

**AMERICAN INSTITUTE OF PHYSICS  
MEDICAL PLANS 2010**

BENEFITS	Aetna - NY & MD Choice PPO- Current Plan		Aetna - Maryland Choice- POS Flex		Aetna - Maryland HMO - Open Access
	Member's Responsibility		Member's Responsibility		Member's Responsibility
	In Network	Out of Network	In Network	Out of Network	In Network Only
<b>PHYSICIAN SERVICES</b>					
<b>Physician Office Visits</b>					
Annual Deductible	\$100/\$200	\$600/1,200	None	\$1,000/\$2,000	\$100/\$200
Your Co-pay (Primary/Spec.)	\$25/\$40	20% after Ded	\$25/\$40	20% after Ded	\$25/\$40
Annual OP Max.(Incl. Ded.)	N/A	\$1,500/\$3,000	\$1500/\$3000	\$5,000/\$10,000	\$1500/\$3000
<b>Maternity - Your Co-pay</b>	Copay 1st visit only	20% after Ded	\$25/\$40/1X then none	20% after Ded	\$25/\$40/1X then none
<b>Outpat Surg.</b>	\$150 co-pay	\$150 + 20% after Ded	\$250 copay	20% after Ded	\$200 copay
<b>Allergy Tests/Treatment</b>	Member cost sharing is based on the type of service performed and the place of service where it is rendered.				Member cost sharing is based on the type of service performed and the place of service where it is rendered.
Your Co-pay		20% after Ded	\$25/\$40	20% after Ded	
<b>Preventive Care</b>					
Annual Physical	\$25/\$40	20% after Ded	\$25/\$40	Not Covered	\$25/\$40
Mammography	Covered in Full	20% after Ded	\$25/\$40	20% after Ded	\$25/\$40
Well Child Care	\$25/\$40	20% after Ded	\$25/\$40	Not Covered	\$25/\$40
Immunizations/Screening	\$25/\$40	20% after Ded	\$25/\$40	20% after Ded	\$25/\$40
Pap Smears	\$25/\$40	20% after Ded	\$25/\$40/1X/yr	Not Covered	\$25/\$40
<b>Ment. Health/Subst. Abuse</b>	combined in/out of network				
<b>Inpatient Coverage</b>	100% after \$500 per confinement copay	\$500 per confinement copay, 20% after Ded	100% after \$500 per confinement copay	20% after Ded	\$700 copay
<b>Partial Hospitalization</b>	100% after Deductible	20% after Ded			
<b>Outpatient Coverage</b>	100% for all visits in a calendar year	Covered Same as specialist office visit after deductible	\$40 copay per visit	20% per visit	\$40 copay per visit
<b>Phys, Speech &amp; Occ. Ther.</b>					
Your Co-pay	Covered in Full	20% after Ded	\$25/\$40	20% after Ded	\$25/\$40
	Treatment of cleft lip, cleft palate, orthodontics, oral surgery, otologic, audiologic, speech therapy, physical therapy, and occupational therapy for covered children in conjunction with congenital or genetic birth defects				
Annual Maximum	combined 120 visits		120 visits	120 visits	120 visits
<b>Durable Medical Equipment</b>	Covered in Full	Covered in Full	Covered in Full	20% after Ded	Covered in Full
Your Co-pay					
<b>HOSPITAL SERVICES</b>					
<b>Semi-Private Room &amp; Board</b>		\$500 copay & 20% after Ded			
Your Co-pay	\$500		\$500	20% after Ded	\$700
<b>Emergency Room</b>	\$150 co-pay/vis. waived if admitted within 24 hours	\$150 co-pay/vis. waived if admitted within 24 hours	\$150 co-pay/visit waived if admitted within 24 hours	\$50 co-pay/visit waived if admitted within 24 hours	\$150 co-pay/visit waived if admitted within 24 hours
<b>Hospice Care (In&amp;Outpat.)</b>	Inpatient limited to 30 days per lifetime				
Your Co-pay	\$500 inpatient copay; Outpatient covered in full	\$500 copay & 20% after Ded	\$500 copay/100%	20% after Ded (\$10,000 lifetime max combined in and outpatient)	\$700 copay/100%
<b>OTHER BENEFITS</b>					
<b>Skilled Nursing Facility</b>		20% after Ded			
Your Co-pay	Covered in Full		\$500	20% after Ded Limited to 240 days and 35 visits	\$700
Annual Maximum	Limited to 70 eight hour shifts per calendar year		Covered in Full		Covered in Full
<b>Home Health Care</b>	combined 120 days/yr				
Your Co-pay	Covered in Full	Covered in Full	Covered in Full	20% after Ded	Limited to 3 intermittent visits per day; 1 visit equals 4 hrs or less.
<b>Chiropractic Care</b>					
Your Co-pay	Covered in Full	20% after Ded	\$40 copay/V, 20 visits	20% after Ded/\$1000 calendar yr max except NY	\$25/\$40 copay/V, 20 visits
<b>Prescription Drugs</b>					
Your Co-pay (Retail)	\$15generic/\$25brand/\$40nonform		\$15generic/\$25brand/\$40nonform		\$15gen/\$25brand/\$40nonform
Mail Order Co-pay (90 day)	\$30 generic/\$50 formulary/\$80 non formulary		\$30 generic/\$50 formulary/\$80 non formulary		\$30 gen/\$50 form/\$80 non form
<b>LIFETIME MAXIMUM</b>	Unlimited	Unlimited	Unlimited	\$1,000,000	Unlimited