**Summary of Benefits and Coverage**: What this Plan Covers & What You Pay for Covered Services

**Coverage Period: 01/01/2027-12/31/2027**

aetna®

**DEPARTMENT OF WAR -NONAPPROPRIATED FUND HEALTH BENEFITS : PROGRAM: Aetna Choice® POS II - HDHP Medical without Dental**

**Coverage for: All Tiers | Plan Type: POS**

**The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, www.HealthReformPlanSBC.com or by calling 1-800-370-4526. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary/ or call 1-800-370-4526 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | In-Network: EE Only $2,000; EE+ Family (employee + one or more dependents) $6,000. Out-of-Network: EE Only $6,000; EE+ Family (employee + one or more dependents) $12,000. | Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay. |
| **Are there services covered before you meet your deductible?** | Yes. In-network preventive care is covered before you meet your deductible. | This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/. |
| **Are there other deductibles for specific services?** | No. | You don't have to meet deductibles for specific services. |
| **What is the out-of-pocket limit for this plan?** | In-Network: EE Only $7,000; EE+ Family (employee + one or more dependents) $14,000. Out-of-Network: EE Only $14,000; EE+ Family (employee + one or more dependents) $18,500. | The out–of–pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, the overall family out–of–pocket limit must be met. |
| **What is not included in the out-of-pocket limit?** | Premiums, balance-billing charges, health care this plan doesn't cover & penalties for failure to obtain pre-authorization for services. | Even though you pay these expenses, they don't count toward the out–of–pocket limit. |
| **Will you pay less if you use a network provider?** | Yes. See www.aetna.com/docfind or call 1-800-370-4526 for a list of In-Network providers. | This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services. |
| **Do you need a referral to see a specialist?** | No. | You can see the specialist you choose without a referral. |



All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | In-Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | 30% coinsurance | 40% coinsurance | None |
| | Specialist visit | 30% coinsurance | 40% coinsurance | None |
| | Preventive care /screening /immunization | No charge | Not covered | You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | 30% coinsurance | 40% coinsurance | None |
| | Imaging (CT/PET scans, MRIs) | 30% coinsurance | 40% coinsurance | None |
| **If you need drugs to treat your illness or condition**<br><br>More information about **prescription drug coverage** is available at www.aetnapharmacy.com/standard | Generic drugs | 0% coinsurance (retail & mail order) | Not covered | Covers 30 day supply (retail), 31-90 day supply (mail order). Includes contraceptive drugs & devices obtainable from a pharmacy, oral & injectable fertility drugs. No charge for preferred generic FDA-approved women's contraceptives in-network. Your cost will be higher for choosing Brand over Generics; cost difference penalty doesn't apply to out-of-pocket limit. Maintenance drugs- after two retail fills, you are required to fill a 90-day supply at a participating mail service pharmacy or at selected participating retail providers. Deductible doesn't apply to certain preventive medications. For overseas pharmacies 0% coinsurance for generic drugs & 20% coinsurance for brand drugs. |
| | Preferred brand drugs | 35% copay up to maximum/ prescription: $75 (retail), $150 (mail order) | Not covered | |
| | Non-preferred brand drugs | 50% copay up to maximum/ prescription: $125 (retail), $250 (mail order) | Not covered | |
| | Specialty drugs | 50% copay up to maximum/ prescription: $125 | Not covered | First prescription fill at a retail pharmacy or specialty pharmacy. Subsequent fills must be through the Aetna Specialty Pharmacy Network. Precertification required for coverage. |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 30% coinsurance | 40% coinsurance | None |
| | Physician/surgeon fees | 30% coinsurance | 40% coinsurance | None |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | In-Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| **If you need immediate medical attention** | Emergency room care | 30% coinsurance | 30% coinsurance | Out-of-network emergency use paid the same as in-network. 50% coinsurance after $350 copay/visit for non-emergency use. |
| | Emergency medical transportation | 30% coinsurance | 30% coinsurance | Out-of-network emergency use paid the same as in-network. Non-emergency transport: not covered, except if pre-authorized |
| | Urgent care | 30% coinsurance | 40% coinsurance | No coverage for non-urgent use. |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 30% coinsurance | 40% coinsurance after $400 copay/stay | Penalty of $500 for failure to obtain pre-authorization for out-of-network care. |
| | Physician/surgeon fees | 30% coinsurance | 40% coinsurance | None |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | Office & other outpatient services: 30% coinsurance | Office & other outpatient services: 40% coinsurance | None |
| | Inpatient services | 30% coinsurance | 40% coinsurance after $400 copay/stay | Penalty of $500 for failure to obtain pre-authorization for out-of-network care. |
| **If you are pregnant** | Office visits | No charge | 40% coinsurance | Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). Penalty of $500 for failure to obtain pre-authorization for out-of-network care may apply. |
| | Childbirth/delivery professional services | 30% coinsurance | 40% coinsurance | |
| | Childbirth/delivery facility services | 30% coinsurance | 40% coinsurance after $400 copay/stay, except copay doesn't apply for newborn hospital expenses | |
| **If you need help recovering or have other special health needs** | Home health care | 30% coinsurance | 40% coinsurance | 90 visits/calendar year. Penalty of $500 for failure to obtain pre-authorization for out-of-network care. |
| | Rehabilitation services | 30% coinsurance | 40% coinsurance | 60 visits/calendar year for Physical, Occupational & Speech Therapy combined. |
| | Habilitation services | 30% coinsurance | 40% coinsurance | None |
| | Skilled nursing care | 30% coinsurance | 40% coinsurance | 90 days/calendar year. Penalty of $500 for failure to obtain pre-authorization for out-of-network care. |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | In-Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| | Durable medical equipment | 30% coinsurance | 40% coinsurance | Limited to 1 durable medical equipment for same/similar purpose. Excludes repairs for misuse/abuse. |
| | Hospice services | 0% coinsurance | 0% coinsurance | Penalty of $500 for failure to obtain pre-authorization for out-of-network care. |
| If your child needs dental or eye care | Children's eye exam | No charge | Not covered | 1 routine eye exam/calendar year. |
| | Children's glasses | No charge | No charge | $150 maximum/calendar year. |
| | Children's dental check-up | Not covered | Not covered | Not covered. |

