Your Health Benefits Program

AETNA INTERNATIONAL TRADITIONAL CHOICE® MEDICAL PLAN

Summary Plan Description

The Department of Defense
Nonappropriated Fund
Health Benefits Program

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Welcome

Your health and wellbeing are important. That's why the Department of Defense Nonappropriated Fund (DoD NAF) employers offer you a flexible benefits package that encourages you to be healthy and helps you pay for the care needed to treat an illness or injury. This book provides important information about the Aetna International Traditional Choice® Medical Plan (the Plan) that is part of the DoD NAF Health Benefits Program (HBP).

OCONUS Benefits

The Plan described in this book is for DoD NAF employees and their covered dependents who are located outside the 50 states (OCONUS).

Understanding the Terms

Key words and phrases that appear in the text are defined in the Glossary.

Keep in Mind

- Unless otherwise noted at the beginning of a chapter, "you" or "your" refers to an employee, retired employee, spouse, domestic partner or dependent child covered by the Plan. Refer to Who Is Eligible for more information about eligible dependents.
- As used in this book, the term "the 50 states" means the 48 contiguous states, Alaska, Hawaii, and the District of Columbia.

Amendment and Termination of the Plan

The DoD NAF employers reserve the right, at their discretion, to amend, change, or terminate any of their benefit plans, programs, practices, or policies, as the DoD NAF employers require. Nothing contained in this book shall be construed as creating an express or implied obligation on the part of the DoD NAF employers to maintain such benefit plans, programs, practices, or policies.

Plan Administration

The DoD NAF employers are the plan sponsor and official administrator of the Plan (the "Plan Administrator"). The Plan Administrator may, in its discretion, delegate to any other individual or entity the authority to perform for and on behalf of the Plan Administrator one or more of its duties and/or responsibilities under the Plan.

The Plan Administrator (or its delegate) has full discretionary authority to grant or deny benefits under the Plan, including (but not limited to):

- The discretionary authority to interpret and construe the Plan in regard to all questions of eligibility;
- The status and rights of any participant or covered dependent under the Plan; and
- The manner, time and amount of payment of any benefits under the Plan.

The Plan Administrator (or its delegate) has the authority to require participants and/or covered dependents to furnish it with such information as it deems necessary for the proper administration of the Plan. The Plan Administrator also may adopt such rules and procedures as it deems desirable for the administration of the Plan.

All actions, interpretations, and decisions of the Plan Administrator (and its delegates) are conclusive and binding on all persons, and will be given the maximum possible deference permitted by law.

Eligibility and Enrollment

This chapter describes who is eligible for coverage, how to enroll for coverage, and when coverage goes into effect.

Note: As used in this chapter, "you" or "your" refers to an employee or retired employee covered by the Plan.

Who Is Eligible

Eligibility for the Plan is subject to change at any time. Contact your Human Resources Office (HRO) if you need more information about Plan eligibility.

Active Employees

You are eligible for the Plan if you are a regular full-time or part-time civilian employee who:

- Is scheduled to work at least 20 hours per week;
- Employed on the U.S. payroll;
- Has a Social Security number or individual tax identification number; and
- Is subject to U.S. income tax, and not subject to a Status of Forces Agreement (SOFA) provision that precludes eligibility.

Retired Employees

You may be eligible to continue participation in the Plan after you retire. To be eligible for post-retirement coverage, you must:

- Be participating in the Plan on the day before you retire;
- Retire on an immediate annuity; and
- Have 15 years of creditable participation in the DoD Nonappropriated Fund (NAF) Health Benefits Program.

Your Plan option choices are affected by your or your dependent's eligibility for Medicare. Refer to Coordination With Medicare for more information.

TRICARE-for-Life

A retiree (annuitant) or the eligible surviving spouse of a retiree (surviving annuitant) who is eligible for both Medicare and TRICARE-for-Life may suspend enrollment in the DoD NAF Health Benefits Program and enroll instead in TRICARE-for-Life.

> *Keep in Mind*
>
> A retiree who is enrolled in TRICARE-for-Life and eligible for Medicare may immediately return to the DoD NAF HBP if there is an involuntary loss of TRICARE-for-Life coverage.

Dependents

You may enroll your eligible dependents. Your eligible dependents are:

- Your spouse (including a common-law husband or wife in a state that recognizes common-law marriages) or your domestic partner.

  Your domestic partner is your same-sex spouse, same-sex civil union partner, or any other same-sex individual where ***all*** of the following requirements are met:

  - Both you and your partner are at least 18 years old and mentally competent to consent to contract;
  - You and your partner are each other's sole domestic partner and intend to remain so indefinitely;
  - You and your partner maintain a common residence and intend to continue to do so (or would maintain a common residence but for an assignment abroad or other employment-related, financial, or similar obstacle);
  - You and your partner share responsibility for a significant measure of each other's financial obligations;
  - You and your partner are not related in a way that, if you were of opposite sex, would prevent you from being married to each other under the law of the U.S. jurisdiction in which you reside;
  - Neither you nor your partner is married or joined in a civil union to anyone else;
  - Neither you nor your partner is the domestic partner of anyone else; and
  - You and your partner are willing to disclose any dissolution or material change in the status of the domestic partnership.

  ### *Does My Domestic Partner Have to Qualify as My Dependent for Income Tax Purposes?*

  No, your domestic partner does not have to qualify as your dependent under U.S. tax code to be eligible for dependent coverage under the DoD NAF HBP.

- Your children to age 26. Your eligible children are:
  - Your children or the children of your domestic partner by birth or adoption;
  - Children placed with you, your spouse, or your domestic partner for adoption (this means that you, your spouse, or your domestic partner has taken on the legal obligation for total or partial support of children whom you, your spouse, or your domestic partner plans to adopt);
  - Your stepchildren;
  - Your foster children or the foster children of your domestic partner;
  - Children you or your domestic partner support under a qualified medical child support order (QMCSO); see Qualified Medical Child Support Orders (below) for details; and
  - Any other child who lives with you and is dependent on you for support. You must provide proof of dependency (for example, copies of income tax forms, a court order, or a custody agreement).
- Your child of any age who is handicapped, provided that the handicap began before the child reached the Plan's age limit for coverage. See Continued Coverage for a Handicapped Child for more information.

What If My Spouse/Domestic Partner and I Both Work for a NAF Employer?

No one may be covered both as an employee and as a dependent, and no family member may be covered by more than one employee. If you and your spouse/domestic partner are both eligible employees, you have these options:

- One of you may enroll as an employee and cover the other as a dependent; or
- You may each enroll as an employee.

Only one of you may enroll your children as dependents.

Qualified Medical Child Support Orders

A qualified medical child support order (QMCSO) is a court order that requires a parent to provide health care benefits to one or more children. Coverage is not optional. Your employer must enroll the child upon receipt of a QMCSO, even if you do not request the enrollment.

A child covered by a QMCSO will be covered by the Plan if:

- You and the child meet the Plan's eligibility requirements; and
- You enroll your child as of the date of the QMCSO.

The coverage is mandated by the terms of the QMCSO. If you are eligible for coverage, but not enrolled in the Plan, your employer will enroll you and your dependent(s) for family coverage as of the date on the court order.

If you are the non-custodial parent, the custodial parent may submit health claims for the child. Aetna will pay benefits for such claims to the custodial parent.

How To Enroll

Participation in the Plan is not automatic. You must enroll yourself and your dependents in order to have coverage. You and your dependents can enroll:

- Within 31 days of the date you become eligible for coverage;
- During an open enrollment period (active employees only); or
- Within 31 days of certain life events.

You may enroll electronically (if your employer has health benefits electronic capability) or by using an enrollment form (included in your enrollment packet). Either form of enrollment will allow your employer to deduct contributions from your pay to cover your share of the cost of the plan option you elect.

Your Benefit Choices

When choosing coverage, keep these rules in mind:

- If you enroll in medical and dental, you must elect the same level of coverage for medical and dental — employee only, or employee plus family.
- You may enroll in the PPO Dental Plan if you are enrolled in an employer-sponsored medical plan (the Aetna Open Choice PPO Plan, Aetna Traditional Choice Indemnity Plan, Aetna International Traditional Choice Plan, or an HMO without dental). If you are not enrolled in medical coverage, you may choose to enroll in the Stand Alone Dental Plan for dental-only benefits.

Newly Eligible Employees

When you become eligible for coverage (as a new employee or an employee whose employment status has changed, making you eligible for coverage), you must enroll yourself and your dependents within 31 days of the date you become eligible.

- **If you enroll within this 31-day period**, your coverage will be effective as described in When Coverage Begins.
- **If you do not enroll within this 31-day period**, you will not be eligible to enroll for coverage until the next open enrollment period, unless you have a HIPAA qualifying life event (see HIPAA Special Enrollment Rights).

Open Enrollment

Active Employees

During the biennial (every two years) open enrollment period, you have a chance to review your benefit needs and make certain coverage changes. If you are an eligible employee, you may:

- Enroll in this Plan if you are not participating in the DoD NAF Health Benefits Program.
- Opt out of coverage.
- Enroll in the dental plan associated with your medical plan option.
- Change to family coverage if you are enrolled in self-only coverage.

Exceptions

If your hours are reduced because troop deployment has reduced NAF business operations, and you subsequently drop your enrollment in the Plan, you may re-enroll outside of the open enrollment period if you meet both of the following conditions:

- Your employer increases your hours and you otherwise meet Plan eligibility requirements; and
- You re-enroll within 31 days of the increase in hours.

Coverage will be effective no earlier than the date of the Business Based Action (BBA) that increased your hours.

Retired Employees

Retirees are not eligible to enroll during open enrollment periods.

Annual Plan Selection Period

The DoD NAF employers hold an annual plan selection period. During the annual plan selection period, eligible employees who are already enrolled in the DoD NAF HBP may switch medical plans You must be enrolled in the DoD NAF HBP to be eligible to select a different plan.

- While you are outside the 50 states, the Aetna International Traditional Choice Medical Plan is the only DoD NAF HBP option available to you. If you are not already participating, you may not enroll in the DoD NAF HBP until the next open enrollment period.
- When you are no longer permanently residing outside the 50 states, you may switch medical plans during the plan selection period. Your DoD NAF employer can give you information about the plans available to you as a CONUS employee.

Keep in Mind

- If you are not already enrolled in the DoD NAF HBP, you may ***not*** enroll during the annual plan selection period.
- If you have self-only coverage, you cannot enroll dependents during the annual plan selection period.
- If you have medical-only coverage, you cannot enroll in the dental plan associated with your medical plan option during the annual plan selection period.

Retired Employees

Retirees are not eligible to enroll during open enrollment periods. The Plan does, however, allow retired employees to make the following changes:

- A retiree who is enrolled in TRICARE-for-Life and eligible for Medicare may immediately return to the DoD NAF HBP if there is an involuntary loss of TRICARE-for-Life coverage.
- A retiree who is enrolled in the DoD NAF HBP and not eligible for Medicare may switch coverage during annual plan selection to another DoD NAF sponsored group plan (HMO) in the geographic area, as long as he or she has not yet reached age 65.

Status Changes

Once enrolled, you may make changes only:

- During the annual plan selection period or an open enrollment period (active employees only); or
- When you qualify for a HIPAA special enrollment period.

HIPAA Special Enrollment Rights

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) allows you to make changes to your coverage when:

- You lose creditable coverage* under another group plan, or
- You have a qualifying life event such as marriage, birth, or adoption.

* Creditable coverage is prior medical coverage as defined in the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Such coverage can be group or individual coverage. Examples include Medicare, Medicaid, military-sponsored health care, and the Federal Employees' Health Benefits Program (FEHBP).

You must request any change within 31 days after the loss of the other coverage or the qualifying life event. The change in coverage you request must be consistent with, and due to, the event.

Special Enrollment Rights for Your Domestic Partner

The DoD NAF HBP gives your domestic partner the same special enrollment rights as those given to a spouse under HIPAA.

The following are examples of HIPAA qualifying life events and the enrollment changes you can make as a result:

Qualifying Life Event	Enrollment Changes Allowed
You get married.	Enroll yourself, your spouse, and your spouse's dependent children Drop coverage for yourself
You enter into a domestic partnership.	Enroll your domestic partner and the children of your domestic partner
You, your spouse, or your domestic partner has a child by birth, adoption, or placement for adoption. You add a stepchild or foster child to your family.	Enroll the child (if you are already enrolled) Enroll yourself, your spouse/domestic partner, and child(ren)
You get divorced, your marriage is annulled, or your domestic partnership ends.	Drop coverage for your former spouse or domestic partner and any children who are no longer eligible Add coverage for yourself (if you were previously covered by your former spouse's or domestic partner's plan)
A covered dependent dies.	Cancel coverage for your deceased dependent Add coverage for your eligible children if your spouse/domestic partner dies, and the children were previously covered by your spouse's/domestic partner's plan
Your covered child reaches the Plan's age limit for coverage.	Drop coverage for your child
Your spouse's/domestic partner's employment changes. As a result, you and your dependents are eligible for coverage under a medical plan offered by your spouse's/domestic partner's employer.	Drop coverage for yourself and any dependents who enroll in the other plan
Your spouse's/domestic partner's employment changes. As a result, health care coverage under your spouse's/domestic partner's plan is lost.	Add coverage for yourself and any eligible dependent who lost the other coverage

This chart does not list all possible qualifying events. If you have a question, contact your Human Resources Office (HRO).

When Coverage Begins

When Plan coverage goes into effect depends on when you and your dependents enroll or change coverage.

Newly Eligible Employees

For people who enroll when they first become eligible, coverage begins on the later of:

- The date you become eligible for coverage; or
- The date you return your signed enrollment form to your Human Resources Manager or the date your enrollment is processed electronically.

Open Enrollment

For people enrolling or making changes during an open enrollment period, coverage begins on the following January 1.

Status Changes

A status change due to birth, adoption, or placement for adoption is effective on the date of the birth, adoption, or placement for adoption, as long as you request the change within 31 days, as described in HIPAA Special Enrollment Rights.

For people enrolling or changing coverage because of any other qualifying life event, coverage is effective on the later of:

- The date of the qualifying life event; or
- The date you return your signed form to your Human Resources Manager or the date your request for change is processed electronically.

Qualified Medical Child Support Order

Coverage is effective on the date of the court order.

How You Pay for Coverage

Active Employees

You share the cost of coverage under the Plan through payroll contributions. Your contribution may be deducted from your pay on a before-tax basis.

Retired Employees

Depending on your employer's policies, you pay your share of the cost of Plan coverage either as an annuity deduction or when you receive a monthly billing statement.

Tax Implications of Domestic Partner Coverage

Tax treatment of the cost of health coverage for your domestic partner follows IRS guidelines.

> *Consult Your Tax Advisor*
>
> Before enrolling your domestic partner in the Plan, check with your tax advisor to learn how the coverage will affect your personal income and tax situation.

Your Medical ID Card

You will receive an ID card when you enroll in the Plan. You are encouraged to carry your ID card with you at all times. Present the card to medical providers before receiving services. Be sure to present the card when purchasing prescription drugs in the 50 states

If your card is lost or stolen, please notify Aetna immediately. To print a temporary card, log on to Aetna Navigator® at **www.aetnainternational.com**.

Your Medical Plan at a Glance

The Plan pays benefits for covered expenses. You must be covered by the Plan on the date when you incur a covered medical expense. The Plan does not pay benefits for expenses incurred before your coverage starts or after it ends.

You may receive care from any licensed physician, hospital, or other health care provider.

Summary of Benefits

Understanding the terms listed below will help you make the most of your benefits.

- The Plan pays benefits only for care that is medically ***necessary***, as determined by Aetna.
- The Plan covers only expenses related to ***non-occupational injury*** and ***non-occupational disease***.
- A ***copay*** (or copayment) is a fee that you must pay at the time you fill a prescription. Prescription drug copays do not apply toward your deductible.
- The ***deductible*** is the part of your covered expenses you pay before the Plan starts to pay benefits each year. The deductible does not apply to all expenses. It is waived for:
  - Preventive care;
  - Second surgical opinions;
  - Pre-operative testing done within seven days of a scheduled surgery; and
  - Hospice care.

  There are two types of calendar year deductible:
  - *Individual*: The individual deductible applies separately to each covered person in the family. When a person's deductible expenses reach the individual deductible, the person's deductible is met. The Plan then starts to pay benefits for that person at the appropriate coinsurance percentage.
  - *Family*: The family deductible applies to the family as a group. When the combined deductible expenses of all covered family members reach the family deductible, the family deductible is met. The Plan then begins to pay benefits for all covered family members.

