

<p>Please note that the information contained in this table is a summary only. For more detailed information, please contact the Plan at the number provided. You may also contact your local human resource professional. In the event that the information in this table differs from that contained in the Summary Plan Document (SPD), or otherwise provided by the Plan, the information in the SPD and/or provided by the Plan shall control.</p>	<p>Aetna Traditional Choice</p>	<p>PacifiCare Guam</p>
	<p>For Information:</p>	<p>For Information:</p>
	<p>1-800-367-6276</p>	<p>1-671-647-3526</p>
	<p>www.aetna.com</p>	<p>www.pacificare.com</p>
<p>Price</p>		
	<p>Single: \$46.20</p>	<p>Single: \$31.89</p>
	<p>Family: \$107.49</p>	<p>Family: \$89.70</p>
<p>General</p>		
<p>Network benefits available?</p>	<p>No. You can see any physician you choose.</p>	<p>Yes. To receive coverage, you must see an in-network provider. There is also an Out-of-Network benefit that reimbursed you 50% of UCR is you go to an Out-of-Network provider.</p>
<p>Primary Care Physician (PCP) required?</p>	<p>No. However, you are responsible for obtaining pre-certification from the Plan before you receive inpatient care. (Typically, your physician will obtain pre-certification on your behalf). (\$500 penalty for failure to obtain pre-certification; penalty waived for overseas associates)</p>	<p>Yes. All healthcare services and supplies must be coordinated through your primary care physician.</p>
<p>Deductible</p>		
<p>Individual</p>	<p>\$200; You do not have to meet your deductible to receive 100% coverage for most preventive care.</p>	<p>None</p>
<p>Family</p>	<p>\$600; You do not have to meet your deductible to receive 100% coverage for most preventive care.</p>	<p>None</p>
<p>Out-of-Pocket Limit (Plan pays 100% of eligible expenses after you reach this)</p>		
<p>Individual</p>	<p>\$2,000</p>	<p>\$1,000</p>
<p>Family</p>	<p>\$6,000</p>	<p>\$3,000</p>
<p>Lifetime Maximum</p>		
	<p>Unlimited</p>	<p>None</p>

Preventive Care		
Routine physical exam and immunizations (once per year)	100% coverage, no deductible	\$5 copay per office visit
Well-child care	100% coverage, no deductible	\$5 copay per office visit
Routine gynecological exam (including Pap test and related lab fees, once per year)	100% coverage, no deductible	\$5 copay per office visit
Mammogram (once per year for women ages 35 and over)	100% coverage, no deductible	\$5 copay (PacifiCare's baseline is 40, but we will allow at a younger age if there are high risk factors)
Prostate screening exam (once per year for men ages 40 and over)	100% coverage, no deductible	\$5 if done by a primary care provider or \$25 if done by a specialist
Routine eye screening	80% coverage, no deductible (one per calendar year)	\$5 (refraction only) by an optometrist however if you need to see an ophthalmologist then it's \$25
Lenses, eyeglass frames and contacts (in addition to Vision plan benefit)	100% coverage, no deductible (up to a \$75 maximum benefit per calendar year per person)	Not covered
Routine hearing exam	100% coverage, no deductible (one per calendar year)	\$5 if done by a primary care provider
Hearing aids	100% coverage, no deductible (up to a \$500 lifetime maximum per person)	Not covered
Physician Services		
Office visits for treatment of illness or injury	80% coverage after deductible	\$5 copay
Maternity	80% coverage after deductible	Delivery (room and board) and physician, surgeon or anesthesiologist covered at 80%, Pre & Post delivery exams: \$5 copay in office

