

<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 Open Choice PPO Plan</p>		<p>Scott & White Waco TX</p>
	<p>For Information:</p>		<p>For Information:</p>
	<p>1-800-367-6276</p>		<p>1-254-298-3369</p>
	<p>www.aetna.com</p>		
	<p>In Network ("Preferred Provider")</p>	<p>Out of Network</p>	
<p>Price</p>			
	<p>Single: \$46.20</p>		<p>Single: \$38.65</p>
	<p>Family: \$107.49</p>		<p>Family: \$99.27</p>
<p>General</p>			
<p>Network benefits available?</p>	<p>Yes. You can see any physician you choose, but you will receive a higher coverage level if you obtain treatment and supplies from in-network providers.</p>		<p>Yes. To receive coverage, you must see an in-network provider.</p>
<p>Primary Care Physician (PCP) required?</p>	<p>No</p>		<p>Yes. All healthcare services and supplies must be coordinated through your primary care physician.</p>
<p>Deductible</p>			
<p>Individual</p>	<p>None</p>	<p>\$400</p>	<p>None</p>
<p>Family</p>	<p>None</p>	<p>\$1,200</p>	<p>None</p>
<p>Out-of-Pocket Limit (Plan pays 100% of eligible expenses after you reach this)</p>			<p>\$1,000 per person, \$2,000 per family</p>
<p>Individual</p>	<p>\$2,000</p>	<p>\$3,000</p>	<p>\$1,500</p>
<p>Family</p>	<p>\$6,000</p>	<p>\$9,000</p>	<p>\$2,500</p>
<p>Lifetime Maximum</p>			
	<p>Unlimited</p>	<p>Unlimited</p>	<p>No Maximum</p>
<p>Preventive Care</p>			
<p>Routine physical exam and immunizations (once per year)</p>	<p>100% coverage, no copay</p>	<p>No coverage</p>	<p>\$10 copay</p>
<p>Well-child care</p>	<p>100% coverage, no copay</p>	<p>No coverage</p>	<p>\$10 copay</p>

Routine gynecological exam	100% coverage, no copay	No coverage	\$10 copay
(including Pap test and related lab fees, once per year)			
Mammogram	100% coverage, no copay	No coverage	100%
(once per year for women ages 35 and over)			
Prostate screening exam	100% coverage, no copay	No coverage	\$10 copay
(once per year for men ages 40 and over)			
Routine eye screening	100% after copay: \$15 PCP/\$25 Specialist	No coverage	\$10 copay
Lenses, eyeglass frames and contacts	100% coverage (up to a \$75 maximum benefit per calendar year per person)	100% coverage (up to a \$75 maximum benefit per calendar year per person)	Not covered
(in addition to Vision plan benefit)			
Routine hearing exam	100% coverage, no copay	No coverage	\$10 copay
Hearing aids	100% coverage (up to a \$500 lifetime maximum per person)	100% coverage (up to a \$500 lifetime maximum per person)	Covered under DME
Physician Services			
Office visits for treatment of illness or injury	100% coverage after copay: \$15 PCP/\$25 Specialist	70% after deductible	\$10 copay
Maternity	100% coverage after first \$15 copayment (\$25 for specialist)	70% after deductible	Inpatient: \$100 copay/day up to \$500
			Outpatient: \$100 copay
In-office surgery, x-ray and lab work	100% coverage after copay: \$15 PCP/\$25 Specialist	70% after deductible	\$100
Allergy testing, serum and injections	100% coverage after \$15/\$25 copay when part of office visit otherwise 100%, no copay	70% after deductible	\$25 per vial serum
Specialists	100% coverage after \$25 copayment	70% after deductible	\$10 copay with referral
(Office Visits)			
Second Surgical Opinion	100% coverage, no copay	100% coverage, no deductible	Not covered
Hospital Services - Inpatient			
Hospital room & board, and ancillary services	90% after \$200 per confinement fee	70% after deductible and separate \$400 per confinement fee	\$100 copay per day to a maximum of \$500

