Aetna Choice® POS II Medical Plan

Department of Defense Nonappropriated Fund (NAF) Health Benefits Program

Summary of Benefits effective January 1, 2025

Plan Provisions	**Preferred** (In Network)	**Non-Preferred** (Out of Network)*
Calendar-Year Deductible[1]		
Employee only	$600	$1,800
Family (employee + one or more dependents)	$1,800	$5,400
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, expenses covered at 50% and non-covered expenses.		
Employee only	$5,000	$10,000
Family (employee + one or more dependents)	$10,000[3]	$20,000
Lifetime maximum	Unlimited	Unlimited
Health Incentives		
Each year employees and covered spouses can each earn up to $300 by completing certain healthy actions. Earned incentive monies can go toward paying eligible out-of-pocket health care expenses. **For details, visit nafhealthplans.com > Wellness and rewards > 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.)	**Plan pays**	**Plan pays**
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

[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 you pay after you meet the deductible.*
[3] *In compliance with the Affordable Care Act, if one individual under family coverage has $9,200 applied toward the in-network out-of-pocket maximum, that 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.*

* *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.*

MOD DOD-1764 CPII (1/25)

Aetna Choice® POS II Medical Plan

Department of Defense Nonappropriated Fund (NAF) Health Benefits Program

Summary of Benefits effective January 1, 2025

Plan Provisions	**Preferred** (In Network)	**Non-Preferred** (Out of Network)
Coinsurance	**Plan pays**	**Plan pays**
UPDATE Plan share of costs - as a percentage - after you reach the deductible. For example, if the plan pays 80% of a covered expense, you pay 20%. You must pay and meet deductible amount before coinsurance applies (unless specifically noted deductible does not apply). Both your deductible and your coinsurance amount apply to your out-of-pocket maximum.	80% after deductible	60% after deductible
Physician Services	**Plan pays**	**Plan pays**
Office visits for treatment of illness or injury	100% after copay: $40 PCP[5]/ $60 specialist; no deductible	60% after deductible
Walk-in clinic visit	100% after $40 copay	60% after deductible
Diagnostic lab and X-ray		
• When part of an office visit (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: $40 PCP[5]/ $60 specialist; no deductible	60% after deductible
• Independent facility (not affiliated with a doctor's office that may be located in the same location)	80% after deductible	60% after deductible
Maternity care office visits	100% after copay: $40 PCP[5]/ $60 specialist for first visit; subsequent visits are included in the delivery fee and paid at 80% after deductible	60% after deductible
In-office surgery	100% after copay: $40 PCP[5]/ $60 specialist; no deductible	60% after deductible
Physician hospital visits	80% after deductible	60% after deductible
Anesthesia	80% after deductible	60% after deductible
Allergy testing, serum and injections	100% after copay: $40 PCP[5]/$60 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 Health[6]		
General medicine	100%, no copay	N/A
Behavioral health	100% after $60 copay	N/A
Dermatology	100% after $60 copay	N/A

[5] *A primary care provider (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 Health is not available overseas.*

* *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 Choice® POS II Medical Plan

Department of Defense Nonappropriated Fund (NAF) Health Benefits Program

Summary of Benefits effective January 1, 2025

Plan Provisions	**Preferred** (In Network)	**Non-Preferred** (Out of Network)
Hospital Services		
Inpatient hospital room and board and ancillary services	80% after deductible and $200 per-confinement fee[7]	60% after deductible and $400 per-confinement fee[7]
Inpatient and outpatient surgery	80% after deductible	60% after deductible
Outpatient services	80% after deductible	60% after deductible
Pre-operative testing	80%, no deductible	60%, no deductible
Other hospital services	80% after deductible	60% after deductible
Urgent and Emergency Care		
Hospital emergency room	80% after separate $500 emergency room copay (waived if admitted); no deductible	80% after separate $500 emergency room deductible (waived if admitted); no deductible
Hospital emergency room for non-emergency care	50% after deductible plus separate $500 emergency room copay	50% after deductible plus separate $500 emergency room deductible
Urgent care facility	100% after $40 copay	60% after deductible
Ambulance	80% after $500 copay; no deductible	80% after $500 copay; no deductible
Other Health Care	**Plan pays**	**Plan pays**
Convalescent facility (up to 90 days per calendar year)	80% after deductible	60% after deductible
Home health care (up to 90 visits per calendar year)	80% after deductible	60% after deductible
Private duty nursing (up to 70 eight-hour shifts per calendar year)	80% after deductible	60% after deductible
Hospice (inpatient and outpatient)	100%, no copay, no deductible	100%, no deductible
Independent lab and X-ray facilities	80% 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	$60 copay, deductible waived	60% after deductible
Habilitative occupational therapy	$60 copay, deductible waived	60% after deductible
Habilitative speech therapy	$60 copay, deductible waived	60% after deductible
Autism behavioral therapy (treated as 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	$60 copay, deductible waived	60% after deductible
Autism occupational therapy	$60 copay, deductible waived	60% after deductible
Autism speech therapy	$60 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 $60 specialist copay; no deductible	60% after deductible
Bariatric surgery	80% after deductible	Not covered
Hearing aids ($3,000 maximum every 3 years) You are also eligible to use the Amplifon Hearing Health Care Discount Program.	80% after deductible	60% after deductible

