

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	PacificCare of Washington
	For information: 1-800-367-5278 www.aetna.com	For information: 1-800-692-3004 www.pacificcare.com
	In Network ("Preferred Provider")	Out of Network
Price		
Single:	\$53.74	\$61.52
Family:	\$1,020.00	\$1,146.55
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
Family	\$600.00	\$1,800
Out of Pocket Maximum (Plan Pays 100% of eligible expenses after you reach this)		
Out-of-Pocket Maximums - Individual	\$3,000	\$4,000
Out-of-Pocket Maximums - Family	\$9,000	\$12,000
Lifetime Maximum	Unlimited	Unlimited
Preventive Care		
Physical Exams	100% coverage, no copay	No coverage
Routine and Well Baby Care; Immunizations	100% coverage, no copay	No coverage
Routine Gynecological exam	100% coverage, no copay (once per year, including Pap test and related lab fees)	No coverage
Routine Mammogram	100% coverage, no copay (once per year for women ages 35 and over)	No coverage
Prostate Screening	100% coverage, no deductible (once per year for men ages 40 and over)	No coverage
Routine Eye Exam	100% coverage, no copay (one per calendar year)	No coverage
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)
Routine Hearing Exam	100% coverage, no copay	No coverage
Hearing Aid	100% coverage (up to a \$1,000 lifetime maximum per person)	100% coverage (up to a \$1,000 lifetime maximum per person)
Physician Office Services		
Office Visits	100% coverage after copay: \$15 PCP/\$35 Specialist	60% after deductible
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
In-office Surgeries, X-Ray and Lab Work	100% coverage after copay: \$15 PCP/\$35 Specialist	60% after deductible
Allergy Treatment and Testing	100% coverage after \$15/\$35 copay when part of office visit otherwise 100%, no copay, no deductible	60% after deductible
Specialist	100% coverage after \$35 copayment	60% after deductible
Second Surgical Opinion	100% coverage, no copay, no deductible	100% coverage, no deductible
Hospital Services		
Room and Board	80% after deductible plus \$200 per confinement fee	60% after deductible plus \$400 per confinement fee
Pre-Admission Testing	90% coverage, no deductible	60% coverage, no deductible
Lab & X-ray	90% coverage, after deductible	60% coverage, after deductible
Surgery	90% coverage, after deductible	60% coverage, after deductible
Physician Visits (In Hospital)	90% coverage, after deductible	60% coverage, after deductible
Anesthesia	90% coverage, after deductible	60% coverage, after deductible
Outpatient Services		
Surgery	90% coverage, after deductible	60% coverage, after deductible
Lab & X-ray	90% coverage, after deductible	60% coverage, after deductible
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
Hospital Emergency Room (Non-emergency Care)	50% coverage after deductible plus \$150 copay	50% coverage after deductible plus separate \$150 emergency room deductible
Ambulance	80% coverage after deductible	80% coverage after deductible
Alternative Care		
Convenient 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)
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)
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)
Hospice	100% coverage, no deductible	100% coverage, no deductible
Other Services		
Family Planning (Voluntary Sterilization)	100% coverage after \$100 copay, no deductible	60% coverage, after deductible
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)
Durable Medical Equipment	80% coverage after deductible	80% coverage after deductible
Chiropractic Care	100% coverage after a \$15-\$35 copay (20 visits per calendar year)	60% coverage, after deductible (20 visits per calendar year)
Bariatric surgery	50% after deductible	50% after deductible
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
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)
Outpatient Psychiatric	See Outpatient Benefits	See Outpatient Benefits
Partial Hospitalization	See Outpatient Benefits	See Outpatient Benefits
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)
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)
Prescription Drug Coverage		
Maximum	Unlimited	None
Retail		
Generic	100% after \$10 copay (30-day supply)	No coverage
Formulary Brand Name	100% after \$25 copay (30-day supply)	No coverage
Non-Formulary Brand Name	100% after \$35 copay (30-day supply)	No coverage
Smoking Cessation Aids	Discount given at pharmacy with a valid prescription	No coverage
Mail Order		
Generic	100% after \$20 copay (90-day supply)	No coverage
Formulary Brand Name	100% after \$40 copay (90-day supply)	No coverage
Non-Formulary Brand Name	100% after \$60 copay (90-day supply)	No coverage
Smoking Cessation Aids	Discount given at mail order pharmacy with a valid prescription	No coverage
Overseas Prescriptions		
Generic		100% after deductible
Formulary Brand Name	Not Applicable	80% after deductible
Non-Formulary Brand Name	Not Applicable	Not Applicable
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.