  Prescription drug copays and amounts above the reasonable and customary charge do not count toward your calendar year deductible.
- Your ***coinsurance*** is the percentage of your covered expenses that you pay after you have satisfied the Plan's calendar year deductible.
- The Plan puts a limit on the amount you pay for covered expenses out of your own pocket each year, called the ***out-of-pocket maximum***.
  - Once a person reaches the individual out-of-pocket maximum, the Plan pays 100% of that person's covered medical and prescription drug expenses for the rest of the calendar year.
  - When a family's combined out-of-pocket expenses satisfy the family out-of-pocket maximum, the Plan pays 100% of the family's covered medical and prescription drug charges for the rest of the calendar year.

Certain expenses do ***not*** apply toward the out-of-pocket maximum:

- Expenses over the reasonable and customary charge;
- Expenses, services and supplies associated with bariatric surgery to treat morbid obesity;
- Prescription eyewear expenses;
- Penalties, including any additional out-of-pocket expenses you pay because you did not obtain the necessary precertification for a service; and
- Charges for services and supplies that are not covered by the Plan.

After you reach the individual and/or family out-of-pocket maximum for a calendar year, you are still responsible for the expenses outlined above.

- The Plan pays benefits only for the part of a covered expense that is reasonable and customary. If your provider charges more than the ***reasonable and customary charge***, you will be responsible for any expenses incurred that are above the reasonable and customary charge.
- ***Precertification*** is a process that determines whether the services being recommended are covered by the Plan. Precertification is required for certain types of care you receive in the 50 states. It is not required for care outside the 50 states. Contact Member Services for more information about precertification if you need medical care while in the 50 states.

The Summary of Benefits charts summarize the benefits available to you.

Keep in Mind

The Plan covers preventive care at 100%, with no deductible. You don't have to meet the deductible before the Plan begins to pay benefits for preventive care.

Cost Sharing

Plan Feature	You Pay
Deductible	
Individual	$400 per calendar year
Family of 2	$800 per calendar year
Family of 3 or more	$1,200 per calendar year
Out-of-Pocket Maximum (includes deductible)	
Individual	$3,000 per calendar year
Family of 2	$6,000 per calendar year
Family or 3 or more	$9,000 per calendar year
Lifetime Maximum Benefit	
Per covered person	Unlimited

Health Incentive Credit
By taking steps to improve your health, you can earn credit toward your deductible and or/coinsurance. The chart below outlines the actions that are eligible for a health incentive credit.

Refer to Health Incentive Credits for more information.

Activity	Health Incentive Credits Earned
Covered Adults	
Complete Health Assessment	$50 each – 1 per year
Have a Preventive Care Exam	$50 each – 1 per year
Complete an Online Wellness Program	$50 each – 1 per year
Respond to items on Member Health Engagement Plan “To-Do” List	$50 each – 1 per year
Covered Dependents under 18	
Have a Preventive Care Exam	$100 each – 1 per year
Incentive Yearly Maximum	
Individual	$150 maximum credit
Family of 2	$300 maximum credit
Family or 3 or more	$450 maximum credit

Covered Services

The Traditional Choice Plan allows you to receive care from any licensed health care provider.

Covered Services	Benefit Level (based on reasonable and customary charge)
Preventive Care*[1]	
Routine Physical Exam (for employee and covered dependents age 7 and above) • 1 exam per calendar year	The Plan pays 100% No deductible
Well-Child Visits • first 12 months of life: 7 exams • age 1: 3 exams • age 2: 3 exams • ages 3-7: 1 exam per calendar year	The Plan pays 100% No deductible
Screening and Counseling	
• obesity — up to age 22: unlimited visits — age 22 and over: up to 26 visits per calendar year (healthy diet counseling limited to 10 visits)	The Plan pays 100% No deductible
• use of tobacco products: up to 8 counseling sessions per calendar year	The Plan pays 100% No deductible
• misuse of alcohol or drugs: up to 5 visits per calendar year	The Plan pays 100% No deductible
• women's health screenings and counseling	The Plan pays 100% No deductible
Routine Ob/Gyn Exam (includes 1 Pap smear and related lab fees) • 1 exam per calendar year	The Plan pays 100% No deductible
Routine Mammogram • age 35 and over: 1 mammogram per calendar year	The Plan pays 100% No deductible
Routine Prostate Screening • 1 prostate specific antigen test (PSA) and digital rectal exam (DRE) per calendar year for men age 40 and over	The Plan pays 100% No deductible

*[1] The Plan's coverage of preventive care follows guidelines that are subject to periodic evaluation and change. You can learn more about preventive care coverage on Aetna's website at **www.aetna.com** or by calling Aetna Member Services at **1-800-367-6276**.

Covered Services	Benefit Level (based on reasonable and customary charge)
Preventive Care (cont'd)	
Routine Colorectal Cancer Screening (for those age 50 and over who are at average risk) • fecal occult blood stool test: 1 per calendar year; and • colonoscopy: 1 every 10 years; or • sigmoidoscopy: 1 every 5 years; or • double contrast barium enema: 1 every 5 years	The Plan pays 100% No deductible
Vision and Hearing Exams	
Routine Vision Exams • 1 exam per calendar year	The Plan pays 100% No deductible
Routine Hearing Exams • 1 exam per calendar year	The Plan pays 100% No deductible

Covered Services	Benefit Level (based on reasonable and customary charge)
Office Visits	
Physician Office Visits	You pay deductible, then the Plan pays 80%
Walk-In Clinic	You pay deductible, then the Plan pays 80%
Allergy Testing and Treatment	You pay deductible, then the Plan pays 80%
Spinal Manipulation Treatment • up to 20 visits per calendar year	You pay deductible, then the Plan pays 80%
Outpatient Diagnostic Testing	
Diagnostic X-Ray and Lab Tests	You pay deductible, then the Plan pays 80%
MRI, PET Scan, and CAT Scan (coverage for complex imaging includes magnetic resonance imaging (MRI), positron emission tomography (PET) scan, and computerized axial tomography (CAT) scan)	You pay deductible, then the Plan pays 80%
Precertification (requirement waived for care you receive outside the 50 states) Precertification is required for confinements in a hospital or treatment facility	
Penalty for Failure To Precertify	The Plan does not cover the first $500 of expenses if you do not get the required precertification of services
Hospital Care Precertification is required for inpatient care (requirement waived for care you receive outside the 50 states).	
Inpatient Care (room and board are covered up to the hospital's semi-private room rate)	You pay deductible, then the Plan pays 80%
Outpatient Care	You pay deductible, then the Plan pays 80%
Urgent and Emergency Care	
Urgent Care Facility	
• urgent care	You pay deductible, then the Plan pays 80%
• non-urgent care	Not covered
Hospital Emergency Room	
• in an emergency	You pay deductible, then the Plan pays 80%
• non-emergency use of the emergency room	You pay deductible, then the Plan pays 50%
Ambulance	You pay deductible, then the Plan pays 80%

Covered Services	Benefit Level (based on reasonable and customary charge)
Surgery and Anesthesia	
Second Surgical Opinion	The Plan pays 100% No deductible
Pre-Operative Testing	You pay deductible, then the Plan pays 80% Deductible waived if testing done within 7 days of scheduled surgery
Inpatient Surgery (physician's services)	You pay deductible, then the Plan pays 80%
Outpatient Surgery	
• physician's office	The Plan pays 100% of the first $1,000 per calendar year, then you pay deductible and the Plan pays 80%
• outpatient facility	You pay deductible, then the Plan pays 80%
Bariatric Surgery to Treat Morbid Obesity	You pay deductible, then the Plan pays 50%
Anesthesia	You pay deductible, then the Plan pays 80%
Maternity Care	
Routine Physician Services*[2]	
• initial visit to confirm pregnancy	You pay deductible, then the Plan pays 80%
• routine prenatal office visits	The Plan pays 100% No deductible
• delivery and postnatal care	You pay deductible, then the Plan pays 80%
Delivery (hospital inpatient services)	You pay deductible, then the Plan pays 80%
Breast Feeding Support and Supplies	
• lactation counseling	
- visits 1-6 in a 12-month period	The Plan pays 100% No deductible
- additional visits	You pay deductible, then the Plan pays 80%
• breast pumps and supplies - 1 manual or electric breast pump per 36-month period	The Plan pays 100% No deductible

*[2] The benefits shown here are for routine maternity care and services provided by your Ob/Gyn, including routine prenatal care, delivery services and postnatal care. Additional services such as laboratory tests and care that is required due to complications of pregnancy are not considered routine maternity care. Call Member Services at the number shown on your ID card if you have questions about coverage for care during your pregnancy.

Covered Services	Benefit Level (based on reasonable and customary charge)
Alternatives to Inpatient Hospital Care	
Skilled Nursing Facility Care • up to a maximum of 90 days per calendar year	You pay deductible, then the Plan pays 80%
Home Health Care • up to 90 visits per calendar year	You pay deductible, then the Plan pays 80%
Private Duty Nursing • up to 70 8-hour shifts per calendar year	You pay deductible, then the Plan pays 80%
Hospice Care	The Plan pays 100% No deductible
Family Planning	
Voluntary Sterilization (men)	You pay deductible, then the Plan pays 80%
Voluntary Sterilization (women)	The Plan pays 100% No deductible
Contraceptive Counseling	
• first 2 visits in a 12-month period	The Plan pays 100% No deductible
• additional visits	You pay deductible, then the Plan pays 80%
Contraceptives devices and injectables provided and billed by your physician *(includes insertion/administration)*	
• generic*3	The Plan pays 100% No deductible
• brand-name	You pay deductible, then the Plan pays 80%
Infertility Services	
• diagnosis and treatment of the underlying cause of infertility	
– physician services	You pay deductible, then the Plan pays 80%
– outpatient facility	You pay deductible, then the Plan pays 80%
• infertility treatment: ovulation induction and artificial insemination (up to 6 separate attempts per lifetime)	
– physician services	You pay deductible, then the Plan pays 80%
– outpatient facility	You pay deductible, then the Plan pays 80%

*3 Includes contraceptive implants and devices with no generic equivalent

Covered Services	Benefit Level (based on reasonable and customary charge)
Other Covered Expenses	
Acupuncture	You pay deductible, then the Plan pays 80%
Durable Medical Equipment	You pay deductible, then the Plan pays 80%
Hearing Aids • up to a maximum of $3,000 every 3 years	The Plan pays 100% No deductible
Outpatient Short-Term Rehabilitation (physical, occupational, speech) • up to a combined maximum of 60 visits per course of treatment for physical, occupational, and speech therapy • applied behavioral analysis (ABA) therapy to treat pervasive developmental disorder (PDD), including autism: up to $2,500 per month for children through age 6	You pay deductible, then the Plan pays 80%
Prescription Eyewear (lenses, frames, and contacts) • up to $150 per person, per calendar year	The Plan pays 100% No deductible
Pediatric Vision (dependent children up to age 22) (V2020,V2100-2199, V2200-2299, V2300-2399, V2121, V2221, V2321)	The Plan pays 100% No deductible
Behavioral Health Care Precertification is required for confinements in a hospital or treatment facility (requirement waived for care you receive outside the 50 states).	
Mental Health Treatment	
• inpatient	First 60 days per calendar year: you pay deductible, then the Plan pays 80% For the remainder of the calendar year: the Plan pays 60%
• outpatient: up to 45 visits per calendar year	You pay deductible, then the Plan pays 80%
Substance Abuse Treatment	
• inpatient: up to 45 days per calendar year	You pay deductible, then the Plan pays 80%
• outpatient: up to 45 visits per calendar year	You pay deductible, then the Plan pays 80%

Prescription Drug Program

Prescription Drugs	In-Network Pharmacy	Out-of-Network Pharmacy
Up to a 30-Day Supply: Overseas Pharmacy* Prescription drugs obtained from an overseas pharmacy (a pharmacy that is outside the 50 states and U.S territories) are treated as a medical plan expense and subject to the medical plan's deductible and out-of-pocket maximum.		
Tier One: Generic Drug		
• generic contraceptive*[3]	Not applicable	The Plan pays 100% No deductible or copay
• other generic drug	Not applicable	You pay deductible, then the Plan pays 100%
Tier Two: Brand-Name Drug on the Preferred Drug List	Not applicable	You pay medical plan deductible, then the Plan pays 80%
Tier Three: Brand-Name Drug Not on the Preferred Drug List	Not applicable	You pay medical plan deductible, then the Plan pays 80%
31- 90-Day Supply: Mail Order Pharmacy Only (prescriptions must be written by a physician who is licensed to practice in the United States and sent to an APO/FPO mailing address)		
Tier One: Generic Drug		
• generic contraceptive*[3]	The Plan pays 100%	Not covered
• other generic drugs	You pay $20 copay per fill or refill	Not covered
Tier Two: Brand-Name Drug on the Preferred Drug List	You pay $40 copay per fill or refill	Not covered
Tier Three: Brand-Name Drug Not on the Preferred Drug List	You pay 35% of the cost for each fill or refill Minimum: $70 Maximum: $200	Not covered
Up to a 30-Day Supply: Retail and Specialty Pharmacy in the 50 States and U.S. Territories and Mail Order Pharmacy (mail order prescriptions must be written by a physician who is licensed to practice in the United States and sent to an APO/FPO mailing address)		
Tier One: Generic Drug		
• generic contraceptive*[3]	The Plan pays 100%	Not covered
• other generic drugs	You pay $10 copay per fill or refill	Not covered

*[3] Includes contraceptive implants and devices with no generic equivalent

Prescription Drugs	In-Network Pharmacy	Out-of-Network Pharmacy
Up to a 30-Day Supply: Retail and Specialty Pharmacy in the 50 States and U.S. Territories and Mail Order Pharmacy (cont'd)		
Tier Two: Brand-Name Drug on the Preferred Drug List	You pay $20 copay per fill or refill	Not covered
Tier Three: Brand-Name Drug Not on the Preferred Drug List	You pay 35% of the cost for each fill or refill Minimum: $35 Maximum: $100	Not covered
Smoking Cessation Medications • up to a 180-day supply for eligible medications. See the list in Smoking Cessation. • limited to two attempts to stop smoking		
Retail or Mail Order Pharmacy	The Plan pays 100% No copay	Not covered
Overseas Pharmacy	Not applicable	The Plan pays 100% No copay

Coordination With Other Plans

Effect of Another Plan on This Plan's Benefits

If you have coverage under other group plans, this Plan will coordinate the benefits it pays with the benefits paid by the other plans. This process is known as coordination of benefits (COB). The Plan's COB process ensures that total payments from all of your group plans are not greater than what this Plan would pay if it were your only coverage.

For COB purposes, other group plans include any other dental or medical coverage provided by:

- Group health care plans, (whether or not the other plans are insured); and
- Auto insurance (whether or not the coverage is written on a no-fault basis), including individual medical payment coverage.

The first step in the COB process is determining which plan is primary. The primary plan pays benefits first. The secondary plan then calculates its benefits, based on its COB process.

This chart shows which plan pays first:

If . . .	Then . . .
One plan has a COB provision and the other plan does not	The plan without a COB provision determines its benefits and pays first.
One plan covers you as a dependent and the other covers you as an employee or retiree	The plan that covers you as an employee or retiree determines its benefits and pays first.
You are eligible for Medicare and not actively working,	These Medicare Secondary Payer rules apply: • The plan that covers you as a dependent of a working spouse determines its benefits and pays first. • Medicare pays second. • The plan that covers you as a retired employee pays third.
A child's parents are married or living together (whether or not married)	The plan of the parent whose birthday occurs earlier in the calendar year determines its benefits and pays first. If both parents have the same birthday, the plan that has covered the parent the longest determines its benefits and pays first. But if the other plan does not have this "parent birthday" rule, the other plan's COB rule applies.
A child's parents are separated or divorced with joint custody, and a court decree does not assign responsibility for the child's health expenses to either parent or states that both parents are responsible for the child's health coverage	The "birthday rule" described above applies.
A child's parents are separated or divorced, and a court decree assigns responsibility for the child's health expenses to one parent,	The plan covering the child as the assigned parent's dependent determines its benefits and pays first.

