



**US ARMY NAF EMPLOYEE
*DOD HEALTH BENEFIT PLAN***



INTRODUCTION

This booklet is published by the US Army NAF Employee Benefits Office. It is intended to provide you with useful information about the Health Benefit Plans available to US Army NAF Employees and eligible Retirees, including the Department of Defense Joint Uniform NAF Employee Health Benefit Plan and Health Maintenance Organizations (HMOs), which are available in some areas. The information in this booklet is accurate as of the publication date. However, because the Health Benefit Plans are governed by SC1408.AP1, DOD 1400.25-M and the Summary Plan Descriptions of the DOD Health Benefit Plan and the individual HMOs, should the information in this booklet conflict with the provisions of those documents, those documents are the final authority. The full text of SC1408.AP1, DOD 1400.25-M and the Summary Plan Descriptions of the DOD Health Benefit Plan can be found in the Medical and Dental Section of the NAF Benefits web site, www.nafbenefits.com. The Summary Plan Descriptions of HMOs available at some locations are available from the servicing NAF Human Resources Office at those installations.

The information in this booklet applies primarily to the DOD Health Benefit Plan. Although the information is generally applicable to the HMOs, there may be some variation in the provisions of the HMO Plans. Those plans should be reviewed individually.

Should you have any questions concerning the Health Benefit Plans, please contact your servicing NAF Personnel Office or forward your questions to this office using the email link from the NAF Benefits web site, medicalplan@cfsc.army.mil.

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WHAT IS THE DOD HEALTH BENEFIT PLAN

The Department of Defense Health Benefit Plan (DODHBP) was mandated by Congress in the Appropriations Act of 1995. That legislation required that the services develop a uniform health benefit plan for their Nonappropriated Fund employees. The participants in the DODHBP include the Army, Air Force, Navy, USMC, Army & Air Force Exchange Service (AAFES) and the Navy Exchange (NEXCOM). The services jointly manage the plan and determine the benefits available under the plan. The DODHBP is a self-insured medical and dental insurance plan. Claims and administrative costs of the plan are funded by premiums, which are paid by employees and their employers. The plan is administered by Aetna US HealthCare, the third party administrator (TPA) of the plan, which processes claims for services as authorized under the plan provisions and provides access by plan participants to networks of health care facilities and physicians, which have agreed to accept the insurance at negotiated rates.

JOINING THE HEALTH BENEFIT PLAN

WHO MAY PARTICIPATE

You may elect to participate in the Health Benefit Plan if you are in an “eligible class.” You are eligible if you are:

- a regular full time or regular part time NAF employee working at least 20 hours a week

AND

- working in one of the 50 United States, the District of Columbia, or Puerto Rico.

HOWEVER:

- if you are working overseas, you must be a U.S. citizen or the spouse or child of a U.S. citizen.
- Retired NAF employees who meet eligibility requirements for the Post Retirement Medical Benefit may also be enrolled in the Health Benefit Plan. (See the Post Retirement Medical Section).

- Survivors of deceased active and retired employees who meet eligibility requirements may also be enrolled in the Health Benefit Plan. (See the section on Coverage for Surviving Dependents).

WHEN TO JOIN

- Eligible employees may join the plan within 31 days of their hire date.
- Eligible employees who do not join during their first 31 days of hire may enroll during the open season periods which occur every two years in the odd years, i.e., 2005, 2007, 2009, etc.
- Eligible employees may enroll in the Health Benefit Plan outside of open season only if they experience certain life events, which would entitle them to enrollment under HIPAA (Health Insurance Portability and Accountability Act of 1996) or in certain other circumstances. (See the sections on HIPAA and Special Enrollment Provisions)

HOW TO JOIN THE HEALTH BENEFIT PLAN

You must complete and sign DA Form 3473 Part 2 to join the Health Benefit Plan. This form is available from your servicing Civilian Personnel Office.

PARTICIPATION BEGINS

If you are a new employee or you are enrolling outside of open season due to a life event, your coverage is effective on the date you sign the enrollment form.

There is no pre-existing condition exclusion in the DODHBP, so there is no waiting period before you may obtain health care services under the plan, once you are enrolled; even if you are ill when you enroll.

If you enroll in the DODHBP during an open season, your coverage is effective on January 1st, following the open season period.

