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 2011	**Aetna Open Choice PPO Plan**		**TakeCare Insurance**
	For Information:		For Information:
	1-800-367-6276		1-866-825-3227
	www.aetna.com		www.takecarehealth.com
	In Network ("Preferred Provider")	Out of Network	
Single:	$63.85		$44.34
Family:	$148.55		$126.37
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.		To receive the best level of coverage, you must see an in-network provider. Coverage for non-Network providers is provided at a lower benefit level. Coverage is provided at 100% of contracted rate for inpatient and outpatient services at network providers in the Philippines.
Primary Care Physician Required	No		Yes. All healthcare services and supplies must be coordinated through your primary care physician.
Individual	$200.00	$600	None
Family	$600.00	$1,800	None
Out-of-Pocket Maximums - Individual	$3,000	$4,000	$1,000
Out-of-Pocket Maximums - Family	$9,000	$12,000	$3,000
Lifetime Maximum	Unlimited	Unlimited	None
Physical Exams	100% coverage, no copay	No coverage	Coverage is 100%
Routine and Well Baby Care; Immunizations	100% coverage, no copay	No coverage	Coverage is 100%
Routine Gynecological exam	100% coverage, no copay. (once per year, including Pap test and related lab fees)	No coverage	Coverage is 100%
Routine Mammogram	100% coverage, no copay (once per year for women ages 35 and over)	No coverage	Coverage is 100%

Highlighted Areas Reflect Changes for 2011	Aetna Open Choice PPO Plan		TakeCare Insurance
Prostate Screening	100% coverage, no deductible (once per year for men ages 40 and over)	No coverage	Coverage is 100%
Routine Eye Exam	100% coverage, no copay (one per calendar year)	No coverage	Coverage is 100%
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)	Not covered
Routine Hearing Exam	100% coverage, no copay	No coverage	Coverage is 100%
Hearing Aid	100% coverage (up to a $1,000 lifetime maximum per person)	100% coverage (up to a $1,000 lifetime maximum per person)	Not covered
Office Visits	100% coverage after copay: $20 PCP/$35 Specialist	60% after deductible	Network: Coverage is 100% after $15 copay. Non-network: Coverage is 70% of eligible charges.
Maternity	100% coverage after first $20 copayment ($35 for specialist); subsequent visits are included in the delivery fee and paid at 90% after deductible	60% after deductible	Network: Coverage is 100% after $15 copay. Non-network: Coverage is 70% of eligible charges.
In-office Surgeries, X-Ray and Lab Work	100% coverage after copay: $20 PCP/$35 Specialist	60% after deductible	Network: Coverage is 100% after a $15 copay if surgery is done in the doctor's office by a PCP, or $25 copay if done by a specialist. Coverage is 100% after a $15 copay for plain film x-rays, EKGs and Mammograms. Lab work is covered at 100%. Non-network: In-office surgeries, x-ray and lab work is covered at 70% of eligible charges.
Allergy Treatment and Testing	100% coverage after $20/$35 copay when part of office visit otherwise 100%, no copay, no deductible	60% after deductible	Network: Coverage is 100% after $25 copay. Non-Network: Coverage is 70% of eligible charges.
Specialist	100% coverage after $35 copayment	60% after deductible	Network: Coverage is 100% after $25 copay. Non-Network: Coverage is 70% of eligible charges.
Second Surgical Opinion	100% coverage, no copay, no deductible	100% coverage, no deductible	Network: Coverage is 100% after $25 copay. Non-Network: Coverage is 70% of eligible charges.
Room and Board	90% after deductible plus $200 per confinement fee	60% after deductible plus $400 per confinement fee	Network: Coverage is 80% of contracted rate. Non-Network: Coverage is 70% of eligible charges. Coverage is provided at 100% of contracted rate for inpatient and outpatient services at network providers in the Philippines.
Pre-Admission Testing	90% coverage, no deductible	60% coverage, no deductible	Network: Coverage is 80% of contracted rate. Non-Network: Coverage is 70% of eligible charges. Coverage is provided at 100% of contracted rate for inpatient and outpatient services at network providers in the Philippines.
Lab & X-ray	90% coverage, after deductible	60% coverage, after deductible	Network: Coverage is 80% of contracted rate. Non-Network: Coverage is 70% of eligible charges. Coverage is provided at 100% of contracted rate for inpatient and outpatient services at network providers in the Philippines.

