

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

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Outpatient speech therapy	\$20 copay; limited to 50 visits per benefit plan year
Outpatient cardiac rehabilitation	\$20 copay; limited to Phase 1 and Phase 2 care
Family Planning/Maternity Care	
Office visit: pre/postnatal	\$10 copay initial visit only; PCP; \$20 copay specialist initial visit only
In-hospital delivery services	100% covered
Newborn nursery services	100% covered
Fertility services	100% covered after applicable copays; limited to \$25,000 per lifetime for all fertility services combined, including prescription drugs
In vitro fertilization	100% covered after applicable copays; limited to \$25,000 per lifetime for all fertility services combined, including prescription drugs
Artificial insemination	100% covered after applicable copays; limited to \$25,000 per lifetime for all fertility services combined, including prescription drugs
Female tubal ligation	100% covered; in or outpatient hospital setting; \$10 copay PCP/\$20 copay specialist in office setting
Male vasectomy	100% covered; in or outpatient hospital setting; \$10 copay PCP/\$20 copay specialist in office setting
Hearing	
Hearing evaluations	\$10 copay; PCP; \$20 copay specialist; limited to one exam per benefit plan year
Hearing aids	Limited to \$1,000 per benefit plan year; check with Plan for limitations
Vision	
Routine vision exams	\$10 copay; limited to PCP screening only, limited to one exam per benefit plan year
Regular lenses and frames	Not covered
Contact lenses	Not covered
Dental	
Dental implants	Not covered
Accidental injury to teeth	Coverage based on place of service; check with Plan for details
Surgical removal of tumors, cysts and impacted teeth	100% covered; limited to surgical removal of tumors and cysts; removal of impacted teeth not covered
Inpatient Services	
Hospital copay	100% covered
Hospital semi-private room	100% covered
Inpatient lab and X-ray	100% covered
Inpatient surgery	100% covered
Inpatient physician and surgeon services	100% covered
Emergency Care	
Emergency room (not followed by admission)	\$100 copay
Urgent care clinic visit	\$20 copay
Ambulance services	100% covered

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	Prescription Drug Coverage
Annual prescription deductible	Not applicable
Prescription drug website	Same as medical plan
Prescription drug member services	Same as medical plan
Prescription drug vendor	Same as medical plan
Annual Rx out-of-pocket maximum	\$1,500 Individual; \$3,000 Family
	Retail
Retail generic	\$5 copay or 10% coinsurance whichever is greater; 30 day supply
Retail formulary brand	\$20 copay or 10% coinsurance whichever is greater; 30 day supply
Retail nonformulary brand	\$40 copay or 10% coinsurance whichever is greater; 30 day supply
	Mail Order
Mail order generic	\$5 copay or 10% coinsurance whichever is greater; 90 day supply
Mail order formulary brand	\$20 copay or 10% coinsurance whichever is greater; 90 day supply
Mail order nonformulary brand	\$40 copay or 10% coinsurance whichever is greater; 90 day supply
	Other
Oral contraceptives	Retail and mail order available; applicable prescription drug copay applies
Fertility drugs	100% covered; after applicable copays; limited to \$12,500 per lifetime for all fertility services combined
Injectibles	Coverage based on place of service; applicable prescription drug copay or office visit copay applies; check with Plan for details
	Mental Health
Mental Health: Combined with substance abuse	Yes
Mental Health: Outpatient coverage	\$10 copay; limited to 60 individual, group, or family visits per benefit plan year
Mental Health: Inpatient coverage	100% covered; limited to 60 days per benefit plan year; preauthorization required
	Substance Abuse
Detox: Outpatient coverage	\$10 copay; limited to 60 individual, group or family visits per benefit plan year
Detox: Inpatient coverage	100% covered; limited to 60 days per benefit plan year; limited to two inpatient admissions per lifetime; preauthorization required
Rehab: Outpatient coverage	\$10 copay; limited to 60 individual, group, or family visits per benefit plan year
Rehab: Inpatient coverage	100% covered; limited to 60 days per benefit plan year; limited to two inpatient admissions per lifetime; preauthorization required
	Alternative Care
Chiropractic	\$20 copay; limited to 40 visits per benefit plan year; PCP referral not required at participating providers
Acupuncture	\$20 copay; limited to 20 visits per benefit plan year; acupressure not covered
	Care Management Programs
Heart disease care management	Yes
Hypertension care management	No
Diabetes care management	Yes
Asthma care management	Yes

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Prenatal care management	Yes
Cancer care management	No
Smoking cessation program	No
Weight control program	No
	Other
Noncustodial home health care	100% covered; limited to 120 visits per benefit plan year
Hospice care	100% covered
Prescribed care in noncustodial skilled nursing facility	100% covered; limited to 120 visits per benefit plan year
Durable medical equipment	100% covered; must be medically necessary
Prosthetic devices	100% covered; must be medically necessary