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 2007	**Aetna Open Choice PPO Plan**		**HMSA BCBS Hawaii**	**Kaiser Hawaii**
	For Information: 1-800-367-6276 www.aetna.com		For Information: 1-808-948-6372	For Information: 1-800-966-5955 or 1-808-432-5955
	In Network ("Preferred Provider")	Out of Network		
Price				
Single:	$53.74		$34.39	$31.51
Family:	$125.03		$95.94	$88.22
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.	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.	Yes. All healthcare services and supplies must be coordinated through your primary care physician.
Deductible				
Individual	$200.00	$600	None	None
Family	$600.00	$1,800	None	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	$1,500
Out-of-Pocket Maximums - Family	$9,000	$12,000	$4,500	$4,500
Lifetime Maximum	Unlimited	Unlimited	Unlimited	
Preventive Care				
Physical Exams	100% coverage, no copay	No coverage	$14 copay	$14 copay plus 10% lab/X-ray
Routine and Well Baby Care; Immunizations	100% coverage, no copay	No coverage	100% up to 5 years	100% after $14 copay, up to 6 yrs. Immunizations: no charge for most
Routine Gynecological exam	100% coverage, no copay. (once per year, including Pap test and related lab fees)	No coverage	100% one per calendar yr.	$14 copay per visit, plus 10% lab/X-ray
Routine Mammogram	100% coverage, no copay (once per year for women ages 35 and over)	No coverage	100% for women age 35 and over	100% Covered
Prostate Screening	100% coverage, no deductible (once per year for men ages 40 and over)	No coverage	100%	100% Covered
Routine Eye Exam	100% coverage, no copay (one per calendar year)	No coverage	Eye exam (1 / yr): 100% after $14 copay, in network	100% after $14 copay
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)	No additional benefits other than what is available through the Vision plan	Not Covered
Routine Hearing Exam	100% coverage, no copay	No coverage	100% after $14 copay	100% after $14 copay
Hearing Aid	100% coverage (up to a $1,000 lifetime maximum per person)	100% coverage (up to a $1,000 lifetime maximum per person)	80% covered	Not Covered
Physician Office Services				
Office Visits	100% coverage after copay: $15 PCP/$35 Specialist	60% after deductible	100% after $14 copay per visit	$14 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	100%	$14 copay for initial visit, 100% covered thereafter
In-office Surgeries, X-Ray and Lab Work	100% coverage after copay: $15 PCP/$35 Specialist	60% after deductible	$14 copay per visit; surgery, X-ray lab 100% with office visit	$14 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	100% after $14 copay	$14 copay
Specialist	100% coverage after $35 copayment	60% after deductible	100% after $14 copay and PCP referral	$14 copay
Second Surgical Opinion	100% coverage, no copay, no deductible	100% coverage, no deductible	100% after $14 copay and PCP referral	$14 copay
Hospital Services				
Room and Board	90% after deductible plus $200 per confinement fee	60% after deductible plus $400 per confinement fee	Inpatient expenses covered 100%	100%
Pre-Admission Testing	90% coverage, no deductible	60% coverage, no deductible	100%	90% covered for lab, imaging, and testing
Lab & X-ray	90% coverage, after deductible	60% coverage, after deductible	100%	90%
Surgery	90% coverage, after deductible	60% coverage, after deductible	100%	100%
Physician Visits (In Hospital)	90% coverage, after deductible	60% coverage, after deductible	100%	100%
Anesthesia	90% coverage, after deductible	60% coverage, after deductible	100%	100%
Outpatient Services				
Surgery	90% coverage, after deductible	60% coverage, after deductible	100%	$14 copay
Lab & X-ray	90% coverage, after deductible	60% coverage, after deductible	100% for all lab and diagnostic services, 90% X-rays	90% covered
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	$25 copay – statewide; 80% worldwide	$25 copay in Kaiser Hawaii Service area; 80% outside service area
Hospital Emergency Room (Non-emergency Care)	50% coverage after deductible plus $150 copay	50% coverage after deductible plus separate $150 emergency room deductible	Not covered statewide; Not covered worldwide	Not covered
Ambulance	80% coverage after deductible	80% coverage after deductible	80%	20% 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)	Not a benefit	Skilled Nursing Facility, 60 days per benefit period
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)	100%	100% Covered
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)	50%	Not Covered
Hospice	100% coverage, no deductible	100% coverage, no deductible	100%	100% Covered
Other Services				
Family Planning (Voluntary Sterilization)	100% coverage after $100 copay, no deductible	60% coverage, after deductible	Copay varies. Contact plan.	Outpatient surgery $14 copay
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)	$14 copay per office visit. 100% covered for out-patient and in-patient hospital.	$14 copay per visit
Durable Medical Equipment	80% coverage after deductible	80% coverage after deductible	80% covered	20% Copay
Chiropractic Care	100% coverage after a $15/$35 copay (20 visits per calendar year)	60% coverage, after deductible (20 visits per calendar year)	Not a benefit	Not Covered
Bariatric surgery	50% after deductible	50% after deductible	Contact HMO provider	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	100% semi private, 30 days inpatient.	100% covered (30 days per year)
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)	100% after $14 copay for 24 sessions. Substance abuse: maximum of 2 treatment episodes	$14 copay per visit (24 visits per year)
Outpatient Psychiatric	See Outpatient Benefits	See Outpatient Benefits	100% after $14 copay for 24 sessions. Substance abuse: maximum of 2 treatment episodes	$14 copay per visit (24 visits per year)
Partial Hospitalization	See Outpatient Benefits	See Outpatient Benefits	Copay varies. Contact plan.	Not covered
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)	100% semi private. Must be approved by Benefit Manager	100% Covered
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)	100% after $14 copay. Must be approved by Benefit Manager.	$14 copay per visit
Prescription Drug Coverage				
Maximum	Unlimited	None	None	None
Retail				
Generic	100% after $10 copay (30-day supply)	No coverage	$10 (30 day supply)	$10 copay; 30 day supply
Formulary Brand Name	100% after $25 copay (30-day supply)	No coverage	$30 (30 day supply)	$10 copay; 30 day supply
Non-Formulary Brand Name	100% after $35 copay (30-day supply)	No coverage	See brochure for non-formulary costs	Not Covered
Smoking Cessation Aids	Discount given at pharmacy with a valid prescription	No coverage	Contact HMO provider	Contact HMO provider
Mail Order				
Generic	100% after $20 copay (90-day supply)	No coverage	$20 (90 day supply)	$20 copay; 90 day supply
Formulary Brand Name	100% after $40 copay (90-day supply)	No coverage	$60 (90 day supply)	$20 copay; 90 day supply
Non-Formulary Brand Name	100% after $60 copay (90-day supply)	No coverage	Not covered	Not Covered
Smoking Cessation Aids	Discount given at mail order pharmacy with a valid prescription	No coverage	Contact HMO provider	Contact HMO provider
Overseas Prescriptions				
Generic	Not Applicable	100% after deductible	100% after $10 copay	Not Covered
Formulary Brand Name	Not Applicable	80% after deductible	100% after $30 copay	Not Covered
Non-Formulary Brand Name	Not Applicable	Not Applicable	Not covered	Not Covered
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.	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.