Aetna Choice® POS II Medical Plan

Department of Defense Nonappropriated Fund Health Benefits Program

Summary of Benefits effective January 1, 2018

Plan Provisions	Preferred (In-Network)	Non-Preferred (Out-of-Network)†
Calendar Year Deductible*		
✯ Individual	$500	$1,500
✯ Family of 2	$1,000 (2 times individual)	$3,000 (2 times individual)
✯ Family of 3 or more	$1,500 (3 times individual)	$4,500 (3 times individual)
**In-network expenses and out-of-network expenses accumulate separately. In-network expenses are applied to the in-network deductible only; out-of-network expenses are applied to the out-of-network deductible only.*		
Health Incentive Credit		
Earn credit toward your deductible and coinsurance* expenses by completing certain healthy actions. For more details about the healthy actions and the incentives, visit www.nafhealthplans.com > Wellness > Health Incentive Credit. The credit does not apply to copayments. The annual maximum credit is $250 for employee only and $600 for an employee that covers dependents.		
**Coinsurance is the percentage of your covered expenses that you pay after you meet the calendar deductible.*		
Out-of-Pocket Maximum		
This is the maximum amount you pay for your share of covered expenses in a calendar year. It includes deductibles, coinsurance and copays. Prescription eyewear, Choose Generics penalties, expenses covered at 50% and non-covered expenses do not count toward your out-of-pocket maximums.		
✯ Individual	$4,000	$8,000
✯ Family of 2	$8,000 (2 times individual)	$16,000 (2 times individual)
✯ Family of 3 or more	$12,000 (3 times individual)	$24,000 (3 times individual)
Lifetime Maximum	Unlimited	Unlimited
Hospital Precertification Certain services require precertification. Please see your Summary Plan Description (SPD) for details.	Network physician handles	You handle; $500 penalty for failure to precertify
Preventive Care		
Deductible is waived for preventive care services.		
✯ Routine physical exam (one per calendar year) and immunizations	100%, no copay	Not covered
✯ Well-child care and immunizations (Birth to age 7. Please see your SPD for age and frequency schedule.)	100%, no copay	Not covered
✯ Routine gynecological exam including Pap test and related lab fees (one per calendar year)	100%, no copay	Not covered
✯ Routine mammogram (one per calendar year for women age 35 and over)	100%, no copay	Not covered
✯ Routine colonoscopy* (one every 10 years; age 50 and over)	100% of maximum allowable amount, no copay	Not covered
✯ Routine prostate screening exam (one per calendar year for men age 40 and over)	100%, no copay	Not covered
✯ Routine eye exam and/or contact lenses fitting (one each per calendar year)	100%, no copay	Not covered
✯ Prescription eyewear – lenses, frames and contacts. You are also eligible to use Aetna vision discounts.	100%, no copay, up to a $150 maximum benefit per person per calendar year	100%, no copay, up to a $150 maximum benefit per person per calendar year
✯ Pediatric vision (dependent children up to age 22), one pair of basic frames and lenses per calendar year (Covered codes are: V2020, V2100-2199, V2200-2299, V2300–2399, V2121, V2221, V2321)	100%, no copay	100%, no copay
✯ Routine hearing exam (one per calendar year). You are also eligible to use the Amplifon Hearing Health Care Discount Program.	100%, no copay	Not covered

**Maximum allowable amount may apply in your area.*

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Preventive Care (continued)		
✲ Hearing aids ($3,000 maximum every 3 years). You are also eligible to use the Amplifon Hearing Health Care Discount Program.	90% after deductible	60% after deductible
Physician Services		
✲ Office visits for treatment of illness or injury	100% after copay: $30 PCP*/ $45 specialist; no deductible	60% after deductible
✲ Walk-in clinic visit	100% after $30 copay	60% after deductible
✲ Teladoc® phone/online video consultation**	100% after $10 copay	N/A
✲ Diagnostic lab and X-ray		
> When part of an office visit	100% (no additional copay)	60% after deductible
> Separate office visit	100% after copay: $30 PCP*/ $45 specialist; no deductible	60% after deductible
> Independent facility	90% after deductible	60% after deductible
✲ Maternity care office visits	100% after copay: $30 PCP*/ $45 specialist for first visit; subsequent visits are included in the delivery fee and paid at 90% after deductible	60% after deductible
✲ In-office surgery	100% after copay: $30 PCP*/ $45 specialist; no deductible	60% after deductible
✲ Physician hospital visits	90% after deductible	60% after deductible
✲ Anesthesia	90% after deductible	60% after deductible
✲ Allergy testing, serum and injections	100% after copay: $30 PCP*/ $45 specialist when part of office visit; copay/deductible waived if there is no office visit charge for the injection	60% after deductible
✲ Second surgical opinion	100%, no copay, no deductible	100%, no deductible

