

# Summary of Benefits

## Aetna Global Benefits Traditional Choice® Indemnity Medical Plan

Effective January 1, 2007

### Traditional Choice Indemnity Benefits

#### Plan Provisions

#### Plan Benefits\*

#### Calendar Year Deductible

- |              |                            |
|--------------|----------------------------|
| ★ Individual | \$200                      |
| ★ Family     | \$600 (3 times individual) |

#### Out-of-Pocket Limit

(the maximum amount you pay for your share of covered expenses in a calendar year. Copays, expenses covered at 50% and non-covered expenses do not count toward your Out-of-Pocket Limit)

- |              |                              |
|--------------|------------------------------|
| ★ Individual | \$3,000                      |
| ★ Family     | \$9,000 (3 times individual) |

#### Lifetime Maximum

Unlimited

#### Hospital Precertification

Please see your Summary Plan Description (SPD) for details.

You must precertify any scheduled hospital stay.  
\$500 penalty for failure to precertify  
(penalty waived if you are overseas)

#### Preventive Care

- |   |  |
|---|--|
| ★ Routine physical exam and immunizations<br>(one per calendar year)  | 100%, no deductible  |
| ★ Well-child care and immunizations<br>Birth to age 7. Please see your SPD for<br>age and frequency schedule. | 100%, no deductible  |
| ★ Routine gynecological exam<br>including Pap test and related lab fees<br>(one per calendar year)            | 100%, no deductible  |
| ★ Routine Mammogram<br>(one per calendar year for women age 35 and over)                                      | 100%, no deductible  |
| ★ Prostate screening exam<br>(one per calendar year for men age 40 and over)                                  | 100%, no deductible  |
| ★ Routine eye exam<br>(one per calendar year)   | 100%, no deductible  |
| ★ Prescription eyewear - lenses, frames and contacts<br>(in addition to Vision One® Discount Program)         | 100% up to a \$150 maximum benefit<br>per person per calendar year |
| ★ Routine hearing exam<br>(one per calendar year)   | 100%, no deductible  |
| ★ Hearing aids<br>(\$1,000 lifetime maximum)  | 100%, no deductible  |

#### Physician Services

- |  |   |
|--|---|
| ★ Office visits for treatment of illness or injury | 80% after deductible  |
| ★ Diagnostic lab and X-ray                         | 80% after deductible  |
| ★ Maternity care office visits                     | 80% after deductible  |
| ★ In-office surgery                                | 100% of first \$1,000, no deductible; then 80% after deductible |
| ★ Physician hospital visits                        | 80% after deductible  |
| ★ Anesthesia                                       | 80% after deductible  |
| ★ Allergy testing, serum and injections            | 80% after deductible  |
| ★ Specialists (office visits)                      | 80% after deductible  |
| ★ Second surgical opinion                          | 100%, no deductible   |

#### Hospital Services

- |  |                      |
|--|----------------------|
| ★ Inpatient hospital room and board and ancillary services | 80% after deductible |
| ★ Inpatient and outpatient surgery                         | 80% after deductible |
| ★ Outpatient services                                      | 80% after deductible |
| ★ Pre-operative testing                                    | 80%, no deductible   |
| ★ Other hospital services                                  | 80% after deductible |

#### Emergency Care

- |  |                      |
|--|----------------------|
| ★ Hospital emergency room                        | 80% after deductible |
| ★ Hospital emergency room for non-emergency care | 50% after deductible |
| ★ Ambulance                                      | 80% after deductible |

\* Coverage is subject to reasonable and customary charges for services provided in the United States. This provision does not apply for services provided overseas.

# Summary of Benefits

## Aetna Global Benefits

### Traditional Choice® Indemnity Medical Plan

Effective January 1, 2007  
continued

#### Traditional Choice Indemnity Benefits

#### Plan Provisions

#### Plan Benefits\*

##### Other Health Care

★ Convalescent facility (up to 90 days per calendar year)	80% after deductible
★ Home health care (up to 90 visits per calendar year)	80% after deductible
★ Private duty nursing (up to 70 eight-hour shifts per calendar year)	80% after deductible
★ Hospice (inpatient and outpatient)	100%, no deductible
★ Independent lab and X-ray facilities	80% after deductible
★ Voluntary sterilization	80% after deductible
★ Short-term rehabilitation (60-day maximum per course of treatment)	80% after deductible
★ Durable medical equipment	80% after deductible
★ Spinal disorder (chiropractic) (20 visits per calendar year)	80% after deductible
★ Bariatric surgery	50% after deductible

##### Mental Health Care\*\*

★ Inpatient	80% after deductible; up to 60 days per calendar year; 60% thereafter
★ Outpatient (up to 45 visits per calendar year)	80% after deductible

\*\* Outpatient day maximums for mental health and substance abuse are not combined.

##### Substance Abuse Treatment\*\*

★ Inpatient (up to 45 days per calendar year)	80% after deductible
★ Outpatient (up to 45 visits per calendar year)	80% after deductible

\*\* Outpatient day maximums for mental health and substance abuse are not combined.

##### Prescription Drug Benefits

###### Participating Retail Pharmacy Program

(Up to a 12-month supply purchased at a participating U.S. pharmacy.  
Separate copays apply to each 30-day supply.)

	Participating Pharmacies	Non-Participating Pharmacies
★ Generic drugs	100% after \$10 copay	Not covered
★ Formulary brand-name drugs	100% after \$25 copay	Not covered
★ Non-formulary brand-name drugs	100% after \$35 copay	Not covered

###### Prescriptions Purchased Overseas

★ Generic drugs	Not applicable	100% after deductible
★ Brand-name drugs	Not applicable	80% after deductible

###### Mail-Order Service

(up to a 90-day supply)

★ Generic drugs	100% after \$20 copay
★ Formulary brand-name drugs	100% after \$40 copay
★ Non-formulary brand-name drugs	100% after \$60 copay

\* Coverage is subject to reasonable and customary charges for services provided in the United States. This provision does not apply for services provided overseas.



This chart displays only a general description of your benefits under the DoD NAF HBP. Should there be a conflict between the benefits shown on the chart and those in the Aetna Global Benefits Summary Plan Description (SPD), the terms of the SPD will be used to determine coverages and benefits.