

Highlighted items reflect changes from Blue Shield 2007 plans

MEDICAL BENEFITS - AETNA								
	*Aetna HMO - Low Option ²	*Aetna HMO - High Option ²	*Aetna's Managed Choice POS ^{2,3}		*Aetna's Open Access Plan ^{2,3}		*Aetna's HDHP Plan ^{2,3}	
			In-Network	Out-of-Network ¹	In-Network	Out-of-Network ¹	In-Network	Out-of-Network ¹
How it works	You must use Aetna's HMO providers or your care will not be covered (except in an emergency).		You may see any provider when you need care. You decide whether to see a network or an out-of-network provider each time you need care. When you see network providers you typically pay less.		You may see any provider when you need care. You decide whether to see a network or an out-of-network provider each time you need care. When you see network providers you typically pay less.		You may see any provider when you need care. You decide whether to see a network or an out-of-network provider each time you need care. When you see network providers you typically pay less.	
Medical Plan								
Annual Deductible	None	None	None	\$250/\$750	\$500/\$1500 (combined)		\$1,500/\$3,000 (combined)	
Lifetime Maximum	None	None	Unlimited		\$6 million (combined)		\$6 million (combined)	
Annual Co-Pay Maximum	\$1,500 individual \$3,000 family	\$1,500 individual \$3,000 family	\$1,500 individual \$4,500 family	\$3,000 individual \$9,000 family	\$4,000 / \$8,000	\$6,000 / \$12,000	\$4,500/\$9,000 (combined)	
Hospital Care								
Inpatient	\$250 copay / admit + 20%	\$100 copay / admit	\$200 copay / admit	\$200 copay / admit +20%	\$250 copay /admit +20%	40%	20%	40%
Outpatient	No charge	No charge	No charge	20%	20%	40%	20%	40%
Emergency Room (Copay waived if admitted)	\$100 copay No coverage for non-emergency	\$50 copay No coverage for non-emergency	\$50 copay No coverage for non-emergency	\$50 copay No coverage for non-emergency	\$75 copay+20% No coverage for non-emergency	\$75 copay+20% No coverage for non-emergency	20% No coverage for non-emergency	20% No coverage for non-emergency
Urgent Care**	\$20 copay	\$15 copay	\$15 copay	20%	\$30 copay	40%	20%	40%
Skilled Nursing	\$250 copay 100 days/year	No charge 100 days/year	No charge	20%	20%	40%	20%	20%
			100 days/year combined		100 days/year combined		100 days/year combined	
Physician Care								
Office Visits	\$20 copay	\$15 copay	\$15 copay	20%	\$30 copay	40%	20%	40%
Specialist Visits	\$20 copay	\$15 copay	\$15 copay	20%	\$30 copay	40%	20%	40%
Periodic Health Evaluation	\$20 copay	No charge	No charge	20%	\$30 copay	40%	No charge	40%
X-Ray & Lab Services	No charge	No charge	No charge	20%	20%	40%	20%	40%
Outpatient Rehabilitation Therapy	\$20 copay	\$15 copay	No charge	20%	20%	40%	20%	40%
Immunizations	\$20 copay	No charge	No charge	20%	\$30 copay	40%	No charge	40%
Home Health Care Services	\$20 copay 100 visits / year	\$15 copay 100 visits/year	No charge	20%	20%	20%	20%	40%
			100 visits / year combined		100 visits / year combined			
Chiropractic (Benefits provided through contracted chiropractic in ASH Plans Network)	\$20 copay 30 visits/year	\$15 copay 30 visits/year	\$15 copay 30 visits/year	Not covered	\$30 copay 12 visits/year	Not covered	20%	40%
							20 visits / year combined	
Prosthetics/Orthotics	No charge	No charge	No charge	20%	20%	40%	20%	40%