## Excluded Services & Other Covered Services:

**Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)**

- Cosmetic surgery
- Dental care (Adult & Child)
- Routine foot care
- Long-term care
- Non-emergency care when traveling outside the U.S.

**Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)**

- Acupuncture - 10 visits/calendar year for disease, injury & chronic pain.
- Bariatric surgery - Limited to in-network providers.
- Chiropractic care - 20 visits/calendar year.
- Hearing aids - $3,000 maximum/3 years.
- Infertility treatment - For more information & exceptions, see policy document provided by your employer or call the number on your ID card.
- Private-duty nursing - 70- 8 hour shifts/calendar year.
- Routine eye care (Adult) - 1 routine eye exam/calendar year for in-network only.
- Weight loss programs - For more information & exceptions, see policy document provided by your employer or call the number on your ID card.

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is:

- For more information on your rights to continue coverage, contact the plan at 1-800-370-4526.
- If your group health coverage is subject to ERISA, you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform
- For non-federal governmental group health plans, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.

- If your coverage is a church plan, church plans are not covered by the Federal COBRA continuation coverage rules. If the coverage is insured, individuals should contact their State insurance regulator regarding their possible rights to continuation coverage under State law.

Other coverage options may be available to you, too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact:

- If your group health coverage is subject to ERISA, you may contact Aetna directly by calling the toll-free number on your Medical ID Card, or by calling our general number at 1-800-370-4526. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform
- For non-federal governmental group health plans, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.
- Additionally, a consumer assistance program can help you file your appeal. Contact https://www.aetna.com/individuals-families/member-rights-resources/complaints-grievances-appeals.html

**Does this plan provide Minimum Essential Coverage?** **Yes.**

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

**Does this plan meet Minimum Value Standards?** **Yes.**

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

*To see examples of how this plan might cover costs for a sample medical situation, see the next section*

