

Aetna High Deductible Health Plan

(for Aetna Traditional Choice®)

Department of Defense Nonappropriated Fund Health Benefits Program

Summary of Benefits effective January 1, 2026

Plan Provisions

Plan Benefits

UPDATE

Calendar-Year Deductible (includes pharmacy)

Employee only	\$2,000
Family (employee + one or more dependents)	\$6,000

UPDATE

Out-of-Pocket Maximum

This is the maximum amount you pay for your share of covered expenses in a calendar year. It includes the deductible and coinsurance². It does not include prescription eyewear, Choose Generics penalties, expenses covered at 50% and non-covered expenses.

Employee only	\$7,000
Family (employee + one or more dependents)	\$14,000 ³
Lifetime maximum	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 & rewards > Health Incentives Program.

Hospital Precertification

Certain services require precertification. Please see your Summary Plan Description (SPD) for details. Network physical handles

Preventive Care (Deductible is waived for preventive care services.)

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 45 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%, no deductible, 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 deductible
Routine hearing exam (one per calendar year)	100%, no deductible

¹ The IRS sets minimum deductible amounts for qualified HDHPs requiring the employee-only deductible to increase to \$1,700 in 2026.

² Coinsurance is the percentage of your covered expenses you pay after you meet the calendar-year deductible.

³ In compliance with the Affordable Care Act, if one individual under family coverage has \$10,150 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.



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Coinsurance

Plan share of costs - as a percentage - after you reach the deductible. For example, if the plan pays 70% of a covered expense, you pay 30%. 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.

Plan pays

70% after deductible

Physician Services

Office visits for treatment of illness or injury

Walk-in clinic visit

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)

- Separate office visit

- Independent facility (not affiliated with a doctor's office that may be located in the same location)

Maternity care office visits

In-office surgery

Physician hospital visits

Anesthesia

Allergy testing, serum and injections

Second surgical opinion

Plan pays

70% after deductible

70% after deductible

70% after deductible

70% after deductible

70% after deductible

70% after deductible

70% after deductible

70% after deductible

70% after deductible

70% after deductible

100% after deductible

Teladoc Health⁵

General medicine

Behavioral Health

Dermatology

100% after deductible

70% after deductible

70% after deductible

Hospital Services

Inpatient hospital room and board and ancillary services

Inpatient and outpatient surgery

Outpatient services

Pre-operative testing

Other hospital services

Plan pays

70% after deductible

70% after deductible

70% after deductible

70% after deductible

70% after deductible

Urgent and Emergency Care

Hospital emergency room

Hospital emergency room for non-emergency care

Urgent care facility

Ambulance

70% after deductible

50% after deductible

70% after deductible

70% after deductible

⁵ Teladoc Health is not available overseas.



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Other Health Care	Plan pays
Convalescent facility (up to 90 days per calendar year)	70% after deductible
Home health care (up to 90 visits per calendar year)	70% after deductible
Private duty nursing (up to 70 eight-hour shifts per calendar year)	70% after deductible
Hospice (inpatient and outpatient)	100% after deductible
Independent lab and X-ray facilities	70% after deductible
Voluntary sterilization	70% after deductible
Outpatient short-term rehabilitation (60-visit maximum per course of treatment)	70% after deductible
Habilitative physical therapy	70% after deductible
Habilitative occupational therapy	100% after deductible
Habilitative speech therapy	70% after deductible
Autism behavioral therapy (treated as outpatient mental health visits)	70% after deductible
Autism applied behavior analysis (covered same as any other outpatient mental health – all other)	70% after deductible
Autism physical therapy	70% after deductible
Autism occupational therapy	70% after deductible
Autism speech therapy	70% after deductible
Durable medical equipment	70% after deductible
Spinal disorder (chiropractic) (20-visit maximum per calendar year)	70% after deductible
Bariatric surgery	70% after deductible
Hearing aids (\$3,000 maximum every 3 years). You are also eligible to use the Amplifon Hearing Health Care Discount Program.	70% after deductible
Mental Health Care	
Inpatient (no maximum number of days)	70% after deductible
Outpatient (no maximum number of visits)	70% after deductible
Outpatient – all other ⁶ (no maximum number of visits)	70% after deductible
Substance Abuse Treatment	Plan pays
Inpatient (no maximum number of days)	70% after deductible
Outpatient (no maximum number of visits)	70% after deductible

⁶ 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).



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Plan Benefits

Prescription Drug Benefits (Formulary: Aetna Standard Plan for DoD)

Plan pays

Participating Retail Pharmacy Program (up to a 30-day supply)⁷

• Tier One – Generic drugs	0% after deductible
• Tier Two – Preferred brand-name drugs	35% after deductible; \$75 maximum
• Tier Three – Non-preferred brand-name drugs ⁸	50% after deductible; \$125 maximum
• Tier Four – Specialty drugs	50% after deductible; \$125 maximum

Maintenance Choice®: CVS Caremark® Mail Service Pharmacy or CVS Pharmacy® (a 31- to 90-day supply)⁷

• Tier One – Generic drugs	0% after deductible
• Tier Two – Preferred brand-name drugs	35% after deductible; \$150 maximum
• Tier Three – Non-preferred brand-name drugs ⁸	50% after deductible; \$250 maximum

Preventive Drug List (up to a 30-day supply)

• Tier One – Generic drugs	Deductible waived; 0%
• Tier Two – Preferred brand-name drugs	Deductible waived; 35% with \$75 maximum
• Tier Three – Non-preferred brand-name drugs ⁸	Deductible waived; 50% with \$125 maximum

Smoking-cessation medications⁹

• Tier One – Generic drugs	0% after deductible
• Tier Two – Preferred brand-name drugs	35% after deductible; \$75 maximum
• Tier Three – Non-preferred brand-name drugs ⁸	50% after deductible; \$125 maximum

⁵ 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 benefits.

⁸ 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 coinsurance. 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.

⁹ 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 eight counseling sessions per calendar year.



Aetna Passive PPO Dental Plan

Department of Defense Nonappropriated Fund (NAF) Health Benefits Program

Summary of Benefits effective January 1, 2026

Plan Provisions	Preferred (In Network)	Non-Preferred (Out of Network)
Calendar-Year Deductible		
Individual	\$100	\$100
Family of 2	\$100	\$200 (2 times individual)
Family of 3 or more	\$100	\$300 (3 times individual)
Calendar-year benefits maximum	\$100	\$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	50% 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 \$2000 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](https://www.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.

