

<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>Kaiser Hawaii</p>	<p>HMSA BCBS Hawaii</p>
	<p>For Information:</p>		<p>For information:</p>	<p>For Information:</p>
	<p>1-800-367-6276</p>		<p>1-800-966-5955 or</p>	<p>1-808-948-6372</p>
	<p>www.aetna.com</p>		<p>1-808-432-5955</p>	
	<p>In Network ("Preferred Provider")</p>	<p>Out of Network</p>		
<p>Price</p>				
	<p>Single: \$46.20</p>		<p>Single: \$26.61</p>	<p>Single: \$27.52</p>
	<p>Family: \$107.49</p>		<p>Family: \$74.24</p>	<p>Family: \$76.79</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>Yes. All 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>
<p>Deductible</p>				
<p>Individual</p>	<p>None</p>	<p>\$400</p>	<p>None</p>	<p>None</p>
<p>Family</p>	<p>None</p>	<p>\$1,200</p>	<p>None</p>	<p>None</p>

Out-of-Pocket Limit (Plan pays 100% of eligible expenses after you reach this)				
Individual	\$2,000	\$3,000	\$1,500	\$750
Family	\$6,000	\$9,000	\$4,500	\$2,250
Lifetime Maximum				
	Unlimited	Unlimited	Unlimited	Unlimited
Preventive Care				
Routine physical exam and immunizations (once per year)	100% coverage, no copay	No coverage	\$10 copay plus 50% lab/X-ray	\$10 copay
Well-child care	100% coverage, no copay	No coverage	100% after \$10 copay, up to 6 yrs. Immunizations: no charge for most	100% up to 5 years
Routine gynecological exam	100% coverage, no copay	No coverage	\$10 copay per visit, plus 50% lab/X-ray	100% one per calendar yr.
(including Pap test and related lab fees, once per year)				
Mammogram	100% coverage, no copay	No coverage	50% lab/X-ray	100% for women age 35 and over
(once per year for women ages 35 and over)				
Prostate screening exam	100% coverage, no copay	No coverage	\$10 copay per visit, plus 50% lab/X-ray	100%
(once per year for men ages 40 and over)				
Routine eye screening	100% after copay: \$15 PCP/\$25 Specialist	No coverage	Eye Exam: 100% after \$10 copay	Eye exam (1 / yr): 100% after \$10 copay, in network
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)	Not Covered	No additional benefits other than what is available through the Vision plan
(in addition to Vision plan benefit)				
Routine hearing exam	100% coverage, no copay	No coverage	100% after \$10 copay	100% after \$10 copay

Hearing aids	100% coverage (up to a \$500 lifetime maximum per person)	100% coverage (up to a \$500 lifetime maximum per person)	Not Covered	80% covered
Physician Services				
Office visits for treatment of illness or injury	100% coverage after copay: \$15 PCP/\$25 Specialist	70% after deductible	\$10 copay per visit, plus 50% of lab/X-ray	100% after \$10 copay per visit
Maternity	100% coverage after first \$15 copayment (\$25 for specialist)	70% after deductible	100%, after pregnancy confirmed at normal \$10 copay office visit	100%
In-office surgery, x-ray and lab work	100% coverage after copay: \$15 PCP/\$25 Specialist	70% after deductible	100% surgery; 50% lab/X-ray after \$10 copay per visit	\$10 copay per visit; surgery, X-ray lab 100% with office visit
Allergy testing, serum and injections	100% coverage after \$15/\$25 copay when part of office visit otherwise 100%, no copay	70% after deductible	\$10 copay per visit; \$10 per injection	100% after \$10 copay
Specialists (Office Visits)	100% coverage after \$25 copayment	70% after deductible	\$10 copay per visit, plus 50% of lab/X-ray	100% after \$10 copay and PCP referral
Second Surgical Opinion	100% coverage, no copay	100% coverage, no deductible	\$10 copay per visit, plus 50% of lab/X-ray, within network	100% after \$10 copay and PCP referral
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%	Inpatient expenses covered 100%
Preoperative testing	90% coverage, no copay	70% coverage, no deductible	50%	100%
Lab and x-ray	90% coverage, no copay	70% coverage, after deductible	50%	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% surgery; 50% lab/X-ray after \$10 copay per visit	100%
Independent lab and x-ray facilities	90% coverage, no copay	70% coverage, after deductible	50% lab/X-ray	100%
Emergency				
Hospital emergency room (emergency care)	100% coverage after \$100 copay (waived if admitted)	100% coverage after \$100 copay (waived if admitted)	\$25 copay in Kaiser Hawaii Service area; 80% outside service area	\$35 copay – statewide; 80% worldwide
Hospital emergency room (non-emergency care)	50% coverage after \$100 copayment	50% coverage after deductible	Not covered	Not covered statewide; Not covered worldwide
Ambulance	80% coverage, no copay	80% coverage after deductible	20% Copay	100%
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)	Skilled Nursing Facility, 60 days per benefit period	Not a benefit
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%, after \$10 copay per visit, must be medically necessary	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	50%
Hospice	100% coverage, no copay	100% coverage, no deductible	100%; two 90-day periods followed by an unlimited number of 60-day periods	100%
Other Health Care				
Family planning (voluntary sterilization)	100% coverage after \$100 copay	70% coverage, after deductible	100% surgery; 50% lab/X-ray after \$10 copay per visit	Copay varies. Contact plan.

