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**		**HMSA BCBS Hawaii**	**Kaiser Hawaii**
	For Information:		For Information:	For Information:
	1-800-367-6276		1-808-948-6372	1-800-966-5955 or 1-808-432-5955
	www.aetna.com			
	In Network ("Preferred Provider")	Out of Network		
Single:	$63.85		$48.13	$45.78
Family:	$148.55		$134.26	$128.18
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.
Individual	$200.00	$600	None	None
Family	$600.00	$1,800	None	None
Out-of-Pocket Maximums - Individual	$3,000	$4,000	$2,500	$2,000
Out-of-Pocket Maximums - Family	$9,000	$12,000	$7,500	$6,000
Lifetime Maximum	Unlimited	Unlimited	Unlimited	
Physical Exams	100% coverage, no copay	No coverage	100% covered once a year	100% covered

Highlighted Areas Reflect Changes for 2011	Aetna Open Choice PPO Plan		HMSA BCBS Hawaii	Kaiser Hawaii
Routine and Well Baby Care; Immunizations	100% coverage, no copay	No coverage	100% up through age 5 for child child exams; 100% covered-standard immunizations	100% covered
Routine Gynecological exam	100% coverage, no copay. (once per year, including Pap test and related lab fees)	No coverage	100% one per calendar yr.	100% covered
Routine Mammogram	100% coverage, no copay (once per year for women ages 35 and over)	No coverage	100% covered	100% Covered
Prostate Screening	100% coverage, no deductible (once per year for men ages 40 and over)	No coverage	Regular Plan Benefit	100% Covered
Routine Eye Exam	100% coverage, no copay (one per calendar year)	No coverage	Eye exam (1 / yr): 100% after $15 copay, in network	100% after $15 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)	$10 copay for single and multifocal lenses; $15 copay for frames (every 24 months); $25 copay plus remaining eligible charge after $130 plan payment for contacts. Frames must be chosen from a group selected by provider. If member chooses a frame outside of the group, the member will have to pay any difference beween HMSA's allowance and the provider's charge for the frames. If member receives benefits for contact lenses, the member is not eligible for frames in the same year	All costs greater than a $150 allowance per calendar year. When optical prescription is filled at a Kaiser Permanente Hawaii optical center, the allowance may be used for prescription glasses lenses/frames/lens treatment OR prescription contact lens/contact lens exam
Routine Hearing Exam	100% coverage, no copay	No coverage	$15 copay only for evaluation for hearing aid	100% after $15 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)	50% covered for analog hearing aid; one per ear every 5 years	$500 allowance
Office Visits	100% coverage after copay: $20 PCP/$35 Specialist	60% after deductible	100% after $15 copay per visit	$15 copay
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	100% covered prenatal and postnatal visit after $15 initial visit	$15 copay for initial visit, 100% covered thereafter
In-office Surgeries, X-Ray and Lab Work	100% coverage after copay: $20 PCP/$35 Specialist	60% after deductible	$15 outpatient professional charge; lab and x-ray: 90% covered	90% covered
Allergy Treatment and Testing	100% coverage after $20/$35 copay when part of office visit otherwise 100%, no copay, no deductible	60% after deductible	100% after $15 copay	$15 copay for office visit; 90% covered for lab, imaging, and testing
Specialist	100% coverage after $35 copayment	60% after deductible	100% after $15 copay and PCP referral	$15 copay
Second Surgical Opinion	100% coverage, no copay, no deductible	100% coverage, no deductible	100% after $15 copay and PCP referral	$15 copay

Highlighted Areas Reflect Changes for 2011	Aetna Open Choice PPO Plan		HMSA BCBS Hawaii	Kaiser Hawaii
Room and Board	90% after deductible plus $200 per confinement fee	60% after deductible plus $400 per confinement fee	$75 copay per day	$50 copay per day
Pre-Admission Testing	90% coverage, no deductible	60% coverage, no deductible	100%	90% covered
Lab & X-ray	90% coverage, after deductible	60% coverage, after deductible	100%	100%
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% covered inpatient; $15 outpatient	100%
Surgery	90% coverage, after deductible	60% coverage, after deductible	100% covered in outpatient surgical center; $15 outpatient professional charges	$15 copay
Lab & X-ray	90% coverage, after deductible	60% coverage, after deductible	90% covered oupatient	90% covered
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	$75 copay – statewide and BlueCard providers out of state; 80% non-BlueCard providers out of state	$50 copay
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%	80% covered

