

<p>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.</p>	<p>Aetna Open Choice PPO Plan</p>		<p>Aetna of Georgia</p>	<p>Kaiser GA</p>
	<p>For Information:</p>		<p>For Information:</p>	<p>For information:</p>
	<p>1-800-367-6276</p>		<p>1-800-323-9930</p>	<p>1-800-611-1811</p>
	<p>www.aetna.com</p>		<p>www.aetna.com</p>	
	<p>In Network ("Preferred Provider")</p>	<p>Out of Network</p>		
<p>Price</p>				
	<p>Single: \$46.20</p>		<p>Single: \$43.76</p>	<p>Single: \$32.05</p>
	<p>Family: \$107.49</p>		<p>Family: \$128.08</p>	<p>Family: \$93.91</p>
<p>General</p>				
<p>Network benefits available?</p>	<p>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.</p>		<p>Yes. To receive coverage, you must see an in-network provider.</p>	<p>Yes. To receive coverage, you must see an in-network provider.</p>
<p>Primary Care Physician (PCP) required?</p>	<p>No</p>		<p>Female members can visit their in-network GYN w/o referral for routine annual exam & medically necessary GYN care. Otherwise, healthcare services and supplies must be coordinated through your primary care physician.</p>	<p>Yes. All healthcare services and supplies must be coordinated through your primary care physician.</p>

Deductible				
Individual	None	\$400	None	None
Family	None	\$1,200	None	None
Out-of-Pocket Limit (Plan pays 100% of eligible expenses after you reach this)				
Individual	\$2,000	\$3,000	\$1,500	\$2,000
Family	\$6,000	\$9,000	\$3,000	\$6,000 family
Lifetime Maximum				
	Unlimited	Unlimited	Unlimited	No Maximum
Preventive Care				
Routine physical exam and immunizations (once per year)	100% coverage, no copay	No coverage	\$15 copay (Not covered if solely for the purpose of travel or employment)	100%; well child care until age 24 months, \$10 per visit thereafter
Well-child care	100% coverage, no copay	No coverage	\$15 copay	100% after \$10 copay
Routine gynecological exam	100% coverage, no copay	No coverage	\$15 copay	\$15 per visit
(including Pap test and related lab fees, once per year)				
Mammogram	100% coverage, no copay	No coverage	\$15 copay (1 base line age 35-39, age 40 and over, 1 per year)	100% covered
(once per year for women ages 35 and over)				
Prostate screening exam	100% coverage, no copay	No coverage	\$15 copay	\$15 per visit
(once per year for men ages 40 and over)				
Routine eye screening	100% after copay: \$15 PCP/\$25 Specialist	No coverage	\$15 copay, frequency and age schedules apply.	100% at eye centers after \$15 copay
Lenses, eyeglass frames and contacts	100% coverage (up to a \$75 maximum benefit per calendar year per person)	100% coverage (up to a \$75 maximum benefit per calendar year per person)	Discounts available through the Vision One Discount Program.	Discounts for vision hardware
(in addition to Vision plan benefit)				

Routine hearing exam	100% coverage, no copay	No coverage	\$15 copay	\$15 per visit
Hearing aids	100% coverage (up to a \$500 lifetime maximum per person)	100% coverage (up to a \$500 lifetime maximum per person)	Not covered	Not covered
Physician Services				
Office visits for treatment of illness or injury	100% coverage after copay: \$15 PCP/\$25 Specialist	70% after deductible	\$15 copay	100% after \$10 copay; specialty copay \$15
Maternity	100% coverage after first \$15 copayment (\$25 for specialist)	70% after deductible	100% after \$15 copay for first visit only. 100% hospitalization after \$240 copay	100% hospital and office visit expenses. No charge for pre-natal or 1st post-natal visit; \$15 for additional postnatal visits
In-office surgery, x-ray and lab work	100% coverage after copay: \$15 PCP/\$25 Specialist	70% after deductible	\$15 copay	100% after \$15 copay
Allergy testing, serum and injections	100% coverage after \$15/\$25 copay when part of office visit otherwise 100%, no copay	70% after deductible	\$15 copay for testing. \$15 copay for allergy injection in PCP office. No serum copay	\$15 allergist visit, \$50/6 months for serum, \$5 injection copay
Specialists	100% coverage after \$25 copayment	70% after deductible	\$25 copay	\$15 per visit
(Office Visits)				
Second Surgical Opinion	100% coverage, no copay	100% coverage, no deductible	Standard Copay Applies	\$15 per visit
Hospital Services - Inpatient				
Hospital room & board, and ancillary services	90% after \$200 per confinement fee	70% after deductible and separate \$400 per confinement fee	100% after \$240 copay	100% for semi-private room after \$250 copay
Preoperative testing	90% coverage, no copay	70% coverage, no deductible	100%	100%
Lab and x-ray	90% coverage, no copay	70% coverage, after deductible	100%	100%
Surgery	90% coverage, no copay	70% coverage, after deductible	100%	100%

