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		Aetna Dallas	HMO Blue Dallas TX
	For Information: 1-800-367-6276		For Information: 1-800-992-7947	For Information 1-877-299-2377
	www.aetna.con		www.aetna.con	www.bcbstx.com
	In Network ("Preferred Provider")	Out of Network		
Price				
Single:	$53.74		$71.28	$64.84
Family:	$125.03		$190.34	$173.24
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.		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		Female members can visit their in-network GYN w/o referral for routine annual exam and medically necessary GYN care. Other healthcare services and supplies must be coordinated through your primary care physician. Other 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.
Deductible				
Individual	$200.00	$600	None	None
Family	$600.00	$1,800	None	None
Out of Pocket Maximum (Plan Pays 100% of eligible expenses after you reach this)				
Out-of-Pocket Maximums - Individual	$3,000	$4,000	$1,500	$1,500
Out-of-Pocket Maximums - Family	$9,000	$12,000	$3,000	$3,000
Lifetime Maximum	Unlimited	Unlimited	Unlimited	Information not provided by carrier
Preventive Care				
Physical Exams	100% coverage, no copay	No coverage	$20 copay; Once Per Year	100% after $20 copay
Routine and Well Baby Care; Immunizations	100% coverage, no copay	No coverage	$20 copay (Pediatric Immunizations only visit 0 - 6 years -- no copay. Immunizations not covered if solely for the purpose of travel or employment)	100% coverage
Routine Gynecological exam	100% coverage, no copay. (once per year, including Pap test and related lab fees)	No coverage	$35 copay; PCP or Specialist depending on location, Once Per Year, (including Pap test and related lab fees), copay may vary depending on location and service rendered.	100% coverage
Routine Mammogram	100% coverage, no copay (once per year for women ages 35 and over)	No coverage	$35 copay (Once per year for women ages 35 and over)	100% as part of annual well woman exam
Prostate Screening	100% coverage, no deductible (once per year for men ages 40 and over)	No coverage	$20 copay (Once Per Year for men ages 40 and over), specialist copay may apply, depending on location and service rendered.	100% coverage
Routine Eye Exam	100% coverage, no copay (one per calendar year)	No coverage	$35 copay (frequency and age schedules apply)	Included in Office Visit 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)	Discounts Available through the Vision One Discount Program.	Glasses Lenses, 1/yr.: Various copays. Glasses Frames, one/24 mos.: Standard = $15 copay others available. Contact lenses & exam, 1/yr. in lieu of standard eyeglass benefit.
Routine Hearing Exam	100% coverage, no copay	No coverage	$20 copay, specialist copay may apply, depending on location and service rendered.	100% after $20 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	1 per ear every 36 months. $1,000 limit per ear.
Physician Office Services				
Office Visits	100% coverage after copay: $15 PCP/$35 Specialist	60% after deductible	$20 copay; $25 copay for after-hours/home visits.	100% after $20 copay
Maternity	100% coverage after first $15 copayment ($35 for specialist); subsequent visits are included in the delivery fee and paid at 90% after deductible	60% after deductible	100% after $35 copay for initial visit, 100% after $240 copay delivery and nursery services. Additional prenatal office visits - no charge	100% after $20 copay on initial visit
In-office Surgeries, X-Ray and Lab Work	100% coverage after copay: $15 PCP/$35 Specialist	60% after deductible	$35 copay (Includes x-ray and lab work)	100% after $20 copay
Allergy Treatment and Testing	100% coverage after $15/$35 copay when part of office visit otherwise 100%, no copay, no deductible	60% after deductible	$35 copay for testing, $20 copay for allergy injection in PCP office (No Serum copay)	50% copay
Specialist	100% coverage after $35 copayment	60% after deductible	$35 copay	100% after $20 copay
Second Surgical Opinion	100% coverage, no copay, no deductible	100% coverage, no deductible	$35 copay, PCP referral required.	100% coverage
Hospital Services				
Room and Board	90% after deductible plus $200 per confinement fee	60% after deductible plus $400 per confinement fee	100% after $240 copay	100% after $500 copay
Pre-Admission Testing	90% coverage, no deductible	60% coverage, no deductible	Covered 100% after Inpatient Hospital copay.	Information not provided by carrier
Lab & X-ray	90% coverage, after deductible	60% coverage, after deductible	Covered 100% after Inpatient Hospital copay	100% coverage
Surgery	90% coverage, after deductible	60% coverage, after deductible	Covered 100% after Inpatient Hospital copay	100% coverage
Physician Visits (In Hospital)	90% coverage, after deductible	60% coverage, after deductible	No copay for physician's hospital visits.	100% coverage
Anesthesia	90% coverage, after deductible	60% coverage, after deductible	Covered 100% after Inpatient Hospital copay when medically necessary and pre-authorized by the HMO.	100% coverage
Outpatient Services				
Surgery	90% coverage, after deductible	60% coverage, after deductible	100% after $150 copay	100% after $200 copay
Lab & X-ray	90% coverage, after deductible	60% coverage, after deductible	$35 copay with PCP referral at facility. Included in specialist copay at specialist office visit.	100% coverage
Emergency Room Care				