(NOTE: See the section on Special Enrollment Provisions)

PARTICIPATION ENDS

Your coverage ends at midnight on the date of your termination from employment or the date you terminated your coverage, unless you have elected to continue your coverage after termination of employment under the TCC (Temporary Continuation of Coverage) program. (See the section on TCC). Employees who accept an appropriated fund position under portability of benefits may continue their coverage without charge for up to 31 days, pending enrollment in the Federal Employee Health Benefit Plan.

COST OF THE HEALTH BENEFIT PLAN

Premiums for your health insurance are deducted from your pay each pay period. Due to steadily increasing health care costs, rates are adjusted each year. The current premium rates for the DODHBP and the HMOs are available in the Medical and Dental Section of the NAF Benefits web site. Your employer contributes a substantial share of your bi-weekly premiums. Employees pay 30% of the premium, and their employer pays 70%. The HMO employee/employer share split is 50/50.

Your premiums are deducted from your salary on a pre-tax basis under Section 125 of the Internal Revenue Code. This means your premium deduction is taken before Federal and State Income Taxes, Social Security and Medicare are withheld. This effectively lowers your health care premium costs by your applicable tax rate, normally 25% to 35%, thus making health and dental care for your family more affordable.

If you participate in the Section 125 Pre-Tax Program, you may not terminate your participation during the plan year (calendar year) except under certain circumstances authorized by the Internal Revenue Code.

Because this effectively lowers your Social Security wage, upon which your Social Security benefit is based, some lower paid employees who are approaching retirement may want to opt out of the Section 125 Pre-Tax Program. To assist you in making this determination, the NAF Benefits web site includes information on how to calculate the effect of this pre-tax program. Should you decide to opt out of the Section 125 Pre-Tax Program, please see your servicing NAF Personnel Office. You may do this only during open seasons or during plan selection periods, which are held in alternate years.

NOTE: New Jersey and Puerto Rico do not allow pre-tax premiums for their state and local tax withholding.

WHO MAY BE COVERED UNDER THE DODHBP

The following individuals may be covered under the DODHBP.

- Eligible employees
- Their legal and common law spouses, where common law spouses are recognized by their state.
- Their biological, adopted or step children who live with them and are dependent upon them for support.
- Any other child who is their biological, adopted or step child, but who lives with them and is dependent upon them for financial support. Evidence of dependency is required
- Dependent children who are unmarried may be covered until age 19.
- Dependent children who are unmarried may be covered until age 25 if they are a full time student in an accredited educational institution and are not employed on a full time basis.
- Certain dependent children with disabilities may continue to be covered, regardless of age. (Please see the Child with Disabilities Section of the Summary Plan Description).

(NOTE: See the section on Special Enrollment Provisions)

HEALTH BENEFIT PLAN COVERAGE

MEDICAL PLAN

The DODHBP consists of the Preferred Provider Organization (PPO), also known as the Open Choice (OC) Plan, the Traditional Choice or Indemnity Plan (TC), and HMO Plans. A PPO or Indemnity Plan will be offered in all areas where eligible active and retired employees are located. The PPO Plan will be offered wherever feasible. The Indemnity Plan will be offered in areas where the PPO Plan is not offered. Employees and retirees in overseas locations will be in the Indemnity Plan because there are no PPO networks outside the United States and Puerto Rico. HMOs will be established in locations based on availability and where there is sufficient demand for an HMO, normally 25 or more participants. Where HMOs are available, employees may choose between the DODHBP and an HMO. (NOTE: Retirees may not participate in HMOs). The following HMOs are available:

- Aetna HMO (National Capitol Region, Baltimore, NY & NJ)
- Hawaii Medical Service Association (Hawaii)
- Kaiser Permanente Health Plan (National Capitol Region)
- Kaiser Permanente Hawaii (Hawaii)
- Keystone Health Plan (Ft Indiantown Gap & Carlisle Brks, PA)
- Scott & White Health Plan (Fort Hood, TX)
- Triple S (Puerto Rico)

DODHBP DENTAL PLAN

A comprehensive Dental Plan is also available on an optional basis to all active employees who are participating in the DODHBP or an HMO if the HMO in which they are enrolled does not offer a Dental Plan. Retirees may also enroll in the Dental Plan if they meet the eligibility requirements for the Post Retirement Medical and Dental Benefit.

