

<p>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.</p>	<p>Aetna Open Choice PPO Plan</p>		<p>HMO Colorado</p>
	<p>For Information:</p>		<p>For information:</p>
	<p>1-800-367-6276</p>		<p>Group Service 1-800-533-5643 or</p>
	<p>www.aetna.com</p>		<p>HMO Service 1-800-664-6557</p>
	<p>In Network ("Preferred Provider")</p>	<p>Out of Network</p>	
<p>Price</p>			
	<p>Single: \$46.20</p>		<p>Single: \$51.93</p>
	<p>Family: \$107.49</p>		<p>Family: \$119.43</p>
<p>General</p>			
<p>Network benefits available?</p>	<p>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.</p>		<p>Yes, members must receive all care through in-network provider. There is no out-of-network benefits for routine care.</p>
<p>Primary Care Physician (PCP) required?</p>	<p>No</p>		<p>Yes. All healthcare services and supplies must be coordinated through your primary care physician.</p>
<p>Deductible</p>			
<p>Individual</p>	<p>None</p>	<p>\$400</p>	<p>None</p>
<p>Family</p>	<p>None</p>	<p>\$1,200</p>	<p>None</p>

Out-of-Pocket Limit (Plan pays 100% of eligible expenses after you reach this)			
Individual	\$2,000	\$3,000	Two times individual annual premium
Family	\$6,000	\$9,000	Two times individual annual premium
Lifetime Maximum			
	Unlimited	Unlimited	None
Preventive Care			
Routine physical exam and immunizations (once per year)	100% coverage, no copay	No coverage	\$20 PCP office visit copay; \$40 Specialist office visit copay
Well-child care	100% coverage, no copay	No coverage	\$20 PCP office visit copay; \$40 Specialist office visit copay
Routine gynecological exam	100% coverage, no copay	No coverage	\$20 PCP office visit copay; \$40 Specialist office visit copay
(including Pap test and related lab fees, once per year)			
Mammogram	100% coverage, no copay	No coverage	\$20 PCP office visit copay; \$40 Specialist office visit copay
(once per year for women ages 35 and over)			
Prostate screening exam	100% coverage, no copay	No coverage	\$20 PCP office visit copay; \$40 Specialist office visit copay
(once per year for men ages 40 and over)			
Routine eye screening	100% after copay: \$15 PCP/\$25 Specialist	No coverage	Discount program
Lenses, eyeglass frames and contacts	100% coverage (up to a \$75 maximum benefit per calendar year per person)	100% coverage (up to a \$75 maximum benefit per calendar year per person)	Discount program
(in addition to Vision plan benefit)			
Routine hearing exam	100% coverage, no copay	No coverage	No coverage

Hearing aids	100% coverage (up to a \$500 lifetime maximum per person)	100% coverage (up to a \$500 lifetime maximum per person)	No coverage
Physician Services			
Office visits for treatment of illness or injury	100% coverage after copay: \$15 PCP/\$25 Specialist	70% after deductible	\$20 PCP office visit copay; \$40 Specialist office visit copay
Maternity	100% coverage after first \$15 copayment (\$25 for specialist)	70% after deductible	\$40 Specialist office visit copay or \$300 inpatient hospital copay
In-office surgery, x-ray and lab work	100% coverage after copay: \$15 PCP/\$25 Specialist	70% after deductible	Covered under office visit copay, \$100 copay for MRI/MRA/CT/PET scans
Allergy testing, serum and injections	100% coverage after \$15/\$25 copay when part of office visit otherwise 100%, no copay	70% after deductible	Covered under office visit copay
Specialists	100% coverage after \$25 copayment	70% after deductible	\$40 Specialist office visit copay
(Office Visits)			
Second Surgical Opinion	100% coverage, no copay	100% coverage, no deductible	\$40 Specialist office visit copay
Hospital Services - Inpatient			
Hospital room & board, and ancillary services	90% after \$200 per confinement fee	70% after deductible and separate \$400 per confinement fee	\$300 inpatient hospital copay
Preoperative testing	90% coverage, no copay	70% coverage, no deductible	Covered under inpatient hospital copay
Lab and x-ray	90% coverage, no copay	70% coverage, after deductible	Covered under inpatient hospital copay
Surgery	90% coverage, no copay	70% coverage, after deductible	Covered under inpatient hospital copay
Physician hospital visits	90% coverage, no copay	70% coverage, after deductible	Covered under inpatient hospital copay