Hospital Emergency Room (Emergency Care)	100% coverage after $150 copay (waived if admitted), no deductible	100% coverage after $150 copay (waived if admitted) no deductible	$150 copay for ER and Urgent Care. Copay waived if admitted, $240 Inpatient Hospital copay would then apply.	100% after $75 copay (waived if admitted). Urgent Care Center: $40 copay per visit
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	Not covered
Ambulance	80% coverage after deductible	80% coverage after deductible	100% when medically necessary during a medical emergency. Routine transportation not covered.	100% after $100 copay per service
Alternative Care				
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)	100% after $240 copay. Convalescent care not covered. Skilled nursing facility covered after $240 copay, pre-certification required.	100% after $20 copay per day limited to 60 days per year
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% covered when rendered by a participating Home Health Care Agency, referred by the PCP, and pre-certified and pre-authorized by the HMO.	100% after $20 copay
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)	100% covered after $240 copay, when medically necessary and pre-authorized by the HMO.	100% after $25 copay per day limited to 60 days per year
Hospice	100% coverage, no deductible	100% coverage, no deductible	100% covered after $240 copay for inpatient. No copay for outpatient. Must be pre-certified and pre-authorized by the HMO.	100% coverage limited to $20,000 per year
Other Services				
Family Planning (Voluntary Sterilization)	100% coverage after $100 copay, no deductible	60% coverage, after deductible	Covered with applicable specialist, outpatient surgery or inpatient hospital copay. Reversal of voluntary sterilization including related follow-up care and treatment of complications of such procedures is not covered.	100% after $25 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)	$35 copay per visit; limits determined by physician	100% after $20 copay
Durable Medical Equipment	80% coverage after deductible	80% coverage after deductible	$0 copay	No charge
Chiropractic Care	100% coverage after a $15/$35 copay (20 visits per calendar year)	60% coverage, after deductible (20 visits per calendar year)	$35 copay per visit (20 visit maximum per calendar year)	100% after $20 copay (medical necessity required)
Bariatric surgery	50% after deductible	50% after deductible	Contact HMO provider	Contact HMO provider
Mental Health Care				
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	100% after $240 copay (Serious Mental Illness - 45 days per calendar year maximum, Non-Serious Mental Illness - not covered)	50%; 30 treatment days per cal. Yr.
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)	Serious Mental Illness - $35 copay (60 visit maximum), Non-Serious Mental Illness - $35 copay (20 visit maximum)	100% after $25 copay (20 visits per calendar year)
Outpatient Psychiatric	See Outpatient Benefits	See Outpatient Benefits	See Outpatient Benefits	100% after $25 copay (20 visits per calendar year)
Partial Hospitalization	See Outpatient Benefits	See Outpatient Benefits	See Outpatient Benefits	See EOC
Substance Abuse				
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)	100% after $240 copay (3 episodes maximum per lifetime, IP/OP combined)	$500 copay per admit (limited to 3 separate series of treatments per lifetime)
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)	$35 copay (3 episodes maximum per lifetime, IP/OP combined)	$20 copay per visit (limited to 3 separate series of treatments per lifetime)
Prescription Drug Coverage				
Maximum	Unlimited	None	Unlimited	Information not provided by carrier
Retail				
Generic	100% after $10 copay (30-day supply)	No coverage	$10 copay (30 day supply)	$10 copay; 30 day supply
Formulary Brand Name	100% after $25 copay (30-day supply)	No coverage	$20 copay (30 day supply)	$25 copay; 30 day supply
Non-Formulary Brand Name	100% after $35 copay (30-day supply)	No coverage	Not Covered	$40 copay; 30 day supply
Smoking Cessation Aids	Discount given at pharmacy with a valid prescription	No coverage	Contact HMO provider	Contact HMO provider
Mail Order				
Generic	100% after $20 copay (90-day supply)	No coverage	$20 copay (90 day supply)	$30; 90 day supply
Formulary Brand Name	100% after $40 copay (90-day supply)	No coverage	$40 copay (90 day supply)	$75; 90 day supply--if a generic equivalent is available, member will pay the generic copay, plus the difference in cost between the brand and generic drug.
Non-Formulary Brand Name	100% after $60 copay (90-day supply)	No coverage	Not Covered	$120; 90 day supply----if a generic equivalent is available, member will pay the generic copay, plus the difference in cost between the brand and generic drug.
Smoking Cessation Aids	Discount given at mail order pharmacy with a valid prescription	No coverage	Contact HMO provider	Contact HMO provider
Overseas Prescriptions				
Generic	Not Applicable	100% after deductible	Not Applicable	Information not provided by carrier
Formulary Brand Name	Not Applicable	80% after deductible	Not Applicable	Information not provided by carrier
Non-Formulary Brand Name	Not Applicable	Not Applicable	Not Applicable	Information not provided by carrier
Coverage Continuation				
	Yes. See Benefits Portal	Yes. See Benefits Portal	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.