

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 2007

	Aetna Open Choice PPO Plan	Wellness Blue Cross Blue Shield Colorado	For information:
	1-800-367-6276 www.aetna.com	Group Service: 1-800-533-6643 or HMO Service: 1-800-664-6667	
	In-Network (Preferred Provider)	Out of Network	
Price			
Single	\$67.74	\$62.50	
Family	\$173.17	\$171.75	
General			
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.	No	Yes. Members must receive all care through in-network provider. There is no out-of-network benefit for routine care.
Primary Care Physician Required	Yes	No	Yes. All healthcare services and supplies must be coordinated through your primary care physician.
Deductible			
Individual	\$200.00	\$100.00	None
Family	\$600.00	\$1,800.00	None
Out of Pocket Maximum (Plan Pays 100% of eligible expenses after you reach this)			
Individual Maximum - Individual	\$3,000	\$4,000	\$2,000
Out of Pocket Maximum - Family	\$9,000	\$12,000	\$4,000
Lifetime Maximum	Unlimited	Unlimited	None
Preventive Care			
Physical Exams	100% coverage, no copay	No coverage	PCP: \$20 copay, Specialist: \$40 copay
Routine and Well Baby Care; Immunizations	100% coverage, no copay	No coverage	PCP: \$20 copay, Specialist: \$40 copay
Routine Gynecological exam	100% coverage, no copay (once per year, including Pap test and related fee, least)	No coverage	PCP: \$20 copay, Specialist: \$40 copay
Routine Mammogram	100% coverage, no copay (once per year for women ages 35 and over)	No coverage	PCP: \$20 copay, Specialist: \$40 copay
Prostate Screening	100% coverage, no deductible (once per year for men ages 40 and over)	No coverage	PCP: \$20 copay, Specialist: \$40 copay
Routine Eye Exam	100% coverage, no copay (one per calendar year)	No coverage	No Coverage
Lasers, 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)	No Coverage
Routine Hearing Exam	100% coverage, no copay	No coverage	No Coverage
Hearing Aid	100% coverage (up to a \$1,000 lifetime maximum per person)	100% coverage (up to a \$1,000 lifetime maximum per person)	No Coverage
Physician Office Services			
Office Visits	100% coverage after copay (in-network Specialist)	80% after deductible	PCP: \$20 copay, Specialist: \$40 copay
Maternity	100% coverage after first \$15 copayment (20% for pre-delivery; subsequent visits are included in the delivery fee and paid at 80% after deductible)	80% after deductible	\$40 Specialist office visit copay, \$300 hospital copay
In-office Surgeries, X-Ray and Lab Work	100% coverage after copay (in-network Specialist)	80% after deductible	Covered under office visit copay. \$100 copay for MRI/BRAC/CTPET scans
Allergy Treatment and Testing	100% coverage after \$15 copay when part of office visit otherwise 100% no copay, deductible	80% after deductible	Covered under office visit copay
Specialist	100% coverage after \$15 copayment	80% after deductible	\$40 Specialist Copay
Second Surgical Opinion	100% coverage, no copay, no deductible	100% coverage, no deductible	\$40 Specialist Copay
Hospital Services			
Room and Board	80% after deductible plus \$200 per confinement fee	80% after deductible plus \$400 per confinement fee	\$300 inpatient hospital copay
Pre-Admission Testing	80% coverage, no deductible	80% coverage, no deductible	Covered under inpatient hospital copay
Lab & X-ray	80% coverage, after deductible	80% coverage, after deductible	Covered under inpatient hospital copay
Surgery	80% coverage, after deductible	80% coverage, after deductible	Covered under inpatient hospital copay
Physician Visits (In Hospital)	80% coverage, after deductible	80% coverage, after deductible	Covered under inpatient hospital copay
Anesthesia	80% coverage, after deductible	80% coverage, after deductible	Covered under inpatient hospital copay
Outpatient Services			
Surgery	80% coverage, after deductible	80% coverage, after deductible	\$225 copay per procedure
Lab & X-ray	80% coverage, after deductible	80% coverage, after deductible	Services must be received through a contracted facility and then will be covered under outpatient surgery copay
Emergency Room Care			
Hospital Emergency Room (Emergency Care)	100% coverage after \$150 copay (waived if admitted), no deductible	100% coverage (waived if admitted), no deductible	\$100 copay, waived if admitted to hospital, Urgent Care Copay \$40.