**A primary care physician (PCP) can be an internist, pediatrician, family practitioner or general practitioner. A provider who does not meet this definition is considered a specialist.*

***Teladoc may not be available in all states and is not available overseas.*

Hospital Services		
✲ Inpatient hospital room and board and ancillary services	90% after deductible plus $200 per confinement fee*	60% after deductible plus $400 per confinement fee*
✲ Inpatient and outpatient surgery	90% after deductible	60% after deductible
✲ Outpatient services**	90% after deductible	60% after deductible
✲ Pre-operative testing	90%, no deductible	60%, no deductible
✲ Other hospital services	90% after deductible	60% after deductible

**Hospital confinement fee is waived for newborns and for subsequent hospital confinements for the same condition within the same calendar year.*

***With certain outpatient procedures, the plan will pay up to the maximum allowable amount toward facility costs for the service. You pay any facility costs above the maximum allowable amount. For more information, visit www.nafhealthplans.com.*

Urgent and Emergency Care		
✲ Hospital emergency room	90% after $350 emergency room copay (waived if admitted); no calendar year deductible	90% after separate $350 emergency room deductible (waived if admitted); no calendar year deductible
✲ Hospital emergency room for non-emergency care	50% after deductible plus separate $350 emergency room copay	50% after deductible plus separate $350 emergency room deductible
✲ Urgent care facility	100% after $30 copay	60% after deductible
✲ Ambulance	80% after deductible	80% after deductible
Other Health Care		
✲ Convalescent facility (up to 90 days per calendar year)	90% after deductible	60% after deductible
✲ Home health care (up to 90 visits per calendar year)	90% after deductible	60% after deductible
✲ Private duty nursing (up to 70 eight-hour shifts per calendar year)	90% after deductible	60% after deductible

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Other Health Care (continued)		
Hospice (inpatient and outpatient)	100%, no copay; no deductible	100% no deductible
Independent lab and X-ray facilities	90% after deductible	60% after deductible
Voluntary sterilization	100% after $100 copay; no deductible	60% after deductible
Short-term rehabilitation (60-visit maximum per course of treatment)	80% after deductible	80% after deductible
Durable medical equipment	80% after deductible	80% after deductible
Spinal disorder (chiropractic) (up to 20 visits per calendar year)	100% after copay; $45 specialist; no deductible	60% after deductible
Bariatric surgery	90% after deductible	Not covered
Mental Health Care		
Inpatient (no maximum number of days)	90% after deductible plus $200 inpatient per confinement fee	60% after deductible plus $400 inpatient per confinement fee
Outpatient (no maximum number of visits)	100% after $45 copay per visit; no deductible	60% after deductible
Substance Abuse Treatment		
Inpatient (no maximum number of days)	90% after deductible plus $200 inpatient per confinement fee	60% after deductible plus $400 inpatient per confinement fee
Outpatient (no maximum number of visits)	100% after $45 copay per visit; no deductible	60% after deductible
Prescription Drug Benefits		
Participating Retail Pharmacy Program (up to a 30-day supply)*		
> Tier One – Generic drugs	100% after $10 copay	Not covered
> Tier Two – Preferred brand-name drugs	100% after $35 copay	Not covered
> Tier Three – Non-preferred brand-name drugs Choose Generics program**	100% after 35% copay – the minimum you pay per prescription is $60; the maximum is $125.	Not covered
> Tier Four – Specialty drugs	100% after 40% copay – the minimum you pay per prescription is $60; the maximum is $125.	Not covered
Maintenance Choice®: Aetna Rx Home Delivery® mail order pharmacy or CVS pharmacy (for a 31- to 90-day supply)*		
> Tier One – Generic drugs	100% after $20 copay	Not covered
> Tier Two – Preferred brand-name drugs	100% after $70 copay	Not covered
> Tier Three – Non-preferred brand-name drugs**	100% after 35% copay – the minimum you pay per prescription is $120; the maximum is $250.	Not covered
Prescriptions Purchased Overseas		
> Generic drugs	Not applicable	100% after deductible
> Brand-name drugs**	Not applicable	80% after deductible
Smoking Cessation Medications	100%, no copay	Not covered
Covers a 180-day supply of the following FDA-approved medications with a valid prescription: Bupropion SR, nicotine gum, nicotine inhaler, nicotine lozenge, nicotine nasal spray, nicotine patch and varenicline. Includes 8 counseling sessions per calendar year.		
Anti-Obesity Medications***	100% after applicable Tier Two and Tier Three copays	Not covered

