

Aetna Traditional Choice[®] Indemnity Medical Plan

Summary of Benefits effective January 1, 2015

Plan Provisions

Plan Benefits*

New

Calendar Year Deductible

★ Individual	\$500
★ Family of 2	\$1,000 (2 times individual)
★ Family of 3 or more	\$1,500 (3 times individual)

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. The credit does not apply to copayments. The maximum credit per individual is \$150 up to a maximum of \$450 for a family of 3 or more.

**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, bariatric surgery expenses and non-covered expenses do not count toward your out-of-pocket maximums.

★ Individual	\$3,000
★ Family of 2	\$6,000 (2 times individual)
★ Family of 3 or more	\$9,000 (3 times individual)

Lifetime Maximum

Unlimited

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

★ Routine physical exam and immunizations (one per calendar year)	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 50 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 <small>(covered codes are: V2020, V2100-2199, V2200-2299, V2300—2399, V2121, V2221, V2321)</small>	100%, no copay
★ Routine hearing exam (one per calendar year). You are also eligible to use the HearPO [®] Hearing Discount Program.	100%, no deductible
★ Hearing aids (\$3,000 maximum every 3 years). You are also eligible to use the HearPO Hearing Discount Program.	80% after deductible

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Plan Provisions

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Physician Services

★ 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

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

Other Health Care

★ 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
★ Durable medical equipment	80% after deductible
★ Spinal disorder (chiropractic) (up to 20 visits per calendar year)	80% after deductible
★ Bariatric surgery	50% after deductible

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Mental Health Care

- ★ Inpatient 80% after deductible; up to 60 days per calendar year; 60% thereafter
- ★ Outpatient** (up to 45 visits per calendar year) 80% after deductible

**Outpatient visit maximums for mental health and substance abuse are not combined.

Substance Abuse Treatment

- ★ Inpatient (up to 45 days per calendar year) 80% after deductible
- ★ Outpatient** (up to 45 visits per calendar year) 80% after deductible

**Outpatient visit maximums for mental health and substance abuse are not combined.

New

Prescription Drug Benefits

- | ★ Participating Retail Pharmacy Program (up to a 30-day supply) | Participating Pharmacy | Non-Participating Pharmacy |
|---|--|----------------------------|
| > 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 | 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 |
|-------------------------------|--|-------------|

** For up to a 30-day supply, the retail copays listed above will apply.

★ Mail-Order Service – Aetna Rx Home Delivery® (for a 31 – 90-day supply)**

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|---|---|-------------|
| > 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 |
| > Tier Four – Specialty drugs | 100% after 40% copay – the minimum you pay per prescription is \$120; the maximum is \$250. | Not covered |

** For up to a 30-day supply, the retail copays listed above will apply.

★ Prescriptions Purchased Overseas

- | | | |
|--------------------|----------------|-----------------------|
| > Generic drugs | Not applicable | 100% after deductible |
| > Brand-name drugs | 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.

100%, no copay Not covered

New

★ Anti-Obesity Medications**

100% after applicable Tier Two and Tier Three copays Not covered

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

* Coverage is subject to reasonable and customary charges.

Aetna Passive PPO Dental Plan

Summary of Benefits effective January 1, 2015

Plan Provisions	Preferred Care Benefits (In-Network)	Non-Preferred Care Benefits (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	80% after deductible*	80% after deductible**
Fillings, root canal therapy, extractions, general anesthesia, space maintainers to age 19, palliative treatments		
Restorative Care	50% after deductible*	50% after deductible**
Inlays, crowns, fixed bridgework, gold fillings		
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 reasonable and customary 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 reasonable and customary 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.