If . . .	Then . . .
A child's parents are separated, divorced, or not living together (whether or not they have ever been married) and there is no court decree assigning responsibilities for the child's health expenses to either parent	Benefits are determined and paid in this order: 1. The plan of the custodial parent pays, then 2. The plan of the spouse of the custodial parent pays, then 3. The plan of the non-custodial parent pays, then 4. The plan of the spouse of the non-custodial parent pays.
You have coverage: • As an active employee and also have coverage as a retired or laid-off employee; or • As the dependent of an active employee and also have coverage as the dependent of a retired or laid-off employee	The plan that covers you as an active employee or as the dependent of an active employee determines its benefits and pays first.
You are covered under a federal or state right of continuation law (such as COBRA)	The plan other than the one that covers you under a right of continuation law will determine its benefits and pay first.
The above rules do not establish an order of payment	The plan that has covered you for the longest time will determine its benefits and pay first.

When the other plan pays first:

- Aetna calculates the amount this Plan would pay if it were the only coverage in place, *then subtracts*
- The benefits paid by the other plan(s).

This prevents the sum of your benefits from being more than you would receive from just this Plan.

If your other plan(s) pays benefits in the form of services rather than cash payments, the Plan uses the cash value of those services in the calculation.

> *Keep in Mind*
>
> This Plan's prescription drug expenses are not coordinated with other prescription drug coverage. Reimbursement for a prescription drug expense can be made only from one plan. You cannot be reimbursed for the cost of a prescription drug, in whole or in part, by another plan and this Plan.

TRICARE

For those covered by TRICARE:

- TRICARE is primary for active duty service members who are covered by the Plan.
- TRICARE is secondary for the dependents of active duty family members, retirees, and the dependents of retirees.

Coordination With Medicare

Plan Options for Those Who Are Eligible for Medicare

Your Plan option choices are affected by your or your dependent's eligibility for Medicare:

- When you and all of your covered dependents become eligible for Medicare because of age or disability, you may remain enrolled in the Traditional Choice Plan. Medicare becomes your primary coverage, and the Traditional Choice Plan is your secondary coverage. You are no longer eligible for the Open Choice Plan.
- If you are eligible for Medicare because of age or disability, but at least one of your covered dependents is not eligible for Medicare, you may select either the Open Choice PPO Plan or the Traditional Choice Plan during the annual plan selection period.

Medicare Eligibility

A person is eligible for Medicare (Part A and Part B) if he or she:

- Is eligible for, and covered by, Medicare; or
- Is eligible for, but not covered by, Medicare because he or she:
  - Refused or dropped Medicare coverage; or
  - Did not make a proper request for Medicare coverage.

When you are eligible for Medicare, Aetna must determine whether this Plan or Medicare is the primary plan. All health expenses covered under this Plan will be reduced by any Medicare (Part A and Part B) benefits available for those expenses. This will be done before the health benefits of this Plan are figured.

> *Keep in Mind*
>
> The Plan's benefits are calculated as though you have enrolled in Part B – ***whether or not you've actually enrolled***. This is why it's important to enroll in Part B as soon as you become eligible for it.

When This Plan Is Primary

The DoD NAF HBP is primary, and Medicare is secondary, if a covered person is eligible for Medicare and is:

- An active employee, regardless of age.
- A totally disabled employee who is:
  - Not terminated or retired; or
  - Not receiving Social Security retirement or Social Security disability benefits.
- A Medicare-eligible dependent spouse of:
  - An active employee; or
  - A totally disabled employee who is not terminated or retired.
- Any other person for whom this Plan's benefits are payable to comply with federal law.

When this Plan is the primary plan, Aetna will not take Medicare benefits into account when figuring the benefits this Plan will pay.

End-Stage Renal Disease

This Plan is primary for the first 30 months after a covered person becomes eligible for Medicare due to end-stage renal disease (ESRD). The Plan will pay its benefits first, before Medicare benefits are available.

Medicare becomes the primary plan beginning with the 31st month of Medicare eligibility due to ESRD.

When Medicare Is Primary

Medicare is the primary plan, and this Plan is secondary, if a covered person is eligible for Medicare and is:

- A retired employee.
- A totally disabled employee who is:
  - Terminated or retired; or
  - Receiving Social Security retirement or Social Security disability benefits.
- A Medicare-eligible dependent of:
  - A retired employee; or
  - A totally disabled employee who is terminated or retired.
- Any other dependent for whom this Plan's benefits are payable to comply with federal law.

How Medicare Affects Your Plan Benefits

When Medicare is your primary plan, as described above, this Plan is secondary and pays benefits based on:

- **If the provider accepts Medicare assignment**: Medicare's approved amount for the service you've received; or
- **If the provider doesn't accept Medicare assignment**: Medicare's balance billing limit.

The Plan's benefit for a covered service is figured by:

- Calculating the allowable expense, depending on whether the provider accepts or does not accept Medicare assignment (see above); *then*
- Subtracting the amount payable by Medicare (even if you haven't signed up for Medicare and therefore haven't received Medicare reimbursement); *then*
- Applying the Plan's deductible and coinsurance to the allowable expense.

If You Reside Outside the U.S. or a U.S. Territory

If you are eligible for Medicare, but are unable to receive Medicare benefits while residing outside the U.S., the Commonwealth of Puerto Rico, the Virgin Islands, Guam or American Samoa, you are entitled to this Plan's benefits without a reduction for Medicare. This provision applies only to medical treatment performed outside the U.S.

You should enroll for Medicare Part B if you reside outside the U.S. or a territory. If you receive medical care in the U.S., this Plan's benefits will be calculated as if you are enrolled in Medicare Part B … whether or not you've actually enrolled.

For dependents who are under age 65, this Plan is the primary plan that will pay benefits first.

Medicare Part D

This Plan's prescription drug expenses are not coordinated with Medicare Part D prescription drug coverage. Reimbursement for a prescription drug expense can be made only from one plan. You cannot be reimbursed for the cost of a prescription drug, in whole or in part, by both Medicare Part D and this Plan.

Subrogation and Right of Recovery

If you receive benefits as the result of an illness or injury caused by another party, the Plan has the right to be reimbursed for those benefits from any settlement or payment you receive from the person who caused the illness or injury. This process is called subrogation and reimbursement.

Definitions

The description of the subrogation and reimbursement process uses three terms that you need to understand:

- "third party" means any party that is, or may be, or is claimed to be responsible for illness or injuries to you. Such illness or injuries are referred to as "third party injuries."
- "responsible party" includes any party responsible for payment of expenses associated with the care or treatment of third party injuries.
- "you" or "your" includes anyone on whose behalf this Plan pays or provides any benefits.

Right of Recovery

When the Plan pays benefits to you for expenses incurred due to third party injuries, then the Plan retains the right to repayment of the full cost of all benefits provided by the Plan on your behalf that are associated with the third party injuries. The Plan's rights of recovery apply to any recoveries made by or on your behalf from the following sources, including but not limited to:

- Payments made by a third party or any insurance company on behalf of the third party;
- Any payments or awards under an uninsured or underinsured motorist coverage policy;
- Any Workers' Compensation or disability award or settlement;

- Medical payments coverage under any:
  - automobile policy;
  - premises or homeowners' medical payments coverage; or
  - premises or homeowners' insurance coverage; and
- Any other payments from a responsible party or another source intended to compensate you for injuries resulting from an accident or alleged negligence.

When You Accept Plan Benefits

By accepting benefits under this Plan, you specifically acknowledge the Plan's right of subrogation. When this Plan pays health care benefits for expenses incurred due to third party injuries, the Plan shall be subrogated to your right of recovery against any party to the extent of the full cost of all benefits provided by this Plan. The Plan may proceed against any party with or without your consent.

By accepting benefits under this Plan, you also specifically acknowledge the Plan's right of reimbursement. This right of reimbursement attaches to any payment received by you or your representative from any party responsible for paying for expenses associated with the care or treatment of third party injuries. By providing any benefit under this Plan, the Plan is granted an assignment of the proceeds of any settlement, judgment, or other payment received by you to the extent of the full cost of all benefits provided by this Plan. The Plan's right of reimbursement is cumulative with and not exclusive of the Plan's subrogation right and the Plan may choose to exercise either or both rights of recovery.

By accepting benefits under this Plan, you or your representatives further agree to:

- Notify the Claim Administrator, Aetna, in writing, within 30 days of the time when notice is given to any party of the intention to investigate or pursue a claim to recover damages or obtain compensation due to third party injuries sustained by you;
- Cooperate with Aetna and its designees and do whatever is necessary to secure the Plan's rights of subrogation and reimbursement under this Plan;
- Give the Plan a first-priority lien on any recovery, settlement, judgment, or other source of compensation that may be had from any party to the extent of the full cost of all benefits associated with third party injuries provided by this Plan (regardless of whether specifically set forth in the recovery, settlement, judgment, or compensation agreement);
- Pay, as the first priority, from any recovery, settlement, judgment, or other source of compensation, any and all amounts due to the Plan as reimbursement for the full cost of all benefits associated with third party injuries paid by this Plan (regardless of whether specifically set forth in the recovery, settlement, judgment, or compensation agreement), unless otherwise agreed to by Aetna in writing;
- Do nothing to prejudice the Plan's rights as set forth above. This includes, but is not limited to, refraining from making any settlement or recovery that specifically attempts to reduce or exclude the full cost of all benefits paid by the Plan; and
- Serve as a constructive trustee for the benefits of this Plan over any settlement or recovery funds received as a result of third party injuries.

The Plan's recovery rights under this provision are first priority rights and the Plan is entitled to reimbursement, even if such reimbursement results in a recovery to you that is insufficient to compensate you in whole or in part for your damages from a third party injury. The Plan may recover the full cost of all benefits paid by this Plan without regard to any claim of fault on your part, whether by comparative negligence or otherwise. No court costs or attorney fees may be deducted from the Plan's recovery, and the Plan and Claim Administrator are not required to pay or contribute to paying court costs or attorney's fees for the attorney hired by you to pursue your claim or lawsuit against any third party without the prior express written consent of the Claim Administrator.

If You Do Not Follow the Process

In the event you or your representative fail to cooperate with the Plan and its Claim Administrator, you shall be responsible for all benefits paid by this Plan in addition to costs and attorney's fees incurred by the Plan and its Claims Administrator in obtaining repayment.

What the Plan Covers

In this chapter, you'll find more detailed information about the services and supplies covered by the Plan. It's important to remember that the Plan covers only services and supplies that are necessary to prevent, diagnose, or treat an illness or injury. If a service or supply is not necessary, it will not be covered, even if it is listed as a covered expense in this book.

The Plan pays benefits for covered expenses only. The benefit level and frequency for each type of covered expense is shown in the Summary of Benefits.

When you have questions about coverage for a specific service or supply, contact Member Services at **1-888-506-2278** (toll free) or **1-813-775-0189** (direct).

Preventive Care

The Plan covers preventive care services. The Summary of Benefits shows how often the Plan will pay benefits for preventive care, and any maximums that apply.

> *If You Have High Risk Factors*
>
> The Plan may cover additional screenings and immunizations for those who are identified as being at a higher risk for certain diseases or conditions such as high cholesterol, tuberculosis, lead poisoning, Hepatitis B, meningitis, and pneumonia. Call Member Services if you need more information.

Routine Physical Exams and Well Child Visits

The Plan covers charges for a routine physical exam or well child visit. Included as part of the exam are:

- X-rays, laboratory services, and other tests given in connection with the exam;
- Immunizations for infectious diseases and the materials needed to administer the immunizations; and
- Testing for tuberculosis.

The exam must be given by a physician or under the direction of a physician.

If an exam is given to diagnose or treat a suspected or identified injury or disease, it is ***not*** considered a routine physical exam.

Routine Ob/Gyn Exams

The Plan covers routine ob/gyn exams, including Pap smears and related laboratory fees.

Routine Cancer Screenings

The Plan covers:

- Routine mammograms for women age 35 and over. The Plan may cover mammograms for a woman under age 35 based on family history and the recommendation of the woman's physician.
- Digital rectal exams (DRE) and prostate specific antigen (PSA) tests for men age 40 and over.

Beginning at age 50, the Plan covers the following tests when recommended by your physician:

- Fecal occult blood stool test; and
- Colonoscopy, sigmoidoscopy, or double contrast barium enema.

Screening and Counseling Services

The Plan covers charges made by your primary care physician for the following in an individual or group setting:

- Obesity: screening and counseling services to help you lose weight if you are obese. Coverage includes medical nutrition therapy and nutritional counseling.
- Use of tobacco products: screening and counseling services to help you stop using tobacco products. Coverage includes visits for preventive counseling and treatment.
- Misuse of alcohol and/or drugs: screening and counseling services to help prevent or reduce the use of alcohol or controlled substances. Coverage includes preventive counseling, risk factor reduction intervention, and a structured assessment.

The Plan's preventive care coverage includes the following services for women:

- Screening and counseling services for:
  - Interpersonal and domestic violence;
  - Sexually transmitted diseases (up to two occurrences per year); and
  - Human Immune Deficiency Virus (HIV).
- High risk Human Papillomavirus (HPV) DNA testing for women age 30 and older.
- Screening for gestational diabetes.

Vision and Hearing Exams

Routine Eye Exams

The Plan covers charges for routine eye exams performed by an ophthalmologist or optometrist.

Routine Hearing Exams

The Plan covers charges for an audiometric hearing exam when the exam is performed by:

- An otolaryngologist or otologist; or
- An audiologist who:
  - Is legally qualified in audiology; or holds a certificate of Clinical Competence in Audiology from the American Speech and Hearing Association; and
  - Performs the exam at the written direction of an otolaryngologist or otologist.

Office Visits

The Plan covers treatment by a doctor in his or her office.

Walk-In Clinics

A walk-in clinic (sometimes called a retail clinic) is a free-standing health care facility. The Plan covers visits to these clinics for non-emergency treatment of an illness or injury, and for administration of certain immunizations.

> *Keep in Mind*
>
> A walk-in clinic is not an urgent care clinic. Refer to Urgent and Emergency Care for information about coverage for urgent care facilities.

Spinal Manipulation

The Plan covers manipulative treatment of a condition caused by (or related to) biomechanical or nerve conduction disorders of the spine. Care must be given by a physician or licensed chiropractor in the provider's office. Treatment of scoliosis, of a fracture, or before or after surgery is not covered as a spinal manipulation benefit.

Outpatient Diagnostic Testing

Diagnostic X-Ray and Laboratory Tests

The Plan covers necessary X-rays, laboratory services, and pathology tests to diagnose an illness or injury.

MRI, PET Scan, and CAT Scan

The Plan covers complex imaging services to diagnose an illness or injury, including:

- Computerized axial tomography (CAT) scans;
- Magnetic resonance imaging (MRI); and
- Positron emission tomography (PET) scans.

Hospital Care

> *Remember*
>
> Hospital inpatient care must be precertified in the 50 states. The precertification requirement is waived for care you receive outside the 50 states. Contact Member Services if you have questions about precertification.

The Plan covers charges made by a hospital for room and board and other hospital services and supplies when you are an inpatient. Room and board charges are covered up to the hospital's semi-private room rate. The Plan covers up to the private room rate only if the private room is appropriate because of an infectious illness or immune system problems.

When You Need Hospital Care Overseas

Choosing a Direct Settlement hospital can help you manage your out-of-pocket expenses. Aetna International provides direct settlement to certain international hospitals and medical facilities. This means that Aetna International directly reimburses the facility for the Plan's share of covered expenses, and you pay your deductible and coinsurance.

You can find an Aetna International direct settlement partner online at **www.aetnainternational.com**.

Urgent and Emergency Care

Urgent Care

The Plan covers the services of an urgent care provider to evaluate and treat an urgent condition. Urgent care providers are physician-staffed facilities offering unscheduled medical services.

Emergency Care

The Plan covers emergency care provided in a hospital emergency room or a free-standing emergency facility. The care must be for an emergency condition.

> *Keep in Mind*
>
> The Plan pays a reduced benefit if you use an emergency facility when you don't need emergency care. Refer to the Summary of Benefits for more information about the penalty that applies. Please limit use of the emergency room to emergencies to avoid paying this penalty.

Ambulance

The Plan covers charges made for a professional ambulance or an ambulance service owned by a hospital for**:**

- Transportation in a medical emergency to the first hospital where treatment is given;
- Transportation in a medical emergency from one hospital to another hospital when the first hospital does not have the required services or facilities for your condition;
- Transportation from hospital to home or to another facility when an ambulance is medically necessary for safe and adequate transport; and
- Transportation while confined in a hospital or skilled nursing facility to receive medically necessary inpatient or outpatient treatment when an ambulance is required for safe and adequate transport.