In-office surgery, x-ray and lab work	100% coverage of first \$1,000, then 80% coverage after deductible (first \$1,000 does not apply to x-ray and lab work which is covered at 80% after deductible)	Depending on the location of the surgery it can either be \$5 if done in the doctor's office by a PCP or \$25 if done by a specialist, or 80% covered if done in a surgicenter or hospital as an out-patient procedure. Also, plain film x-rays, EKGs and Mammograms are \$5 all other x-rays or diagnostic testing is \$25 (ie. CT Scan, ultra sound, MRI etc.), lab work is free
Allergy testing, serum and injections	80% coverage after deductible	\$25 copay
Specialists (Office Visits)	80% coverage after deductible	\$25 copay
Second Surgical Opinion	100% coverage, no deductible	\$25 copay
Hospital Services - Inpatient		
Hospital room & board, and ancillary services	80% coverage after deductible	80%
Preoperative testing	80% coverage, no deductible	80%
Lab and x-ray	80% coverage after deductible	80%
Surgery	80% coverage after deductible	80%
Physician hospital visits	80% coverage after deductible	80%
Anesthesia	80% coverage after deductible	80%
Hospital Services - Outpatient		
Surgery	80% coverage after deductible	\$5/\$25 copay depending on PCP or specialist in the office otherwise 80% coverage.
Independent lab and x-ray facilities	80% coverage after deductible	\$5 copay for plain film, EKGs and mammograms all others \$25, 100% for lab
Emergency		
Hospital emergency room (emergency care)	80% coverage after deductible	100% of allowable charges after \$25 ER copay for in or out-of-area.
Hospital emergency room (non-emergency care)	50% coverage after deductible	Not covered
Ambulance	80% coverage after deductible	100% it is a true emergency
Health Care Alternatives		
Convalescent facility	80% coverage (up to 90 days per calendar year per person) after deductible	Not covered
Home health care	80% coverage (up to 90 visits per calendar year per person) after deductible	100%
Private duty nursing	80% coverage (up to 70 8-hour shifts per calendar year per person) after deductible	Not covered
Hospice	100% coverage, no deductible	100% when provided by PacifiCare Home Health
Other Health Care		

Family planning	100% coverage of first \$1,000, then 80% after deductible (part of in-office surgery benefits). Reversal of voluntary sterilization including related follow-up care and treatment of complications of such procedures is not covered.	80% at surgicenter or hospital
(voluntary sterilization)		
Short-term rehabilitation	80% coverage after deductible (up to 60-day maximum per course of treatment)	Outpatient \$25 copay (20 visit max./yr), Inpatient covered 80%
Durable medical equipment	80% coverage after deductible	Not covered
Chiropractic	80% coverage (up to 20 visits per calendar year per person) after deductible	Not covered
Mental Health Care		
Inpatient	80% coverage after deductible (up to 60 days per calendar year per person) 60% coverage thereafter	80%
Outpatient	80% coverage after deductible (up to 45 visits per calendar year per person)	\$25 each office visit
Outpatient Psychiatric	See Outpatient Benefits	\$25 each office visit
Partial Hospitalization	See Outpatient Benefits	80% sub-acute facility only
Substance Abuse Treatment		
Inpatient	80% coverage after deductible (up to 45 days per calendar year per person)	80% limited to \$8,000/year or \$16,000/lifetime(this is a combined inpatient/outpatient limit)
Outpatient	80% coverage after deductible (up to 45 visits per calendar year per person)	\$25 per visit limited to \$8,000/year or \$16,000/lifetime(this is a combined inpatient/outpatient limit)
Prescriptions		
Maximum	Information not provided by carrier	None
Local retail network pharmacies	Generic: 100% coverage after \$10 copayment (no coverage for non-participating pharmacy) (30-day supply)	Generic: \$5
	Formulary Brand Name: 100% coverage after \$20 copayment (no coverage for non-participating pharmacy) (30-day supply)	Formulary Brand Name: \$10

	Non-formulary Brand Name: 100% coverage after \$30 copayment (no coverage for non-participating pharmacy) (30-day supply)	Non-formulary Brand Name: \$20
Mail-order Service	Generic: 100% coverage after \$10 copayment (no coverage for non-participating pharmacy) (90-day supply)	Generic: \$0
	Formulary brand name: 100% coverage after \$20 copayment (no coverage for non-participating pharmacy) (90-day supply)	Formulary Brand Name: \$0
	Non-formulary brand name: 100% coverage after \$30 copayment (no coverage for non-participating pharmacy) (90-day supply)	Non-formulary Brand Name: Two times retail copay for a 90-day supply non-formulary
Overseas Prescriptions	Generic: 100% after deductible	not covered unless inpatient as a result of an emergency
	Formulary Brand Name: 80% after deductible	
Coverage Continuation		
		For information regarding continuation of coverage, you must contact the HMO directly. If you are enrolled in the HMO option, only the continuation of coverage offered by the HMO will apply. The DoD NAF plan's continuation of coverage option will not apply if you are enrolled in the HMO option when your coverage ends.
Footnotes:	¹ Inpatient Biologically Based illnesses include: schizophrenia, autism, drug & alcohol addiction, schizo affective disorder, bipolar disorder, panic disorder, major depressive disorder, obsessive-compulsive disorder and attention deficit hyperactive disorder.)	
	² Outpatient Biologically Based illnesses include: schizophrenia, autism, drug & alcohol addiction, schizo affective disorder, bipolar disorder, panic disorder, major depressive disorder, obsessive-compulsive disorder and attention deficit hyperactive disorder.)	

³ If you or your physician insist on a brand name drug when a generic equivalent is available, you are responsible for the difference in cost between the generic and the brand name drug, plus your brand name copay.