# Benefits at a glance

STATE OF COLORADO 2011 - 2012 BENEFITS

| | PPO Co-Pay Choice Plus | PPO HDHP Definity® Plan |
|---|---|---|
| | Network/Non-network | Network/Non-network |
| **Medical** | | |
| **Deductible** | | |
| Employee | $1,500 / $3,000 | $1,500 / $4,500 |
| Family*** | $3,000 / $6,000 | $3,000 / $9,000 |
| **Out-of-pocket maximum** | | |
| Employee | $5,000 / $10,000 | $3,000 / $9,000 |
| Family*** | $10,000 / $20,000 | $6,000 / $18,000 |
| **Lifetime maximum benefit** | Unlimited | Unlimited |
| Annual adult physical | 100% / 50% | 100% / 50% |
| Well-child visits | 100% / 50% | 100% / 50% |
| Mammogram | 100% / 50% | 100% / 50% |
| PSA tests | 100% / 50% | 100% / 50% |
| Doctor visit | 100% after $30 copayment / 50%* | 80% after deductible has been met / 50%* |
| Specialist visit | 100% after $50 copayment / 50%* | 80% after deductible has been met / 50%* |
| Urgent care visit | 80% after $75 copayment per visit. Deductible does not apply / 50%* | 80%* / 50%* |
| Emergency room | 80%* | 80%* |
| Ambulance | 80%* | 80%* |
| Outpatient surgery | 80%* / 50%* | 80%* / 50%* |
| Lab and X-ray | Preventive: 100% / 50%<br>Diagnostic: 80%* / 50%* | Preventive: 100% / 50%<br>Diagnostic: 80%* / 50%* |
| Hospital stay | 80% after $1,000 copayment per inpatient stay / 50%* | 80%* / 50%* |
| Mental health services | Outpatient at 100% after a $30 copayment per visit / 50%* | 80%* / 50%* |
| Pharmacy | Retail (up to a 31-day supply)<br>Tier 1 $10<br>Tier 2 $25<br>Tier 3 $50<br><br>Mail Order** (up to a 90-day supply)<br>Tier 1 $25<br>Tier 2 $62.50<br>Tier 3 $125 | Retail (up to a 31-day supply)<br>Tier 1 $10<br>Tier 2 $25<br>Tier 3 $50<br><br>Mail Order** (up to a 90-day supply)<br>Tier 1 $25<br>Tier 2 $62.50<br>Tier 3 $125<br>Copays apply after you've reached your deductible |

*After you've reached your deductible.

**Only certain Prescription Drugs are available through mail order; please visit our pre-member Web site at welcometouhc.com/colorado for more information.

***Employee plus spouse/same-gender domestic partner/child or children/family.

This information is a brief, general description of your coverage, and is not a contract and does not replace your Summary of Benefits. For a complete list of your coverage, including exclusions and limitations relating to your coverage, please read your Summary of Benefits. If descriptions, percentages, and dollar amounts conflict with official benefit coverage documents, the official benefits coverage documents prevail.

Copayments don't apply to deductible. Copayments and coinsurance apply to out-of-pocket maximum.

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