Surgery and Anesthesia

The Plan covers the charges made by a physician for:

- Performing your surgical procedure;
- Pre-operative and post-operative visits; and
- Consultation with another physician to obtain a second opinion prior to the surgery.

Keep in Mind

- You may need to have multiple surgical procedures done at the same time or during a single operating session. The Plan normally pays a lower percentage of the fees that are charged for the secondary procedure(s).
- The Plan does ***not*** cover any surgery that is not medically necessary, even if performed with another procedure that is necessary.
- The Plan does not cover separate fees for a secondary procedure that is an integral part of the surgery.

Pre-Operative Testing

The Plan covers outpatient testing done by a hospital, surgery center, physician, or licensed diagnostic lab before a covered surgical procedure. The tests must be:

- Related to surgery that will take place in a hospital or surgery center;
- Completed within 7 days before your surgery;
- Covered if you were confined in a hospital; and
- Included in your medical record kept by the hospital or surgery center where the surgery takes place.

The tests are covered only if they are not repeated in or by the hospital or surgery center where the surgery will take place.

Oral Surgery

The Plan covers treatment of accidental injury to natural teeth and oral surgery that is considered medical-in-nature. Oral surgery that is dental-in-nature may be covered by a dental plan offered by the DoD NAF employers. Refer to the separate book describing dental coverage for more information.

Medical or Dental?

Oral surgery that is medical-in-nature is typically covered by a medical plan. It involves:

- Disease of the facial bones
- Trauma to the soft and hard tissue structures of the face and oral cavity
- Correcting facial deformities present at birth or later

Surgery that is dental-in-nature involves the teeth, such as:

- Bone replacement grafts
- Surgical removal of impacted teeth

Tooth surgery is typically covered by a dental plan.

If you aren't sure whether the dental care you need is medical- or dental-in-nature, you can call Member Services at **1-888-506-2278** (toll-free) or **1-813-775-0189** (direct).

The Plan covers:

- Hospital services and supplies.
- Services of a physician or dentist for:
  - Surgery necessary to treat a fracture, dislocation, or wound;
  - Surgery necessary to alter the jaw, jaw joints, or bite relationships by a cutting procedure when appliance therapy alone cannot improve function;
  - Surgery necessary to cut out cysts, tumors, or other diseased tissues;
  - Surgery to cut into gums and tissues of the mouth, as long as this is not done in connection with the removal, replacement, or repair of teeth; and
  - Non-surgical treatment of infections or diseases not related to the teeth.
- Treatment of accidental injury to sound natural teeth or tissues of the mouth. The treatment must occur within the calendar year of the accident, or in the following calendar year. The teeth must have been free from decay or in good repair, and firmly attached to the jaw bone at the time of the injury.
  The Plan's coverage of dentures, bridgework, crowns, and appliances is limited to:
  - The first denture or fixed bridgework to replace teeth lost because of the injury;
  - The first crown (cap) needed to repair each damaged tooth; and
  - An in-mouth appliance used in the first course of orthodontic treatment after the injury.

Except as described above to treat accidental injury, the Plan does ***not*** cover charges for services, treatment, or supplies related to the care, filling, removal, or replacement of teeth, including:

- Dental-in-nature oral surgery expenses;
- In-mouth appliances, crowns, bridgework, dentures, tooth restorations, or any related fitting, repair, restoration or adjustment services, whether or not the purpose of those services or supplies is to relieve pain;
- Removal, repair, replacement, restoration, or repositioning of teeth lost or damaged in the course of biting or chewing; or
- Myofunctional therapy. This is muscle training therapy or training to correct or control harmful habits.

Outpatient Surgery

The Plan covers outpatient surgery in:

- A physician's or dentist's office;
- A surgery center; or
- The outpatient department of a hospital.

The Plan covers the following outpatient surgery expenses:

- Services and supplies provided by the hospital, surgery center, or physician's office on the day of the procedure;
- The operating physician's services for performing the procedure, related pre- and post-operative care, and the administration of anesthesia; and
- Services of another physician for related post-operative care and the administration of anesthesia (other than a local anesthetic).

The Plan does ***not*** cover the services of a physician who renders technical assistance to the operating physician**.**

Reconstructive Surgery

The Plan covers reconstructive and cosmetic surgery if the surgery is needed:

- To repair an accidental injury that happens while you are covered by the Plan. The surgery must be performed in the calendar year of the accident or the following calendar year.
- To correct a severe anatomical defect present at birth (or appearing after birth) if:
  - The defect has caused severe facial disfigurement or significant functional impairment; and
  - The purpose of the surgery is to improve function.
- To improve function when the treatment of an illness has resulted in severe facial disfigurement or significant functional impairment of a body part.
- As part of reconstruction following a mastectomy.

Surgical Treatment of Morbid Obesity

The Plan covers inpatient and/or outpatient charges made by a hospital or a physician for the medically necessary surgical treatment of morbid obesity. The surgery must be approved in advance by Aetna.

Coverage includes one morbid obesity surgical procedure, including related outpatient services, within a two-year period that starts with the date of the first surgical procedure to treat morbid obesity, unless a multistage procedure is planned.

Keep in Mind

- Your 50% coinsurance share does not apply toward your calendar year out-of-pocket maximum.
- The Plan does not cover surgical treatment of obesity when done for cosmetic reasons.

Call Member Services at **1-888-506-2278** (toll free) or **1-813-775-0189** (direct) or refer to Aetna's Clinical Policy Bulletins (CPBs) to learn more about coverage for bariatric (weight loss) surgery. You can find the CPBs at **www.aetna.com**.

Transplants

Aetna offers a wide range of support services to those who need a transplant or other complex medical care. If you need a transplant, you or your physician should contact the International Health Advisory Team (IHAT) at **1-888-506-2278** (toll free) or **1-813-775-0189** (direct). The IHAT will provide the support and help that you and your physician need to make informed decisions about your care.

The Institutes of Excellence™ Network

Through the Institutes of Excellence™ (IOE) network, you have access to a provider network in the U.S. that specializes in transplants. For more information, refer to Resources and Tools.

Transplant Services

A transplant coverage period begins at the point of evaluation for a transplant and ends on the later of:

- 180 days from the date of the transplant; or
- The date you are discharged from a hospital or outpatient facility for the admission or visit(s) related to the transplant.

The Plan covers:

- Evaluation.
- Compatibility testing of prospective organ donors who are immediate family members.
- Charges for activating the donor search process with national registries.
- The direct costs of obtaining the organ. Direct costs include surgery to remove the organ, organ preservation and transportation, and the hospitalization of a live donor, provided that the expenses are not covered by the donor's group or individual health plan.
- Physician or transplant team services for transplant expenses.
- Hospital inpatient and outpatient supplies and services.
- Follow-up care.

As part of the transplant benefit, the Plan does ***not*** cover:

- Services and supplies provided to a donor when the recipient is not covered by this Plan.
- Outpatient drugs, including biomedicals and immunosuppressants, that are not related to an outpatient transplant occurrence.
- Home infusion services after the transplant coverage period ends.
- Harvesting or storage of:
  - Organs without the expectation of an immediate transplant for an existing illness.
  - Bone marrow, tissue, or stem cells without the expectation of a transplant to treat an existing illness within 12 months.
- Cornea or cartilage transplants unless otherwise preauthorized by Aetna.

Anesthesia

The Plan covers the administration of anesthetics and oxygen by a physician (other than the operating physician) or Certified Registered Nurse Anesthetist (CRNA) in connection with a covered procedure.

Acupuncture

The Plan covers acupuncture services given by a physician as a form of anesthesia in connection with a covered surgical procedure.

Maternity Care

The Plan covers prenatal, delivery, and postnatal maternity care. For inpatient care of the mother and newborn child, benefits will be payable for a minimum of:

- 48 hours after a vaginal delivery; and
- 96 hours after a cesarean section.

If you and your attending physician agree to an earlier discharge from the hospital, the Plan will pay for one post-delivery home visit by a health care provider.

As required by the Newborns' and Mothers' Health Protection Act, precertification is not required for the first 48 hours of hospital confinement after a vaginal delivery or 96 hours after a cesarean delivery. Any days of confinement that exceed these time frames must be precertified. You, your doctor, or other health care provider can request precertification by calling **1-888-506-2278** (toll-free) or **1-813-775-0189** (direct).

Refer to Women's Health Provisions for more information about the Newborns' and Mothers' Health Protection Act.

Birthing Center

The Plan covers prenatal, delivery, and postnatal maternity care provided by a birthing center. Postnatal care must be given within 48 hours after a vaginal delivery or 96 hours after a cesarean section.

Breast Feeding Support, Counseling and Supplies

The Plan covers:

- Breast feeding assistance, training, and counseling services by a certified lactation support provider in a group or individual setting.
- Purchase of a standard (not hospital-grade) electric breast pump, if you have not purchased either a standard electric or a manual pump within the past three years. The pump must be purchased within 60 days from the date of your child's birth.
- Purchase of a manual breast pump, if you have not purchased either a standard electric or a manual pump within the past three years. The pump must be purchased within 12 months from the date of your child's birth.
- Purchase of the accessories needed to operate the breast pump.

If you use a breast pump from a prior pregnancy, the Plan covers the purchase of a new set of breast pump supplies within the first 12 months following the birth of your child.

Alternatives to Hospital Inpatient Care

Skilled Nursing Facility

The Plan covers charges made by a skilled nursing facility for room and board and other services and supplies when you are an inpatient. Room and board charges are covered up to the facility's semi-private room rate. The Plan covers up to the private room rate only if the private room is appropriate because of an infectious illness or immune system problems.

> *Keep in Mind*
>
> Skilled nursing facility coverage does not include treatment of drug addiction, alcoholism, senility, mental retardation, or any other mental illness.

Home Health Care

The Plan covers home health care services when ordered by a physician and given to you under a home health care plan while you are homebound. Coverage includes:

- Part-time nursing care that requires the medical training of, and is given by, a registered nurse (RN) or by a licensed practical nurse (LPN) if an RN is not available. The services must be provided during intermittent visits of four hours or less.
- Part-time home health aide services, when provided in conjunction with, and in direct support of, care by an RN or LPN. The services must be provided during intermittent visits of four hours or less.
- Medical social services by a qualified social worker, when provided in conjunction with, and in direct support of, care by an RN or LPN.
- Medical supplies, prescription drugs, and lab services given by (or for) a home health care agency. Coverage is limited to what would have been covered if you had remained in a hospital.

> *Keep in Mind*
>
> Physical, speech, and occupational therapy given as part of a home health care plan are subject to the maximum for short-term rehabilitation shown in the Summary of Benefits.

Hospice Care

The Plan covers inpatient and outpatient hospice care for a person who is terminally ill.

- Coverage includes room and board and other services and supplies when you are an inpatient in a hospice facility, hospital, or skilled nursing facility. Room and board charges are covered up to the facility's semi-private room rate.
- Charges made by a hospice care agency for:
  - Part-time or intermittent nursing care by an RN or LPN for up to eight hours in a day.
  - Part-time or intermittent home health aide services for up to eight hours in a day. These services consist mainly of caring for the patient.
  - Medical social services under a physician's direction.
  - Psychological and dietary counseling.
  - Consultation or case management services provided by a physician.

  - Physical and occupational therapy.
  - Medical supplies.
- Charges made by providers that are not employed by the hospice care agency, as long as the agency retains responsibility for your care, including:
- A physician for consultation or case management.
  - A physical or occupational therapist.
  - A home health care agency for part-time or intermittent home health aide services for up to eight hours in any one day.

Private Duty Nursing

The Plan covers charges made by a Registered Nurse (RN) or Licensed Practical Nurse (LPN) for private duty nursing if a person's condition requires skilled nursing services and visiting nursing care is not enough.

The Plan pays benefits up to the maximum shown in the Summary of Benefits. A "shift" consists of up to 8 hours of skilled nursing care.

The Plan's coverage of private duty nursing care includes skilled observation following:

- A change in your medication;
- Treatment of an emergency or urgent medical condition, or the onset of symptoms that indicate the need for emergency treatment;
- Surgery; or
- A hospital stay.

Coverage for skilled observation is limited to one four-hour period per day, for up to 10 days.

The private duty nursing benefit does ***not*** cover:

- Any care that does not require the education, training, and technical skills of a RN or LPN. This would include transportation, meal preparation, charting of vital signs, and companionship activities.
- Any private duty nursing care provided on an inpatient basis.
- Care provided to help a person in the activities of daily life, such as bathing, feeding, personal grooming, dressing, getting in and out of bed or a chair, or toileting.
- Any service provided only to administer oral medicines, except where the law requires medication to be administered by an RN or LPN.

Family Planning

Voluntary Sterilization

The Plan covers charges made by a physician or hospital for a vasectomy or tubal ligation. The Plan does ***not*** cover the reversal of a sterilization procedure.

Contraception Services

The Plan covers the following contraceptive services and supplies when obtained from, and billed by, your physician:

- Contraceptive counseling;
- Contraceptive devices, when obtained from a physician who provides insertion and removal of the drugs or device;
- Office visit for the injection of injectable contraceptives; and
- Related outpatient services such as consultations, exams, and procedures.

Other contraceptives may be covered as part of the prescription drug program. Refer to the section of this book describing the Prescription Drug Program for more information.

Infertility Services

The Plan covers certain infertility services when ***all*** the following tests are met:

- The woman has a condition that is a demonstrated cause of infertility that was not caused by voluntary sterilization or a hysterectomy; or

  The man has a condition that is a demonstrated cause of infertility that was not caused by voluntary sterilization and/or a vasectomy.
- The procedures are performed on an outpatient basis.
- Follicle-stimulating hormone (FSH) levels are less than 19 mIU/ml on day 3 of the menstrual cycle.
- The woman can't become pregnant through less costly treatment that is covered by the Plan.

The Plan covers the diagnosis and treatment of the underlying cause of infertility, including:

- Initial evaluation, including history, physical exam, and laboratory studies performed at an appropriate laboratory;
- Evaluation of ovulatory function;
- Endometrial biopsy;
- Ultrasound of ovaries; and
- Post-coital test.

If you are eligible for infertility services, the Plan covers the following, up to the maximum shown in the Summary of Benefits:

- Monitoring of ovulation induction with ovulatory stimulant drugs; and
- Intrauterine insemination.

Infertility Service Limits

The Plan does ***not*** cover:

- Infertility services for couples in which one of the partners has had a previous sterilization procedure, with or without surgical reversal.
- Reversal of a sterilization procedure.
- Advanced reproductive therapies – in vitro fertilization (IVF), gamete intra-fallopian transfer (GIFT), zygote intra-fallopian transfer (ZIFT), cryopreserved embryo transfers, intra-cytoplasmic sperm injection (ICSI), and ovum microsurgery.
- Purchase of donor sperm.
- Storage of sperm.
- Purchase of donor eggs.
- Care of the donor required for donor egg retrievals or transfers.
- Cryopreservation or storage of cryopreserved eggs or embryos.
- All charges associated with gestational carrier programs, for either the covered person or the gestational carrier.
- Home ovulation prediction kits.
- Infertility services for covered women with FSH levels 19 or greater mIU/ml on day 3 of the menstrual cycle.
- Infertility services that are not reasonably likely to be successful.
- Prescription drugs, including injectable infertility drugs.
  Note: while not covered as a medical expense, oral and injectable drugs to treat infertility may be covered by the prescription drug program if you have been approved for infertility treatment.
- Services received by a spouse or partner who is not covered by the Plan.

Other Covered Services and Supplies

Acupuncture Therapy

The Plan covers acupuncture therapy to treat the following conditions, when necessary and performed by a physician:

- Chronic headaches (for example: migraines)
- Myofascial complaints (for example: neck and lower back pain)
- Neuritis
- Osteoarthritis
- Post-therapeutic neuralgia
- Rheumatoid arthritis
- Sciatica
- Tic douloureux

Keep in Mind

Acupuncture therapy is covered only when performed by a physician. If performed under the direction of a physician, but not by a physician, the therapy is not covered.

Durable Medical and Surgical Equipment

The Plan covers the rental of durable medical and surgical equipment. Examples include wheelchairs, crutches, hospital beds, and oxygen for home use. The Plan covers only one item for the same (or a similar) purpose, plus the accessories needed to operate the item.

Instead of rental, the Plan may cover the purchase of equipment if:

- It either can't be rented or would cost less to purchase than to rent; and
- Long-term use is planned.

