

Please note that the information contained in this table is a summary only. For more detailed information, please contact the Plan at the number provided. You also contact your local human resource professional. In the event that the information in this table differs from that contained in the Summary Plan Description (SPD), or the Summary Plan Description (SPD), or the information provided by the Plan, the information in the SPD and/or provided by the Plan shall control.

Highlighted Areas Reflect Changes for 2017		Aetna Open Choice PPO Plan	Aetna of Arizona
		Plan Information 1-800-387-4276 www.aetna.com	Plan Information 1-800-380-4407 www.aetna.com
		31 Network (PPO/POS) In-Network (Preferred)	31 Network (PPO/POS) In-Network (Preferred)
Price		\$13.75	\$13.75
Cost		\$13.75	\$13.75
Category		\$13.75	\$13.75
Network Benefits Available	Yes. You can see any physician you choose. You may see a higher coverage level if you select treatment and supplies from in-network providers.	Yes. You can see any physician you choose. You may see a higher coverage level if you select treatment and supplies from in-network providers.	Yes. To receive coverage, you must see an in-network provider.
Primary Care Physician Required	No	No	People members can visit their in-network (PPO) or Specialist depending on location and network (POS) care. Other healthcare services and supplies must be coordinated through your primary care physician. Other healthcare services and supplies must be coordinated through your primary care physician.
Out-of-Pocket Maximum	\$200.00	\$200.00	None
Family	\$200.00	\$1,800.00	None
Out-of-Pocket Maximum - Individual	\$3,000	\$4,000	\$1,500
Out-of-Pocket Maximum - Family	\$9,000	\$12,000	\$3,000
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Preventive Care	100% coverage, no copay	No coverage	\$37 copay, Once Per Year
Routine and Well Baby Care, Immunizations	100% coverage, no copay	No coverage	\$37 copay, not covered if solely for the purpose of travel or employment
Routine Gynecological exam	100% coverage, no copay, once per year, including Pap test and related lab fees	No coverage	\$35 copay, PPO or Specialist depending on location and network (POS) care. Other healthcare services and supplies must be coordinated through your primary care physician. Other healthcare services and supplies must be coordinated through your primary care physician.
Routine Mammogram	100% coverage, no copay (once per year for women ages 35 and over)	No coverage	\$35 copay (1 time, one age 35-39, age 40 and over, 1 per year)
Prostate Screening	100% coverage, no copay (once per year for men ages 45 and over)	No coverage	\$37 copay (Check Per Year for men ages 40 and over), Specialist copay may apply, depending on location and service rendered.
Routine Eye Exam	100% coverage, no copay (one per calendar year)	No coverage	\$37 copay (frequency and age schedule apply)
Lenses, Frames & Contact Lenses	100% coverage (up to a \$150 maximum benefit per calendar year per person)	100% coverage (up to a \$150 maximum benefit per calendar year per person)	Beneficiary Available through the Vision One Request Program
Routine Hearing Exam	100% coverage, no copay	No coverage	\$37 copay, specialist copay may apply, depending on location and service rendered.
Hearing Aid	100% coverage (up to a \$1,000 lifetime maximum per device)	100% coverage (up to a \$1,000 lifetime maximum per device)	Not Covered
Physician Office Services	100% coverage after copay	80% after deductible	\$37 copay, \$25 copay for after-hours/weekend
Consultation	100% coverage after \$15 copay (up to 15 visits per calendar year per person)	80% after deductible	100% after \$25 copay for initial visit, 100% after \$25 copay (includes and therapy services). Additional personal office visits - no charge.
In-office Surgeries, X-Ray and Lab Work	100% coverage after copay: \$15 PPO/POS Specialist	80% after deductible	\$35 copay (includes x-ray and lab work)
Allergy Treatment and Testing	100% coverage after \$15 copay (up to 15 visits per calendar year per person)	80% after deductible	\$35 copay for testing, \$20 copay for allergy injection in PCP office (See Surgeries copay)
Specialist	100% coverage after \$35 copay	80% after deductible	\$35 copay
Second Surgical Opinion	100% coverage, no copay, no deductible	100% coverage, no deductible	\$35 copay, PPO Member request
Hospital Services			
Room and Board	80% after deductible plus \$100 per confinement fee	80% after deductible plus \$400 per confinement fee	100% after \$240 copay
Pre-Admission Testing	80% coverage, no deductible	80% coverage, no deductible	Covered 100% after Inpatient Hospital copay
Lab & X-ray	80% coverage, after deductible	80% coverage, after deductible	Covered 100% after Inpatient Hospital copay
Surgey	80% coverage, after deductible	80% coverage, after deductible	Covered 100% after Inpatient Hospital copay
Physician Visits (In-Hospital)	80% coverage, after deductible	80% coverage, after deductible	Not covered - physician's Hospital visits.
Anesthesia	80% coverage, after deductible	80% coverage, after deductible	Covered 100% after Inpatient Hospital copay. Must be medically necessary and pre-authorized by the HMO.
Outpatient Services			
Surgey	80% coverage, after deductible	80% coverage, after deductible	100% after \$150 copay
Lab & X-ray	80% coverage, after deductible	80% coverage, after deductible	\$35 copay with PCP referral at facility, included in specialist copay at specialist office visit.
