

Aetna Choice® POS II Medical Plan

Department of Defense Nonappropriated Fund Health Benefits Program

Summary of Benefits effective January 1, 2020

Plan Provisions	Preferred (In Network)	Non-Preferred (Out of Network)*
Calendar Year Deductible¹		
Employee only	\$500	\$1,500
Family (employee + one or more dependents)	\$1,500	\$4,500
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 ² and copays. It does not include prescription eyewear, Choose Generics penalties and expenses covered at 50%.		
Employee only	\$4,000	\$8,000
Family (employee + one or more dependents) ³	\$8,000	\$16,000
Lifetime maximum	Unlimited	Unlimited
Health Incentives		
Earn incentive monies toward your deductible and coinsurance ² expenses by completing certain healthy actions. The monies do not apply to copayments. The annual maximum is \$300 for employee only and \$600 for an employee that covers dependents. For more details about the healthy actions and the incentives, visit nafhealthplans.com > Wellness > Health Incentives Program.		
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.)		
You pay	You pay	You pay
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 45 and over)	100%, 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 ⁴	100%, no copay	100%, no copay
Routine hearing exam (one per calendar year).	100%, no copay	Not covered
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

¹ 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.

² Coinsurance is the percentage of your covered expenses that you pay after you meet the calendar deductible.

³ In compliance with the Affordable Care Act, if one individual under family coverage has \$7,900 applied toward the in-network out-of-pocket maximum, this individual will have the plan pay 100% for covered services for the remainder of the plan year.

⁴ Covered codes are: V2020, V2100-2199, V2200-2299, V2300-2399, V2121, V2221, V2321

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Physician Services	Plan pays	Plan pays
Office visits for treatment of illness or injury	100% after copay: \$30 PCP ⁵ / \$45 specialist; no deductible	60% after deductible
Walk-in clinic visit	100% after \$30 copay	60% after deductible
Diagnostic lab and X-ray		
• When part of an office visit (When not billed separately or provided by an Independent Lab that may be located in your doctor's office)	100% (no additional copay)	60% after deductible
• Separate office visit	100% after copay: \$30 PCP ⁵ / \$45 specialist; no deductible	60% after deductible
• Independent facility (When not affiliated with a doctor's office, that may be located in the same location)	90% after deductible	60% after deductible
Maternity care office visits	100% after copay: \$30 PCP ⁵ / \$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 ⁵ / \$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 ⁵ / \$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
Teladoc^{®5}		
General medicine	100% after \$10 copay	N/A
Behavioral health	100% after \$45 copay	N/A
Dermatology	100% after \$45 copay	N/A
Hospital Services		
Inpatient hospital room and board and ancillary services	90% after deductible plus \$200 per confinement fee ⁷	60% after deductible plus \$400 per confinement fee ⁷
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
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









⁵ 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.

⁶ Teladoc may not be available in all states and is not available overseas.

⁷ Hospital confinement fee is waived for newborns and for subsequent hospital confinements for the same condition within the same calendar year.

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Plan Provisions	Preferred (In Network)	Non-Preferred (Out of Network)*
Other Health Care	Plan pays	Plan pays
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
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
Outpatient short-term rehabilitation (60 visit maximum per course of treatment)	80% after deductible	80% after deductible
 Habilitative physical therapy	\$45 copay; deductible waived	60%; after deductible
 Habilitative occupational therapy	\$45 copay; deductible waived	60%; after deductible
 Habilitative speech therapy	\$45 copay; deductible waived	60%; after deductible
 Autism behavioral therapy (combined with outpatient mental health visits)	Refer to Mental Health Care benefits below	Refer to Mental Health Care benefits below
 Autism applied behavior analysis (covered same as any other outpatient mental health – all other)	Refer to Mental Health Care benefits below	Refer to Mental Health Care benefits below
 Autism physical therapy	\$45 copay; deductible waived	60%; after deductible
 Autism occupational therapy	\$45 copay; deductible waived	60%; after deductible
 Autism speech therapy	\$45 copay; deductible waived	60%; after deductible
Durable medical equipment	80% after deductible	80% after deductible
Spinal disorder (chiropractic) (20 visit maximum 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
Outpatient – all other ⁸ (no maximum number of visits)	90% after 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

⁸ Includes Transcranial Magnetic Stimulation (TMS), Psychological/Neuropsychological testing (PTS), Psychiatric & SUD Home Care Services, Psychiatric & SUD Partial Hospitalization (PHP), Psychiatric & SUD Intensive Outpatient (IOP), Outpatient Detox (OPD) and Applied Behavior Analysis (ABA).

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Plan Provisions	Preferred (In Network)	Non-Preferred (Out of Network)*
Prescription Drug Benefits (The Aetna Standard Plan Formulary)	You Pay	You Pay
Participating Retail Pharmacy Program (up to a 30-day supply) ⁹		
• Tier One – Generic drugs	\$10 copay	Not covered
• Tier Two – Preferred brand-name drugs	\$35 copay	Not covered
• Tier Three – Non-preferred brand-name drugs ¹⁰	35% copay – The minimum you pay per prescription is \$60; the maximum is \$125.	Not covered
• Tier Four – Specialty drugs	40% coinsurance – The minimum you pay per prescription is \$60; the maximum is \$125.	Not covered
Maintenance Choice®: CVS Caremark Mail Service Pharmacy™ or CVS Pharmacy® (for a 31- to 90-day supply) ⁹		
• Tier One – Generic drugs	\$20 copay	Not covered
• Tier Two – Preferred brand-name drugs	\$70 copay	Not covered
• Tier Three – Non-preferred brand-name drugs ¹⁰	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 ¹⁰	Not applicable	80% after deductible
Smoking Cessation Medications 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.	No copay	Not covered
Anti-Obesity Medications ¹¹	0% after applicable Tier Two and Tier Three copays	Not covered

⁹ 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 CVS Caremark Mail Service 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 only a 30-day supply.**

¹⁰ 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.

¹¹ Learn more at 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, 2020

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		
	Plan pays	Plan pays
Routine oral exams and cleanings – two per calendar year ¹	100%, no deductible ²	100%, no deductible ³
Problem-focused exams – two per calendar year	100%, no deductible ²	100%, no deductible ³
X-rays (frequency limits apply), fluoride (no age limit) and sealants to age 18	100%, no deductible ²	100%, no deductible ³
Basic Care		
Fillings, root canal therapy, extractions, general anesthesia, space maintainers to age 19, palliative treatments	80% after deductible ²	80% after deductible ³
Restorative Care		
Inlays, crowns, fixed bridgework, gold fillings	50% after deductible ²	50% after deductible ³
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 ²	100% of first \$1,000; then 80% thereafter, not subject to the deductible and calendar year maximum ³
TMJ Treatment		
Temporomandibular Joint Dysfunction	50%, no deductible ² \$750 lifetime maximum per person	50%, no deductible ³ \$750 lifetime maximum per person
Orthodontia for adults and children		
Includes TMJ appliances	50%, no deductible ² \$2,000 lifetime maximum per person	50%, no deductible ³ \$2,000 lifetime maximum per person
Network savings and convenience		
When you receive care from a dentist who participates in the Aetna dental network, you pay less for your share of the dental expense because network dentists have agreed to accept Aetna's contracted rates. A network dentist will file your claim.		
When you use a non-participating dentist, your coverage is subject to recognized charges. You may be responsible for filing claims when care is provided by a non-participating dentist.		

¹ 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.

² Based on contracted rates.

³ 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.