

Plan Facts

	Aetna Select EPO
Web site	custom.aetna.com/NGC
Member services	1-877-254-6765; see your medical ID card for phone number
Find a network provider	Find a Doctor or Hospital
Binding arbitration	No

Cost

	Aetna Select EPO
Health Reimbursement Arrangement	
Eligible expenses for reimbursement	Not applicable
General Medical Expenses	
Deductible: Individual/Family	\$0 Individual; \$0 Family
Primary doctor office visit	\$20 copay
Specialist office visit	\$40 copay
Out-of-pocket maximum: Individual/Family	\$0 Individual; \$0 Family
Lifetime coverage limit	\$2,000,000; for all Northrop Grumman-sponsored medical plan options; retiree and active combined
Inpatient Hospital Care	
Hospital copay	\$200 copay per admission
Hospital semi-private room	100% covered after inpatient hospital copay
Inpatient lab and X-ray	100% covered; after inpatient hospital copay
Inpatient physician and surgeon services	100% covered; after inpatient hospital copay
Outpatient Care	
Outpatient surgery	100% covered
Outpatient laboratory services	100% covered; physician's office; \$20 copay at outpatient network laboratories
Outpatient X-ray	100% covered; physician's office; \$20 copay at outpatient network laboratories
Emergency room (not followed by admission)	\$250 copay
Urgent care clinic visit	\$20 copay
Prescription Drug Expenses	
Prescription drug vendor	Same as medical plan
Prescription drug Web site	Same as medical plan
Prescription drug member services	Same as medical plan
Annual prescription deductible	Not applicable
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; chemically equivalent generics required; check with Plan for details

Retail nonformulary brand	\$40 copay or 10% coinsurance whichever is greater; 30 day supply; chemically equivalent generics required; check with Plan for details
Mail order generic	\$5 copay or 10% coinsurance whichever is greater; 90 day supply; mail order required for maintenance medications; check with Plan for details
Mail order formulary brand	\$20 copay or 10% coinsurance whichever is greater; 90 day supply; chemically equivalent generics required; mail order required for maintenance medications; check with Plan for details
Mail order nonformulary brand	\$40 copay or 10% coinsurance whichever is greater; 90 day supply; chemically equivalent generics required; mail order required for maintenance medications; check with Plan for details
Oral contraceptives	Retail and mail order available; applicable prescription drug copay applies

Coverage

Aetna Select EPO	
Adult Preventive Care	
Physical exam	\$20 copay; PCP; \$40 copay specialist
Well-woman exam (includes pap)	\$20 copay; PCP; \$40 copay specialist
Mammogram	100% covered; age schedules apply; check with Plan for details
Cancer screenings	Included with office visit copay
Cardiovascular screenings	Included with office visit copay
Family Planning	
Fertility drugs	100% covered; after applicable copays; limited to \$12,500 per lifetime for all fertility services combined
Fertility services	100% covered; after applicable copays; limited to \$12,500 per lifetime including prescription drugs
Artificial insemination	100% covered; after applicable copays; limited to \$12,500 per lifetime for all fertility services combined including prescription drugs
In vitro fertilization	100% covered; after applicable copays; limited to \$12,500 per lifetime for all fertility services combined including prescription drugs
Male vasectomy	100% covered; outpatient hospital setting; \$20 copay PCP/\$40 copay specialist in office setting; \$200 copay inpatient hospital setting
Maternity Care	

Office visit: Pre/postnatal	\$20 copay initial visit only; PCP; \$40 copay specialist initial visit only
In-hospital delivery services	\$200 copay; per admission
Newborn nursery services	100% covered; after inpatient hospital copay
Prenatal care management	Yes
Well-Baby/Well-Child Preventive Care	
Well-child exams	\$20 copay; PCP; \$40 copay specialist
Immunizations (child)	Included with office visit copay
Mental Health Care	
Mental Health: Combined with substance abuse	Yes
Mental Health: Outpatient coverage	\$20 copay; limited to 60 individual, group, or family visits per benefit plan year
Mental Health: Inpatient coverage	\$200 copay per admission; limited to 60 days per benefit plan year; preauthorization required
Substance Abuse Care	
Detox: Outpatient coverage	\$20 copay; limited to 60 individual, group, or family visits per benefit plan year
Detox: Inpatient coverage	\$200 copay per admission; limited to 60 days per benefit plan year; limited to two inpatient admissions per lifetime; preauthorization required
Rehab: Outpatient coverage	\$20 copay; limited to 60 individual, group, or family visits per benefit plan year
Rehab: Inpatient coverage	\$200 copay per admission; limited to 60 days per benefit plan year; limited to two inpatient admissions per lifetime; preauthorization required
Dental Care	
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
Vision Care	
Routine vision exams	\$20 copay; limited to PCP screening only; limited to one exam per benefit plan year
Regular lenses and frames	Not covered
Contact lenses	Not covered
Other Services	
Ambulance services	100% covered
Allergy tests and treatments	100% covered; injections; \$20 copay PCP/\$40 copay specialist for physician testing
Durable medical equipment	100% covered; must be medically necessary

Hearing Care

Hearing evaluations	\$20 copay; PCP; \$40 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

Medical Therapy

Acupuncture	\$40 copay; limited to 20 visits per benefit plan year; acupuncture not covered
Chiropractic	\$40 copay; limited to 40 visits per benefit plan year; PCP referral not required at participating providers
Outpatient physical therapy	\$20 copay; limited to 50 visits per benefit plan year
Outpatient speech therapy	\$20 copay; limited to 50 visits per benefit plan year
Outpatient occupational therapy	\$20 copay; limited to 50 visits per benefit plan year

Care at Alternate Sites

Noncustodial home health care	100% covered; limited to 120 visits per benefit plan year
Prescribed care in noncustodial skilled nursing facility	100% covered; limited to 120 days per benefit plan year
Hospice care	100% covered

Access

	Aetna Select EPO
Out-of-area dependent coverage	No
Out-of-area participant coverage	No

Ease of Use

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Need to file claims	No; except for non-routine, out-of-network, or emergency care
Number of PCP changes allowed/year	Not available
Ability to self-refer to OB/GYN	Yes
Ability to self-refer to specialists	No

Care Management: Education and Assistance

	Aetna Select EPO
Asthma care management	Yes
Cancer care management	No
Diabetes care management	Yes
Heart disease care management	Yes
Hypertension care management	No
Smoking cessation program	No
Weight control program	No