Preoperative testing	90% coverage, no copay	70% coverage, no deductible	100%
Lab and x-ray	90% coverage, no copay	70% coverage, after deductible	100%
Surgery	90% coverage, no copay	70% coverage, after deductible	100%
Physician hospital visits	90% coverage, no copay	70% coverage, after deductible	100%
Anesthesia	90% coverage, no copay	70% coverage, after deductible	100%
Hospital Services - Outpatient			
Surgery	90% coverage, no copay	70% coverage, after deductible	100%, \$100 copay for day surgery
Independent lab and x-ray facilities	90% coverage, no copay	70% coverage, after deductible	100%, \$10 copay for day surgery
Emergency			
Hospital emergency room (emergency care)	100% coverage after \$100 copay (waived if admitted)	100% coverage after \$100 copay (waived if admitted)	\$75 copay per emergency visit (\$40 copay per visit for Urgent care facility)
Hospital emergency room (non-emergency care)	50% coverage after \$100 copayment	50% coverage after deductible	Not covered
Ambulance	80% coverage, no copay	80% coverage after deductible	100%
Health Care Alternatives			
Convalescent facility	90% coverage, no copay (up to 90 days per calendar year per person)	70% coverage, after deductible (up to 90 days per calendar year per person)	Not covered
Home health care	90% coverage, no copay (up to 90 visits per calendar year per person)	70% coverage, after deductible (up to 90 visits per calendar year per person)	\$10 copay
Private duty nursing	90% coverage, no copay (up to 70 8-hour shifts per calendar year per person)	70% coverage, after deductible (up to 70 8-hour shifts per calendar year per person)	100%-Approval of Medical Director required
Hospice	100% coverage, no copay	100% coverage, no deductible	100% with referral and approval of Medical Director
Other Health Care			
Family planning (voluntary sterilization)	100% coverage after \$100 copay	70% coverage, after deductible	\$10 copay
Short-term rehabilitation	80% coverage, no copay	80% coverage, after deductible	\$10 copay
	(60 day max per course of treatment)	(60 day max per course of treatment)	
Durable medical equipment	80% coverage, no copay	80% coverage, no deductible	20% Copay \$1000 annual maximum benefit

Chiropractic	100% coverage after a \$15/\$25 copay (20 visits per calendar year)	70% coverage, after deductible (20 visits per calendar year)	Not covered
Mental Health Care			
Inpatient	80% after \$200 per confinement fee; no maximum on number of days	60% after \$400 per confinement fee; no maximum on number of days	Days 1-5, \$100 per day copay; 6-20, 50% copay. Over 20 days not covered.
Outpatient	100% after \$25 copay per visit (up to 45 visits per calendar year per person)	60% coverage after deductible (up to 45 visits per calendar year per person)	Visits 1-5: \$10 copay. Visits 6-20; 50% copay. Over 20 visits, not covered
Outpatient Psychiatric	See Outpatient Benefits	See Outpatient Benefits	Same as Mental Health Care Outpatient
Partial Hospitalization	See Outpatient Benefits	See Outpatient Benefits	Information not provided by carrier
Substance Abuse Treatment			
Inpatient	80% coverage after \$200 per confinement fee (up to 45 visits per calendar year per person)	60% coverage after \$400 per confinement fee (up to 45 days per calendar year per person)	\$100 copay per day to a maximum of \$500
Outpatient	100% after \$25 copay per visit (up to 45 visits per calendar year per person)	60% coverage after deductible (up to 45 visits per calendar year per person)	\$10 copay per visit
Prescriptions			
Maximum	Unlimited	None	\$2,000 plan max per person / plan year
Local retail network pharmacies	Generic: 100% after \$10 copay (30-day supply)	Generic: No coverage	Generic: \$5
	Formulary Brand Name: 100% after \$20 copay (30-day supply)	Formulary Brand Name: No coverage	Formulary brand name: \$20 Formulary
	Non-formulary Brand Name: 100% after \$30 copay (30-day supply)	Non-formulary Brand Name: No coverage	Non-formulary brand name: \$50 or 50% copayment, 50% copay for list D drugs
Mail-order Service	Generic: 100% after \$10 copay (90-day supply)	Generic: No coverage	Generic: 2 times retail copay for a 90 day supply
	Formulary brand name: 100% after \$20 copay (90-day supply)	Formulary brand name: No coverage	Formulary brand name: 2 times retail copay for a 90 day supply
	Non-formulary brand name: 100% after \$30 copay (90-day supply)	Non-formulary brand name: No coverage	Non-formulary brand name: 50% of cost for lesser of 34 day supply or 100 units

Overseas Prescriptions	Generic: Not applicable	Generic: 100% after deductible	Information not provided by carrier
	Brand name: Not applicable	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:			