

## CALIFORNIA AETNA ADVANTAGE PLAN OPTIONS

	Managed Choice Open Access Value 5000	
MEMBER BENEFITS	In-Network	Out-of-Network <sup>+</sup>
<b>Deductible</b> Individual Family	\$5,000 \$10,000	\$10,000 \$20,000
<b>Coinsurance</b> (Member's Responsibility)	30% after deductible	50% after deductible
<b>Co-insurance Maximum</b> Individual Family	\$2,500 \$5,000	\$2,500 \$5,000
<b>Out-of-Pocket Maximum</b> Individual Family (deductible included)	\$7,500 \$15,000	\$12,500 \$25,000
<b>Lifetime Maximum*</b>	\$5,000,000	
<b>Non-specialist Office Visit</b> (General Physician, Family Practitioner, Pediatrician or Internist)	30% after deductible	50% after deductible
<b>Specialist Visit</b>	30% after deductible	50% after deductible
<b>Hospital Admission</b>	30% after deductible	50% after deductible
<b>Outpatient Surgery</b>	30% after deductible	50% after deductible
<b>Emergency Room</b> (After deductible)	\$100 copay** (waived if admitted) 30% coinsurance	
<b>Annual Routine Gyn Exam</b> (Annual Pap/Mammogram)	No Copay not subject to deductible	50% after deductible
Maternity	Not covered	Not covered
<b>Preventive Health</b> (\$200 per exam)	\$50 copay not subject to deductible	50% after deductible
<b>Lab/X-Ray</b>	30% after deductible	50% after deductible
<b>Skilled Nursing</b> (In lieu of Hospital) (30 days per calendar year*)	30% after deductible	50% after deductible
<b>Physical/Occupational Therapy &amp; Chiropractic Care</b> (\$25 Max -24 visits per calendar year*)	30% after deductible	50% after deductible
<b>Home Health Care</b> (In lieu of Hospital) (30 visits per calendar year*)	30% after deductible	50% after deductible
<b>Durable Medical Equipment</b> (\$2000 per calendar year*)	30% after deductible	50% after deductible
<b>PHARMACY</b>		
<b>Pharmacy Deductible per Individual</b> (does not apply to generic)*	\$1,000	\$1,000
<b>Generic</b> (Oral Contraceptives included)	\$20 copay not subject to deductible	\$20 copay plus 50% not subject to deductible
<b>Preferred Brand Name</b>	\$40 copay after deductible	\$40 copay plus 50% after deductible
<b>Non-Preferred Brand</b> (Oral Contraceptives Included)	Not covered	Not covered
<b>Calendar Year Maximum per Individual*</b>	\$2,500	\$2,500

\* Maximum applies to combined in and out-of-network benefits.

\*\* Copay is billed separately and not due at time of service. Copay does not count towards co-insurance or out of pocket max.

+ Payment for out of network facility care is determined based upon Aetna's Allowable Fee Schedule. Payment for other out-of-network facility care is determined based upon the negotiated charge that would apply if such services or supplies were received from a Preferred Provider.

For a full list of benefit coverage and exclusions refer to the plan documents.

The Aetna Advantage Plans for Individuals and Families are offered, underwritten or administered by Aetna Life Insurance or through an out-of-state blanket trust.

We want you to know<sup>®</sup>



www.aetna.com