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 may also contact your local human resource professional. In the event that the information in this table differs from that contained in the Summary Plan Document (SPD), or otherwise provided by the Plan, the information in the SPD and/or provided by the Plan shall control.

Highlighted Areas Reflect Changes for 2011	**Aetna Open Choice PPO Plan**		**Triple-S Puerto Rico**
	For Information:		
	1-800-367-6276		
	www.aetna.com		
	In Network ("Preferred Provider")	Out of Network	
Single:	$63.85		$29.21
Family:	$148.55		$68.17
Network Benefits Available	Yes. You can see any physician you choose, but you will receive a higher coverage level if you obtain treatment and supplies from in-network providers.		Yes. In Basic Coverage, Dental and Pharmacy. Out of Network coverage through Major Medical
Primary Care Physician Required	No		No.
Individual	$200.00	$600	The upfront deductible will not apply. The 20% coinsurance will apply from the first dollar cost amount.
Family	$600.00	$1,800	The upfront deductible will not apply. The 20% coinsurance will apply from the first dollar cost amount.
Out-of-Pocket Maximums - Individual	$3,000	$4,000	The maximum Out of Pocket will not apply. The 20% coinsurance will apply to all services.
Out-of-Pocket Maximums - Family	$9,000	$12,000	The maximum Out of Pocket will not apply. The 20% coinsurance will apply to all services.
Lifetime Maximum	Unlimited	Unlimited	Major Medical lifetime maximum of $1 million per life, per insured. Organ and Tissue Transplant has a lifetime maximum of $1 million per type, per insured, per life.
Physical Exams	100% coverage, no copay	No coverage	$15 copay
Routine and Well Baby Care; Immunizations	100% coverage, no copay	No coverage	Covers DPT, Polio, MMR, Varivax, Hemophilus Influenza B, Hepatitis B, Td, Tetanus Toxoid, Influenza and respiratory syncytial virus vaccines according to the Triple-S Salud established protocol.
Routine Gynecological exam	100% coverage, no copay. (once per year, including Pap test and related lab fees)	No coverage	$15 copay, lab fees 25% coinsurance
Routine Mammogram	100% coverage, no copay (once per year for women ages 35 and over)	No coverage	25% coinsurance; According to Medical Recommendation
Prostate Screening	100% coverage, no deductible (once per year for men ages 40 and over)	No coverage	25% coinsurance; According to Medical Recommendation
Routine Eye Exam	100% coverage, no copay (one per calendar year)	No coverage	25% coinsurance; by Ophthalmologist

Highlighted Areas Reflect Changes for 2011	Aetna Open Choice PPO Plan		Triple-S Puerto Rico
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)	up to $150; Frames and Contact lenses covered by reimbursement every two years
Routine Hearing Exam	100% coverage, no copay	No coverage	Covered in Major Medical
Hearing Aid	100% coverage (up to a $1,000 lifetime maximum per person)	100% coverage (up to a $1,000 lifetime maximum per person)	$250 per year; In Major Medical Coverage
Office Visits	100% coverage after copay: $20 PCP/$35 Specialist	60% after deductible	$5 copay Generalist/$15 Specialist
Maternity	100% coverage after first $20 copayment ($35 for specialist); subsequent visits are included in the delivery fee and paid at 90% after deductible	60% after deductible	$15 copay
In-office Surgeries, X-Ray and Lab Work	100% coverage after copay: $20 PCP/$35 Specialist	60% after deductible	75% coinsurance - X-Rays and Laboratories
Allergy Treatment and Testing	100% coverage after $20/$35 copay when part of office visit otherwise 100%, no copay, no deductible	60% after deductible	50 tests covered, Injections not covered
Specialist	100% coverage after $35 copayment	60% after deductible	$15 copay
Second Surgical Opinion	100% coverage, no copay, no deductible	100% coverage, no deductible	Standard Office Visit copay
Room and Board	90% after deductible plus $200 per confinement fee	60% after deductible plus $400 per confinement fee	$50 copay
Pre-Admission Testing	90% coverage, no deductible	60% coverage, no deductible	Apply 25% coinsurance
Lab & X-ray	90% coverage, after deductible	60% coverage, after deductible	100%
Surgery	90% coverage, after deductible	60% coverage, after deductible	100%
Physician Visits (In Hospital)	90% coverage, after deductible	60% coverage, after deductible	100%

