

Aetna Open Choice[®] PPO Medical Plan

Summary of Benefits effective January 1, 2015

Plan Provisions

Preferred (In-Network)

Non-Preferred (Out-of-Network)

New

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. 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

New

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	\$ 6,000
★ Family of 2	\$6,000 (2 times individual)	\$12,000 (2 times individual)
★ Family of 3 or more	\$9,000 (3 times individual)	\$18,000 (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 and immunizations (one per calendar year)	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% of maximum allowable amount,* no copay	Not covered
★ Routine colonoscopy (one every 10 years; age 50 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%, 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	100%, no copay
★ Routine hearing exam (one per calendar year). You are also eligible to use the HearPO [®] Hearing Discount Program.	100%, no copay	Not covered

*Maximum allowable amount may apply in your area.

Aetna Open Choice PPO Plan

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Preventive Care (continued)

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|---|----------------------|----------------------|
| ★ Hearing aids (\$3,000 maximum every 3 years)
You are also eligible to use the HearPO Hearing Discount Program. | 90% after deductible | 60% after deductible |
|---|----------------------|----------------------|

New

Physician Services (In 2015, PCP copays increase from \$20 to \$30; specialist copays increase from \$35 to \$45.)

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|--|---|----------------------|
| ★ 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 |
| ★ 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.

Hospital Services

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| ★ 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

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| ★ 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 |

New

Other Health Care

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|---|----------------------|----------------------|
| ★ 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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Plan Provisions

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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
New ★ Spinal disorder (chiropractic) (up to 20 visits per calendar year)	100% after copay: \$45 specialist; no deductible	60% after deductible
★ Bariatric surgery	50% after deductible	50% after deductible

Mental Health Care

★ Inpatient (no maximum on number of days)	80% after deductible plus \$200 inpatient per confinement fee	60% after deductible plus \$400 inpatient per confinement fee
New ★ Outpatient* (up to 45 visits per calendar year)	100% after \$45 copay per visit; no deductible	60% after deductible

*Outpatient visit maximums for Mental Health and Substance Abuse are not combined. However, Preferred and Non-preferred visit maximums are combined.

Substance Abuse Treatment

★ Inpatient (up to 45 days per calendar year)	80% after deductible plus \$200 inpatient per confinement fee	60% after deductible plus \$400 inpatient per confinement fee
New ★ Outpatient* (up to 45 visits per calendar year)	100% after \$45 copay per visit; no deductible	60% after deductible

*Outpatient visit maximums for Mental Health and Substance Abuse are not combined. However, Preferred and Non-preferred visit maximums are combined.

New Prescription Drug Benefits

	Participating Pharmacy	Non-Participating Pharmacy
★ 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	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
★ Mail-Order Service – Aetna Rx Home Delivery® (for a 31 – 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
> 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
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New ★ Anti-Obesity Medications*	100% after applicable Tier Two and Tier Three copays	Not covered
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*Learn more at www.aetna.com/products/lrxnonmedicare/data/2014/MISC/antiobesity.html.

Non-preferred benefits are subject to reasonable and customary charges.

Covered dependents who live outside the Open Choice 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

Summary of Benefits effective January 1, 2015

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**
<small>+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.</small>		
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.



Aetna Member Services 1-800-367-6276 • www.nafhealthplans.com