* *With Maintenance Choice, you can get a 90-day supply of maintenance medications such as drugs that treat conditions like arthritis, asthma, diabetes or high cholesterol by using either Aetna Rx Home Delivery mail-order pharmacy or a CVS pharmacy near you.* ***After two fills at your local retail pharmacy, you will pay the full cost of the drug if you choose to continue to receive a 30-day supply.***

** *With the Choose Generics program, your pharmacy will automatically fill your prescription with a generic drug, if one is available. If you choose the brand name instead, you will pay the difference in actual cost between the brand name and generic equivalent plus the Tier Three copay. If you choose a brand drug, the amount that is the difference between the actual brand cost and actual generic cost does NOT go toward your plan's calendar year out-of-pocket maximum.*

*** *Learn more at www.aetna.com/products/rxnonmedicare/data/2014/MISC/antiobesity.html.*

† *Non-preferred benefits are subject to recognized charges. Covered dependents who live outside the Aetna Choice POS II network area will receive the Traditional Choice® indemnity plan level of benefits. Please see your Human Resources Representative for details.*

Aetna Passive PPO Dental Plan

Department of Defense Nonappropriated Fund Health Benefits Program

Summary of Benefits effective January 1, 2018

Plan Provisions	Preferred (In-Network)	Non-Preferred (Out-of-Network)
Calendar Year Deductible		
✭ Individual	$100	$100
✭ Family of 2	$200 (2 times individual)	$200 (2 times individual)
✭ Family of 3 or more	$300 (3 times individual)	$300 (3 times individual)
Calendar Year Benefit Maximum	$2,500 per person	$2,500 per person
Preventive Care		
Routine oral exams and cleanings – two per calendar year†	100%, no deductible*	100%, no deductible**
Problem-focused exams – two per calendar year	100%, no deductible*	100%, no deductible**
X-rays (frequency limits apply), fluoride (no age limit) and sealants to age 18	100%, no deductible*	100%, no deductible**
†A third cleaning will be covered for those who qualify due to certain medical conditions such as pregnancy, diabetes or heart disease. Contact Member Services for details.		
Basic Care Fillings, root canal therapy, extractions, general anesthesia, space maintainers to age 19, palliative treatments	80% after deductible*	80% after deductible**
Restorative Care Inlays, crowns, fixed bridgework, gold fillings	50% after deductible*	50% after deductible**
Oral Surgery Services that are dental in nature	100% of first $1,000; then 80% thereafter, not subject to the deductible and calendar year maximum*	100% of first $1,000; then 80% thereafter, not subject to the deductible and calendar year maximum**
TMJ Treatment Temporomandibular Joint Dysfunction	50%, no deductible* $750 lifetime maximum per person	50%, no deductible** $750 lifetime maximum per person
Orthodontia for adults and children Includes TMJ appliances	50%, no deductible* $2,000 lifetime maximum per person	50%, no deductible** $2,000 lifetime maximum per person

Benefit Payments
When you use a dentist who participates in the dental PPO network, you pay less for your share of the dental expense because network dentists have agreed to accept Aetna's contracted rates. When you use a non-participating dentist, your coverage is subject to recognized charges.

Claim Filing
When you receive care from a dentist who participates in Aetna's dental network, the dentist will file your claim. You may be responsible for filing claims when care is provided by a non-participating dentist.

* *Based on contracted rates.*
** *Subject to recognized charges.*

These charts display 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 Summary Plan Description (SPD), the terms of the SPD will be used to determine coverages and benefits.

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