Physician hospital visits	90% coverage, no copay	70% coverage, after deductible	100%	100%
Anesthesia	90% coverage, no copay	70% coverage, after deductible	100%	100%
Hospital Services - Outpatient				
Surgery	90% coverage, no copay	70% coverage, after deductible	100% after \$100 copay	100% after \$100 copay
Independent lab and x-ray facilities	90% coverage, no copay	70% coverage, after deductible	\$15 copay	100% after \$15 copay
Emergency				
Hospital emergency room (emergency care)	100% coverage after \$100 copay (waived if admitted)	100% coverage after \$100 copay (waived if admitted)	100% after \$100 copay; \$35 copay for urgent care facility (waived if admitted within 24 hours)	\$100 at all Emergency Rooms - waived if admitted
Hospital emergency room (non-emergency care)	50% coverage after \$100 copayment	50% coverage after deductible	Not covered	Not covered
Ambulance	80% coverage, no copay	80% coverage after deductible	100% when medically necessary during a medical emergency. Routine transportation not covered.	\$100 copay for authorized trips
Health Care Alternatives				
Convalescent facility	90% coverage, no copay (up to 90 days per calendar year per person)	70% coverage, after deductible (up to 90 days per calendar year per person)	100% after \$240 copay	Up to 100 days per calendar year when medically necessary
Home health care	90% coverage, no copay (up to 90 visits per calendar year per person)	70% coverage, after deductible (up to 90 visits per calendar year per person)	100%	100%
Private duty nursing	90% coverage, no copay (up to 70 8-hour shifts per calendar year per person)	70% coverage, after deductible (up to 70 8-hour shifts per calendar year per person)	Not covered unless pre-authorized by HMO; no copay when covered	100% in patient if physician determines medically necessary
Hospice	100% coverage, no copay	100% coverage, no deductible	100% after \$240 copay	Benefits of hospice care instead of traditional services - 100%
Other Health Care				

Family planning	100% coverage after \$100 copay	70% coverage, after deductible	Covered with applicable specialist, outpatient surgery or inpatient hospital copay. Reversal of voluntary sterilization including related follow-up care and treatment of complications of such procedures is not covered.	Female tubal--\$100 copay for Outpatient; \$250 copay for Inpatient. Male vasectomy--\$15 copay for outpatient; \$250 copay for inpatient
(voluntary sterilization)				
Short-term rehabilitation	80% coverage, no copay	80% coverage, after deductible	\$15 copay per visit up to 60 consecutive day maximum per course of treatment	Greater of 2 consecutive months or 20 visits per year, per condition. \$15 copay
	(60 day max per course of treatment)	(60 day max per course of treatment)		
Durable medical equipment	80% coverage, no copay	80% coverage, no deductible	100%	20% coinsurance
Chiropractic	100% coverage after a \$15/\$25 copay (20 visits per calendar year)	70% coverage, after deductible (20 visits per calendar year)	Not covered	Not covered
Mental Health Care				
Inpatient	80% after \$200 per confinement fee; no maximum on number of days	60% after \$400 per confinement fee; no maximum on number of days	100% after \$240 copay up to 35 days per contract yr	100%, unlimited days after \$250 copay
Outpatient	100% after \$25 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)	\$25 copay up to 20 visits per contract year	\$15 copay per visit, unlimited visits
Outpatient Psychiatric	See Outpatient Benefits	See Outpatient Benefits	See Outpatient Benefits	\$15 copay per visit
Partial Hospitalization	See Outpatient Benefits	See Outpatient Benefits	See Outpatient Benefits	100% covered, semi-private room after \$15 copay; when medically necessary
Substance Abuse Treatment				

Inpatient	80% coverage after \$200 per confinement fee (up to 45 visits per calendar year per person)	60% coverage after \$400 per confinement fee (up to 45 days per calendar year per person)	100% after \$240 copay up to 35 days per contract yr	100% for detoxification unlimited number of treatments. \$250 copay for inpatient, Limited to 30 days per calendar year; \$15 copay for outpatient.
Outpatient	100% after \$25 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)	\$15 copay up to 60 visits per contract year	\$15 copay per visit up to 40 visits per calendar year
Prescriptions				
Maximum	Unlimited	None	Unlimited	No Maximum
Local retail network pharmacies	Generic: 100% after \$10 copay (30-day supply)	Generic: No coverage	Generic: \$10; 30 day supply	Generic: \$10 at Kaiser Pharmacies, \$16 when filled at Eckerd's. 30 day supply
	Formulary Brand Name: 100% after \$20 copay (30-day supply)	Formulary Brand Name: No coverage	Formulary Brand Name: \$20; 30 day supply	Formulary Brand Name: \$20 at Kaiser Pharmacies, \$26 when filled at Eckerd's. 30 day supply
	Non-formulary Brand Name: 100% after \$30 copay (30-day supply)	Non-formulary Brand Name: No coverage	Non-formulary Brand Name: Not covered	Non-formulary Brand Name: Formulary applies
Mail-order Service	Generic: 100% after \$10 copay (90-day supply)	Generic: No coverage	Generic: \$20; 90 day supply	Generic: Three times the retail copay.
	Formulary brand name: 100% after \$20 copay (90-day supply)	Formulary brand name: No coverage	Formulary brand name: \$40; 90 day supply	Formulary brand name: Three times the retail copay.
	Non-formulary brand name: 100% after \$30 copay (90-day supply)	Non-formulary brand name: No coverage	Non-formulary brand name: Not covered	Non-formulary brand name: Formulary applies
Overseas Prescriptions	Generic: Not applicable	Generic: 100% after deductible	Not applicable	Not applicable
	Brand name: Not applicable	Brand name: 80% after deductible		
Coverage Continuation				

			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.
Footnotes:				