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,			
Highlighted Areas Reflect Changes for 2011	**Aetna Open Choice PPO Plan**		**Kaiser - Georgia**
	For Information:		For Information:
	1-800-367-6276		1-800-611-1811
	www.aetna.com		
	In Network ("Preferred Provider")	Out of Network	
Single:	$63.85		$49.41
Family:	$148.55		$144.76
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.
Individual	$200.00	$600	None
Family	$600.00	$1,800	None
Out-of-Pocket Maximums - Individual	$3,000	$4,000	None
Out-of-Pocket Maximums - Family	$9,000	$12,000	None

Highlighted Areas Reflect Changes for 2011	Aetna Open Choice PPO Plan		Kaiser - Georgia
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Physical Exams	100% coverage, no copay	No coverage	100% covered to age 24 months
Routine and Well Baby Care; Immunizations	100% coverage, no copay	No coverage	100% covered to age 24 months
Routine Gynecological exam	100% coverage, no copay. (once per year, including Pap test and related lab fees)	No coverage	100% covered
Routine Mammogram	100% coverage, no copay (once per year for women ages 35 and over)	No coverage	100% covered
Prostate Screening	100% coverage, no deductible (once per year for men ages 40 and over)	No coverage	100% covered
Routine Eye Exam	100% coverage, no copay (one per calendar year)	No coverage	$25 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)	Discount for Vision Hardware
Routine Hearing Exam	100% coverage, no copay	No coverage	$25 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)	Not Covered
Office Visits	100% coverage after copay: $20 PCP/$35 Specialist	60% after deductible	$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%; No Charge for pre-natal or 1st post-natal visit; $25 for additional post-natal visits

Highlighted Areas Reflect Changes for 2011	Aetna Open Choice PPO Plan		Kaiser - Georgia
In-office Surgeries, X-Ray and Lab Work	100% coverage after copay: $20 PCP/$35 Specialist	60% after deductible	$25 copay for specialist visit; $100 copay for outpatient surgery
Allergy Treatment and Testing	100% coverage after $20/$35 copay when part of office visit otherwise 100%, no copay, no deductible	60% after deductible	$25 copay allergist visit, 100% covered for serum, Injection subject to the copayment of the provider specialty.
Specialist	100% coverage after $35 copayment	60% after deductible	$25 copay
Second Surgical Opinion	100% coverage, no copay, no deductible	100% coverage, no deductible	$25 copay
Room and Board	90% after deductible plus $200 per confinement fee	60% after deductible plus $400 per confinement fee	$250 inpatient copay; 100% after copay for semi-private room
Pre-Admission Testing	90% coverage, no deductible	60% coverage, no deductible	Covered 100% after Inpatient Hospital copay
Lab & X-ray	90% coverage, after deductible	60% coverage, after deductible	Covered 100% after Inpatient Hospital copay
Surgery	90% coverage, after deductible	60% coverage, after deductible	Covered 100% after Inpatient Hospital copay
Physician Visits (In Hospital)	90% coverage, after deductible	60% coverage, after deductible	Covered 100% after Inpatient Hospital copay

Highlighted Areas Reflect Changes for 2011	Aetna Open Choice PPO Plan		Kaiser - Georgia
Anesthesia	90% coverage, after deductible	60% coverage, after deductible	Covered 100% after Inpatient Hospital copay
Surgery	90% coverage, after deductible	60% coverage, after deductible	$100 copay
Lab & X-ray	90% coverage, after deductible	60% coverage, after deductible	100% covered when performed in an outpatient hospital setting
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 copay; Waived if admitted
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 copay; Authorized Trips only
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)	Up to 60 days per calendar year when medically necessary
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 a maximum of 120 visits per year.
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	100%; Benefits of Hospice Care instead of traditional services
Family Planning (Voluntary Sterilization)	100% coverage after $100 copay, no deductible	60% coverage, after deductible	Female tubule - $100 copay for outpatient, $250 copay for inpatient. Male Vasectomy - $25 copay for outpatient; $250 copay for inpatient

Highlighted Areas Reflect Changes for 2011	Aetna Open Choice PPO Plan		Kaiser - Georgia
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)	Outpatient rehabilitation at $25 copay; limited to combined count (PT & OT) of 20 visits per calendar year. Speech therapy at $25 copay; limited to 20 visits per calendar year.
Durable Medical Equipment	80% coverage after deductible	80% coverage after deductible	20% coinsurance
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	$250 copay per visit
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)	$15 copay (individual visit); $7 copay (group visit)
Outpatient Psychiatric	See Outpatient Benefits	See Outpatient Benefits	$15 copay (individual visit)
Partial Hospitalization	See Outpatient Benefits	See Outpatient Benefits	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)	$250 copay
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)	$15 copay
Maximum	Unlimited	None	None
Retail			
Generic	100% after $10 copay (30-day supply)	No coverage	$15 copay at Kaiser Pharmacies/$21 at network pharmacies (30 day supply)
Formulary Brand Name	100% after $20 copay (30-day supply)	No coverage	$30 copay at Kaiser Pharmacies/$36 at network pharmacies (30 day supply)

Highlighted Areas Reflect Changes for 2011	Aetna Open Choice PPO Plan		Kaiser - Georgia
Non-Formulary Brand Name	Participant pays 35% of cost (minimum of $35 but no more than $100) for a 30-day supply	No coverage	Not Covered
Smoking Cessation Aids	Discount given at pharmacy with a valid prescription	No coverage	Contact HMO provider
Mail Order			
Generic	100% after $20 copay (90-day supply)	No coverage	2X retail copay (90 day supply)
Formulary Brand Name	100% after $40 copay (90-day supply)	No coverage	2X retail 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	Not Covered
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 Applicable
Formulary Brand Name	Not Applicable	80% after deductible	Not Applicable
Non-Formulary Brand Name	Not Applicable	Not Applicable	Not Applicable
	Yes. Click here for more information	Yes. Click here for more information	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)
	(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				

	Aetna Dental		Stand Alone Dental	
(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.