The Plan also covers the repair of this equipment when necessary. Maintenance and repairs needed because of misuse or abuse of the equipment are ***not*** covered.

Replacement is covered if you show Aetna that the repair is needed because of a change in your physical condition, or if it is likely to cost less to purchase a replacement than to repair existing equipment or rent similar equipment.

Experimental or Investigational Services

In general, the Plan does ***not*** cover drugs, devices, treatments, or procedures that are experimental or investigational. There are, however, some situations where the Plan will cover a drug, device, treatment, or procedure that would otherwise be considered experimental or investigational.

The Plan will cover care that is considered experimental or investigational if the care meets ***all*** the following conditions:

- You have been diagnosed with cancer or a condition likely to cause death within one year;
- Standard therapies have not been effective or are inappropriate;
- Aetna determines, based on at least two documents of medical and scientific evidence, that you would likely benefit from the treatment;
- You are enrolled in a clinical trial that meets these criteria:
  - The drug, device, treatment, or procedure to be investigated has been granted investigational new drug (IND) or Group C/treatment IND status;
  - The clinical trial has passed independent scientific scrutiny and has been approved by an institutional review board that will oversee the investigation;
  - The clinical trial is sponsored by the National Cancer Institute (NCI) or similar national organization (such as the U.S. Food and Drug Administration or the Department of Defense) and conforms to NCI standards;
  - The clinical trial is not a single institution or investigator study unless the clinical trial is performed at an NCI-designated cancer center; and
- You are treated in accordance with protocol.

Call Member Services at **1-888-506-2278** (toll free) or **1-813-775-0189** (direct) if you have questions about the Plan's coverage for care your physician has recommended. You can also find information in Aetna's Clinical Policy Bulletins (CPBs) at **www.aetna.com**.

Hearing Aids

The Plan covers hearing aids, including hearing aid evaluations and audiometric exams, up to the lifetime maximum shown in the Summary of Benefits. The hearing aid must be installed in accordance with a prescription written during an audiometric exam.

Limits

The Plan does not cover:

- Replacement of lost, stolen, or broken hearing aids; or
- Repairs, batteries, or replacement parts.

> *Keep in Mind*
>
> When in the 50 states, you can maximize the Plan's benefits for hearing exams and hearing aids by taking advantage of the discounts offered through the Aetna Hearing℠ discount program. Visit Aetna Navigator at **www.aetna.com** for more information about the hearing discount program. Even if you've used up your hearing aid lifetime maximum, you are still eligible for the discounts.

Outpatient Short-Term Rehabilitation

Physical, Occupational, and Speech Therapy

The Plan covers short-term outpatient rehabilitation therapy to improve a body function lost as the result of an illness, injury, pervasive developmental disorder, or congenital defect. The treatment must be:

- Provided by a physician or a licensed or certified physical, occupational, or speech therapist.
- Expected to result in significant improvement of the condition within 60 days of the start of treatment. (This requirement is waived for treatment of pervasive developmental disorder.)
- Part of a treatment plan.

The Plan limits benefits for all rehabilitation therapy to the maximum shown in the Summary of Benefits.

Covered expenses include services for:

- **Physical therapy** expected to significantly improve, develop, or restore physical functions that were lost or impaired because of an acute illness, injury, pervasive developmental disorder, or surgical procedure.

  The Plan's coverage of physical therapy does not include educational training or services designed to develop physical function.

- **Occupational therapy** expected to:
  - Significantly improve, develop, or restore physical functions lost or impaired because of an acute illness, injury, pervasive developmental disorder, or surgical procedure; or
  - Relearn skills to improve independence in the activities of daily living.

  The Plan's coverage of occupational therapy does not include educational training or services designed to develop physical function.

- **Speech therapy**:
  - To restore the loss of speech function or correct a speech impairment resulting from disease, injury, or pervasive developmental disorder; or
  - To treat delays in the development of speech function that are the result of a gross anatomical defect present at birth (for example: a cleft palate or a cleft lip).

  Speech function is the ability to express thoughts, speak words, and form sentences. Speech impairment is difficulty with expressing thoughts with spoken words.

Applied Behavioral Analysis Therapy

The Plan covers applied behavioral analysis (ABA) therapy for children through age 6 to treat Pervasive Developmental Disorders (PDD), including Asperger's syndrome and autism, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association. The treatment must be prescribed by the child's treating physician in accordance with a treatment plan.

Refer to the Summary of Benefits for information about the maximum that applies to ABA therapy.

Limits

The Plan does not cover:

- Treatment for delays in speech development that are not the result of disease, injury, congenital defect, or pervasive developmental disorder.
- Speech therapy to improve speech skills that have not fully developed.
- Special education to teach someone who has lost the ability to speak how to function without speech, including sign language lessons.

Prescription Eyewear

The Plan covers charges for eyeglasses (lenses and frames) and contact lenses, up to the maximum shown in the Summary of Benefits. The eyewear must be prescribed by a legally qualified ophthalmologist or optometrist. The allowance applies to any combination of medically necessary prescription eyewear.

Limits

The Plan does not cover the charges made for:

- Special supplies such as nonprescription sunglasses and subnormal vision aids;
- Anti-reflective coatings or tinting; or
- Lenses and frames furnished or ordered because of an eye exam that was done before the date you become covered.

Keep in Mind

You can make the most of your benefits by taking advantage of the Aetna Vision℠ discount program when in the 50 states. When you visit a participating U.S. provider, you have access to discounts on eyeglasses and contact lenses to help stretch your eyewear allowance. You can also save on eye care services such as LASIK surgery (even though LASIK surgery is not covered by the Plan). For more information, go to **www.aetna.com** and log on to Aetna Navigator.

Prosthetic Devices

The Plan covers internal and external prosthetic devices and special appliances. The device or appliance must improve or restore the function of a body part lost or damaged by illness, injury, or congenital defect.

Coverage includes:

- Purchase of the first prosthesis that you need to temporarily or permanently replace an internal body part or organ, or an external body part.
- Instruction and incidental supplies needed to use a covered prosthetic device.
- Replacement of a prosthetic device if:
  - The replacement is needed because of a change in your physical condition or because of normal growth or wear and tear;
  - Replacement is likely to cost less than repairing the existing device; or
  - The existing device cannot be made serviceable.

Women's Health Provisions

Federal law affects how certain health conditions are covered by the Plan. Your rights under these laws are described here.

The Newborns' and Mothers' Health Protection Act

Maternity hospital stays under the Plan will be covered for a minimum of 48 hours following a vaginal delivery, or 96 hours for a cesarean section delivery. The Plan may pay for a shorter stay if the attending provider (physician, nurse midwife, or physician's assistant) discharges the mother or newborn earlier, after consulting with the mother.

Under the Newborns' and Mothers' Health Protection Act:

- The level of benefits for any portion of the hospital stay that extends beyond 48 hours (or 96 hours) cannot be less favorable to the mother or newborn than the earlier portion of the stay.
- The Plan cannot require precertification for a stay of up to 48 or 96 hours, as described above. Stays beyond those times must be precertified. The precertification requirement is waived for care you receive outside the 50 states.

The Women's Health and Cancer Rights Act

The Women's Health and Cancer Rights Act requires the Plan to cover these procedures after a woman's medically necessary mastectomy:

- Reconstruction of the breast on which a mastectomy has been performed;
- Surgery and reconstruction of the other breast to create a symmetrical (balanced) appearance;
- Prostheses; and
- Treatment of physical complications of all stages of mastectomy, including lymphedema.

If you have a question about the Plan's coverage of mastectomies and reconstructive surgery, call Member Services at **1-888-506-2278** (toll free) or **1-813-775-0189** (direct).

Behavioral Health Care

The Plan includes coverage for behavioral health care. To be covered by the Plan, the care must be for:

- The effective treatment of alcohol or substance abuse; or
- The effective treatment of a mental disorder.

Inpatient Care

> *Keep in Mind*
>
> Inpatient care must be precertified in the 50 states. The precertification requirement is waived for care you receive outside the 50 states. Contact Member Services if you have questions about precertification.

The Plan covers inpatient services in a hospital, psychiatric hospital, or residential treatment center when your condition requires services that are available only in an inpatient setting. Coverage includes:

- Room and board charges, up to the facility's semi-private room rate; and
- Other necessary services and supplies.

Outpatient Treatment

The Plan also covers the effective treatment of mental disorders or alcohol or substance abuse on an outpatient basis.

Prescription Drug Program

The prescription drug program covers prescription drugs that are to be taken on an outpatient basis.

When You Are Overseas

> *Keep in Mind*
>
> As used in this chapter, "overseas" refers to a location that is outside the 50 states and U.S. territories.

Local Pharmacy

You may visit a local pharmacy to fill a prescription when you are overseas. You must pay for your prescription up-front, then submit a claim for reimbursement. Your prescription drug expenses will be treated as medical plan expenses, subject to the medical plan's deductible and out-of-pocket maximum. Refer to the Summary of Benefits for information about the Plan's benefits or prescriptions filled at an overseas pharmacy.

Mail-Order Pharmacy

While overseas, you can also take advantage of the mail-order pharmacy service for long-term prescriptions (up to a 90-day supply). The prescriptions must be:

- Written by a physician who is licensed to practice in the United States; and
- Sent to an APO/FPO mailing address.

Use the mail-order program to save on medications you need on a regular, long-term basis. You may order up to a 90-day supply through Aetna Rx Home Delivery, Aetna's mail-order drug service. You enjoy the convenience of home delivery, and you'll pay less for your prescription than you would at your local pharmacy.

Three Tiers of Coverage

The mail-order program has three copay levels for covered prescriptions:

- Tier One – generic drugs
- Tier Two – brand name drugs that are on the Preferred Drug List
- Tier Three – brand name drugs that are not on the Preferred Drug List

You pay the Tier One copay when your doctor prescribes a generic drug or you ask your pharmacist to substitute a generic drug for a brand name drug, when available. A generic drug is a prescription drug that is not protected by trademark registration. It is produced and sold under its chemical name.

The Tier Two and Tier Three copays apply to brand name drugs. A brand name drug is a prescription drug that is protected by trademark registration. It is sold under the trade name given to it by the pharmaceutical company. Whether you pay the Tier Two or Tier Three copay depends on whether the brand name drug is on Aetna's Preferred Drug List:

- The Tier Two copay applies to brand name drugs that are on Aetna's Preferred Drug List.
- The Tier Three copay applies to brand name drugs that are not on the list.

The Preferred Drug List is a list of prescription drugs that have been:

- Approved by the FDA as safe and effective; and
- Evaluated and selected by Aetna pharmacists based on their overall ability to meet members' needs at a reasonable cost.

You can find Aetna's Preferred Drug List online at **www.aetnainternational.com**. Select *Consult the Preferred Drug List*, click on the link to the list, then choose *Three Tier Open Formulary* as the plan type. You can also call Member Services at **1-888-506-2278** (toll free) or **1-813-775-0189** (direct) to request a printed copy of the list without charge.

> *Lowering Your Copay*
>
> By law, generic and brand name drugs must meet the same standards for safety, purity, strength, and effectiveness. You can reduce your copay by using a generic drug (Tier One) or a brand-name drug that appears on the Preferred Drug List (Tier Two). Your copay will be highest if your physician prescribes a brand-name drug that does not appear on the Preferred Drug List (Tier Three).

How to Order

To order by mail, send your original prescription, together with an order form and a check, money order, or credit card number for the applicable copayment to Aetna. Order forms are available online at **www.aetnarxhomedelivery.com**. You can also contact your Human Resources Office or call Member Services for forms.

When you receive your original prescribed medication from the mail service program, you will receive refill information. You can order refills by mail, by phone, or online at **www.aetnarxhomedeliverycom**.

When You Are in the 50 States or a U.S. Territory

You can fill a prescription in the 50 states or a U.S. territory through:

- The retail pharmacy program;
- The mail-order pharmacy program described above; or
- The Aetna Specialty Pharmacy service.

In-Network Retail Pharmacy

You may fill your prescription for up to a 30-day supply at a retail pharmacy that belongs to Aetna's pharmacy network. Show your ID card and pay the copay shown in the Summary of Benefits at the time of your purchase. There are no claim forms to fill out.

You can find a list of in-network pharmacies using DocFind at **www.aetna.com** or by calling **1-888-506-2278** (toll free) or **1-813-775-0189** (direct). A Member Services representative can help you find an in-network pharmacy in your area.

> *Keep in Mind*
>
> Prescriptions filled at an out-of-network pharmacy are ***not*** covered by the Plan.

Aetna Specialty Pharmacy

Specialty medications help people who have chronic conditions. The medications may require special storage and handling, and sometimes cause side effects that must be watched carefully.

Aetna Specialty Pharmacy fills prescriptions for specialty medications and offers support for patients with chronic medical conditions, including:

- Asthma
- Blood disorders
- Cancer
- Chronic renal failure
- Cystic fibrosis
- Growth hormone deficiency
- Hepatitis
- HIV/AIDS
- Infertility
- Multiple sclerosis
- Osteoporosis
- Psoriasis
- Pulmonary disease
- Rheumatoid arthritis
- Transplants

Ordering medications from Aetna Specialty Pharmacy is easy:

- Your physician can call Aetna Specialty Pharmacy at **1-866-782-2779** (in the U.S. only).
- You or your physician can mail the prescription to:

  Aetna Specialty Pharmacy
  503 Sunport Lane
  Orlando, FL 32809

Your medications will usually be shipped to you within 24-48 hours. Specialty medications cannot be shipped overseas.

Covered Drugs

The Plan covers:

- Federal legend drugs (drugs that require a label stating: “Caution: Federal law prohibits dispensing without prescription”) or any other drug that under the applicable state law may be dispensed only upon the written prescription of a physician.
- Compounded medication, of which at least one ingredient is a federal legend drug. **Note**: The prescription drug program does not cover compound drugs that are manufactured in a compound pharmacy.
- Contraceptives:
  - Oral contraceptives;
  - Injectable contraceptives such as Depo-Provera; and
  - Patches and rings.
- Diabetic needles and syringes.
- Insulin.
- Oral and injectable fertility drugs.
- Over-the-counter diabetic supplies.

Refills

Refills of prescriptions are covered, subject to the terms of the prescription drug program and the following rules:

- **For a 1- to 9-day supply**: at least 50% of the prior prescription or refill has been used. (This is for short-term therapy drugs such as antibiotics.)
- **For a 10- to 30-day supply**: at least 75% of the prior prescription or refill has been used.
- **For mail order drugs using Aetna Rx Home Delivery**: at least 60% of the prior prescription or refill has been used.

Smoking Cessation

The Plan covers up to a 180-day supply of the following FDA medications that can ease withdrawal symptoms and help you stop smoking:

- Bupropion SR
- Nicotine gum
- Nicotine inhaler
- Nicotine lozenge
- Nicotine nasal spray
- Nicotine patch
- Varenicline

You must have a prescription from your doctor for the medication. Coverage is limited to two attempts to stop smoking.

> *Keep in Mind*
>
> The Plan covers up to eight smoking cessation counseling sessions per calendar year. Refer to the Summary of Benefits for more information.

What the Plan Does Not Cover

The Plan does not cover all medical expenses; certain expenses are excluded. The list of excluded expenses in this chapter is representative, not comprehensive. Just because a service or supply is not listed here does not mean that it will be covered by the Plan.

General Exclusions

The Plan does ***not*** cover charges:

- For any item or service that is primarily for the personal comfort and convenience of you or a third party.
- For care, treatment, services, or supplies:
  - Given by an unlicensed provider; or
  - Outside the scope of the provider's license.
- For care, treatment, services, or supplies not prescribed, recommended, or approved by a physician or dentist.
- For drugs, devices, treatments, or procedures that are experimental or investigational, except as described in What the Plan Covers.
- For services and supplies Aetna determines are not necessary for the diagnosis, care, or treatment of the disease or injury involved – even if they are prescribed, recommended, or approved by a physician or dentist.
- For services given by volunteers or persons who do not normally charge for their services.
- For services and supplies provided as part of treatment or care that is not covered by the Plan.
- For services and supplies provided in school, college, or camp infirmaries.
- For services and supplies that are associated with injuries, illnesses, or conditions suffered due to the acts or omissions of a third party, as determined by Aetna or its authorized representative.
- For services, supplies, medical care, or treatment given by members of your immediate family (your spouse, domestic partner, child, step-child, brother, sister, in-law, parent, or grandparent) or your household.
- Incurred before the date coverage starts or after the date coverage ends.
- In excess of the reasonable and customary charge for a service or supply.
- Made only because you have health coverage or that you are not legally obligated to pay.
- Related to employment or self-employment. This includes injuries that arise out of (or in the course of) any work for pay or profit.
- Resulting from a felony that you commit or attempt to commit.