ENROLLMENT OPTIONS

Eligible employees and retirees may enroll for the following coverages:

- Single Medical coverage without Dental
- Single Medical coverage with Dental
- Family Medical coverage without Dental
- Family Medical coverage with Dental

DODHBP PLAN BENEFITS

Benefits and levels of coverage for Medical and Dental may change each Plan Year (calendar year) based on a number of factors, such as utilization, health care costs, developments in health care, network and pharmaceutical agreements, and other factors. For the most current Plan Benefits, please consult the Summary Plan Description or the Plan Summary, both of which are available in the Medical and Dental Section of the NAF Benefits web site. For 2006 and until any future plan changes are approved, the following are the benefit highlights.

OPEN CHOICE (PPO) PLAN (In Network Benefits)

- Calendar Year Deductible - \$200 Individual/\$600 Family
- Annual Out of Pocket Limit - \$3000 Individual/\$9000 Family

- Lifetime Maximum – Unlimited
- Preventive Care – 100%, no deductible
- Physician Services – 100% after \$15 PCP or \$35 Specialist copay, no deductible
- Hospital Services – 90% after deductible plus \$200 confinement fee
- Hospital Emergency Room – 100% if admitted
- Mental Health Care & Substance Abuse Treatment – Inpatient - 80% after deductible plus \$200 inpatient confinement fee/Outpatient – 100% after \$35 copay, no deductible.
- Prescription Drug (Participating Pharmacy)
 - Generic – 100% after \$10 copay
 - Formulary brand name – 100% after \$25 copay
 - Non-formulary brand name – 100% after \$35 copay
- Prescription Drug (Non-Participating Pharmacy)
 - Generic – Not covered
 - Formulary brand name – Not covered
 - Non-formulary brand name – Not Covered
- Prescription Drug (Mail Order up to 90 day supply)
 - Generic – 100% after \$20 copay
 - Formulary brand name – 100% after \$40 copay
 - Non-formulary brand name – 100% after \$60 copay
- Prescription Eyewear – 100% up to \$150 per person, per year in addition to Vision One Discount Program
- Other Health Care – Per Summary of Benefits Chart

OPEN CHOICE (PPO) PLAN (Out-of-Network Benefits)

- Calendar Year Deductible - \$600 Individual/\$1800 Family
- Annual Out of Pocket Limit - \$4,000 Individual/\$12,000 Family
- Lifetime Maximum – Unlimited
- Preventive Care – Not covered
- Physician Services – 60% after deductible
- Hospital Services – 60% after deductible plus \$400 confinement fee
- Hospital Emergency Room – 100% if admitted
- Mental Health Care & Substance Abuse Treatment – Inpatient - 60% after deductible plus \$400 inpatient confinement fee/Outpatient – 60% after deductible.
- Prescription Drug (Non-Participating Pharmacy)

- Generic – Not covered
 - Formulary brand name – Not covered
 - Non-formulary brand name – Not Covered
- Prescription Eyewear – 100% up to \$150 per person, per year
 - Other Health Care – Per Summary of Benefits Chart

TRADITIONAL CHOICE (TC) INDEMNITY PLAN

- Calendar Year Deductible - \$200 Individual/\$600 Family
- Annual Out of Pocket Limit - \$3000 Individual/\$9000 Family
- Lifetime Maximum – Unlimited
- Preventive Care – 100%, no deductible
- Physician Services – 80% after deductible
- Hospital Services – 80% after deductible
- Hospital Emergency Room – 80% after deductible
- Mental Health Care & Substance Abuse Treatment – Inpatient - 80% after deductible up to 60 days; 60% thereafter/Outpatient – 80% after deductible.
- Prescription Drug (Participating Pharmacy)
 - Generic – 100% after \$10 copay
 - Formulary brand name – 100% after \$25 copay
 - Non-formulary brand name – 100% after \$35 copay
- Prescription Drug (Non-Participating Pharmacy)
 - Generic – Not covered
 - Formulary brand name – Not covered
 - Non-formulary brand name – Not Covered
- Prescription Drug (Mail Order up to 90 day supply)
 - Generic – 100% after \$20 copay
 - Formulary brand name – 100% after \$40 copay
 - Non-formulary brand name – 100% after \$60 copay
- Prescriptions Purchased Overseas
 - Generic – 100% after deductible
 - Brand name – 80% after deductible
- Prescription Eyewear – 100% up to \$150 per person, per year
- Other Health Care – Per Summary of Benefits Chart

DENTAL PLAN BENEFITS

The Dental Plan is a Passive PPO Dental Plan. That means that you may use the Aetna Dental Network or you may use a non-network Dentist at your discretion. Although the benefits are the same in and out of network, the advantage of using a network Dentist is access to negotiated service fees which would lower the cost of your family's dental care for you and the plan.

