### Plan Name: Aetna Open Choice PPO 1

**Hours**
- In-Network: Mon - Fri 8:00 A.M. - 6:00 P.M. Eastern Time
- Out-of-Network: Mon - Sun - 24 hours

**Phone Numbers**
- Member Services: (800) 862-5441
- Behavioral Health: (800) 424-1601
- www.aetna.com or http://custom.aetna.com/Inova
  - (800) 556-1555 Mon - Sun - 24 hours

**Office Visits:**
- Preventive:
  - Copay: $20 per visit; Not Covered
- Diagnostic, Specialist, or OB/GYN:
  - Copay: $20 per visit; 60% coinsurance after deductible
  - Copay: $30 per visit; 60% coinsurance after deductible

**Annual Medical Deductible:**
- Individual: $250 per year; Applies to all expenses
- Family: $500 per year; Applies to all expenses

**Annual Coinsurance Limit Maximum:**
- Per Individual: $2,500
- Max Per Family: $5,000

**Annual Out-of-Pocket Maximum:**
- Individual: $5,000 per year; Including deductible, excluding copays
- Family: $10,000 per year; Including deductible, excluding copays

**Inpatient Services**
- Copay: $500 per admission; 80% coinsurance after deductible for Inova hospitals and affiliates; 70% other network hospitals
- Copay: $750 per admission; 60% coinsurance after deductible

**Outpatient Services:**
- Emergency Room:
  - $100 copay per incident, then 80% coinsurance after deductible; Copay is waived if confined;
  - If not classified as emergency, participant pays 100% of charges
  - Physician fees: 80% coinsurance after deductible;
  - Facility fees: 80% coinsurance after deductible (Inova hospitals);
  - 70% after deductible (other network hospitals)
- Urgent Care:
  - Copay: $20 per visit at Inova + non-hospital facilities
- Outpatient Surgery:
  - OB Copay: $30 for initial visit; then 60% coinsurance after deductible
  - Copay is waived if confined;
- Durable Medical Equipment:
  - 80% coinsurance after deductible
  - 80% coinsurance after deductible
  - 80% coinsurance after deductible
- X-ray and Lab Tests:
  - 80% coinsurance after deductible
- Maternity Care:
  - 80% coinsurance after deductible; maximum of 120 days per calendar year
- Home Health Care:
  - 80% coinsurance after deductible; maximum of 120 days per calendar year
- Mental Health and Substance Abuse:
  - Inpatient: 80% coinsurance after deductible (30 days Per Plan Year)
  - Outpatient: 80% coinsurance after deductible (42 visits Per Plan Year)
- Short-Term Rehabilitation:
  - 80% coinsurance after deductible; Each outpatient therapy – occupational, physical, and speech, is subject to a maximum of 30 visits per calendar year
  - 60% coinsurance after deductible; Each outpatient therapy – occupational, physical, and speech, is subject to a maximum of 30 visits per calendar year
- Licensed Chiropractor:
  - Copay: $30 per visit; Maximum of 30 visits per calendar year
  - 60% coinsurance after deductible; Maximum of 30 visits per calendar year

**Prescription Drugs:**
- Retail:
  - Copay: $10 generic/$25 brand formulary; $40 brand non-formulary; up to 30 day supply
  - Copay is waived if confined;
- Mail/Home Delivery:
  - Copay: $25 generic; $60 brand formulary; $100 brand non-formulary; up to 90 day supply

**Vision:**
- Examinations:
  - Benefits of $50 per exam; Visual Analysis $40 per exam
- Lenses:
  - Benefits of Single Vision $50 per pair/Bifocals $60 per pair/
  - Trifocals $70 per pair/Lenticular $85 per pair
  - Benefit of $50 per pair
- Contact Lenses:
  - $100 or $250 per pair dependent on condition

**Details:**
- You will be required to pay the copay plus the difference between brand name drugs and their generic equivalents if you receive brand name drugs when a generic alternative is available.
- You will be required to pay a higher copay on retail refills for maintenance medications. The penalty on the 4th fill (3rd refill) is a copay of $20 for generic, $50 for brand formulary, and $80 for brand non-formulary.

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