Behavioral Health Care

The Plan does ***not*** cover charges for:

- Applied behavioral analysis therapy, except as described in Outpatient Short Term Rehabilitation for children through age 6 to treat pervasive developmental disorders (PDD), including Asperger's syndrome and autism.
- Bereavement counseling.
- Biofeedback, psychodrama, Lovaas therapy, or primal therapy.
- Erhard Seminar Training (EST) or similar motivational services.
- Hypnosis and hypnotherapy.
- Marriage, family, career, social adjustment, religious, pastoral, or financial counseling.
- Mental and psychoneurotic disorders not listed in the International Statistical Classification of Diseases, Ninth Revision (ICD-9).
- Psychological counseling related to changing sex or sexual characteristics.
- Therapies for the treatment of delays in development, except as described in Outpatient Short-Term Rehabilitation.
- Treatment of antisocial personality disorder.
- Treatment of impulse control disorders such as caffeine or nicotine use, kleptomania, pathological gambling, or pedophilia.
- Treatment of health care providers who specialize in mental health and receive treatment as part of their training in that field.
- Treatment of mental retardation, defects, and deficiencies. This exclusion does not apply to mental health services or to medical treatment for someone who is mentally incapacitated.
- Wilderness programs.

Cosmetic Procedures

The Plan does ***not*** cover the following, regardless of whether the service is provided for psychological or emotional reasons:

- Plastic or cosmetic surgery;
- Reconstructive surgery, except as described under Reconstructive Surgery; or
- Other services, treatments, or supplies that improve, alter, or enhance the shape or appearance of the body.

Custodial and Protective Care

The Plan does ***not*** cover charges for:

- Care provided to create an environment that protects a person against exposure that can make his or her disease or injury worse.
- Care, services, and supplies provided in a:
  - Rest home, assisted living facility, health resort, spa, or sanitarium; or
  - Similar institution serving as an individual's primary residence or providing primarily custodial or rest care.

- Custodial care – care provided to help a person in the activities of daily life – even if the care is provided by a nursing professional, and family members or other caretakers cannot provide the necessary care.
- Maintenance or respite care.
- Removal from your home, work place, or other environment of potential sources of allergy or illness, including asbestos, dust, mold, or paint.

Education and Training

Except as specifically described in What the Plan Covers, the Plan does ***not*** cover charges for:

- Evaluation or treatment, regardless of the underlying cause, of learning disabilities, minimal brain dysfunction, developmental, learning, and communication disorders, or behavioral disorders.
- Services or supplies related to education, training, retraining services, or testing, including:
  - Special or remedial education; or
  - Job training or job hardening programs.
- Services, treatment, and education testing or training related to behavioral (conduct) problems, learning disabilities, and delays in developing skills, except as described in Outpatient Short-Term Rehabilitation.

Evacuations

The Plan does ***not*** cover medical evacuation if you or your eligible dependent develops an emergency medical condition requiring immediate attention, even if adequate medical facilities are not available locally.

Family Planning and Maternity

The Plan does ***not*** cover:

- Home births. This is childbirth that takes place outside a hospital or birthing center, or in a place that is not licensed to perform deliveries.
- Home uterine activity monitoring.
- Over-the-counter contraceptive supplies, including (but not limited to) condoms and contraceptive foams, jellies, and ointments.
- Reversal of sterilization procedures.

Foot Care

Unless required to prevent complications of diabetes, the Plan does ***not*** cover services, supplies, or devices to improve the comfort or appearance of toes, feet, or ankles, including:

- Shoes (including orthopedic shoes), orthotics, arch supports, shoe inserts, ankle braces, guards, protectors, creams, ointments, or other equipment, devices, or supplies, even when required after treatment of an illness or injury that was covered by the Plan.
- Treatment of calluses, bunions, toenails, hammer-toes, subluxations, fallen arches, weak feet, or chronic foot pain.
- Treatment for conditions caused by routine activities such as walking, running, working, or wearing shoes.

Prescription Drugs

The Plan does ***not*** cover:

- Administration or injection of any drug, except as described in Contraception Services.
- Any drug dispensed by a mail order pharmacy other than Aetna Rx Home Delivery.
- Any drug entirely consumed when and where it is prescribed.
- Any drug that does not, by federal or state law, require a prescription, such as an over-the-counter drug or equivalent over-the-counter product, even when a prescription is written for it.
- Any prescription drug obtained illegally outside of the U.S., even if covered when purchased in the U.S.
- Any refill of a drug dispensed more than one year after the latest prescription for it, or as prohibited by law where the drug is dispensed.
- Bio-identical compounds.
- Biological sera, blood, blood plasma, blood products or substitutes, or any other blood products.
- Compound drugs manufactured in a compound pharmacy.
- Drugs or preparations to enhance strength, performance, or endurance.
- Erectile dysfunction:
  - Drugs to treat erectile dysfunction; and
  - Any drug dispensed by a mail order pharmacy to be used to treat erectile dysfunction, impotence, or sexual dysfunction or inadequacy.

  This exclusion applies whether or not the drug is delivered in oral, injectable, or topical forms (including but not limited to gels, creams, ointments, and patches).
- Experimental or investigational drugs or devices. This exclusion will not apply to drugs that:
  - Have been granted treatment investigational new drug (IND) or Group C/ treatment IND status; or
  - Are being studied at the Phase III level in a national clinical trial sponsored by the National Cancer Institute; and
  - Aetna determines, based on available scientific evidence, are effective or show promise of being effective for the illness.
- Food items, even when the item is the only source of nutrition.
- Genetics. Any treatment, device, drug, or supply to alter the body's genes, genetic make-up, or the expression of the body's genes except for the correction of congenital birth defects.
- Immunizations related to travel or work.
- Less than a 30-day supply of any prescription filled through Aetna Rx Home Delivery, the Plan's mail order service.
- Lost, stolen, or damaged medications.
- More than a 30-day supply of a prescription filled at a retail pharmacy.
- More than the number of refills specified by the prescribing doctor. Aetna may require a new prescription or proof of need if the prescriber has not specified the number of refills or if the frequency or number of refills seems excessive under accepted medical practice standards.

- Non-emergency prescription drugs bought outside of the United States if:
  - You travel outside of the U.S. to obtain the prescription drugs or supplies, even if they would be covered by the Plan if purchased in the U.S.;
  - The drugs or supplies are unavailable or illegal in the U.S.; or
  - The purchase of these drugs or supplies outside of the U.S. is illegal.
- Smoking cessation products, except as described in Smoking Cessation.
- Weight loss and weight gain drugs, including (but not limited to) stimulants, preparations, foods, diet supplements, dietary regimens, and appetite suppressants.

Reproductive and Sexual Health

The Plan does ***not*** cover charges for:

- Therapy, supplies, or counseling for sexual dysfunction or inadequacies with no physiological or organic basis.
- Treatment, drugs, services, or supplies related to changing sex or sexual characteristics.
- Treatment, drugs, services, or supplies to treat sexual dysfunction, enhance sexual performance, or enhance sexual desire.

Vision, Speech, and Hearing

The Plan does ***not*** cover charges for:

- Any vision or hearing device or service that does not meet professionally acceptable standards.
- Any tests, appliances, and devices to:
  - Improve hearing, except as described in Hearing Aids;
  - Enhance other forms of communication to compensate for hearing loss; or
  - Simulate speech.
- Eye surgery to correct vision, including radial keratotomy, LASIK, and similar procedures.
- Hearing aid therapy or training.
- Special procedures and services such as vision perceptual training and subnormal vision aids.

Weight Control Services

Regardless of the existence of comorbid conditions, the Plan does not cover charges for weight control, except as described in Surgical Treatment of Morbid Obesity. The Plan does ***not*** cover charges for:

- Weight control/loss programs.
- Dietary regimens, dietary supplements, food, or food supplements.
- Appetite suppressants and other medications.
- Exercise programs or equipment.
- Mental health treatment for weight reduction or control.

Other Services and Supplies

The Plan does ***not*** cover:

- Acupuncture, acupuncture therapy, and acupressure, except as described under Anesthesia and Acupuncture Therapy.
- Alterations or additions to your home, work place, or other environment, or any related equipment or device.
- Alternative or non-standard allergy services and supplies.
- Alternative therapies, including aromatherapy, bioenergetic therapy, carbon dioxide therapy, massage therapy, megavitamin therapy, and sleep therapy.
- Cancelled or missed appointments.
- Charges for claim form completion.
- Charges made for the services of a resident physician or intern.
- Chelation therapy (except for heavy metal poisoning).
- Disposable outpatient supplies.
- Exams or related reports required:
  - By a third party, including exams to obtain or maintain employment, or which an employer must provide under a labor agreement.
  - For professional or other licenses.
  - To obtain insurance.
  - To travel; attend a school, camp, or sporting event; or participate in a sport or other recreational activity.
- Fees that give you preferred access to a physician's services, such as boutique or concierge physician practices.
- Full-body CAT scans.
- Growth hormones, surgical procedures, or any other treatment, device, drug, service, or supply to increase or decrease height or alter the rate of growth.
- Hair analysis.
- Herbal medicine and holistic or homeopathic care, including drugs.
- Hyperbaric therapy, except to treat decompression or promote healing of a wound.
- Purging.
- Recreational therapy.
- Rolfing.
- Sensory or auditory integration therapy.
- Services or supplies provided, paid for, or for which benefits are provided or required:
  - Because of a person's past or present service in the armed forces of a government.
  - Under any government law.
- Services, devices, and supplies to enhance your strength, physical condition, endurance, or physical performance.
- Thermography and thermograms.

Claims

The Plan has procedures for submitting claims, making decisions on claims, and filing an appeal when you don't agree with a claim decision. You, Aetna, and the NAF employers must meet certain deadlines that are assigned to each step of the process, depending on the type of claim.

Types of Claims

To understand the claim and appeal process, you need to understand how claims are defined:

- **Urgent care claim**: A claim for medical care or treatment where delay could:
  – Seriously jeopardize your life or health, or your ability to regain maximum function; or
  – Subject you to severe pain that cannot be adequately managed without the requested care or treatment.
- **Pre-service claim**: A claim for a benefit that requires Aetna's approval of the benefit in advance of obtaining medical care (precertification).
- **Concurrent care claim extension**: A request to extend a previously-approved course of treatment.
- **Concurrent care claim reduction or termination**: A decision to reduce or terminate a course of treatment that was previously approved.
- **Post-service claim**: A claim for a benefit that is not a pre-service claim.

Filing Claims

You must file a claim to be reimbursed for covered expenses. You must use a claim form to submit your claim. You can obtain a claim form from Aetna Member Services by calling **1-888-506-2278** (toll free) or **1-813-775-0189** (direct).

File your claims promptly – ***the filing deadline is 90 days after the date you incur a covered expense***. If, through no fault of your own, you cannot meet that deadline, your claim will be accepted if you file it as soon as possible. Claims filed more than two years after the deadline will be accepted only if you had been legally incapacitated.

You may file claims and appeals yourself or through an "authorized representative," which is someone you authorize in writing to act on your behalf. In a case involving urgent care, a health care professional with knowledge of your condition may always act as your authorized representative. The Plan will also recognize a court order giving someone authority to submit claims on your behalf.

Physical Exams

Aetna has the right to require an exam of any person for whom precertification or benefits have been requested. The exam will be done at any reasonable time while precertification or a claim for benefits is pending or under review. The exam may be performed by a doctor or dentist Aetna has chosen, and it will be done at no cost to you.

Claim Processing

Aetna will make a decision on your claim.

- **If Aetna approves the claim**, benefits are payable to you. Aetna has the right, however, to pay any benefits directly to your physician or other care provider, and will do so unless you tell Aetna otherwise when you file the claim.
- **If Aetna denies your claim**, Aetna must give you a written notice of the denial. The chart below shows when Aetna must notify you that your claim has been denied.

Type of Claim	Aetna Must Notify You
Urgent care claim	As soon as possible, but not later than 72 hours
Pre-service claim	Within15 calendar days
Concurrent care claim extension	• Urgent care claim – as soon as possible, but not later than 24 hours, provided the request was received at least 24 hours before the expiration of the approved treatment • Other claims – 15 calendar days
Concurrent care claim reduction or termination	With enough advance notice to allow you to appeal
Post-service claim	Within 30 calendar days

The notice you receive from Aetna will provide important information that will assist you in making an appeal of the claim denial, if you wish to do so; see How to Appeal a Claim Decision for details.

Extensions of Time Frames

The time periods described in the chart may be extended, as follows:

- **For urgent care claims**: If Aetna does not have enough information to decide the claim, Aetna will notify you within 24 hours after receiving the claim that additional information is needed. You will then have at least 48 hours to provide the information. Aetna will make a decision on your claim within 48 hours after you provide the additional information.
- **For non-urgent pre-service and post-service claims**: The time frames may be extended for up to 15 additional days for reasons beyond the Plan's control. In this case, Aetna will notify you of the extension before the original notification time period has ended. If you do not provide the information, the claim will be denied.

If an extension of time is needed because Aetna needs more information to process your post-service claim:

- Aetna will notify you and give you an additional period of at least 45 days after receiving the notice to provide the information.
- Aetna will then inform you of the claim decision within 15 days after the additional period has ended (or within 15 days after Aetna receives the information, if earlier).

If you do not provide the information, your claim will be denied.

Appeals

This chapter explains the process you can follow if you don't agree with a claim decision.

How to Appeal a Claim Decision

A claim denial is a decision on a claim that results in:

- Denial, reduction, or termination of a benefit, or the amount paid for a service or supply.
- A decision not to provide a benefit or service.

Aetna will send you notice of a claim denial in the form of an Explanation of Benefits (EOB). The EOB may be electronic or in writing. The notice will give the reason for the decision and will explain what steps you must take if you wish to appeal. The notice will also tell you about your rights to receive additional information that may be relevant to the appeal.

> *Keep in Mind*
>
> You can receive EOBs electronically or by mail. Visit Aetna Navigator and indicate your preference for paper or electronic EOBs.

Four Steps in the Appeal Process

The Plan provides for two levels of appeal to Aetna, followed by a voluntary external review for claims that qualify, and the option to submit an appeal to the employee's NAF employer:

- You must request your first appeal (level one) within 180 calendar days after you receive the notice of a claim denial.
- If you are dissatisfied with the outcome of your level one appeal to Aetna, you may ask for second review (a level two appeal). You must request a level two appeal no later than 60 days after you receive the level one notice of denial.
- Your claim may be eligible for review by an independent external review organization (ERO). You must submit a request for external review within 123 calendar days of the date you receive the level two denial notice.
- You can file an appeal with the employee's NAF employer after you have exhausted the level one and level two appeal process and the voluntary external review process (if your claim qualifies). You have 30 days to submit the appeal to the NAF employer after you receive the final denial notice, or the denial by the external review organization.

Level One and Level Two Appeals to Aetna

Your appeal may be submitted in writing or by making a phone call to Aetna Member Services, and should include:

- Your name;
- The name of the employee's NAF employer;
- A copy of Aetna's notice of the adverse benefit determination;
- Your reasons for making the appeal; and
- Any other information you would like to have considered.

Send your appeal to Aetna Member Services at the address shown on your ID card, or call Member Services at **1-888-506-2278** (toll free) or **1-813-775-0189** (direct).

Based on the type of claim, Aetna must respond to your appeal within the time frames shown in the following chart:

Type of Claim	Level One Appeal Aetna Will Notify You Within:	Level Two Appeal Aetna Will Notify You Within:
Urgent care claim:	36 hours	36 hours
Pre-service claim	15 calendar days	15 calendar days
Concurrent care claim extension	Treated like an urgent care claim or a pre-service claim, depending on the circumstances	Treated like an urgent care claim or a pre-service claim depending on the circumstances
Post-service claim	30 calendar days	30 calendar days

You may also choose to have another person (an authorized representative) make the appeal on your behalf by providing written consent to Aetna. In the case of an urgent care claim or a pre-service claim, a physician familiar with the case may represent you in the appeal.

External Review

An external review is an optional review of a claim denial (an adverse benefit determination) by an external review organization (ERO).