Emergency Room (Emergency Care)	100% coverage after \$150 copay (unless it is admitted, no deductible)	100% coverage after \$150 copay (unless it is admitted, no deductible)	100% after \$150 copay. Waived if admitted, \$240 inpatient hospital copay would then apply.
Hospital Emergency Room (Non-emergency Care)	80% coverage after deductible plus \$150 copay	80% coverage after deductible plus separate \$150 emergency room deductible	Not covered
Ambulance	80% coverage after deductible	80% coverage after deductible	100% when medically necessary during a medical emergency. Routine transportation not covered.
Alternative Care			
Conjunctive Facility	80% coverage after deductible (up to 30 days per calendar year per person)	80% coverage, after deductible (up to 30 days per calendar year per person)	100% after \$240 copay. Conjointive care is not covered. Skilled nursing facility covered after \$240 copay, pre-certification required.
Home Health Care	80% coverage after deductible (up to 20 visits per calendar year per person)	80% coverage after deductible (up to 20 visits per calendar year per person)	100% covered when mandated by participating Home Health Care Agency, referred by the PCP, and pre-authorized and pre-certified by the HMO.
Private-Duty Nursing	80% coverage after deductible (up to 75 8-hour shifts per calendar year per person)	80% coverage after deductible (up to 75 8-hour shifts per calendar year per person)	100% covered after the \$240 copay when medically necessary and pre-authorized by the HMO.
Hospice	100% coverage, no deductible	100% coverage, no deductible	100% covered after the \$240 copay for inpatient care. No copay for outpatient care, must be pre-authorized and pre-certified.
Other Services			
Family Planning (Voluntary Sterilization)	100% coverage after \$100 copay, no deductible	80% coverage, after deductible	Covered with applicable specialist, outpatient surgery or inpatient hospital copay. Reversal of voluntary sterilization including related follow-up care and treatment of complications of such procedures is not covered.
Short-term Rehabilitation	80% coverage after deductible (90 day max per course of treatment)	80% coverage, after deductible (90 day max per course of treatment)	\$35 copay per visit. Treatment over a 60 consecutive day period per incident of illness or injury beginning with the first day of treatment.
Durable Medical Equipment	80% coverage after deductible	80% coverage after deductible	\$0 copay
Chiropractic Care	80% coverage after a \$150 copay (20 visits per calendar year)	80% coverage after deductible (20 visits per calendar year)	\$35 copay per visit, 20 visit maximum per calendar year, no PCP referral required.
Biometric Surgery	80% coverage after deductible	80% coverage after deductible	Contact HMO provider
Mental Health Care			
Inpatient	80% after deductible plus \$100 per confinement fee, no maximum on number of days	80% after \$400 per confinement fee, no maximum on number of days	100% after \$240 copay (30 days per calendar year maximum)
Outpatient	100% after \$35 copay per visit (up to 45 visits per calendar year per person)	80% coverage after deductible plus \$400 payment per confinement (up to 45 visits per calendar year per person)	\$35 copay (up to 20 visits per calendar year)
Outpatient Psychiatric	See Outpatient Benefits	See Outpatient Benefits	See Outpatient Benefits
Partial Hospitalization	See Outpatient Benefits	See Outpatient Benefits	See Outpatient Benefits
Outpatient Abuse			
Inpatient	80% coverage after deductible plus \$200 per confinement fee (up to 45 visits per calendar year per person)	80% coverage after deductible plus \$400 per confinement fee (up to 45 days per calendar year per person)	100% after \$240 copay (30 day maximum per contract year)
Outpatient	100% after \$35 copay per visit (up to 20 visits per calendar year per person)	80% coverage after deductible (up to 45 visits per calendar year per person)	\$35 copay (up to 20 visits per contract year)
Prescription Drug Coverage			
Maximum	Unlimited	None	Unlimited
Retail			
Generic	100% after \$10 copay (30-day supply)	No coverage	\$10 copay (30 day supply)
Formulary Brand Name	100% after \$25 copay (30-day supply)	No coverage	\$20 copay (30 day supply)
Non-Formulary Brand Name	100% after \$25 copay (30-day supply)	No coverage	Not Covered
Smoking Cessation Aids	Discount given at pharmacy with valid prescription.	No coverage	Contact HMO provider
Mail Order			
Generic	100% after \$20 copay (90-day supply)	No coverage	\$20 copay (90 day supply)
Formulary Brand Name	100% after \$40 copay (90-day supply)	No coverage	\$40 copay (90 day supply)
Non-Formulary Brand Name	100% after \$60 copay (90-day supply)	No coverage	Not Covered
Smoking Cessation Aids	Discount given at mail order pharmacy with a valid prescription	No coverage	Contact HMO provider
Outpatient Prescriptions			
Generic	Not Applicable	100% after deductible	Not Applicable
Formulary Brand Name	Not Applicable	80% after deductible	Not Applicable
Non-Formulary Brand Name	Not Applicable	Not Applicable	Not Applicable
Coverage Continuation	Yes. See the Benefits Portal	Yes. See the Benefits Portal	Yes. Information regarding continuation of coverage, you must contact the HMO directly. If you are enrolled in the HMO, only the continuation of coverage allowed by the HMO will apply. The QDHP plan's continuation of coverage option will not apply if you are enrolled in the HMO option when your coverage ends.