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

* *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.*

MOD DOD-1764 CPII (1/25)

Aetna Member Services **1-800-367-6276 (TTY: 711)** **nafhealthplans.com**

NAF health benefits
nafhealthplans.com

Aetna Choice® POS II Medical Plan

Department of Defense Nonappropriated Fund (NAF) Health Benefits Program

Summary of Benefits effective January 1, 2025

Plan Provisions	**Preferred** (In Network)	**Non-Preferred** (Out of Network)
Mental Health Care		
Inpatient (no maximum number of days)	80% 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 $60 copay per visit; no deductible	60% after deductible
Outpatient – all other[8] (no maximum number of visits)	80% after deductible	60% after deductible
Substance Abuse Treatment		
Inpatient (no maximum number of days)	80% 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 $60 copay per visit; no deductible	60% after deductible
Prescription Drug Benefits (Formulary: Aetna Standard Plan for DoD)	**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	25% – The minimum you pay per prescription is $45; the maximum is $70.	Not covered
• Tier Three – Non-preferred brand-name drugs[10]	35% – The minimum you pay per prescription is $75; the maximum is $200.	Not covered
• Tier Four – Specialty drugs	40% – 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	25% – The minimum you pay per prescription is $90; the maximum is $140.	Not covered
• Tier Three – Non-preferred brand-name drugs[10]	35% – The minimum you pay per prescription is $150; the maximum is $400.	Not covered
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

[8] *Includes transcranial magnetic stimulation (TMS), psychological/neuropsychological testing (PTS), psychiatric & substance use disorder (SUD) home care services, psychiatric & SUD partial hospitalization (PHP), psychiatric & SUD intensive outpatient (IOP), outpatient detox (OPD) and applied behavior analysis (ABA).*

[9] *With Maintenance Choice, it is* ***mandatory*** *that you get a 90-day supply of certain 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 30-day fills, the plan will no longer cover 30-day fills. You will be responsible for paying the full cost of the drug, and it will not count toward your out-of-pocket maximum. View the Maintenance Choice drug list at nafhealthplans.com > Explore benefits > Pharmacy program.***

[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. In addition, 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.*

* *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.*

MOD DOD-1764 CPII (1/25)

Aetna Passive PPO Dental Plan

Department of Defense Nonappropriated Fund (NAF) Health Benefits Program

Summary of Benefits effective January 1, 2025

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 benefits 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 the Aetna® dental network, you pay less for your share of the dental expense because network dentists have agreed to accept the Aetna contracted rates. A network dentist will file your claim. You can search for Dental PPO network providers on **Aetna.com.**

When you use an out-of-network dentist, your coverage is subject to recognized charges. You may be responsible for filing claims when care is provided by an out-of-network 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 Aetna Member Services for details.*
[2] *Based on contracted rates.*
[3] *Subject to recognized charges.*

These charts show only a general description of your benefits under the DoD NAF Health Benefits Program.
If there is a conflict between the benefits shown in the charts and those in the Summary Plan Description (SPD), the terms of the SPD will be used to determine coverage and benefits.

MOD DOD–1764 PPO DENTAL (1/25)

Aetna Member Services **1-800-367-6276 (TTY: 711)** **nafhealthplans.com**

NAF health benefits
nafhealthplans.com