Highlighted Areas Reflect Changes for 2011	Aetna Open Choice PPO Plan		Triple-S Puerto Rico
Anesthesia	90% coverage, after deductible	60% coverage, after deductible	100%
Surgery	90% coverage, after deductible	60% coverage, after deductible	100% covered; $75 copay for ambulatory services
Lab & X-ray	90% coverage, after deductible	60% coverage, after deductible	25% coinsurance
Hospital Emergency Room (Emergency Care)	90% coverage after $200 copay (waived if admitted), no deductible	90% coverage after $200 copay (waived if admitted), no deductible	$20 copay; waived if pre-certified through Teleconsulta
Hospital Emergency Room (Non-emergency Care)	50% coverage after deductible plus $150 copay	50% coverage after deductible plus separate $150 emergency room deductible	Urgency Rooms not covered/ Covered $20 deductible
Ambulance	80% coverage after deductible	80% coverage after deductible	$80 by reimbursement
Convalescent Facility	90% coverage after deductible (up to 90 days per calendar year per person)	60% coverage, after deductible (up to 90 days per calendar year per person)	Covered at 100% up to 120 days per policy year
Home Health Care	90% coverage after deductible (up to 90 visits per calendar year per person)	60% coverage, after deductible (up to 90 visits per calendar year per person)	25% coinsurance
Private-Duty Nursing	90% coverage after deductible (up to 70 8-hour shifts per calendar year per person)	60% coverage, after deductible (up to 70 8-hour shifts per calendar year per person)	Special Nurses only included in home health care and in the hospital. Mental Disorders
Hospice	100% coverage, no deductible	100% coverage, no deductible	Covered under Individual Case Management.
Family Planning (Voluntary Sterilization)	100% coverage after $100 copay, no deductible	60% coverage, after deductible	100%
Short-term Rehabilitation	80% coverage after deductible (60 day max per course of treatment)	80% coverage, after deductible (60 day max per course of treatment)	$7 copay - Physical therapy up to 20 therapies per policy year combined with chiropractor manipulations. $5 copay - Respiratory therapy up to 20 therapies per policy year.
Durable Medical Equipment	80% coverage after deductible	80% coverage after deductible	25% coinsurance; Covered up to a maximum of $5,000 per policy year
Chiropractic Care	100% coverage after a $20/$35 copay (20 visits per calendar year)	60% coverage, after deductible (20 visits per calendar year)	Covered up to 20 manipulations combined with physical therapies.
Bariatric surgery	50% after deductible	50% after deductible	Contact HMO provider
Inpatient	80% after deductible plus $200 per confinement fee; no maximum on number of days	60% after $400 per confinement fee; no maximum on number of days	$50 copay
Outpatient	100% after $35 copay per visit (up to 45 visits per calendar year per person)	60% coverage after deductible plus $400 inpatient per confinement fee(up to 45 visits per calendar year per person)	$15 copay; According to medical necessity
Outpatient Psychiatric	See Outpatient Benefits	See Outpatient Benefits	$15 copay: According to medical necessity

Highlighted Areas Reflect Changes for 2011	Aetna Open Choice PPO Plan		Triple-S Puerto Rico
Partial Hospitalization	See Outpatient Benefits	See Outpatient Benefits	$50 copay
Inpatient	80% coverage after deductible plus $200 per confinement fee (up to 45 visits per calendar year per person	60% coverage after deductible plus $400 per confinement fee (up to 45 days per calendar year per person)	$50 copay
Outpatient	100% after $35 copay per visit (up to 45 visits per calendar year per person)	60% coverage after deductible (up to 45 visits per calendar year per person)	Covered according to justified medical necessity.
Maximum	Unlimited	None	Acute drugs 15 day supply no refills, maintenance drugs 30 day supply 5 refills
Retail			
Generic	100% after $10 copay (30-day supply)	No coverage	$5 copay (Generic Bioequivalent mandatory)
Formulary Brand Name	100% after $20 copay (30-day supply)	No coverage	$8 copay for preferred, $10 copay for brand
Non-Formulary Brand Name	Participant pays 35% of cost (minimum of $35 but no more than $100) for a 30-day supply	No coverage	20% coinsurance; minimum $10
Smoking Cessation Aids	Discount given at pharmacy with a valid prescription	No coverage	Contact HMO provider
Mail Order			
Generic	100% after $20 copay (90-day supply)	No coverage	$10 copay (Generic Bioequivalent mandatory)
Formulary Brand Name	100% after $40 copay (90-day supply)	No coverage	$16 copay for preferred, $20 copay for brand
Non-Formulary Brand Name	Participant pays 35% of cost (minimum of $70 but no more than $200) for a 90-day supply	No coverage	20% coinsurance, minimum $30
Smoking Cessation Aids	Discount given at mail order pharmacy with a valid prescription	No coverage	Not Covered
Overseas Prescriptions			
Generic	Not Applicable	100% after deductible	Triple-S will reimburse 75% if established fees for those drugs
Formulary Brand Name	Not Applicable	80% after deductible	Triple-S will reimburse 75% if established fees for those drugs
Non-Formulary Brand Name	Not Applicable	Not Applicable	Triple-S will reimburse 75% if established fees for those drugs
	Yes. Click here for more information	Yes. Click here for more information	Continuation of coverage is available through this vendor. For information regarding COBRA, you must contact the HMO directly.