> *Keep in Mind*
>
> You do not have to file for review by an ERO. This is a voluntary review.

Claims That Qualify for External Review

You or your authorized representative may request an external review of:

- A rescission (coverage that was cancelled or discontinued retroactively); or
- A claim denial based on medical judgment if:
  - You have exhausted the Plan's appeal process as described above; or
  - Aetna or the Plan did not follow all claim and appeal rules (described above) under federal law (except for minor violations), and the appeal process was therefore considered complete. This is called "deemed exhaustion."

> *Keep in Mind*
>
> A denial based upon your eligibility does not qualify for external review.

If you file for external review, any applicable statute of limitations will be suspended while the appeal is pending. Your request for an external review will not affect your rights to any other benefits under the Plan.

The External Review Process

1. You must submit a request for external review within 123 calendar days of the date you receive the final denial notice. The request must be in writing (oral requests are accepted for urgent care) and include a copy of the denial notice and all other information that supports your request.

2. Aetna will do a preliminary review of your request for an external review within five days of receiving the request. The preliminary review determines whether the claim qualifies for external review and includes all necessary documentation. Aetna must notify you in writing of the results within one business day after completing the review.

3. If your request is approved, Aetna will assign an accredited ERO to conduct the review. An independent clinical reviewer, with appropriate expertise in the area in question, will review all of the information and documents you have provided. The reviewer will not be bound by any decisions made during the Plan's claims and appeals process. The ERO must provide written notice of the final decision within 45 days after receiving the request for external review. The ERO must deliver the final decision to you, Aetna and the Plan.
   - If the ERO reverses the claim denial, the Plan must immediately provide coverage or pay the claim, as applicable.
   - If the ERO upholds the claim denial, you can appeal to your NAF employer, as described below.

Expedited External Review

You may be eligible for an expedited external review if your treating physician believes that a delay in decision making might seriously put your life or health at risk or jeopardize your ability to regain maximum function. The ERO will make a decision within 72 hours after receiving your request for the expedited review.

Appeal to a NAF Employer

You may file an appeal to the employee's NAF employer after the first two levels of the appeal process have been exhausted or after the ERO upholds the claim denial. This level of appeal is voluntary, so you are not required to pursue it before initiating legal action.

If you file an appeal to a NAF employer, any applicable statute of limitations will be suspended while the appeal is pending.

You must submit your voluntary appeal to a NAF employer in writing, and include the following information:

- The reason for the appeal;
- Copies of all past correspondence with Aetna (including your Explanation of Benefits); and
- Any applicable information that you have not yet sent to Aetna.

The NAF employer has the right to obtain information from Aetna that is relevant to your claim.

The NAF employer will review your appeal and make a decision within 30 days after you file your appeal. If the employer's reviewer needs more time, the reviewer may take an additional 30-day period. You will be notified in advance of this extension.

The reviewer will notify you of the final decision on your appeal electronically or in writing. The notice will give you the reason for the decision and the Plan provisions upon which the decision was based.

All decisions by a NAF employer will be final and binding.

Claim Fiduciary

The Claim Fiduciary makes claim decisions based on the provisions of the Plan. The Claim Fiduciary has complete authority to review denied claims for benefits under the Plan. This includes, but is not limited to, determining whether hospital or medical treatment is, or is not, medically necessary. The Claim Fiduciary has discretionary authority to:

- Determine whether, and to what extent, you and your covered dependents are entitled to benefits; and
- Interpret the provisions of the Plan when a question arises.

The Claim Fiduciary has the right to adopt reasonable policies, procedures, rules, and interpretations of the Plan to promote orderly and efficient administration. The Claim Fiduciary may not act arbitrarily or capriciously, which would be an abuse of its discretionary authority.

The Plan provides for two standard levels of appeal for adverse benefit determinations. Aetna is the Claim Fiduciary that will provide full and fair review for all level one and level two appeals.

The Plan also provides two types of voluntary appeals: external review and review by the employee's NAF employer. Aetna is the Claim Fiduciary for external review. Each NAF employer is Claim Fiduciary for its review.

Recovery of Overpayment

If Aetna makes a benefit payment over the amount that you are entitled to under this Plan, Aetna has the right to:

- Require that the overpayment be returned on request; or
- Reduce any future benefit payment by the amount of the overpayment.

This right does not affect any other right of overpayment recovery Aetna may have.

Legal Action

You cannot bring legal action to recover a benefit after three years from the deadline for filing claims.

Aetna (on behalf of the Plan) will not take action to reduce or deny a benefit payment on the grounds that the condition existed before a person's coverage went into effect, as long as the loss occurs more than two years from the date coverage started. This will not apply to any condition that is not covered as of the date of the loss.

When Coverage Ends

Note: As used in this chapter, “you” or “your” refers to an employee or retired employee covered by the Plan.

Plan coverage for an employee ends when any of the following occurs:

- You no longer meet the Plan’s eligibility requirements;
- The Plan is terminated;
- Employment ends; or
- You fail to pay any required contribution for coverage.

Coverage for your dependents ends when:

- Your coverage ends;
- The dependent is no longer eligible for dependent coverage;
- You certify that your domestic partnership has ended (contact your NAF employer for instructions);

  When Your Domestic Partnership Ends

  You may continue coverage for the children of your domestic partner when the partnership ends if the children meet the Plan's eligibility rules for dependent coverage.

- You do not pay the required contribution for dependent coverage;
- The dependent becomes covered as an employee;
- The dependent becomes eligible for comparable benefits under this Plan or any other group plan offered by your employer; or
- All dependent coverage under the Plan ends.

When your coverage ends, the Plan will provide you with a certificate of creditable coverage. This certificate may help you shorten or avoid any pre-existing condition exclusion in another group medical plan.

Options for Continuing Coverage

You may be able to continue coverage beyond the time when it would otherwise end. See these sections for information:

- Temporary Continuation of Coverage Program
- Converting Coverage to an Individual Insurance Policy

Leaves of Absence

The Plan includes rules about how a leave of absence affects your coverage. The rules vary based on the reason for the leave.

Family and Medical Leave Act

Through the Family and Medical Leave Act (FMLA), you may request up to 12 work weeks of leave during any 12-month period:

- For the birth or adoption of a child; or
- For a serious health condition affecting you or a family member.

You may request up to 26 weeks of leave during a 12-month period if you are the spouse, child, parent, or next of kin of a service member who is recovering from a serious illness or injury sustained in the line of duty while on active duty. The 26-week limit is combined for all FMLA leaves in the 12-month period.

During FMLA leave, your Plan coverage continues as long as you continue making your contributions.

When you return to work after your FMLA leave, your coverage under the Plan will continue without interruption if you apply for coverage as an active employee within 31 days of the date that your FMLA leave ended.

If your employer terminates your FMLA leave, and you lose Plan coverage as a result, you may be eligible to continue medical coverage under the Temporary Continuation of Coverage Program. See Temporary Continuation of Coverage Program for more information.

> *Keep in Mind*
>
> You cannot continue dental coverage through the TCC Program.

Check with your supporting Human Resources Office (HRO) for more information about family and medical leaves.

Military Leave

USERRA

The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) allows qualified employees to continue their enrollment in the Plan for up to 24 months when they are called to active duty.

If you are participating in the Plan when you are called to active duty and you choose to cancel your enrollment because of TRICARE coverage, you may re-enroll in the Plan within 31 days of the date your TRICARE coverage ends if you meet the Plan's eligibility rules.

Employees on Leave Without Pay (Non-Contingency Operations)

Employees who are on leave without pay (LWOP) while performing military duty may continue to participate in the DoD NAF HBP medical and dental plan for up to 24 months by paying the employee share of the cost of coverage. Employees who elect not to continue DoD NAF HBP coverage while on military duty can re-enroll in the Plan when they return to NAF employment, without waiting for an open enrollment period.

Military Reservist in Contingency Operations

The DoD NAF employers will pay the full cost of coverage (employee's share and employer's share) for an enrolled employee who is called to active duty (voluntarily or involuntarily) in support of a Contingency Operation, for up to 24 months. The reservist must be placed on LWOP or separated from NAF employment to perform active duty for more than 30 consecutive days.

Check with your supporting Human Resources Office (HRO) for more information about USERRA and military leave.

Continuing Coverage

When Plan coverage would normally end, you or your covered dependents may be able to continue coverage in certain circumstances. This chapter describes how you or your covered dependents may be able to continue coverage:

- For a handicapped child;
- In the event of the employee's death;
- Through the Temporary Continuation of Coverage Program; and
- By converting this group coverage to an individual insurance policy.

Note: As used in this chapter, "you" or "your" refers to an employee or retired employee covered by the Plan.

Continued Coverage for a Handicapped Child

If your child is handicapped, the child's health care coverage may be continued past the Plan's age limit for dependents.

Your child is considered handicapped if:

- He or she is unable to earn a living because of a mental or physical handicap that starts before he or she reaches the Plan's age limit for dependents; and
- He or she depends mainly on you for support and maintenance.

Aetna will send you a letter before the child reaches the Plan's dependent age limit. The letter will include forms that you and the child's treating physician must complete to give Aetna proof of your child's handicap. You must complete and submit the forms no later than 30 days after your child reaches the dependent age limit. The child's coverage will end on the first to occur of the following:

- Your child is no longer handicapped;
- You fail to provide proof that the handicap continues;
- You fail to have any required exam performed; or
- Your child's coverage ends for a reason other than reaching the age limit.

Aetna has the right to require proof that the handicap continues. Aetna also has the right to examine your child as often as needed while the handicap continues. Once the child is two years beyond the Plan's dependent age limit, these exams will not be required more than once a year. The Plan will pay for the exams.

Continuation for Survivors

The dependents of a covered employee may continue Plan coverage if the employee dies while covered by the Plan. This continued coverage also applies to:

- A child conceived before the employee's death; and
- An adopted child, as long as the legal process for adoption was initiated before the employee's death.

To be eligible for continued coverage, the dependents must be:

- Enrolled in a DOD NAF HBP medical plan (HMO or non-HMO) on the date of the employee's death to continue medical plan coverage.
- Enrolled in a DOD NAF HBP dental plan on the date of the employee's death to continue dental plan coverage.

The cost and duration of the continued coverage are determined as follows:

- **Employees with less than 90 days of participation**: no continuation of medical or dental coverage.
- **Employees with 90 days, but less than 15 years of participation**:
  - **Medical coverage:** dependents who were covered by a DOD NAF HBP medical plan on the date of the employee's death are eligible for four months of continued medical coverage. The cost of the continued medical coverage will be paid by the NAF employer. When this period ends, the surviving dependents may be eligible to continue medical coverage through the Temporary Continuation of Coverage (TCC) Program. See Temporary Continuation of Coverage Program for more information.
  - **Dental coverage**: dependents who were covered by a DOD NAF HBP dental plan on the date of the employee's death are eligible for four months of continued dental coverage. The cost of the continued dental coverage will be paid by the NAF employer. When this period ends, the dependents' coverage ends. The dependents cannot continue dental coverage through the TCC Program.
- **Employees with 15 years of service or more**:
  - **Medical coverage**: dependents who were covered by a DOD NAF HBP medical plan on the date of the employee's death may continue medical coverage for four months. The cost of coverage for this four-month period will be paid by the NAF employer.
  - **Dental coverage**: dependents who were covered by a DOD NAF HBP dental plan on the date of the employee's death are eligible for four months of continued dental coverage. The cost of coverage for this four-month period will be paid by the NAF employer.

  When the four-month continuation period ends:

  - The spouse or domestic partner may continue medical and dental coverage (as applicable), paying the same cost as an employee.
  - Coverage for dependent children may continue until they reach the Plan's age limit for dependent coverage, as long as required contributions for the cost of family coverage are made.

Survivor coverage for a covered dependent ends sooner if that dependent no longer qualifies as an eligible dependent under the Plan.

If your spouse remarries or your domestic partner enters into a new domestic partnership, your spouse/domestic partner may continue his or her Plan coverage, but any dependents acquired as the result of the new marriage or partnership cannot be covered by the Plan.

Temporary Continuation of Coverage Program

If your employment ends for any reason other than for gross misconduct, or if you or your covered dependents are no longer eligible for coverage under the Plan, you and/or your covered dependents may temporarily continue medical coverage through the Temporary Continuation of Coverage (TCC) Program. If you choose this continued coverage, you must do so within 60 days of a qualifying event that ends your coverage under the Plan.

Keep in Mind

- You may not continue dental coverage under the TCC Program.
- Participation in the TCC Program does not count toward accumulated active participation in the Plan or toward qualification for retiree coverage.

Who Is Eligible for Continued Coverage

Employees, retirees, and covered dependents who were enrolled in the Plan on the day before a qualifying event are eligible to continue coverage if:

- The employee has been covered by a DoD NAF HBP medical plan for at least 90 days prior to the date coverage was lost (the qualifying event);
- The employee did not lose coverage because of gross misconduct;
- The employee is not enrolled in TRICARE-for-Life; and
- The employee is not eligible for Medicare.

Qualifying Events

The chart below lists events that could end Plan coverage for you or your covered dependents. For each event, the chart shows how long you may continue your Plan coverage through the TCC Program.

	How Long Coverage Can Be Continued For:		
Reason Coverage Ended ("Qualifying Event")	**You**	**Your Spouse**	**Your Child**
You lose coverage because of reduced work hours	18 months	18 months	18 months
You lose coverage because your employment terminates for any reason, other than for gross misconduct	18 months	18 months	18 months
You retire and you are not eligible for post-retirement medical coverage	18 months	18 months	18 months
You are disabled at the time Plan coverage ends	36 months	N/A – only the employee may elect TCC continued coverage. However, coverage for dependents can continue until the employee's coverage ends.	

	How Long Coverage Can Be Continued For:		
Reason Coverage Ended ("Qualifying Event")	**You**	**Your Spouse**	**Your Child**
You die (see Continuation for Survivors for more information about coverage for surviving dependents)	N/A	36 months*	36 months*
You divorce or your domestic partnership ends	N/A	18 months	18 months
Your child is no longer eligible (for example, your child reaches the Plan's age limit for dependent coverage)	N/A	N/A	18 months

* Includes 4 months of employer-paid coverage. See Continuation for Survivors for more information.

Enrolling in the TCC Program

You have 60 days after the date of your qualifying event to elect continued coverage under the TCC Program. You must enroll in a medical plan option that is determined by your place of residence.

Coverage will be effective on the date of the qualifying event, if you elect coverage and make the initial payment within the 60-day period.

Cost of TCC

Except for disabled employees, as explained below, you pay the full cost of continued coverage, plus a 2% administration fee. The full cost of coverage is different from the contribution you pay while you are actively working, because the full cost includes your employer's share of the cost, too.

For employees (and any eligible dependents) who lose coverage when employment ends due to the employee's disability, the cost for TCC depends on the length of the employee's participation in the DoD NAF Health Benefits Program (HBP):

- **If the employee has participated less than five years**: The cost is the full cost of coverage plus a 2% administration fee (102%), for up to 36 months of TCC.
- **If the employee has participated five years or more***, but does not meet the qualifications for post-retirement medical coverage*: The cost of coverage will be paid by the DoD NAF employer for the first 12 months of TCC. After that 12-month period, the employee must pay the full cost of coverage plus a 2% administration fee (102%) for the next 24 months of TCC, for up to a total of 36 months of TCC.

If you are disabled and wish to continue coverage under the TCC Program, your attending physician must give a written statement to your Human Resources Office (HRO)* that provides proof of the disability. Your HRO must receive the disability statement within 60 days of the date your medical coverage first terminated.

*For employees of the Army Air Force Exchange Service, the attending physician must send the statement proving disability to Aetna.

Paying for Continued Coverage

You pay the cost of continued coverage as described above in Cost of TCC.

- The "single rate" applies to anyone who:
  - Wants coverage only for himself or herself; and
  - Is eligible for that coverage because of his or her individual status.
- The "family rate" applies to all other situations.

Contribution rates for the TCC Program are adjusted at the same time that the rates for active employees are adjusted.

When You Acquire a Dependent During a Continuation Period

If an employee or spouse/domestic partner acquires a new child through birth or adoption during the continuation period, the child can be covered under the TCC Program for the remainder of the continuation period if:

- The child meets the Plan's definition of an eligible dependent;
- The employee notifies his or her DoD NAF employer and the child is enrolled within 31 days of the date of eligibility; and
- Any increase in the cost of coverage is paid on time. If the employee was previously covered as an individual (single rate), the family rate will now apply.