- Calendar Year Deductible - \$100 Individual/\$300 Family
- Calendar Year Benefit Maximum – \$2,000 per person
- Preventive Care – 100%, no deductible
- Basic Care – 80% after deductible
- Restorative Care – 50% after deductible
- Oral Surgery – 100% of first \$1,000, 80% thereafter, not subject to deductible or calendar year maximum.
- TMJ Treatment – 50%, no deductible, subject to \$750 lifetime maximum per person
- Orthodontia – 50%, no deductible, subject to \$1,500 lifetime maximum per person

HOW TO USE THE HEALTH BENEFIT PLAN

Aetna, the third party administrator of the Health Benefit Plan, has prepared a comprehensive, easy to use guide to using your Health Benefit Plan. This guide, called “A Winning Team – Your Uniform Health Care Program” is included in your enrollment kit when you enroll in the Plan. It is also available on the NAF Benefits web site in the Medical Dental Section. There are separate guides for the Open Choice, Traditional Choice, and Dental Plans. Please consult the appropriate guides, as the procedures are different for each plan.

Approximately two to three weeks after you have enrolled in the Health Benefit Plan, you will receive your Member Identification Card. Your card will include your name and member number, the plan in which you are participating, and the copays associated with your plan. You should present this card when receiving health care services. You will be expected to pay your health care provider any copays required at the time the service is provided or when you are filling prescriptions.

If you are in the Open Choice Plan, you should use only network providers to receive the maximum benefit from the plan. If you obtain health care services outside of the network, your benefit will be reduced substantially, as described in the Plan Benefits Section above. If you are in the Traditional Choice Plan, you may seek health care from any qualified health care provider.

FINDING A HEALTH CARE PROVIDER

OPEN CHOICE PLAN

If you are in the Open Choice Plan, you should use only network providers to obtain the maximum benefit under the Plan. To locate a network provider or health care facility, go to the NAF Benefits web site, www.NAFBenefits.com. Then enter the Medical and Dental Section and click on the link to **Aetna DocFind**. Once in Aetna DocFind, you will be asked to enter your preference for the type of provider you desire and the distance you are willing to travel to obtain care. Normally, you will not have to drive more than five or ten miles from your residence to obtain care. When you visit a provider for the first time, present your Member ID Card and ascertain that the provider is an Aetna network provider under your plan. Providers join and opt out of the networks on a daily basis, so you should be certain the provider remains in the network so you do not inadvertently obtain care out of network and thus increase your liability to pay additional fees for your health care. An added word of caution, your primary care provider may occasionally refer you to a specialist for treatment. The referral does not guarantee that the specialist is a network provider. It is your responsibility to make sure that any provider from whom you obtain care is a network provider.

TRADITIONAL CHOICE PLAN

If you are in the Traditional Choice Plan, you may use a health care provider or facility of your choice. To locate a health care provider or facility in your area, you may want to consult the telephone book or other community directories or obtain advice from your friends and co-workers. Once you obtain a primary care provider, they can help you find specialists in your area for other treatment you may require. Overseas participants may also use Military Treatment Facilities in some locations. You should consult your local Military Treatment Facility to determine if they can provide your health care. Often, they can refer you to a local health care provider who speaks English and specializes in treating Americans.

DENTAL PLAN

If you are in the Dental Plan, you have the option of using either network or non-network Dentists. To locate a network Dentist, go to the NAF Benefits web site, www.NAFBenefits.com. Then enter the Medical and Dental Section and click on the link to **Aetna DocFind**. Once in Aetna DocFind, you should search for a Dentist in your area. If you are unable to locate a network Dentist within a reasonable driving distance, you may want to consult the telephone book or other community directories or obtain advice from your friends and co-workers.