## About these Coverage Examples:

**This is not a cost estimator.** Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

### Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

| | |
|---|---|
| **The plan's overall deductible** | **$2,000** |
| **Specialist coinsurance** | **30%** |
| **Hospital (facility) coinsurance** | **30%** |
| **Other coinsurance** | **30%** |

**This EXAMPLE event includes services like:**
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

| | |
|---|---|
| **Total Example Cost** | **$12,700** |
| **In this example, Peg would pay:** | |
| *Cost Sharing* | |
| Deductibles | $2,000 |
| Copayments | $0 |
| Coinsurance | $2,900 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$4,960** |

### Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

| | |
|---|---|
| **The plan's overall deductible** | **$2,000** |
| **Specialist coinsurance** | **30%** |
| **Hospital (facility) coinsurance** | **30%** |
| **Other coinsurance** | **30%** |

**This EXAMPLE event includes services like:**
Primary care provider office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Diabetic supplies *(glucose meter)*

| | |
|---|---|
| **Total Example Cost** | **$5,600** |
| **In this example, Joe would pay:** | |
| *Cost Sharing* | |
| Deductibles | $2,000 |
| Copayments | $800 |
| Coinsurance | $200 |
| *What isn't covered* | |
| Limits or exclusions | $20 |
| **The total Joe would pay is** | **$3,020** |

### Mia's Simple Fracture
(in-network emergency room visit and follow up care)

| | |
|---|---|
| **The plan's overall deductible** | **$2,000** |
| **Specialist coinsurance** | **30%** |
| **Hospital (facility) coinsurance** | **30%** |
| **Other coinsurance** | **30%** |

**This EXAMPLE event includes services like:**
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

| | |
|---|---|
| **Total Example Cost** | **$2,800** |
| **In this example, Mia would pay:** | |
| *Cost Sharing* | |
| Deductibles | $2,000 |
| Copayments | $0 |
| Coinsurance | $200 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$2,200** |

The plan would be responsible for the other costs of these EXAMPLE covered services.

## Assistive Technology

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 1-800-370-4526.

## Smartphone or Tablet

To view documents from your smartphone or tablet, the free WinZip app is required. It may be available from your App Store.

TTY: 711

| | |
|---|---|
| **English -** | **To access language services at no cost to you, call 1-800-370-4526.** |
| Amharic - | የቋንቋ አገልግሎቶችን ያለክፍያ ለማግኘት፣ በ 1-800-370-4526 ይደውሉ።. |
| Arabic - | للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء االتصال على الرقم 1-800-370-4526. |
| Armenian - | Անվճար լեզվական ծառայություններից օգտվելու համար զանգահարեք 1-800-370-4526 հեռախոսահամարով: |
| Carolinian (Kapasal Falawasch) - | ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-800-370-4526. |
| Chamorro - | Para un hago' i setbision lengguåhi ni dibåtde para hågu, ågang 1-800-370-4526. |
| Chinese Traditional - | 如欲使用免費語言服務，請致電 1-800-370-4526. |
| Cushitic-Oromo - | Tajaajiiloota afaanii garuu bilisaa ati argaachuuf,bilbili 1-800-370-4526. |
| French - | Afin d'accéder aux services langagiers sans frais, composez le 1-800-370-4526. |
| French Creole (Haitian) - | Pou jwenn sèvis lang gratis, rele 1-800-370-4526. |
| German - | Um auf für Sie kostenlose Sprachdienstleistungen zuzugreifen, rufen Sie 1-800-370-4526 an. |
| Greek - | Για να επικοινωνήσετε χωρίς χρέωση με το κέντρο υποστήριξης πελατών στη γλώσσα σας, τηλεφωνήστε στον αριθμό 1-800-370-4526. |
| Gujarati - | તમારેકોઇ જાતના ખર્ચવિના ભાષાની સે વિના ઓની પહોંચ્ માટે, કોલ કરોr 1-800-370-4526. |
| Hindi - | आपकेलिए बिना ककसी कीमत केभाषा सेवाओंका उपयोग करनेकेलिए, 1-800-370-4526 पर कॉल करें।. |
| Hmong - | Xav tau kev pab txhais lus tsis muaj nqi them rau koj, hu 1-800-370-4526. |
| Italian - | Per accedere ai servizi linguistici, senza alcun costo per lei, chiami il numero 1-800-370-4526. |
| Japanese - | 言語サービスを無料でご利用いただくには、 1-800-370-4526 までお電話ください。 |
| Karen - | လၢတၫ်ကမၤနှၤ်ကျိၣ်အတၫ်မၤစၢၤအတၫ်ဖံးတၫ်မၤတဖၣ်လၢတအိၣ်ဒီးအပှၤလၢကဘၣ်ဟ့ၣ်အီၤအဂိၢ်ဘၣ်နှၣ် ကိး 1-800-370-4526 တက့ၢ်. |
| Korean - | 무료 언어 서비스를 이용하려면 1-800-370-4526 번으로 전화해 주십시오. |
| Laotian - | ເພື່ອເຂົ້າໃຊ້ການບໍລິການພາສາໂດຍບໍ່ເສຍຄ່າຕໍ່ກັບທ່ານ, ໃຫ້ໂທຫາເບີ 1-800-370-4526. |
| Mon-Khmer, Cambodian - | ដើម្បីទទួលបានសេវាកម្មភាសាដែលឥតគិតថ្លៃសម្រាប់លោកអ្នក សូមហៅទូរស័ព្ទទៅកាន់លេខ 1-800-370-4526 ។ |
| Navajo - | T'áá ni nizaad k'ehjí bee níká a'doowoł doo bą́ą́h ílínígóó kojį' hólne' 1-800-370-4526. |
| Pennsylvania Dutch - | Um Schprooch Services zu griege mitaus Koscht, ruff 1-800-370-4526. |