	Aetna Dental		Stand Alone Dental	
Highlighted Areas Reflect Changes for 2011				
	Preferred Care Benefits* (In-Network)	Non-Preferred Care Benefits* (Out-of-Network/Overseas)	Preferred Care Benefits* (In-Network)	Non-Preferred Care Benefits* (Out-of-Network/Overseas)
Price				
	Single: $4.08		Single: $17.27	
	Family: $9.64		Family: $40.84	
Calendar Year Deductible				
Individual	$100	$100	$100	$100
Family	$300	$300	$300	$300
Calendar Year Benefit Maximum				
	$2,000 per person	$2,000 per person	$2,000 per person	$2,000 per person
Preventive Care				
Routine oral exams & cleanings - two per calendar year	100% no deductible (based on contracted rates)	100% no deductible (subject to reasonable & customary charges)	100% no deductible (based on contracted rates)	100% no deductible (subject to reasonable & customary charges)
Problem focused exams - two per calendar year	100% no deductible (based on contracted rates)	100% non deductible (subject to reasonable & customary charges)	100% no deductible (based on contracted rates)	100% non deductible (subject to reasonable & customary charges)
X-rays (frenquency limits apply), flouride treatment and sealants to age 18	100% no deductible (based on contracted rates) no age limit on flouride treatment	100% no deductible (based on reasonable & customary charges) no age limit on flouride treatment	100% no deductible (based on contracted rates). Flouride treatment to age 15	100% non deductible (subject to reasonable & customary charges) Flouride treatment to age 15
Dental Medical Integration	Provides extra cleaning for high risk medical conditions. Covered at 100% (based on contracted rates) See SPD for details	Provides extra cleaning for high risk medical conditions. Covered at 100% (based on reasonable and customary charges) See SPD for details	N/A	N/A
Basic Care				
Fillings, extractions, general anesthesia, space maintainers to age 19, palliative treatments	80% after deductible (based on contracted rates)	80% after deductible (based on reasonable & customary charges)	80% after deductible (based on contracted rates)	80% after deductible (subject to reasonable & customary charges)
	(based on contracted rates)	(subject to reasonable and customary charges)	(based on contracted rates)	(subject to reasonable and customary charges)
Restorative Care				
Endodontic (root canal therapy), periodontics	80% after deductible	80% after deductible	50% after deductible	50% after deductible
Inlays, crowns, fixed bridgework	50% after deductible (includes gold fillings)	50% after deductible (includes gold fillings)	50% after deductible (includes gold fillings)	50% after deductible (includes gold fillings)
	(based on contracted rates)	(subject to reasonable and customary charges)	(based on contracted rates)	(subject to reasonable and customary charges)
Oral Surgery				

	Aetna Dental		Stand Alone Dental	
(services that are dental in nature)	100% of first $1,000; then 80% thereafter, not subject to the deductible and calendar year maximum (based on contracted rates)	100% of first $1,000; then 80% thereafter, not subject to the deductible and calendar year maximum (subject to reasonable and customary charges)	80% after deductable (based on contracted rates)	80% after deductable (subject to reasonable and customary charges)
TMJ Treatment				
(Temporomandibular Joint Dysfunction)	50%, no deductible	50%, no deductible	not covered	not covered
	(based on contracted rates)	(subject to reasonable and customary charges)		
	$750 lifetime maximum per person	$750 lifetime maximum per person		
Orthodontia for adults and children				
	50%, no deductible	50%, no deductible	50%, no deductible after 12 mo waiting period	50%, no deductible after 12 mo waiting period
	(based on contracted rates)	(subject to reasonable and customary rates)	(based on contracted rates)	(subject to reasonable and customary rates)
	$2,000 lifetime maximum per person.	$2,000 lifetime maximum per person.	$1,500 lifetime maximum per person.	$1,500 lifetime maximum per person
	Coverage includes TMJ appliances.	Coverage includes TMJ appliances.	Coverage includes TMJ appliances.	Coverage includes TMJ appliances.