PARTICIPATING PHARMACIES

In order to receive reimbursement for your prescription medications, you must use a **participating pharmacy**. Aetna has an extensive network of participating pharmacies from which to choose. You can find a complete list in **DocFind**. Overseas participants may obtain their prescription medications from any pharmacy. However, if you are located in the United States or Puerto Rico, and you have your prescriptions filled at a non-participating pharmacy, your prescription costs will not be reimbursed. Participants who are taking maintenance medications should obtain their prescriptions from the Mail-Order Service, which substantially reduces your copays. (See the Mail-Order Prescription Drug Section for more information).

OBTAINING HEALTH CARE WHILE TRAVELING

OPEN CHOICE PLAN PARTICIPANTS

If you are out of your local network area on vacation or business and you need non-emergency health care, you should call the toll free Aetna Member Services telephone number, 1-800-367-6276, to obtain information about the availability of network services in that area. Emergency care required if you are in an accident or are unable to contact Aetna Member Services due to your condition will be reimbursed in accordance with the Summary of Benefits and the Summary Plan Description for your Plan.

If you are traveling overseas, your covered expenses will be reimbursed at the preferred level.

If your dependent child is away at school or living with another parent, you should contact Aetna Member Services for assistance in determining the availability of a network in your child's area. If no network is available, claims for your child's health care will be settled at the Traditional Choice benefit level.

TRADITIONAL CHOICE PLAN PARTICIPANTS

If you are traveling away from home and need medical care, you'll receive benefits for covered services just as if you were at home. If you have a medical emergency, you should get the care you need and notify Aetna Member services within 48 hours to certify the admission. Use of emergency rooms for non-emergency care will result in a substantially reduced benefit. (NOTE: This also applies to OCONUS participants who are traveling in the states).

If your dependent child is away at school or living with another parent, benefits are paid as if your child lived with you.

MAIL ORDER PRESCRIPTION DRUG SERVICE

Aetna provides a mail order prescription drug service, called Aetna RX Home Delivery, for participants who are on maintenance medications and prefer to obtain up to a 90 day supply of their prescriptions. Using the Mail Order Drug Service is convenient, because you don't have to make monthly trips to the local pharmacy to refill your prescriptions. Additionally, it will substantially reduce your pharmacy copays and the total cost of your prescriptions. To have your prescriptions filled by Aetna RX Home Delivery, just complete the Registration form and send your prescription and a check for your copay in the pharmacy mailer included in your welcome kit. Additional mailers will be provided with your medications. Future refills can be requested on line at www.AetnaRXHomeDelivery.com or by calling 1-866-612-3862.

FILING CLAIMS FOR SERVICES

If you are in the Open Choice Plan and obtain health care services from a network provider or health care facility, your claim will be submitted by your provider. You must pay only the copay, if any, when you receive treatment. Once your claim has been settled, you will receive an

Explanation of Benefits (EOB) that provides the details of your claim settlement. You should review the EOB carefully. Because of deductibles and co-insurance for some services, you may be required to pay your health care provider a portion of the cost. Your provider will bill you accordingly. Your provider may not, however, bill you for the cost of services in excess of the allowable, which has been negotiated between Aetna and the provider.

If you are in the Open Choice Plan and obtain health care services from out of network providers or health care facilities, it is unlikely your provider will submit the claim for you. You will likely be required to pay the provider and then file a claim for reimbursement at the out-of-network benefit level. Claim forms are available and can be printed from the Benefit Forms Section of the NAF Benefits web site, www.NAFBenefits.com.

If you are in the Traditional Choice Plan and obtain health care services you will normally be required to pay your provider, and then submit your claim for reimbursement. Many overseas Military Treatment Facilities will invoice you and provide up to 90 days to pay for services received. This will provide you with sufficient time to submit your claim and receive reimbursement before the bill is due. Claim forms are available and can be printed from the Benefit Forms Section of the NAF Benefits web site, www.NAFBenefits.com.

When you have your prescriptions filled at participating pharmacies, you will be required to pay the appropriate copay, and the pharmacy will bill Aetna for the covered amount. Pharmacy claims for prescriptions filled at non-participating pharmacies will not be reimbursed. Overseas participants may have their prescriptions filled at any pharmacy and submit a claim for reimbursement. Claim forms are available and can be printed from the Benefit Forms Section of the NAF Benefits web site, www.NAFBenefits.com.

