

**AMERICAN INSTITUTE OF PHYSICS
MEDICAL PLANS 2010**

MARYLAND
Revised 10/13/2009

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
PHYSICIAN SERVICES					
Physician Office Visits					
Annual Deductible	\$100/\$200 - Applied to Hospital & Surgery	\$600/1,200	None	\$1,000/\$2,000	\$100/\$200 - Applied to Hospital & Surgery
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
Maternity - Your Co-pay	\$40/1X then none	20% after Ded	\$40/1X then none	20% after Ded	\$40/1X then none
Outpat Surg.	\$150 co-pay	\$150 copay & 20% after Ded	\$250 copay	20% after Ded	\$200 copay
Allergy Tests/Treatment	Member cost sharing is based on the type of service performed and the place of service where it is rendered.	20% after Ded		20% after Ded	Member cost sharing is based on the type of service performed and the place of service where it is rendered.
Your Co-pay			\$25/\$40		
Preventive Care					
Annual Physical/Immunization	\$25	20% after Ded	\$25	Not Covered	\$25
Mammography	Covered in Full	20% after Ded	\$40	20% after Ded	\$40
Well Child Care/Immunization	\$25	20% after Ded	\$25	Not Covered	\$25
Immunizations/Screening					\$25
Pap Smears	\$25 - 1 exam per cal yr	20% after Ded	\$40 - 1 exam per cal yr	Not Covered	\$40
Ment. Health/Subst. Abuse	combined in/out of network				
Inpatient Coverage	100% after \$500 per confinement copay	\$500 per confinement copay, 20% after Ded	100% after \$500 per confinement copay	20% after Ded	\$700 copay
Partial Hospitalization	100% after Deductible	20% after Ded			
Partial Hospitalization Max.					
Outpatient Coverage	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
Phys, Speech & Occ. Ther.					
Your Co-pay	Covered in Full	20% after Ded	\$40	20% after Ded	\$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			20 visits per illness or injury	
Annual Maximum	combined 120 visits		60 visits per illness or injury		120 visits
Durable Medical Equipment					
Your Co-pay	Covered in Full	Covered in Full	Covered in Full	20% after Ded	Covered in Full
HOSPITAL SERVICES					
Semi-Private Room & Board					
Your Co-pay	\$500	\$500 copay & 20% after Ded	\$500	20% after Ded	\$700
Emergency Room	\$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	\$150 co-pay/visit waived if admitted within 24 hours	\$150 co-pay/visit waived if admitted within 24 hours
Hospice Care (In&Outpat.)	Inpatient limited to 30 days per lifetime				
Your Co-pay	\$500 inpatient copay; Outpatient covered in full	20% after \$500 copay inpatient; 20% after Ded outpatient	\$500 copay/100%	20% after Ded (\$10,000 lifetime max combined in and outpatient)	\$700 copay/100%
OTHER BENEFITS					
Skilled Nursing Facility					
Your Co-pay	Covered in Full	20% after Ded	\$500	20% after Ded Limited to 240 days per calendar year	\$700
Annual Maximum	Limited to 120 days per calendar year		Covered in Full		Covered in Full
Home Health Care	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.
Chiropractic Care					
Your Co-pay	Covered in Full	20% after Ded	\$40 copay/V, 20 visits	20% after Ded/\$1000 calendar yr max except NY	\$40 copay/V, 20 visits
Prescription Drugs					
Your Co-pay (Retail)	\$15generic/\$25brand/\$40nonform		\$15generic/\$25brand/\$40nonform		\$15gen/\$25brand/\$40nonform
Retail/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
LIFETIME MAXIMUM	Unlimited	Unlimited	Unlimited	\$1,000,000	Unlimited