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 contro

Highlighted Areas Reflect Changes for 2007	**Aetna Open Choice PPO Plan**		**Kaiser Northern California**
	For Information: 1-800-367-6276 www.aetna.com		For Information: 1-800-464-4000
	In Network ("Preferred Provider")	Out of Network	
Price			
Single:	$53.74		$58.63
Family:	$125.03		$134.85
General			
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. To receive coverage, you must see an in-network provider.
Primary Care Physician Required	No		Yes. All healthcare services and supplies must be coordinated through your primary care physician.
Deductible			
Individual	$200.00	$600	None
Family	$600.00	$1,800	None
Out of Pocket Maximum (Plan Pays 100% of eligible expenses after you reach this)			
Out-of-Pocket Maximums - Individual	$3,000	$4,000	$1,500
Out-of-Pocket Maximums - Family	$9,000	$12,000	$3,000
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Preventive Care			
Physical Exams	100% coverage, no copay	No coverage	$20 copay
Routine and Well Baby Care; Immunizations	100% coverage, no copay	No coverage	$20 copay/ $5 Well-child visits to age 2
Routine Gynecological exam	100% coverage, no copay. (once per year, including Pap test and related lab fees)	No coverage	$20 copay (No charge for pap and lab work, once per year)
Routine Mammogram	100% coverage, no copay (once per year for women ages 35 and over)	No coverage	Covered in Full (for women age 35 and over, once per year)
Prostate Screening	100% coverage, no deductible (once per year for men ages 40 and over)	No coverage	$20 copay (for men ages 40 and over, once per year)
Routine Eye Exam	100% coverage, no copay (one per calendar year)	No coverage	$20 copay (no frequency limit; screenings only)
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)	available at member rates
Routine Hearing Exam	100% coverage, no copay	No coverage	$20 copay (no frequency limit; screenings only)
Hearing Aid	100% coverage (up to a $1,000 lifetime maximum per person)	100% coverage (up to a $1,000 lifetime maximum per person)	available at member rates
Physician Office Services			
Office Visits	100% coverage after copay: $15 PCP/$35 Specialist	60% after deductible	$20 copay
Maternity	100% coverage after first $15 copayment ($35 for specialist); subsequent visits are included in the delivery fee and paid at 90% after deductible	60% after deductible	$20 copay
In-office Surgeries, X-Ray and Lab Work	100% coverage after copay: $15 PCP/$35 Specialist	60% after deductible	$20 copay
Allergy Treatment and Testing	100% coverage after $15/$35 copay when part of office visit otherwise 100%, no copay, no deductible	60% after deductible	Testing - $20 copay, Injections - $3 copay
Specialist	100% coverage after $35 copayment	60% after deductible	$20 copay
Second Surgical Opinion	100% coverage, no copay, no deductible	100% coverage, no deductible	$20 copay
Hospital Services			
Room and Board	90% after deductible plus $200 per confinement fee	60% after deductible plus $400 per confinement fee	$200 copay per admission
Pre-Admission Testing	90% coverage, no deductible	60% coverage, no deductible	100%
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%
Anesthesia	90% coverage, after deductible	60% coverage, after deductible	100%
Outpatient Services			
Surgery	90% coverage, after deductible	60% coverage, after deductible	$20 copay per procedure (100% for Lab)
Lab & X-ray	90% coverage, after deductible	60% coverage, after deductible	100%
Emergency Room Care			
Hospital Emergency Room (Emergency Care)	100% coverage after $150 copay (waived if admitted), no deductible	100% coverage after $150 copay (waived if admitted) no deductible	$100 copay (waived if admitted)
Hospital Emergency Room (Non-emergency Care)	50% coverage after deductible plus $150 copay	50% coverage after deductible plus separate $150 emergency room deductible	$100 copay at Kaiser Facility/ Not Covered non-Kaiser Facility
Ambulance	80% coverage after deductible	80% coverage after deductible	$100 copay
Alternative Care			
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)	See EOC
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)	No Copay
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)	See EOC
Hospice	100% coverage, no deductible	100% coverage, no deductible	No Copay
Other Services			
Family Planning (Voluntary Sterilization)	100% coverage after $100 copay, no deductible	60% coverage, after deductible	$20 per visit
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)	$20 per visit
Durable Medical Equipment	80% coverage after deductible	80% coverage after deductible	20% member pays coinsurance (when prescribed by physician (per formulary guidelines)
Chiropractic Care	100% coverage after a $15/$35 copay (20 visits per calendar year)	60% coverage, after deductible (20 visits per calendar year)	Not Covered
Bariatric surgery	50% after deductible	50% after deductible	Contact HMO provider
Mental Health Care			
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	$200 copay (Up to 45 calendar days per year; No limit for mental health parity diagnosis)
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)	$20 copay individual/ $10 copay for group therapy (Maximum of 20 visits per year; No limit for mental health parity diagnosis)
Outpatient Psychiatric	See Outpatient Benefits	See Outpatient Benefits	Same as mental health
Partial Hospitalization	See Outpatient Benefits	See Outpatient Benefits	See EOC
Substance Abuse			
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)	$200 inpatient copay per admission
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)	$20 copay individual, $5 copay per group (20 visit maximum per year, Mental Health and Substance Abuse combined)
Prescription Drug Coverage			
Maximum	Unlimited	None	None
Retail			
Generic	100% after $10 copay (30-day supply)	No coverage	$10 copay (100 day supply)
Formulary Brand Name	100% after $25 copay (30-day supply)	No coverage	$30 copay (100 day supply, 50% for sexual dysfunction drugs)
Non-Formulary Brand Name	100% after $35 copay (30-day supply)	No coverage	$30 copay (100 day supply, 50% for sexual dysfunction drugs)
Smoking Cessation Aids	Discount given at pharmacy with a valid prescription	No coverage	Contact HMO provider
Mail Order			**Mail Order**
Generic	100% after $20 copay (90-day supply)	No coverage	$20 copay (100 day supply)
Formulary Brand Name	100% after $40 copay (90-day supply)	No coverage	$60 copay (100 day supply, 50% for sexual dysfunction drugs)
Non-Formulary Brand Name	100% after $60 copay (90-day supply)	No coverage	$60 copay (100 day supply, 50% for sexual dysfunction drugs)
Smoking Cessation Aids	Discount given at mail order pharmacy with a valid prescription	No coverage	Contact HMO provider
Overseas Prescriptions			
Generic	Not Applicable	100% after deductible	Information not provided by carrier
Formulary Brand Name	Not Applicable	80% after deductible	Information not provided by carrier
Non-Formulary Brand Name	Not Applicable	Not Applicable	Information not provided by carrier
Coverage Continuation			
	Yes. See Benefits Portal	Yes. See Benefits Portal	For information regarding continuation of coverage, you must contact the HMO directly. If you are enrolled in the HMO option, only the continuation of coverage offered by the HMO will apply. The DoD NAF plan's continuation of coverage option will not apply if you are enrolled in the HMO option when your coverage ends.