Anesthesia	90% coverage, no copay	70% coverage, after deductible	Covered under inpatient hospital copay
Hospital Services - Outpatient			
Surgery	90% coverage, no copay	70% coverage, after deductible	\$225 copay per procedure
Independent lab and x-ray facilities	90% coverage, no copay	70% coverage, after deductible	Services must be received through a contracted facility and then will be covered under outpatient surgery copay
Emergency			
Hospital emergency room (emergency care)	100% coverage after \$100 copay (waived if admitted)	100% coverage after \$100 copay (waived if admitted)	\$100 copay, waived if admitted to hospital. Urgent care copay \$40.
Hospital emergency room (non-emergency care)	50% coverage after \$100 copayment	50% coverage after deductible	No coverage
Ambulance	80% coverage, no copay	80% coverage after deductible	\$100 copay
Health Care Alternatives			
Convalescent facility	90% coverage, no copay (up to 90 days per calendar year per person)	70% coverage, after deductible (up to 90 days per calendar year per person)	No coverage
Home health care	90% coverage, no copay (up to 90 visits per calendar year per person)	70% coverage, after deductible (up to 90 visits per calendar year per person)	No copay, 100% covered
Private duty nursing	90% coverage, no copay (up to 70 8-hour shifts per calendar year per person)	70% coverage, after deductible (up to 70 8-hour shifts per calendar year per person)	No coverage
Hospice	100% coverage, no copay	100% coverage, no deductible	No copay, 100% covered
Other Health Care			
Family planning	100% coverage after \$100 copay	70% coverage, after deductible	No coverage

(voluntary sterilization)			
Short-term rehabilitation	80% coverage, no copay	80% coverage, after deductible	No coverage
	(60 day max per course of treatment)	(60 day max per course of treatment)	
Durable medical equipment	80% coverage, no copay	80% coverage, no deductible	No copay, 100% covered, limited to \$3,000 payment per calendar year, combined with oxygen, except for prosthetic devices which are not subject to the maximum payment but do reduce the maximum payment of \$3,000
Chiropractic	100% coverage after a \$15/\$25 copay (20 visits per calendar year)	70% coverage, after deductible (20 visits per calendar year)	No coverage
Mental Health Care			
Inpatient	80% after \$200 per confinement fee; no maximum on number of days	60% after \$400 per confinement fee; no maximum on number of days	50% of billed charges, limited to 45 full or 90 partial days per calendar year
Outpatient	100% after \$25 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)	\$10 visits 1-5; \$25 visits 6-20
Outpatient Psychiatric	See Outpatient Benefits	See Outpatient Benefits	\$40 Specialists office visit copay
Partial Hospitalization	See Outpatient Benefits	See Outpatient Benefits	\$300 inpatient hospital copay
Substance Abuse Treatment			
Inpatient	80% coverage after \$200 per confinement fee (up to 45 visits per calendar year per person)	60% coverage after \$400 per confinement fee (up to 45 days per calendar year per person)	50% of billed charges, covered only for short-term detoxification, rehabilitation not covered

Outpatient	100% after \$25 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)	No coverage
Prescriptions			
Maximum	Unlimited	None	For the tier 4 self-administered injectable prescription drugs, the copayment is 30 percent, to a maximum of \$250 for a 34 day supply and \$500 for a 90 day supply.
Local retail network pharmacies	Generic: 100% after \$10 copay (30-day supply)	Generic: No coverage	Generic: \$15 generic formulary copay, up to a 34 day supply
	Formulary Brand Name: 100% after \$20 copay (30-day supply)	Formulary Brand Name: No coverage	Formulary brand name: \$40 brand formulary copay, up to a 34-day supply
	Non-formulary Brand Name: 100% after \$30 copay (30-day supply)	Non-formulary Brand Name: No coverage	Non-formulary brand name: \$60 non-formulary copay, up to a 34-day supply
Mail-order Service	Generic: 100% after \$10 copay (90-day supply)	Generic: No coverage	Generic: \$30 generic formulary copay, up to a 90 day supply
	Formulary brand name: 100% after \$20 copay (90-day supply)	Formulary brand name: No coverage	Formulary brand name: \$80 brand formulary copay, up to a 90 day supply
	Non-formulary brand name: 100% after \$30 copay (90-day supply)	Non-formulary brand name: No coverage	Non-formulary brand name: \$120 non-formulary copay, up to a 90 day supply
Overseas Prescriptions	Generic: Not applicable	Generic: 100% after deductible	No coverage
	Brand name: Not applicable	Brand name: 80% after deductible	
Coverage Continuation			

			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.
Footnotes:			