Short-term rehabilitation	80% coverage, no copay	80% coverage, after deductible	\$10 copay per visit, plus 50% lab/X-ray, up to 2 months	\$10 copay per office visit. 100% covered for out-patient and in-patient hospital.
	(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	Not Covered	80% covered
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 a benefit
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	2 episodes per lifetime 100% 30 days max. Per year Mental Health and Substance Abuse benefit are combined	100% semi private, 30 days inpatient. Must be approved by Benefit Manager
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)	\$10 copay per visit with 24 visits per year	100% after \$10 copay for 24 sessions. Must be approved by Benefit Manager. Substance abuse: maximum of 2 treatment episodes
			Mental Health and Substance Abuse benefit are combined	
Outpatient Psychiatric	See Outpatient Benefits	See Outpatient Benefits	\$10 copay per visit with 24 visits per year	100% after \$10 copay for 24 sessions. Substance abuse: maximum of 2 treatment episodes
			Mental Health and Substance Abuse benefit are combined	
Partial Hospitalization	See Outpatient Benefits	See Outpatient Benefits	Information not provided by carrier	Copay varies. Contact plan.
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)	2 episodes per lifetime 80% 30 days max. Per year Mental Health and Substance Abuse benefit are combined	100% semi private, 30 days inpatient. Must be approved by Benefit Manager

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)	80% with 24 visits per year	100% after \$10 copay for 24 sessions. Must be approved by Benefit Manager. Substance abuse: maximum of 2 treatment episodes
			Mental Health and Substance Abuse benefit are combined	
Prescriptions				
Maximum	Unlimited	None	None	None
Local retail network pharmacies	Generic: 100% after \$10 copay (30-day supply)	Generic: No coverage	Generic: \$10 copay; 30 day supply; using Kaiser pharmacy	Generic: \$5
	Formulary Brand Name: 100% after \$20 copay (30-day supply)	Formulary Brand Name: No coverage	Formulary Brand Name: \$10 copay; 30 day supply; using Kaiser pharmacy	Formulary brand name: \$15
	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: See brochure for non-formulary costs
Mail-order Service	Generic: 100% after \$10 copay (90-day supply)	Generic: No coverage	Generic: \$20 copay; 90 day supply	Generic: \$10 (90 day supply)
	Formulary brand name: 100% after \$20 copay (90-day supply)	Formulary brand name: No coverage	Formulary brand name: \$20 copay; 90 day supply	Formulary brand name: \$35 (90 day supply)
	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: \$60 (90 day supply)
Overseas Prescriptions	Generic: Not applicable	Generic: 100% after deductible	Not Covered	Generic: 80% after \$5 copay
	Brand name: Not applicable	Brand name: 80% after deductible		Formulary brand name: 80% after \$15 copay
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:				