Highlighted Areas Reflect Changes for 2011	Aetna Open Choice PPO Plan		TakeCare Insurance
Surgery	90% coverage, after deductible	60% coverage, after deductible	Network: Coverage is 80% of contracted rate. Non-Network: Coverage is 70% of eligible charges. Coverage is provided at 100% of contracted rate for inpatient and outpatient services at network providers in the Philippines.
Physician Visits (In Hospital)	90% coverage, after deductible	60% coverage, after deductible	Network: Coverage is 80% of contracted rate. Non-Network: Coverage is 70% of eligible charges. Coverage is provided at 100% of contracted rate for inpatient and outpatient services at network providers in the Philippines.
Anesthesia	90% coverage, after deductible	60% coverage, after deductible	Network: Coverage is 80% of contracted rate. Non-Network: Coverage is 70% of eligible charges. Coverage is provided at 100% of contracted rate for inpatient and outpatient services at network providers in the Philippines.
Surgery	90% coverage, after deductible	60% coverage, after deductible	Network: Coverage is 80% of contracted rate. Non-Network: Coverage is 70% of eligible charges. Coverage is provided at 100% of contracted rate for inpatient and outpatient services at network providers in the Philippines.
Lab & X-ray	90% coverage, after deductible	60% coverage, after deductible	Network: Coverage is 100% after a $15 copay for plain film x-rays, EKGs and Mammograms. Lab work is covered at 100%. Non-network: X-ray and lab work is covered at 70% of eligible charges. Coverage is provided at 100% of contracted rate for outpatient services at network providers in the Philippines.
Hospital Emergency Room (Emergency Care)	90% coverage after $200 copay (waived if admitted), no deductible	90% coverage after $200 copay (waived if admitted), no deductible	100% of allowable charges after $25 ER copay for in or out-of-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
Ambulance	80% coverage after deductible	80% coverage after deductible	100% if it is a true emergency
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 covered
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)	Network: 100% coverage when provided by FHP Home Health. Non-Network: Not 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)	Not covered
Hospice	100% coverage, no deductible	100% coverage, no deductible	Network: 100% coverage when provided by FHP Home Health. Non-Network: Not covered.
Family Planning (Voluntary Sterilization)	100% coverage after $100 copay, no deductible	60% coverage, after deductible	Network: Coverage is 80% of contracted rate. Non-Network: Coverage is 70% of eligible charges. Coverage is provided at 100% of contracted rate for inpatient and outpatient services at network providers in the Philippines.
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)	Network: Coverage is 100% after $25 copay. Non-Network: Coverage is 70% of eligible charges. 20 visits per member per benefit period.

Highlighted Areas Reflect Changes for 2011	Aetna Open Choice PPO Plan		TakeCare Insurance
Durable Medical Equipment	80% coverage after deductible	80% coverage after deductible	Not covered
Chiropractic Care	100% coverage after a $20/$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	Not covered
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	Network: Coverage is 80% of contracted rate. Non-Network: Coverage is 70% of eligible charges.
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)	Network: Coverage is 100% after $15 copay. Non-network: Coverage is 70% of eligible charges.
Outpatient Psychiatric	See Outpatient Benefits	See Outpatient Benefits	Network: Coverage is 100% after $15 copay. Non-network: Coverage is 70% of eligible charges.
Partial Hospitalization	See Outpatient Benefits	See Outpatient Benefits	Network: Coverage is 80% of contracted rate. Non-Network: Coverage is 70% of eligible charges.
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)	Network: Coverage is 80% of contracted rate. Non-Network: Not 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)	Network: Coverage is 100% after $15 copay. Non-network: Not covered.
Maximum	Unlimited	None	None
Retail			
Generic	100% after $10 copay (30-day supply)	No coverage	Network: 100% after $10 copay. Non-Network: 70% of eligible charges.
Formulary Brand Name	100% after $20 copay (30-day supply)	No coverage	Network: 100% after $20 copay. Non-Network: 70% of eligible charges.
Non-Formulary Brand Name	Participant pays 35% of cost (minimum of $35 but no more than $100) for a 30-day supply	No coverage	Network: 100% after $30 copay. Non-Network: 70% of eligible charges.
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	No Copay
Formulary Brand Name	100% after $40 copay (90-day supply)	No coverage	No Copay
Non-Formulary Brand Name	Participant pays 35% of cost (minimum of $70 but no more than $200) for a 90-day supply	No coverage	3x retail copay (90 day supply)
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	not covered unless inpatient as a result of an emergency
Formulary Brand Name	Not Applicable	80% after deductible	not covered unless inpatient as a result of an emergency
Non-Formulary Brand Name	Not Applicable	Not Applicable	not covered unless inpatient as a result of an emergency
	Yes. Click here for more information	Yes. Click here for more information	Not Available.