** Same copay for Urgent and Non-Urgent visits

	*Aetna HMO - Low Option ²	*Aetna HMO - High Option ²	*Aetna's Managed Choice POS ^{2,3}		*Aetna's Open Access Plan ^{2,3}		*Aetna's HDHP Plan ^{2,3}	
			In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Durable Medical Equipment (unlimited benefits based on medical necessity)	No charge	No charge	No charge	20%	20%	40%	20%	40%
Mental Health								
Severe Disorders-Inpatient	\$250 copay/ admit+20% unlimited days	\$100 copay/ admit unlimited days	\$200 copay/admit unlimited days	\$200 copay/ admit + 20% unlimited days	\$250 copay/ admit + 20% unlimited days	40% unlimited days	20% unlimited days	40% unlimited days
Severe Disorders-Outpatient	\$20 copay/ visit unlimited visits	\$15 copay/ visit unlimited visits	\$15 copay/visit unlimited visits	20% unlimited visits	\$30 copay /visit unlimited visits	40% unlimited visits	20% unlimited visits	40% unlimited visits
Non-Severe Disorders-Inpatient	\$250 copay/ admit + 20% unlimited days	\$100 copay/admit unlimited days	\$200 copay/admit unlimited days	\$200 copay/admit + 20% unlimited days	\$250 copay/admit + 20% unlimited days	40% unlimited days	20% unlimited days	40% unlimited days
Non-Severe Disorders-Outpatient	\$25 copay/ visit unlimited visits	\$20 copay/visit unlimited visits	\$15 copay/visit unlimited visits	20% unlimited visits	\$30 copay/visit unlimited visits	40% unlimited visits	20% unlimited visits	40% unlimited visits
Chem. Dependency Rehab-Outpatient	\$25 copay 20 visits / year	\$20 copay 20 visits / year	\$15 copay 20 visits / year combined	20% 20 visits / year combined	\$30 copay 20 visits / year combined	40% 20 visits / year combined	20% 20 visits / year combined	40% 20 visits / year combined
Detoxification-Inpatient (Detoxification only)	\$250 copay/ admit+20% 30 days / year	\$100 copay / admit 30 days / year	\$200 copay/ admit	\$200 copay/admit + 20%	\$200 copay/admit + 20%	40% per admission	20%	40%
Prescription Drugs								
Retail: Generic/Brand/Non-formulary	\$10 / \$35 / \$50 with a \$25 annual deductible on Tier2+3 drugs (30-day limit)	\$10 / \$30 / \$45 with a \$25 annual deductible on Tier2+3 drugs (30-day limit)	\$10 / \$20 / \$35 with a \$25 annual deductible on Tier2+3 drugs (30-day supply)	Not covered	\$15 / \$25 / \$40 with a \$25 annual deductible on Tier2+3 drugs (30-day supply)	Not covered	20%	20%
Mail Order: Generic/Brand/Non-formulary	\$20 / \$70 / \$100 with a \$25 annual deductible on Tier2+3 drugs (90-day limit)	\$20 / \$60 / \$90 with a \$25 annual deductible on Tier2+3 drugs (90-day limit)	\$20 / \$40 / \$70 with a \$25 annual deductible on Tier2+3 drugs (90-day supply)	Not covered	\$30 / \$50 / \$80 with a \$25 annual deductible on Tier2+3 drugs (90-day supply)	Not covered	20%	Not covered
Vision								
Screening (Routine Preventive performed by PCP, excludes refractions)	\$20 copay, subject to RPE schedule	\$15 copay, subject to RPE schedule	No charge	20% after deductible	\$30 copay/visit 1 exam/24 mos.	40%	no charge 1 exam/24 mos.	40%
Eyewear (Lens, Frame)	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered

*See Certificate of Coverage document for more details

1 For POS, Open Access & HDHP & plans, the out-of-network benefit applies to allowable charges. You will be responsible for additional charges above the allowable charges.

2 Some copays do not apply to the Annual Copay Maximum. Check your Certificate of Coverage for details.

3 The Managed Choice POS, Open Access, and HDHP Plans have a 6-month pre-existing condition limitation. If you have been previously covered by another health plan within 63 days, your prior coverage period will be used to reduce or eliminate this limitation. See Certificate of Coverage for details.