Claims are normally processed by Aetna within 30 days of receipt, unless additional documentation of the treatment or translation of foreign claims is required. (NOTE: Claims submitted in foreign currency will be converted to and paid in US Dollars based on the OANDA exchange rate in effect on the date of service. Funds cannot be wire transferred to foreign hospitals or banks).

NOTE: Claims for services out of network are subject to *reasonable and customary charges* limits. That is, the allowable cost of the service must be in line with the average cost of those services in the area.

If you are dissatisfied with the way your claim was settled, you may appeal the claims settlement. The appeals process can be found in the appeals section of the Summary Plan Description.

AETNA MEMBER SERVICES

Participants in the DOD Health Benefit Plan may call Aetna Member Services for assistance and information from 8 am to 6 pm CST, Monday through Friday or 24 hours a day for Aetna's Voice Advantage automated information service. The following information and assistance are provided by Aetna Member Services.

- Information about network providers and health care facilities
- For answers to general health questions
- For information about benefits under the plan
- To precertify hospital care, if required
- To find out if there is an Open Choice network where your child lives with another parent or is away at school
- To check the status of a claim

AETNA NAVIGATOR

Aetna Navigator is an on line service to help you manage your health care. It's easy to use, secure and private. When you log on, there's a general site and a registered site. The general site provides useful information and links to health care information. The registered site takes you into your personal health care information. To access your personal information, you must complete a simple registration process and select a password. You then have access to:

- Your plan information
- The members of your family covered under the plan
- Claims processing status
- Explanation of Benefits for processed claims
- A temporary Member ID card until your card is received

- Information concerning your personal health care

Aetna Navigator is a quick and easy way to get the answers you need about your plan participation and your health care.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 requires that employers provide a means for employees to elect or increase their health insurance coverage when they lose health insurance coverage or experience certain life events.

- If an employee has coverage from another employer or is covered by their spouse's health insurance with their employer and that insurance is subsequently lost, the employee, if otherwise eligible, may enroll in the DOD Health Benefit Plan. The enrollment must be requested within 31 days of the loss of the previous coverage. A HIPAA Certificate from the cancelled health insurance company must be presented to document eligibility.
- If an employee has elected single coverage and subsequently marries or obtains a dependent child by birth or adoption, the employee may increase their coverage from single to family. The change in coverage must be requested within 31 days of the event
- Employees who cease to be eligible to participate in the Health Benefit Plan will receive a HIPAA Certificate from Aetna (for the DODHBP) or from their HMO to document their loss of coverage.

SPECIAL ENROLLMENT PROVISIONS

- Employees whose hours are reduced under a business based action due to troop deployments may drop their enrollment. Once their hours are again increased, they may reenroll in the DODHBP, provided they are otherwise eligible and request enrollment within 31 days.
- Employees who have family coverage but obtain an additional dependent through birth or adoption have 31 days to add the new dependent to their coverage.

- The DODHBP honors Qualified Medical Child Support Orders (QMSCO). If an enrolled employee is ordered by a court or administrative order to provide health insurance for a child under a QMSCO, the employee must increase to family coverage and enroll the child. If the employee fails to enroll the child as required by the order, the employer will enroll the child and the employee must pay the required premium for family coverage.

USERRA

The Uniformed Services Employment and Reemployment Rights Act (USERRA) protects employees called to active duty from loss of benefits. If you are called to active duty you may continue your enrollment in the Health Benefit Plan for up to 24 months at no cost. You will not be required to repay the missed premiums to your employer upon your return to active employment.

If you are participating in the Health Benefit Plan upon being called to active duty and you choose to cancel your enrollment due to TriCare coverage, you may enroll in the Health Benefit Plan within 31 days of the termination of your TriCare coverage.

TEMPORARY CONTINUATION OF COVERAGE

If you have participated in the Health Benefit Plan for 90 days prior to termination of your employment, you are eligible to continue your coverage under the Temporary Continuation of Coverage (TCC) Program for up to 18 months. TCC participants must pay the full premium for the coverage, plus a 2% admin fee.

Retirees who are ineligible for the Post Retirement Medical Benefit may continue their coverage for 18 months under TCC.

