

# Aetna Traditional Choice® Indemnity Medical Plan

Department of Defense Nonappropriated Fund Health Benefits Program

## Summary of Benefits effective January 1, 2016

### Plan Provisions

### Plan Benefits†

#### 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](http://www.nafhealthplans.com) and click on the *Wellness & Resources* tab. The credit does not apply to copayments. The maximum credit per individual is \$250, up to a maximum of \$600 for a family.

\*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, Choose Generics penalties, expenses covered at 50% 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 (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 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 (covered codes are: V2020, V2100-2199, V2200-2299, V2300-2399, V2121, V2221, V2321)	100%, no copay
★ Routine hearing exam (one per calendar year). You are also eligible to use the Amplifon Hearing Health Care Discount Program.	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

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#### Physician Services

★ Office visits for treatment of illness or injury	80% after deductible
★ Walk-in clinic visit	80% after deductible
<b>New</b> ★ Teladoc® phone/online video consultation*	100% after \$10 copay
★ 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 is not available to overseas employees or post-65 retirees and may not be available in all states.

#### 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) (20 visits per calendar year)	80% after deductible
<b>New</b> ★ Bariatric surgery	80% after deductible

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#### **New** Mental Health Care

- ★ Inpatient (no maximum number of days) 80% after deductible
- ★ Outpatient (no maximum number of visits) 80% after deductible

#### **New** Substance Abuse Treatment

- ★ Inpatient (no maximum number of days) 80% after deductible
- ★ Outpatient (no maximum number of visits) 80% after deductible

#### 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
  - New** Choose Generics program\*\*
    - > 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
- ★ Prescriptions Purchased Overseas
  - > Generic drugs Not applicable 100% after deductible
  - > Brand-name drugs\*\* Not applicable 80% after deductible
- ★ Smoking Cessation Medications 100%, no copay Not covered
 

Covers a 180-day supply of the following FDA-approved medications with a valid prescription: Bupropion SR, Nicotine gum, Nicotine inhaler, Nicotine lozenge, Nicotene nasal spray, Nicotine patch and Varenicline. Includes 8 counseling sessions per calendar year.
- ★ Anti-Obesity Medications\*\*\* 100% after applicable Tier Two and Tier Three copays Not covered

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

\*\*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.

\*\*\*Learn more at [www.aetna.com/products/rxnonmedicare/data/2014/MISC/anitobesity.html](http://www.aetna.com/products/rxnonmedicare/data/2014/MISC/anitobesity.html).

†Coverage is subject to recognized charges.