	Aetna Dental		TakeCare Insurance	Stand Alone Dental	
Highlighted Areas Reflect Changes for 2011					
	Preferred Care Benefits* (In-Network)	Non-Preferred Care Benefits* (Out-of-Network/Overseas)		Preferred Care Benefits* (In-Network)	Non-Preferred Care Benefits* (Out-of-Network/Overseas)
Price					
	Single: $4.08		Single: $7.31	Single: $17.27	
	Family: $9.64		Family: $19.29	Family: $40.84	
Calendar Year Deductible					
Individual	$100	$100		$100	$100
Family	$300	$300	None	$300	$300
Calendar Year Benefit Maximum					
	$2,000 per person	$2,000 per person	$1,500 per person	$2,000 per person	$2,000 per person
Preventive Care					
Routine oral exams & cleanings - two per calendar year	100% no deductible (based on contracted rates)	100% no deductible (subject to reasonable & customary charges)	100%	100% no deductible (based on contracted rates)	100% no deductible (subject to reasonable & customary charges)
Problem focused exams - two per calendar year	100% no deductible (based on contracted rates)	100% non deductible (subject to reasonable & customary charges)	N/A	100% no deductible (based on contracted rates)	100% non deductible (subject to reasonable & customary charges)
X-rays (frenquency limits apply), flouride treatment and sealants to age 18	100% no deductible (based on contracted rates) no age limit on flouride treatment	100% no deductible (based on reasonable & customary charges) no age limit on flouride treatment	100%	100% no deductible (based on contracted rates). Flouride treatment to age 15	100% non deductible (subject to reasonable & customary charges) Flouride treatment to age 15
Dental Medical Integration	Provides extra cleaning for high risk medical conditions. Covered at 100% (based on contracted rates) See SPD for details	Provides extra cleaning for high risk medical conditions. Covered at 100% (based on reasonable and customary charges) See SPD for details	N/A	N/A	N/A
Basic Care					
Fillings, extractions, general anesthesia, space maintainers to age 19, palliative treatments	80% after deductible (based on contracted rates)	80% after deductible (based on reasonable & customary charges)	80%	80% after deductible (based on contracted rates)	80% after deductible (subject to reasonable & customary charges)
	(based on contracted rates)	(subject to reasonable and customary charges)	(subject to reasonable and customary charges)	(based on contracted rates)	(subject to reasonable and customary charges)
Restorative Care					
Endodontic (root canal therapy), periodontics	80% after deductible	80% after deductible	80%	50% after deductible	50% after deductible
Inlays, crowns, fixed bridgework	50% after deductible (includes gold fillings)	50% after deductible (includes gold fillings)	50%	50% after deductible (includes gold fillings)	50% after deductible (includes gold fillings)
	(based on contracted rates)	(subject to reasonable and customary charges)	(subject to reasonable and customary charges)	(based on contracted rates)	(subject to reasonable and customary charges)
Oral Surgery					

	Aetna Dental		TakeCare Insurance	Stand Alone Dental	
(services that are dental in nature)	100% of first $1,000; then 80% thereafter, not subject to the deductible and calendar year maximum (based on contracted rates)	100% of first $1,000; then 80% thereafter, not subject to the deductible and calendar year maximum (subject to reasonable and customary charges)	Information not provided by carrier.	80% after deductable (based on contracted rates)	80% after deductable (subject to reasonable and customary charges)
TMJ Treatment					
(Temporomandibular Joint Dysfunction)	50%, no deductible	50%, no deductible	Information not provided by carrier.	not covered	not covered
	(based on contracted rates)	(subject to reasonable and customary charges)			
	$750 lifetime maximum per person	$750 lifetime maximum per person			
Orthodontia for adults and children					
	50%, no deductible	50%, no deductible	50%; Orthodontia for children only	50%, no deductible after 12 mo waiting period	50%, no deductible after 12 mo waiting period
	(based on contracted rates)	(subject to reasonable and customary rates)	(subject to reasonable and customary rates)	(based on contracted rates)	(subject to reasonable and customary rates)
	$2,000 lifetime maximum per person.	$2,000 lifetime maximum per person.	$1,000 lifetime maximum per person.	$1,500 lifetime maximum per person.	$1,500 lifetime maximum per person
	Coverage includes TMJ appliances.	Coverage includes TMJ appliances.	Coverage does not include TMJ appliances.	Coverage includes TMJ appliances.	Coverage includes TMJ appliances.