Dependents who lose their coverage because the sponsoring employee or retiree loses coverage, or who become otherwise ineligible to participate due to age, loss of student status, full time employment, etc. are eligible to continue their coverage for 18 months under TCC.

Totally disabled employees are eligible for up to 36 months of TCC from the date their Health Benefit Plan coverage ends. TCC coverage ends prior to 36 months if the participant ceases to be totally disabled or if they become eligible for Medicare or other health coverage. The following conditions apply:

- If the disabled employee has less than 5 years participation in the Health Benefit Plan, they must pay the full cost of the premium for TCC plus a 2% admin fee.
- If the disabled employee has 5 or more years of participation in the Health Benefit Plan, they will be covered under TCC for 12 months at no cost and for an additional 24 months at the full premium rate plus a 2% admin fee. This provision does not apply to PRM (Post Retirement Medical) eligible disabled employees. (See the section on Post Retirement Medical Benefits).

Surviving spouses may also be eligible for TCC. (See the section on Survivor Benefits)

(NOTE: The TCC Program is administered by Aetna, who will process enrollments of eligible participants and invoice the participant for the required premiums. Employees have 60 days after termination of their coverage to enroll in TCC. Dental Plan coverage is not included in the TCC Program).

CONVERSION OF COVERAGE

Employees, retirees and dependents whose Health Benefit Plan coverage ceases may convert their coverage without a medical exam to a personal policy offered by Aetna. The personal policy coverage will take effect on the day following the termination of Health Benefit Plan coverage or the TCC period, if applicable. All HMOs also offer this conversion privilege. For information on conversion, please consult the Summary Plan Description for your Health Benefit Plan.

POST RETIREMENT MEDICAL (PRM) BENEFITS

Employees may continue to participate in the Health Benefit Plan after retirement if they meet the following eligibility criteria. Participant premiums will be subsidized on a 30/70 employee/employer share split basis. The eligibility requirements for post retirement Dental Plan participation are the same as for the PRM benefit.

- Be enrolled in the Health Benefit Plan (either DODHBP or HMO) on the day preceding retirement on an immediate annuity

- Have 15 years of cumulative participation in any combination of NAF Health Benefit Plans and/or the Federal Employee Health Benefit Plan (FEHBP). Participation does not have to be continuous and is not affected by breaks in service. The following cannot be used to attain eligibility for the PRM benefit.
 - Participation in a Health Benefit Plan as a dependent family member
 - Participation in TriCare or non-government plans
- The requirement for 15 years cumulative participation is waived:
 - if the employee had five continuous years of participation in the FEHBP on the day prior to an involuntary move from a DOD APF position to a DOD NAF position without a break in service of more than three days.
 - If the employee had five years of continuous participation in the FEHBP on the day prior to moving from a DOD APF position to a DOD NAF position under the Uniform Funding and Management (UFM) Program. The move must have occurred after December 2, 2002 without a break in service of more than three days. Documentation is required.
- Employees who were participating in the Army NAF Health Benefit Plan on December 31, 1999 and subsequently enrolled in the DODHBP effective January 1, 2000 are grandfathered under the previous Army Health Benefit Plan PRM eligibility rules which required participation for the five years immediately preceding retirement on an immediate annuity to receive the subsidized PRM benefit and or fifteen years cumulative participation including the five years immediately preceding retirement on an immediate annuity to receive free medical from age 62 to 65. The retirement must occur when the employee is age 62 to 65.

NOTE: Deferred annuitants are not eligible for the PRM benefit. Retirees who do not elect PRM participation at retirement or who cancel their participation may not rejoin the Health Benefit Plan at a later date.

EFFECT OF MEDICARE

Active employees who reach age 65 and become eligible for Medicare may enroll in Medicare Part B. Their Health Benefit Plan benefits will be

coordinated with Medicare. The Health Benefit Plan will pay as primary insurer and Medicare will pay as secondary insurer.

Retirees who become eligible for Medicare at age 65 (or earlier if disabled) must enroll in Medicare Part B. Medicare benefits will be coordinated with the benefits of the Health Benefit Plan. Medicare will pay as the primary insurer and the Health Benefit Plan will pay as the secondary insurer.

For more information on the effect of Medicare or coverage from another insurer, please consult the Summary Plan Description.

