DEPARTMENT of DEFENSE NONAPPROPRIATED FUND HEALTH BENEFITS PROGRAM

Aetna Open Choice® PPO Medical Plan

Summary of Benefits effective January 1, 2012

Plan Provisions	Preferred Care Benefits (In-Network)	Non-Preferred Care Benefits (Out-of-Network)
Calendar Year Deductible		
Update ★ Individual	$300	$ 900
★ Family of 2	$600 (2 times individual)	$1,800 (2 times individual)
★ Family of 3 or more	$900 (3 times individual)	$2,700 (3 times individual)
Update **Health Incentive Credit** Earn credit toward your deductible and coinsurance* expenses by having a routine physical exam and by completing the Simple Steps To A Healthier Life® online health assessment. The credit does not apply to copayments. ★ Adults can earn $50 for taking the health assessment, and another $50 for having a routine physical exam. ★ Children under the age of 18 can earn $100 for having a routine physical exam. ★ The maximum credit per individual is $100, up to a maximum of $300 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 Limit The maximum amount you pay for your share of covered expenses in a calendar year. Copays, pharmacy copays, confinement fees, expenses covered at 50% and non-covered expenses **do not** count toward your Out-of-Pocket Limit.		
★ Individual	$3,000	$ 4,000
★ Family of 2	$6,000 (2 times individual)	$ 8,000 (2 times individual)
★ Family of 3 or more	$9,000 (3 times individual)	$12,000 (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%, 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 (one 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
★ Routine hearing exam (one per calendar year). You are also eligible to use the HearPO® Hearing Discount Program.	100%, no copay	Not covered

Aetna Open Choice PPO Plan

Plan Provisions	Preferred Care Benefits (In-Network)	Non-Preferred Care Benefits (Out-of-Network)
Preventive Care (continued)		
Update ★ 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
Physician Services		
★ Office visits for treatment of illness or injury	100% after copay: $20 PCP*/ $35 specialist; no deductible	60% after deductible
★ Walk-in clinic visit	100% after $20 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: $20 PCP*/ $35 specialist	60% after deductible
> Independent facility	90% after deductible	60% after deductible
★ Maternity care office visits	100% after copay: $20 PCP*/ $35 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: $20 PCP*/ $35 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: $20 PCP*/ $35 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		
★ 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.*		
Urgent and Emergency Care		
Update ★ 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
Update ★ Hospital emergency room for non-emergency care	50% after deductible plus $350 emergency room copay	50% after deductible plus separate $350 emergency room deductible
Update ★ Urgent care facility	100% after $20 copay	60% after deductible
★ Ambulance	80% after deductible	80% after deductible
Other Health Care		
★ 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

Aetna Open Choice PPO Plan

Plan Provisions	Preferred Care Benefits (In-Network)	Non-Preferred Care Benefits (Out-of-Network)
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-day maximum per course of treatment)	80% after deductible	80% after deductible
★ Durable medical equipment	80% after deductible	80% after deductible
★ Spinal disorder (chiropractic) (20 visits per calendar year)	100% after copay: $20 PCP/$35 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
★ Outpatient* (up to 45 visits per calendar year)	100% after $35 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
★ Outpatient* (up to 45 visits per calendar year)	100% after $35 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.*		
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 $20 copay	Not covered
> Tier Three – Non-preferred brand-name drugs	100% after 35% copay – the minimum you pay per prescription is $35; the maximum is $100.	Not covered
★ Mail-Order Service – Aetna Rx Home Delivery® (up to a 90-day supply)		
> Tier One – Generic drugs	100% after $20 copay	Not covered
> Tier Two – Preferred brand-name drugs	100% after $40 copay	Not covered
> Tier Three – Non-preferred brand-name drugs	100% after 35% copay – the minimum you pay per prescription is $70; the maximum is $200.	Not covered
★ Prescriptions Purchased Overseas		
> Generic drugs	Not applicable	100% after deductible
> Brand-name drugs	Not applicable	80% after deductible
Update ★ 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, Nicotine nasal spray, Nicotine patch, and Varenicline. Includes 8 counseling sessions every 12 months.

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.

DEPARTMENT of DEFENSE NONAPPROPRIATED FUND HEALTH BENEFITS PROGRAM

Aetna Passive PPO Dental Plan

Summary of Benefits effective January 1, 2012

	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)
Update **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**
Basic Care Fillings, root canal therapy, extractions, general anesthesia, space maintainers to age 19, palliative treatments	80% after deductible*	80% after deductible**
Restorative Care Inlays, crowns, fixed bridgework, gold fillings	50% after deductible*	50% after deductible**
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

+ 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.

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