Highlighted Areas Reflect Changes for 2011	Aetna Open Choice PPO Plan		HMSA BCBS Hawaii	Kaiser Hawaii
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	100% covered for 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% limited to 365 visits per illness or injury	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
Family Planning (Voluntary Sterilization)	100% coverage after $100 copay, no deductible	60% coverage, after deductible	Copay varies. Contact plan.	Outpatient surgery $15 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)	$15 copay per office visit. 100% covered for out-patient and in-patient hospital.	$15 copay per visit
Durable Medical Equipment	80% coverage after deductible	80% coverage after deductible	100% covered for internal devices; 50% covered for external devices	80% 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 a benefit	Not Covered
Bariatric surgery	50% after deductible	50% after deductible	Plan precertification required; follow up physician visits and/or lab work not covered	Contact HMO provider
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	$75 copay per day	$50 copay per day
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 $15 copay	$15 copay
Outpatient Psychiatric	See Outpatient Benefits	See Outpatient Benefits	100% after $15 copay	$15 copay
Partial Hospitalization	See Outpatient Benefits	See Outpatient Benefits	$75 copay per day	Not covered
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)	$75 copay per day	$50 copay per day
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% covered	$15 copay

Highlighted Areas Reflect Changes for 2011	Aetna Open Choice PPO Plan		HMSA BCBS Hawaii	Kaiser Hawaii
Maximum	Unlimited	None	None	None
Retail				
Generic	100% after $10 copay (30-day supply)	No coverage	$10 (30 day supply)	$15 copay; 30 day supply
Formulary Brand Name	100% after $20 copay (30-day supply)	No coverage	$30 (30 day supply)	$15 copay; 30 day supply
Non-Formulary Brand Name	Participant pays 35% of cost (minimum of $35 but no more than $100) for a 30-day supply	No coverage	$30 (30 day supply)	Not Covered
Smoking Cessation Aids	Discount given at pharmacy with a valid prescription	No coverage	Regular plan benefits (treatment is limited to 180 days per calendar year)	Contact HMO provider
Mail Order				
Generic	100% after $20 copay (90-day supply)	No coverage	$20 (90 day supply)	$30 copay; 90 day supply
Formulary Brand Name	100% after $40 copay (90-day supply)	No coverage	$60 (90 day supply)	$30 copay; 90 day supply
Non-Formulary Brand Name	Participant pays 35% of cost (minimum of $70 but no more than $200) for a 90-day supply	No coverage	$60 (90 day supply)	Not Covered
Smoking Cessation Aids	Discount given at mail order pharmacy with a valid prescription	No coverage	Limited to 1) Nicotine transdermal patches and 2) Zyban or generic equivalent. Regular plan benefits.	Contact HMO provider
Overseas Prescriptions				
Generic	Not Applicable	100% after deductible	$20 (90 day supply)	Not Covered
Formulary Brand Name	Not Applicable	80% after deductible	$60 (90 day supply)	Not Covered
Non-Formulary Brand Name	Not Applicable	Not Applicable	$60 (90 day supply)	Not Covered
	Yes. Click here for more information	Yes. Click here for more information	Continuation of coverage is available through this vendor. For information regarding COBRA, you must contact the HMO directly.	Not Available.

	Aetna Dental		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: $17.27	
	Family: $9.64		Family: $40.84	
Calendar Year Deductible				
Individual	$100	$100	$100	$100
Family	$300	$300	$300	$300
Calendar Year Benefit Maximum				
	$2,000 per person	$2,000 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% 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)	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% 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
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% after deductible (based on contracted rates)	80% after deductible (subject to reasonable & customary charges)
	(based on contracted rates)	(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	50% after deductible	50% after deductible
Inlays, crowns, fixed bridgework	50% after deductible (includes gold fillings)	50% after deductible (includes gold fillings)	50% after deductible (includes gold fillings)	50% after deductible (includes gold fillings)

	Aetna Dental		Stand Alone Dental	
	(based on contracted rates)	(subject to reasonable and customary charges)	(based on contracted rates)	(subject to reasonable and customary charges)
Oral Surgery				
(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)	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	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%, 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)	(based on contracted rates)	(subject to reasonable and customary rates)
	$2,000 lifetime maximum per person.	$2,000 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 includes TMJ appliances.	Coverage includes TMJ appliances.