Hospital Emergency Room (Non-emergency Care)	80% coverage after deductible plus \$150 copay	80% coverage after deductible plus \$150 emergency room deductible	No Coverage
Ambulance	80% coverage after deductible	80% coverage after deductible	\$100 copay
Alternative Care			
Complementary Therapy	80% coverage after deductible (up to 90 days per calendar year per person)	80% coverage, after deductible (up to 90 days per calendar year per person)	No Coverage
Home Health Care	80% coverage after deductible (up to 90 visits per calendar year per person)	80% coverage, after deductible (up to 90 visits per calendar year per person)	No copay, 100% covered
Private-Duty Nursing	80% coverage after deductible (up to 70 8-hour shifts per calendar year per person)	80% coverage, after deductible (up to 70 8-hour shifts per calendar year per person)	No Coverage
Hospice	100% coverage, no deductible	100% coverage, no deductible	No copay, 100% covered
Other Services			
Family Planning (Voluntary Sterilization)	100% coverage after \$100 copay, no deductible	80% coverage, after deductible	No Coverage
Short-term Rehabilitation	80% coverage after deductible (90 day max per course of treatment)	80% coverage, after deductible (90 day max per course of treatment)	No Coverage
Durable Medical Equipment	80% coverage after deductible	80% coverage after deductible	No Copay, 100% covered. Limited to \$3,000 payment per calendar year, combined with co-pay, except for prosthetic devices which are not subject to the maximum payment but do reduce the maximum payment of \$3,000.
Chiropractic Care	100% coverage after a \$16/\$35 copay (20 visits per calendar year)	80% coverage, after deductible (20 visits per calendar year)	No Coverage
Bariatric Surgery	80% after deductible	80% after deductible	Contact HMO provider
Mental Health Care			
Inpatient	80% after deductible plus \$200 per confinement fee, no maximum on number of days	80% after \$400 per confinement fee, no maximum on number of days	50% of total charges (limited to 45 full or 90 partial days per calendar year)
Outpatient	100% after \$15 copay per visit (up to 45 visits per calendar year per person)	80% coverage after deductible plus \$400 inpatient copay (confinement fee) up to 45 visits per calendar year per person)	Strategically based and non-biologically based mental illness will be subject to the physician office copay
Outpatient Psychiatric	See Outpatient Benefits	See Outpatient Benefits	When the physician office copayment is greater than or equal to \$30, the member's maximum copay will be \$30.
Partial Hospitalization	See Outpatient Benefits	See Outpatient Benefits	\$300 inpatient hospital copay
Substance Abuse			
Inpatient	80% coverage after deductible plus \$200 per confinement fee (up to 45 visits per calendar year per person)	80% coverage after deductible plus \$400 per confinement fee (up to 45 days per calendar year per person)	50% of total charges (Covered only for short-term detoxification, rehabilitation not covered)
Outpatient	100% after \$20 copay per visit (up to 45 visits per calendar year per person)	80% coverage after deductible (up to 45 visits per calendar year per person)	No coverage
Prescription Drug Coverage			
Formulary	Preferred	Open	For the tier 4 self-administered (injectable) prescription drugs, the copayment is 30% to a maximum of \$250 for a 30-day supply and \$500 for a 90-day supply.
Retail			
Generic	100% after \$10 copay (30-day supply)	No coverage	\$15 copay (34 day supply)
Formulary Brand Name	100% after \$25 copay (30-day supply)	No coverage	\$40 copay (34 day supply)
Non-Formulary Brand Name	100% after \$35 copay (30-day supply)	No coverage	\$60 copay (34 day supply)
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	\$30 copay (90 day supply)
Formulary Brand Name	100% after \$40 copay (90-day supply)	No coverage	\$60 copay (90 day supply)
Non-Formulary Brand Name	100% after \$60 copay (90-day supply)	No coverage	\$120 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	No Coverage
Formulary Brand Name	Not Applicable	80% after deductible	No Coverage
Non-Formulary Brand Name	Not Applicable	Not Applicable	No Coverage
Coverage Continuation	Yes. See Benefits Page	Yes. See Benefits	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 allowed by the HMO will apply. The Duo HMO plan's continuation of coverage option will not apply if you are enrolled in the HMO option when your coverage ends.