

<b>Feature</b>	<b>Aetna EPO CA - ES Rep</b>
<b>Provider</b>	Aetna, Inc. 1-877-254-6765 See your medical ID card for ongoing number <a href="http://custom.aetna.com/NGC">http://custom.aetna.com/NGC</a>
<b>Cost Sharing</b>	
<b>Annual Deductible</b>	\$0 Individual; \$0 Family
<b>Out-of-pocket maximum</b>	\$0 Individual; \$0 Family
<b>Lifetime coverage limit</b>	\$2,000,000; for all Northrop Grumman-sponsored medical plan options; retiree and active combined
<b>Policies/Requirements</b>	
<b>Need to file claims</b>	No; except for non-routine, out-of-network, or emergency care
<b>Domestic partner benefits</b>	Yes
<b>Access</b>	
<b>Ability to self-refer to OB/GYN</b>	Yes
<b>Ability to self-refer to specialists</b>	No
<b>Out-of-area dependent coverage</b>	No
<b>Out-of-area participant coverage</b>	No
<b>Spending Account</b>	
<b>You only</b>	Not applicable
<b>You and spouse</b>	Not applicable
<b>You and child</b>	Not applicable
<b>You and family</b>	Not applicable
<b>Eligible expenses for reimbursement</b>	Not applicable
<b>Outpatient Services</b>	
<b>Primary doctor office visit</b>	\$10 copay
<b>Specialist doctor office visit</b>	\$20 copay
<b>Preventive Care</b>	
<b>Annual physical exam</b>	\$10 copay PCP; \$20 copay specialist
<b>Well-woman exam (includes pap)</b>	\$10 copay PCP; \$20 copay specialist
<b>Mammogram</b>	100% covered; age schedules apply; check with Plan for details
<b>Pediatric exams</b>	\$10 copay PCP; \$20 copay specialist
<b>Immunizations (child)</b>	Included with office visit copay
<b>Colonoscopy</b>	100% covered
<b>Cancer screenings</b>	Included with office visit copay
<b>Cardiovascular screenings</b>	Included with office visit copay
<b>Allergy tests and treatments</b>	100% covered; injections; \$10 copay PCP/\$20 copay specialist for physician testing
<b>Outpatient Care</b>	
<b>Outpatient surgery</b>	100% covered
<b>Outpatient laboratory services</b>	100% covered; physician's office; \$10 copay at outpatient network laboratories
<b>Outpatient physical therapy</b>	\$20 copay; limited to 50 visits per benefit plan year
<b>Outpatient X-ray</b>	100% covered; physician's office; \$10 copay at outpatient network laboratories
<b>Outpatient occupational therapy</b>	\$20 copay; limited to 50 visits per benefit plan year
<b>Outpatient speech therapy</b>	\$20 copay; limited to 50 visits per benefit plan year
<b>Outpatient cardiac rehabilitation</b>	\$20 copay; limited to Phase 1 and Phase 2 care

<b>Feature</b>	<b>Aetna EPO CA - ES Rep</b>
	<b>Family Planning/Maternity Care</b>
<b>Office visit: pre/postnatal</b>	\$10 copay initial visit only; PCP; \$20 copay specialist initial visit only
<b>In-hospital delivery services</b>	100% covered
<b>Newborn nursery services</b>	100% covered
<b>Fertility services</b>	100% covered after applicable copays; limited to \$25,000 per lifetime for all fertility services combined, including prescription drugs
<b>In vitro fertilization</b>	100% covered after applicable copays; limited to \$25,000 per lifetime for all fertility services combined, including prescription drugs
<b>Artificial insemination</b>	100% covered after applicable copays; limited to \$25,000 per lifetime for all fertility services combined, including prescription drugs
<b>Female tubal ligation</b>	100% covered; in or outpatient hospital setting; \$10 copay PCP/\$20 copay specialist in office setting
<b>Male vasectomy</b>	100% covered; in or outpatient hospital setting; \$10 copay PCP/\$20 copay specialist in office setting
	<b>Hearing</b>
<b>Hearing evaluations</b>	\$10 copay; PCP; \$20 copay specialist; limited to one exam per benefit plan year
<b>Hearing aids</b>	Limited to \$1,000 per benefit plan year; check with Plan for limitations
	<b>Vision</b>
<b>Routine vision exams</b>	\$10 copay; limited to PCP screening only, limited to one exam per benefit plan year
<b>Regular lenses and frames</b>	Not covered
<b>Contact lenses</b>	Not covered
	<b>Dental</b>
<b>Dental implants</b>	Not covered
<b>Accidental injury to teeth</b>	Coverage based on place of service; check with Plan for details
<b>Surgical removal of tumors, cysts and impacted teeth</b>	100% covered; limited to surgical removal of tumors and cysts; removal of impacted teeth not covered
	<b>Inpatient Services</b>
<b>Hospital copay</b>	100% covered
<b>Hospital semi-private room</b>	100% covered
<b>Inpatient lab and X-ray</b>	100% covered
<b>Inpatient surgery</b>	100% covered
<b>Inpatient physician and surgeon services</b>	100% covered
	<b>Emergency Care</b>
<b>Emergency room (not followed by admission)</b>	\$100 copay
<b>Urgent care clinic visit</b>	\$20 copay
<b>Ambulance services</b>	100% covered
	<b>Prescription Drug Coverage</b>
<b>Annual prescription deductible</b>	Not applicable
<b>Prescription drug website</b>	Same as medical plan
<b>Prescription drug member services</b>	Same as medical plan
<b>Prescription drug vendor</b>	Same as medical plan
<b>Annual Rx out-of-pocket maximum</b>	\$1,500 Individual; \$3,000 Family