| | |
|---|---|
| Persian-Farsi - | برای دسترسی به خدمات زبان به طور رایگان، با شماره 1-800-370-4526 تماس بگیرید . |
| Polish - | Aby uzyskać dostęp do bezpłatnych usług językowych proszę zadzwonoć 1-800-370-4526. |
| Portuguese - | Para acessar os serviços de idiomas sem custo para você, ligue para 1-800-370-4526. |
| Punjabi - | ਤੁਹਾਡੇ ਲਈ ਬਿਨਾਂ ਕਿਸੇ ਕੀਮਤ ਵਾਲੀਆਂ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ ਦੀ ਵਰਤੋਂ ਕਰਨ ਲਈ, 1-800-370-4526 'ਤੇ ਫ਼ੋਨ ਕਰੋ। |
| Russian - | Для того чтобы бесплатно получить помощь переводчика, позвоните по телефону 1-800-370-4526. |
| Samoan - | Mo le mauaina o auaunaga tau gagana e aunoa ma se totogi, vala'au le 1-800-370-4526. |
| Serbo-Croatian - | Za besplatne prevodilačke usluge pozovite 1-800-370-4526. |
| Spanish - | Para acceder a los servicios de idiomas sin costo, llame al 1-800-370-4526. |
| Syriac-Assyrian - | ܠܡܬܥܒܕ ܒܚܕܡܬ̈ܐ ܕܠܫܢ̈ܐ ܒܠܝ ܡܨܪܐ ܠܘܬ ܐܢܫ̈ܐ ܕܡܠܝܠ̈ܐ ܠܐ ܫܦܝܪ̈ܐ ܐܝܟ ܐܢ ܨܒܝܬ ܐܢ ܠܐ، ܩܪܝ ܠ1-800-370-4526. |
| Tagalog - | Para ma-access ang mga serbisyo sa wika nang wala kayong babayaran, tumawag sa 1-800-370-4526. |
| Thai - | **หากท่านต้องการเข้าถึงการบริการทางด้านภาษาโดยไม่มีค่าใช้จ่าย โปรดโทร** 1-800-370-4526**.** |
| Ukrainian - | Щоб отримати безкоштовний доступ до мовних послуг, задзвоніть за номером 1-800-370-4526. |
| Vietnamese - | Nếu quý vị muốn sử dụng miễn phí các dịch vụ ngôn ngữ, hãy gọi tới số 1-800-370-4526. |