MEDICARE PART D

Medicare eligible retirees may enroll in Medicare Part D, the prescription drug program under Medicare. However, Medicare Part D benefits are not coordinated with the Pharmacy benefit under the Health Benefit Plan. Because the Prescription Drug benefit under the Health Benefit Plan is more generous than the benefit under Medicare Part D, retirees are cautioned that enrollment in Medicare Part D will require an additional monthly premium to Medicare for a benefit that is already included under the Health Benefit Plan.

COORDINATION OF BENEFITS

Employees often mistakenly believe that enrolling in multiple health insurance plans will result in 100% coverage of their health care. When an employee or retiree has coverage from two insurers, benefits will be coordinated between the two plans. Multiple health insurance will normally not be in your best interest, because the insurers will not both pay for the same services and the benefits paid will not exceed the maximum reimbursement allowed by the more generous insurer. In view of the high cost of health insurance, it is almost never advantageous to enroll in multiple plans.

- For active employees, benefits will be coordinated to ensure that the DODHBP reimbursement takes into account payments made by the other insurer. Under this approach, active employees will not receive a total benefit greater than that provided under the DODHBP.
- For Medicare eligible retirees, benefits will be coordinated to ensure that the DODHBP reimbursement takes into account payments

made by Medicare as the primary insurer. The DODHBP does not act as a Medicare Supplement, and it does not pay the difference between the Medicare allowable and what Medicare reimburses.

For additional information on coordination of benefits, please consult the Summary Plan Description.

SURVIVOR BENEFITS

Surviving dependents of deceased employees may continue participation in the Health Benefit Plan under the following circumstances, provided they were covered dependents under the plan for at least 90 days and were covered dependents on the day of the employee's death. The first four months of continued medical coverage will be paid for by the employer, after that these are the TCC and retiree medical rules:

- Surviving dependents of employees who are not PRM eligible will receive four months of employer paid TCC coverage and an additional 32 months of TCC coverage at their expense. The surviving dependent must pay the full premium plus a 2% admin fee for the additional 32 months of TCC.
- Surviving dependents of employees who were PRM eligible at the time of death may continue Health Benefit Plan coverage at the PRM employee/employer premium share split (30/70). Coverage for surviving spouses will continue for life or until cancelled by the surviving spouse. Coverage for non-spouse benefits may continue until the dependent becomes ineligible due to age or full time employment.

A WORD ABOUT YOUR PRIVACY

Your privacy is protected under the HIPAA Privacy Act, which prevents disclosure of information concerning your health, medical care, or even your participation in the Health Benefit Plan. Under this legislation, all Human Resource and Benefits personnel receive training on protecting your privacy and implementing appropriate administrative, technical and physical safeguards for protected health information (PHI). Your PHI may not be released to anyone without your written consent. Should you or your designated representative call your personnel office or the Army NAF Employee Benefits Office for assistance on Health Benefit Plan matters, you may be requested to execute a release form prior to

obtaining the assistance you desire. Please understand that this is a statutory requirement intended to protect your privacy.

YOUR DOD HEALTH BENEFIT PLAN

Your DOD Health Benefit Plan is an important and valuable benefit provided by your employer. Health care costs are continuing to increase annually, and an uninsured illness could cause severe financial hardship for you and your family. The services of the Department of Defense, the Army NAF Employee Benefits Office, and your employer have developed the very best health benefit plan possible, providing generous benefits at a reasonable cost to you and your family. Additionally, it is a benefit that you can continue to receive during your retirement years, when your health care and your financial security are most important.

We hope that this booklet is helpful to you in managing this valuable benefit. Should you need additional information, please consult the Medical and Dental Section of the NAF Benefits web site, www.nafbenefits.com, visit your servicing civilian personnel office or call Aetna Member Services or the NAF Benefits Office.

WHERE TO GET INFORMATION AND ASSISTANCE

Aetna

Toll free numbers

Aetna Member Services 1-800-367-6276

From overseas call AT&T Direct Access Code and then 800-367-6276

US Army NAF Employee Benefits Office

P.O. Box 107

Arlington, VA 22210-0107

1-877-384-2340 or 703-681-7262 or DSN 761-7262

NAF Benefits web site, www.nafbenefits.com

To access Aetna links to

Aetna DocFind and Aetna Navigator

Go to the Medical and Dental Section