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	<b>Retail</b>
<b>Retail generic</b>	\$5 copay or 10% coinsurance whichever is greater; 30 day supply
<b>Retail formulary brand</b>	\$20 copay or 10% coinsurance whichever is greater; 30 day supply
<b>Retail nonformulary brand</b>	\$40 copay or 10% coinsurance whichever is greater; 30 day supply
	<b>Mail Order</b>
<b>Mail order generic</b>	\$5 copay or 10% coinsurance whichever is greater; 90 day supply
<b>Mail order formulary brand</b>	\$20 copay or 10% coinsurance whichever is greater; 90 day supply
<b>Mail order nonformulary brand</b>	\$40 copay or 10% coinsurance whichever is greater; 90 day supply
	<b>Other</b>
<b>Oral contraceptives</b>	Retail and mail order available; applicable prescription drug copay applies
<b>Fertility drugs</b>	100% covered after applicable copays; limited to \$25,000 per lifetime for all fertility services combined
<b>Injectibles</b>	Coverage based on place of service; applicable prescription drug copay or office visit copay applies; check with Plan for details
	<b>Mental Health</b>
<b>Mental Health: Combined with substance abuse</b>	Yes
<b>Mental Health: Outpatient coverage</b>	\$10 copay; limited to 60 individual, group, or family visits per benefit plan year
<b>Mental Health: Inpatient coverage</b>	100% covered; limited to 60 days per benefit plan year; preauthorization required
	<b>Substance Abuse</b>
<b>Detox: Outpatient coverage</b>	\$10 copay; limited to 60 individual, group or family visits per benefit plan year
<b>Detox: Inpatient coverage</b>	100% covered; limited to 60 days per benefit plan year; limited to two inpatient admissions per lifetime; preauthorization required
<b>Rehab: Outpatient coverage</b>	\$10 copay; limited to 60 individual, group, or family visits per benefit plan year
<b>Rehab: Inpatient coverage</b>	100% covered; limited to 60 days per benefit plan year; limited to two inpatient admissions per lifetime; preauthorization required
	<b>Alternative Care</b>
<b>Chiropractic</b>	\$20 copay; limited to 40 visits per benefit plan year; PCP referral not required at participating providers
<b>Acupuncture</b>	\$20 copay; limited to 20 visits per benefit plan year; acupressure not covered
	<b>Care Management Programs</b>
<b>Heart disease care management</b>	Yes
<b>Hypertension care management</b>	No
<b>Diabetes care management</b>	Yes
<b>Asthma care management</b>	Yes
<b>Prenatal care management</b>	Yes
<b>Cancer care management</b>	No
<b>Smoking cessation program</b>	No
<b>Weight control program</b>	No

<b>Feature</b>	<b>Aetna EPO CA - ES Rep</b>
	<b>Other</b>
<b>Noncustodial home health care</b>	100% covered; limited to 120 visits per benefit plan year
<b>Hospice care</b>	100% covered
<b>Prescribed care in noncustodial skilled nursing facility</b>	100% covered; limited to 120 visits per benefit plan year
<b>Durable medical equipment</b>	100% covered; must be medically necessary
<b>Prosthetic devices</b>	100% covered; must be medically necessary