Aetna Traditional Choice® Indemnity Medical Plan

Department of Defense Nonappropriated Fund Health Benefits Program

Summary of Benefits effective January 1, 2021

Plan Provisions	Plan Benefits*
Calendar Year Deductible (includes pharmacy)	
Employee only	$500
Family (employee + one or more dependents)	$1,500
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[1] and copays. It does not include prescription eyewear, Choose Generics penalties, expenses covered at 50% and non-covered expenses.	
Employee only	$4,000
Family (employee + one or more dependents)[2]	$8,000
Lifetime maximum	Unlimited
Health Incentives	
Earn incentive monies toward your deductible and coinsurance[1] 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	
Please see your Summary Plan Description (SPD) for details.	You must precertify any scheduled hospital stay. $500 penalty for failure to precertify (penalty waived if you are overseas)
Preventive Care (Deductible is waived for preventive care services.)	**Plan pays**
Routine physical exam (one per calendar year) and immunizations	100%, no deductible
Well-child care and immunizations (Birth to age 7. Please see your SPD for age and frequency schedule.)	100%, no deductible
Routine gynecological exam including Pap test and related lab fees (one per calendar year)	100%, no deductible
Routine mammogram (one per calendar year for women age 35 and over)	100%, no deductible
Routine colonoscopy (one every 10 years; age 45 and over)	100%, no deductible
Routine prostate screening exam (one per calendar year for men age 40 and over)	100%, no deductible
Routine eye exam and/or contact lenses fitting (one each per calendar year)	100%, no deductible
Prescription eyewear – lenses, frames and contacts. You are also eligible to use Aetna vision discounts.	100% 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[3]	100%, no copay
Routine hearing exam (one per calendar year).	100%, no deductible
Hearing aids ($3,000 maximum every 3 years). You are also eligible to use the Amplifon Hearing Health Care Discount Program.	80% after deductible

[1] *Coinsurance is the percentage of your covered expenses that you pay after you meet the calendar deductible.*

[2] *In compliance with the Affordable Care Act, if one individual under family coverage has $8,550 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.*

[3] *Covered codes are: V2020, V2100-2199, V2200-2299, V2300-2399, V2121, V2221, V2321*

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Physician Services	**Plan pays**
Office visits for treatment of illness or injury	80% after deductible
Walk-in clinic visit	80% after deductible
Diagnostic lab and X-ray	80% after deductible
Maternity care office visits	80% after deductible
In-office surgery	100% of first $1,000, no deductible; then 80% after deductible
Physician hospital visits	80% after deductible
Anesthesia	80% after deductible
Allergy testing, serum and injections	80% after deductible
Specialists (office visits)	80% after deductible
Second surgical opinion	100%, no deductible
Teladoc®[4]	
UPDATE General medicine	100%, no copay
UPDATE Behavioral health	100% after $60 copay
UPDATE Dermatology	100% after $60 copay
Hospital Services	
Inpatient hospital room and board and ancillary services	80% after deductible
Inpatient and outpatient surgery	80% after deductible
Outpatient services	80% after deductible
Pre-operative testing	80%, no deductible
Other hospital services	80% after deductible
Urgent and Emergency Care	
Hospital emergency room	80% after deductible
Hospital emergency room for non-emergency care	50% after deductible
Urgent care facility	80% after deductible
Ambulance	80% after deductible

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

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Other Health Care	**Plan pays**
Convalescent facility (up to 90 days per calendar year)	80% after deductible
Home health care (up to 90 visits per calendar year)	80% after deductible
Private duty nursing (up to 70 eight-hour shifts per calendar year)	80% after deductible
Hospice (inpatient and outpatient)	100%, no deductible
Independent lab and X-ray facilities	80% after deductible
Voluntary sterilization	80% after deductible
Short-term rehabilitation (60-visit maximum per course of treatment)	80% after deductible
Habilitative physical therapy	80% after deductible
Habilitative occupational therapy	80% after deductible
Habilitative speech therapy	80% after deductible
Autism behavioral therapy (combined with outpatient mental health visits)	80% after deductible
Autism applied behavior analysis (covered same as any other outpatient mental health – all other)	80% after deductible
Autism physical therapy	80% after deductible
Autism occupational therapy	80% after deductible
Autism speech therapy	80% after deductible
Durable medical equipment	80% after deductible
Spinal disorder (chiropractic) (20 visits per calendar year)	80% after deductible
Bariatric surgery	80% after deductible
Mental Health Care	
Inpatient (no maximum number of days)	80% after deductible
Outpatient (no maximum number of visits)	80% after deductible
Outpatient – All other[5] (no maximum number of visits)	80% after deductible
Substance Abuse Treatment	
Inpatient (no maximum number of days)	80% after deductible
Outpatient (no maximum number of visits)	80% after deductible

[5] *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	Plan Benefits*	
Prescription Drug Benefits (The Aetna Standard Plan Formulary)	**Participating Pharmacy**	**Non-Participating Pharmacy**
	You pay	**You pay**
Participating Retail Pharmacy Program (up to a 30-day supply)[6]		
• 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[7]	35% copay – The minimum you pay per prescription is $60; the maximum is $125.	Not covered
• Tier Four – Specialty drugs	40% copay – 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)[6]		
• 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[7]	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[7]	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.	0%, no copay	Not covered
Anti-Obesity Medications[8]	0% after applicable Tier Two and Tier Three copays	Not covered

[6] *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 a 30-day supply.***

[7] *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.*

[8] *Learn more at* ***aetna.com/products/rxnonmedicare/data/2014/MISC/antiobesity.html****.*

**Coverage is subject to recognized charges.*

Aetna Passive PPO Dental Plan

Department of Defense Nonappropriated Fund Health Benefits Program

Summary of Benefits effective January 1, 2021

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 (Alternative Treatment rule may apply. See Summary Plan Description for details.)	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 Aetna's 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.