Visits - Diagnostic (Out of Network)** - Includes lab, x-ray. • **Office Visits - Specialist (In Network)** - For Chiropractic: Spinal Subluxation, $15 copay with PCP referral; 25 visit limit per calendar year; Maintenance therapy NOT covered. • **Office Visits - Specialist (Out of Network)** - For Chiropractic: Spinal Subluxation, 25 visit limit per calendar year; Maintenance therapy NOT covered.	

Prescription Drugs		
Retail	Up to 30 day supply: $0 Merck-brand drugs; $4 Generic drugs; $12 Non-Merck drugs. (SEE NOTE)	Up to 30 day supply: $0 Merck-brand drugs; $4 Generic drugs; $12 Non-Merck drugs. (SEE NOTE)
Mail / Home Delivery	Up to 90 day supply: $0 Merck-brand drugs; $4 Generic drugs; $12 Non-Merck drugs. Oral contraceptives and male erectile dysfunction are covered--but ONLY when ordered by mail or online through Medco Health Home Delivery Service. (SEE NOTE)	Up to 90 day supply: $0 Merck-brand drugs; $4 Generic drugs; $12 Non-Merck drugs. Oral contraceptives and male erectile dysfunction are covered--but ONLY when ordered by mail or online through Medco Health Home Delivery Service. (SEE NOTE)
Note(s)	• **Retail (In Network)** - Oral contraceptives & male erectile dysfunction drugs NOT covered through retail. Prescription contraceptive devices not covered through Managed RX Program (contact Aetna for coverage information about prescription contraceptive through the PPO option. • **Retail (Out of Network)** - Oral contraceptives & male erectile dysfunction drugs NOT covered through retail. Prescription contraceptive devices not covered through Managed RX Program (contact Aetna for coverage information about prescription contraceptive through the PPO option. • **Mail / Home Delivery (In Network)** - Prescription contraceptive devices NOT covered through Managed RX Program. Contact Aetna for more information regarding coverage through the PPO option for prescription contraceptive devices. • **Mail / Home Delivery (Out of Network)** - Prescription contraceptive devices NOT covered through Managed RX Program. Contact Aetna for more information regarding coverage through the PPO option for prescription contraceptive devices.	
Inpatient Services		
Inpatient Hospital Services	80% coverage; subject to deductibles and out-of-pocket maximums for Hospital, Maternity and Surgical.	70% coverage; subject to deductibles, out-of-pocket maximums and reasonable and customary limits for Hospital, Maternity and Surgical.
Outpatient Services		
Emergency Room	80% coverage for emergencies (70% coverage if not an emergency); subject to deductiblesand out-of-pocket maximums.	80% coverage (70% if not an emergency); subject to deductibles, out-of-pocket maximums and reasonable and customary limits.
Home Health Care	Home Health Care (if certified by PCP) and Skilled Nursing Care covered at 80% after deductible, up to out-of-pocket max, subject to reasonable and customary limits. Skilled Nursing Care limited to 120 days per calendar year.	Home Health Care (if certified by PCP) and Skilled Nursing Care covered at 70% after deductible, up to out-of-pocket max, subject to reasonable and customary limits. Skilled Nursing Care limited to 120 days per calendar year.
Mental Health / Substance Abuse		
Mental Health Inpatient	90% coverage in-network (if certified by ValueOptions) after deductible and up to out-of-pocket maximums.	60% coverage, (after deductible and up to out-of-pocket maximums), subject to reasonable and customary charges.
Mental Health Outpatient	100% coverage within Merck	60% coverage after deductible

	Employee Assistance and Behavioral Health Care Program (up to 2 sessions); $10 copay per authorized visit within ValueOptions. (SEE NOTE)	(subject to reasonable and customary charges); $40 maximum per visit. (SEE NOTE)
Substance Abuse Inpatient	90% coverage after deductible (up to out-of-pocket max) if certified by ValueOptions; lifetime limit of 4 treatment programs.	60% coverage after deductible (subject to reasonable and customary charges);lifetime limit of 4 treatment programs.
Substance Abuse Outpatient	100% coverage within Merck Employee Assistance and Behavioral Health Care Program (up to 2 sessions); $10 copay per authorized visit within ValueOptions. (SEE NOTE)	60% coverage after deductible (subject to reasonable and customary charges); $40 maximum per visit. (SEE NOTE)
Note(s)	• **Mental Health Outpatient (In Network)** - Your share of covered expenses does not count toward the annual out-of-pocket max under your medical plan option. • **Mental Health Outpatient (Out of Network)** - Your share of covered expenses does not count toward the annual out-of-pocket max under your medical plan option. • **Substance Abuse Outpatient (In Network)** - Your share of covered expenses does not count toward the annual out-of-pocket max under your medical plan option. • **Substance Abuse Outpatient (Out of Network)** - Your share of covered expenses does not count toward the annual out-of-pocket max under your medical plan option.	

A summary of the benefits provided under the plan is contained in the Summary Plan Description. Full details are provided in the official plan document, which governs the operation of the plan. In the event that the content of this application or any oral representations made by any person regarding the plan conflict with or are inconsistent with the provisions of the plan document, the provisions of the plan document are controlling. Any specific questions regarding coverage information please refer to your Summary Plan Description (SPD) or the carrier.

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