

<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>Triple-S Puerto Rico</p>
	<p>For Information:</p>	
	<p>1-800-367-6276</p>	
	<p>www.aetna.com</p>	
<p>Price</p>		
	<p>Single: \$46.20</p>	<p>Single: \$20.87</p>
	<p>Family: \$107.49</p>	<p>Family: \$48.14</p>
<p>General</p>		
<p>Network benefits available?</p>	<p>No. You can see any physician you choose.</p>	<p>Yes, in the Basic Coverage, Dental and Pharmacy. Out of Network coverage through Major Medical.</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>No, we are a PPO.</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>Out of Network, in the Major Medical coverage \$100.00 per policy year</p>
<p>Family</p>	<p>\$600; You do not have to meet your deductible to receive 100% coverage for most preventive care.</p>	<p>Out of Network, in the Major Medical coverage \$300.00 per policy year</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>Out of Network, in the Major Medical coverage \$2,000 per policy year</p>
<p>Family</p>	<p>\$6,000</p>	<p>Out of Network, in the Major Medical coverage \$6,000 per policy year</p>

Lifetime Maximum		
	Unlimited	Out of Network, in the Major Medical coverage, \$1,000,000.
Preventive Care		
Routine physical exam and immunizations (once per year)	100% coverage, no deductible	\$15 copay. Immunizations up to age 17 per Dept. of Health itinerary \$5.00 ea. Influenza and Tetanus Toxoid without age limit.
Well-child care	100% coverage, no deductible	1 routine monthly visit \$15.00 ea.
		Immunizations up to age 17 per Dept. of Health itinerary \$5.00 ea. Influenza and Tetanus Toxoid without age limit.
Routine gynecological exam	100% coverage, no deductible	\$15 copay; lab fees 25% coinsurance
(including Pap test and related lab fees, once per year)		
Mammogram	100% coverage, no deductible	According to medical recommendation; 25% coinsurance
(once per year for women ages 35 and over)		
Prostate screening exam	100% coverage, no deductible	According to medical recommendation; 25% coinsurance
(once per year for men ages 40 and over)		
Routine eye screening	80% coverage, no deductible (one per calendar year)	By ophthalmologist; 25% coinsurance
Lenses, eyeglass frames and contacts	100% coverage, no deductible (up to a \$75 maximum benefit per calendar year per person)	Frames and contact lenses covered by reimbursement up to \$150 every two years
(in addition to Vision plan benefit)		
Routine hearing exam	100% coverage, no deductible (one per calendar year)	Covered in Major Medical
Hearing aids	100% coverage, no deductible (up to a \$500 lifetime maximum per person)	\$250.00 per year in the Major Medical coverage
Physician Services		
Office visits for treatment of illness or injury	80% coverage after deductible	\$5 copay Generalist / \$15 Specialist or sub-specialist
Maternity	80% coverage after deductible	\$15 copay
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)	25% coinsurance (surgery not covered)

Allergy testing, serum and injections	80% coverage after deductible	50 tests covered. Injections not covered.
Specialists (Office Visits)	80% coverage after deductible	\$15 copay
Second Surgical Opinion	100% coverage, no deductible	Standard office visit copay.
Hospital Services - Inpatient		
Hospital room & board, and ancillary services	80% coverage after deductible	\$50 copay
Preoperative testing	80% coverage, no deductible	Included in the hospital per diem
Lab and x-ray	80% coverage after deductible	100% covered
Surgery	80% coverage after deductible	100% covered
Physician hospital visits	80% coverage after deductible	100% covered
Anesthesia	80% coverage after deductible	100% covered
Hospital Services - Outpatient		
Surgery	80% coverage after deductible	100% covered
Independent lab and x-ray facilities	80% coverage after deductible	25% coinsurance
Emergency		
Hospital emergency room (emergency care)	80% coverage after deductible	\$20.00 waived if pre-certified through Teleconsulta
Hospital emergency room (non-emergency care)	50% coverage after deductible	Urgency rooms not covered
Ambulance	80% coverage after deductible	\$80.00 by reimbursement
Health Care Alternatives		
Convalescent facility	80% coverage (up to 90 days per calendar year per person) after deductible	25% coinsurance
Home health care	80% coverage (up to 90 visits per calendar year per person) after deductible	25% coinsurance
Private duty nursing	80% coverage (up to 70 8-hour shifts per calendar year per person) after deductible	Special nurses only included in home health care and in the hospital
Hospice	100% coverage, no deductible	Not covered
Other Health Care		
Family planning (voluntary sterilization)	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.	100% covered
Short-term rehabilitation	80% coverage after deductible (up to 60-day maximum per course of treatment)	25% coinsurance
Durable medical equipment	80% coverage after deductible	25% coinsurance

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	\$50 copay
Outpatient	80% coverage after deductible (up to 45 visits per calendar year per person)	According to medical necessity, \$15 deductible
Outpatient Psychiatric	See Outpatient Benefits	According to medical necessity, \$15 deductible
Partial Hospitalization	See Outpatient Benefits	\$50 copay
Substance Abuse Treatment		
Inpatient	80% coverage after deductible (up to 45 days per calendar year per person)	1 per year, \$50.00 copay, max. 45 days
Outpatient	80% coverage after deductible (up to 45 visits per calendar year per person)	20 visits per year
Prescriptions		
Maximum	Information not provided by carrier	Acute drugs 15 day supply no refills, Maintenance drugs 30 day supply 5 refills.
Local retail network pharmacies	Generic: 100% coverage after \$10 copayment (no coverage for non-participating pharmacy) (30-day supply)	Generic: \$5 copay
	Formulary Brand Name: 100% coverage after \$20 copayment (no coverage for non-participating pharmacy) (30-day supply)	Formulary brand name: \$8 copay for preferred; \$10 for brand
	Non-formulary Brand Name: 100% coverage after \$30 copayment (no coverage for non-participating pharmacy) (30-day supply)	Non-formulary brand name: 20% coinsurance (minimum \$10)
Mail-order Service	Generic: 100% coverage after \$10 copayment (no coverage for non-participating pharmacy) (90-day supply)	Generic: Not covered

	Formulary brand name: 100% coverage after \$20 copayment (no coverage for non-participating pharmacy) (90-day supply)	Formulary brand name: Not covered
	Non-formulary brand name: 100% coverage after \$30 copayment (no coverage for non-participating pharmacy) (90-day supply)	Non-formulary brand name: Not covered
Overseas Prescriptions	Generic: 100% after deductible	Triple-S will reimburse 75% of established fees for those drugs.
	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.	