> *Keep in Mind*
>
> An employee's newborn or newly adopted child is the only dependent who can be added during a continuation period. For example, if an employee marries while covered under the TCC Program, the new spouse is ***not*** eligible for coverage.

When Continued Coverage Ends

Except in the case of a disabled employee, continued coverage will end when the earliest of the following events occurs:

- You reach the end of the 18/36 month continuation period.
- You again become eligible for regular coverage through the DoD NAF HBP.
- You or your covered dependent becomes eligible for Medicare after electing continued coverage.
- You or your covered dependent becomes covered under another group plan that does not restrict coverage for a pre-existing condition. If your new plan does have a restriction for pre-existing conditions:
  - Your continuation coverage under this Plan can continue until the pre-existing condition restriction ends under the other plan; or
  - You reach the end of the maximum continuation period for this Plan.
- You or your covered dependent does not pay for coverage on time.
- The Plan terminates.

You may convert to an individual policy (see Converting Coverage to an Individual Insurance Policy) when:

- You reach the end of the 18/36-month continuation period; or
- Your TCC Program coverage ends, if earlier.

The TCC Program is not the same as the conversion privilege:

- The TCC Program allows eligible participants to continue coverage in a DoD NAF HBP medical plan by paying 102% of the full cost of coverage.
- The conversion privilege allows eligible participants to convert from regular or TCC coverage to an individual insurance policy without a medical examination. The benefits provided by the conversion policy are not the same as the Plan's benefits.

If You Are Eligible Due to Disability

For employees (and any eligible dependents) who are participating in the TCC Program due to the employee's disability, coverage ends on the earliest to occur of:

- The employee is no longer disabled.
- The employee becomes eligible for Medicare.
- The employee becomes eligible for another group medical plan, unless the other plan limits coverage for a pre-existing condition.
- The employee does not pay for coverage on time.
- 36 months have passed since the employee's regular DoD NAF HBP coverage ended.
- The Plan terminates.

Converting Coverage to an Individual Insurance Policy

If You Are Overseas

You are not eligible to convert if you are residing overseas, unless you return to the United States within 31 days from the date your coverage ends under this Plan.

When your Plan coverage ends – including continued coverage under the Temporary Continuation of Coverage Program – the Plan includes a benefit that allows employees and/or dependents to convert coverage to an individual health insurance policy without proof of good health. The policy offered for conversion will be issued by Aetna in accordance with its established rates and rules then in effect. The conversion policy may differ from the coverage offered under this Plan.

When this Plan's coverage ends, you should contact your Human Resources Office and request a Notice of Conversion Privilege and Request form. You must complete and return this form to Aetna within 31 days after this Plan's coverage ends.

Converting to an Individual Policy After TCC Coverage Ends

You may be eligible to convert to an individual policy after your coverage under the TCC Program ends. Aetna will send you a letter 60 days before the date TCC coverage is scheduled to end. The letter will instruct you to call customer service for Individual Billing Administration (**1-877-848-5837**) within 31 days of the date TCC coverage ends for more information about the conversion process.

Note: NEXCOM members should contact their HRO to request conversion after TCC coverage ends.

Conversion coverage is not available if:

- The employee and/or dependents were covered by the Plan for fewer than three (3) months;
- The employee and/or dependents are eligible for Medicare;
- The employee and/or dependents have other health insurance or coverage with similar benefits;
- The employee and/or dependents reside in a jurisdiction where Aetna does not issue or deliver conversion policies; or
- The Plan is terminated.

You are not eligible to convert if you are residing overseas, unless you return to the United States within 31 days from the date your coverage ends under this Plan.

Glossary

The Glossary defines key words and phrases that appear throughout the text of this book.

Alcohol or Substance Abuse: Repeated use of alcohol or another substance that results in recurring and significant negative consequences. Use of alcohol or another substance is considered abuse when problems related to usage happen more than once during the same 12-month period or persist. Signs of alcohol or substance abuse include:

- Repeated failure to fulfill major role obligations;
- Repeated use in situations in which it is physically hazardous;
- Multiple legal problems; and
- Recurrent social and interpersonal problems.

Behavioral Health Provider: A licensed organization or professional providing diagnostic, therapeutic, or psychological services for the treatment of mental health and alcohol or substance abuse. Behavioral health providers include hospitals, residential treatment facilities, psychiatric physicians, psychologists, and social workers.

Claim Administrator: Aetna Life Insurance Company is the Claim Administrator. Refer to Resources and Tools for address and telephone number information.

Companion: This is a person who needs to be with a National Medical Excellence (NME) patient to enable him or her:

- To receive services in connection with an NME procedure or treatment on an inpatient or outpatient basis; or
- To travel to and from the facility where treatment is given.

Custodial Care: This means services and supplies provided to help you in the activities of daily life. Examples of custodial care include (but are not limited to):

- Routine patient care, such as changing dressings, turning and positioning the patient in bed, and administering medications;
- Respite care, adult or child day care, or convalescent care;
- Help with daily living activities such as walking, bathing, dressing, and eating; or
- Any service that can be performed by a person who has no medical or paramedical training.

Such services and supplies are custodial care no matter who prescribes, recommends, or performs them.

Dentist: This means a legally qualified dentist or a physician licensed to do the dental work he or she performs.

Detox/Detoxification: This is care mainly to overcome the aftereffects of a specific episode of drinking or substance abuse.

Disability: This means that, due to injury or illness:

- An employee is not able to work at his or her customary occupation and is not working at any occupation for pay or profit.
- A dependent is not able to engage in most of the normal activities of a healthy person of the same age and gender.

Domestic Partner: Refer to Who Is Eligible for the definition of a domestic partner.

Durable Medical Equipment: This is equipment – and the accessories needed to operate it – that is:

- Made to withstand prolonged use and suited for use in the home;
- Made for and used mainly in the treatment of a disease or injury;
- Not normally of use to people who do not have a disease or injury;
- Not for use in altering air quality or temperature; and
- Not for exercise or training.

Effective Treatment of Alcohol or Substance Abuse: This means a program of alcohol or substance abuse therapy that is prescribed and supervised by a behavioral health provider and either:

- Has a follow-up therapy program directed by a physician on at least a monthly basis; or
- Includes meetings at least once a month with organizations devoted to the treatment of alcohol or substance abuse.

Note: Maintenance care (providing an alcohol- and/or drug-free environment) and detoxification are not considered "effective treatment."

Effective Treatment of a Mental Disorder: This is a program that:

- Includes a written treatment plan that is prescribed and supervised by a behavioral health provider;
- Includes follow-up treatment; and
- Is for a disorder that can be changed for the better.

Emergency Condition: This means a recent and severe medical condition – including but not limited to severe pain – that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that your condition, sickness, or injury is of such a nature that failure to get immediate medical care could result in:

- Placing your health in serious jeopardy; or
- Serious impairment to bodily function; or
- Serious dysfunction of a body part or organ; or
- Serious jeopardy to the health of the fetus (in the case of a pregnant woman).

Experimental or Investigational: A drug, device, procedure, or care is considered experimental or investigational if:

- There are insufficient outcomes data available from controlled clinical trials published in the peer-reviewed literature to substantiate its safety and effectiveness for the illness or injury involved; or
- It does not have the approval required for marketing by the U.S. Food and Drug Administration (FDA); or
- A nationally-recognized medical or dental society or regulatory agency has determined, in writing, that it is experimental, investigational, or for research purposes; or
- It is a type of drug, device, or treatment that is the subject of a Phase I or Phase II clinical trial or the experimental or research arm of a Phase III clinical trial, using the definition of "phases" indicated in regulations and other official actions and publications of the FDA and U.S. Department of Health and Human Services; or
- The written protocol(s) or written informed consent used by the treating facility – or another facility studying the same drug, device, treatment, or procedure – states that it is experimental, investigational, or for research purposes.

Home Health Care: This is skilled nursing and other therapeutic services provided by a home health care agency in a home setting as an alternative to confinement in a hospital or skilled nursing facility.

Hospice Care: This is palliative and supportive care, either on an inpatient or outpatient basis, given to a terminally ill person and to his or her family. The focus of hospice programs is to allow terminally ill patients to remain, for as long as they can, in the familiar surroundings of their home.

Hospice Care Facility: This is a facility, or distinct part of one, that mainly provides inpatient hospice care to terminally ill persons, and

- Meets any licensing or certification standards established by the jurisdiction where it is located;
- Keeps a medical record for each patient;
- Provides an ongoing quality assurance program, including reviews by physicians other than those who own or direct the facility;
- Is run by a staff of physicians (at least one staff physician must be on call at all times) and provides 24-hour-a-day nursing services under the direction of an RN; and
- Has a full-time administrator.

Hospital: This is a place whose main purpose is to provide on-site, inpatient medical, surgical and diagnostic services. The facility must:

- Be supervised by a staff of physicians and provide 24 hour-a-day RN service, and
- Operate in accordance with the laws of the jurisdiction in which it is located.

The Plan also recognizes a facility that does not meet all of the requirements above, but does meet the hospital licensing requirements where it operates, and is accredited as a hospital by the Joint Commission on the Accreditation of Healthcare Organizations.

Infertile or Infertility: A person is considered infertile if he or she is unable to conceive or produce conception after:

- *For a woman who is under age 35*: one year of timed, unprotected heterosexual sexual intercourse, or 12 cycles of artificial insemination.
- *For a woman who is age 35 or older*: 6 months of timed, unprotected heterosexual sexual intercourse, or 6 cycles of artificial insemination.

In-Network Pharmacy: A pharmacy, including a mail-order pharmacy, that has a contract with Aetna to dispense drugs to members covered by this Plan.

LPN: This means a licensed practical nurse.

Mail-Order Pharmacy: An establishment where prescription drugs are legally dispensed by mail.

Mental Disorder: This is a disease commonly understood to be a mental disorder whether or not it has a physiological or organic basis. Treatment for mental disorders is usually provided by or under the direction of a behavioral health provider such as a psychiatrist, psychologist, or psychiatric social worker. Mental disorders include (but are not limited to):

- Alcohol and substance abuse
- Schizophrenia
- Bipolar disorder
- Panic disorder
- Major depressive disorder
- Psychotic depression
- Obsessive compulsive disorder

Morbid Obesity: This means:

- Your body mass index (BMI) is more than 40; or
- Your BMI is more than 35 and you have one of the following conditions:
  - Coronary heart disease; or
  - Type 2 diabetes mellitus; or
  - Clinically significant obstructive sleep apnea; or
  - Medically refractory hypertension (blood pressure greater than 140 mmHg systolic and/or 90 mmHg diastolic, despite optimal medical management).

Body mass index (BMI) is a marker that is used to assess the degree of obesity. To calculate your BMI:

- Multiply your weight in pounds by 703.
- Divide the result by your height in inches.
- Divide that result by your height in inches again.

Necessary/Medically Necessary: A service or supply furnished by a particular provider is medically necessary if Aetna determines that it is appropriate for the diagnosis, care, or treatment of the disease or injury involved. To be appropriate, the service or supply must be:

- As likely to produce a significant positive outcome (and no more likely to produce a negative outcome) as any alternative service or supply, considering the patient's overall health condition;
- A diagnostic procedure that is as likely to result in information that could affect the course of treatment in a positive manner (and no more likely to produce a negative outcome) as any alternative diagnostic procedure, service, or supply;
- No more costly than any alternative service or supply, taking into account all health expenses incurred in connection with the service or supply;
- Consistent with current standards of medical or health practice, and must require the technical skills of a medical, mental health, or dental professional;
- Provided in the appropriate setting; and
- Not primarily for the convenience of the patient, the patient's family, or the patient's physician or other provider.

In determining if a service or supply is appropriate under the circumstances, Aetna will take into consideration:

- Information provided on your health status;
- Reports in peer-reviewed medical literature;
- Reports and guidelines published by nationally recognized health care organizations that include supporting scientific data;
- Generally recognized professional standards of safety and effectiveness in the United States for diagnosis, care, or treatment;
- The opinion of health professionals in the generally recognized health specialty involved; and
- Any other relevant information brought to Aetna's attention.

The following services or supplies are ***not*** considered necessary:

- Those that do not require the technical skills of a medical, mental health or dental professional; or
- Those provided mainly for the personal comfort or convenience of you, any person who cares for you, any person who is part of your family, and any health care provider or health care facility; or
- Those provided only because you are an inpatient on any day when your disease or injury could safely and adequately be diagnosed or treated while not confined as an inpatient; or
- Those provided only because of the setting, if the service or supply could safely and adequately be furnished in a physician's or a dentist's office or other less costly setting.

Non-Occupational Disease: A non-occupational disease is a disease that does not:

- Result from (or in the course of) any work for pay or profit; or
- Result in any way from a disease that does.

A disease will be considered non-occupational regardless of its cause if proof is provided that you:

- Are covered under any type of workers' compensation law; and
- Are not covered for that disease under such law.

Non-Occupational Injury: A non-occupational injury is an accidental bodily injury that does not:

- Result from (or in the course of) any work for pay or profit; or
- Result in any way from an injury that does.

Pharmacy: A retail or mail-order facility where prescription drugs are legally dispensed.

Physician: This means a legally qualified physician. The term "doctor" is also used in this book, and has the same meaning as "physician."

Prescriber: Any physician or dentist, while acting within the scope of his or her license, who has the legal authority to write an order for a prescription drug.

Prescription: A prescriber's order for a prescription drug. If it is an oral order (such as a phoned-in prescription), it must be put in writing promptly by the pharmacy.

Prescription Drugs: A drug, biological, or compounded prescription that, by federal law, may be dispensed only by prescription and that is required to be labeled "Caution: Federal law prohibits dispensing without prescription."

Psychiatric Hospital: A facility whose main purpose is to provide a program for the diagnosis, evaluation, and treatment of mental disorders or alcohol or substance abuse. The facility must:

- Provide infirmary-level medical services, and provide (or arrange with a hospital in the area to provide) any other medical service that may be needed.
- Be supervised full-time by a psychiatric physician who is there regularly and responsible for patient care.
- Be staffed by psychiatric physicians involved in care and treatment. A psychiatric physician must be present during the whole treatment day.
- Provide, at all times:
  - Psychiatric social work and nursing services; and
  - Skilled nursing services by licensed nurses who are supervised by a full-time RN.
- Prepare and maintain a written plan of treatment for each patient. The plan must be supervised by a psychiatric physician.
- Meets licensing standards.

A psychiatric hospital is not mainly a school or custodial, recreational, or training institution.

RN: This means a registered nurse.

Reasonable and Customary Charge: The Plan covers only that part of a charge which is reasonable and customary. The reasonable and customary charge for a service or supply is the lowest of:

- The provider's usual charge to provide a service or supply; and
- The charge Aetna determines to be appropriate, based on factors such as:
  - The cost of supplying the same or a similar service or supply; and
  - The way charges for the service or supply are made, billed, or coded.

For non-facility charges: Aetna uses the 85th percentile of charges as reported in a database of charges that Aetna receives from a third party. Aetna may contribute information to the third party that is used in assembling the database.

For facility charges: Aetna uses the charge Aetna determines to be the usual charge level for the service in the geographic area where the service is furnished.

When a service or supply is unusual, not often provided in the area, or provided by only a small number of providers in the area, Aetna may take into account such factors as:

- The duration and complexity;
- Whether multiple procedures are billed at the same time, but no additional overhead is required;
- Whether an assistant surgeon is involved and **necessary** for the service;
- Whether follow-up care is included;
- Whether there are any other factors that modify or make the service unique; and
- Whether any services are part of or incidental to the primary service provided if the charge includes more than one claim line.

Aetna's reimbursement policies are based on:

- Aetna's review of policies developed for Medicare;
- Generally accepted standards of medical and dental practice; and
- The views of physicians and dentists practicing in the relevant clinical areas.

In some circumstances, Aetna may have an agreement with a provider (either directly, or indirectly through a third party) which sets the rate that Aetna will pay for a service or supply. In these instances, in spite of the methodology described above, the reasonable and customary charge is the rate established in such agreement.

Residential Treatment Center: This is an institution that specializes in the treatment of psychological and social disturbances that are the result of mental health or substance abuse conditions, and:

- Provides a sub-acute, structured, psychotherapeutic treatment program under the supervision of physicians;
- Provides 24-hour care, in which the patient lives in an open setting; and
- Is licensed as a residential treatment center in accordance with the laws of the appropriate legally authorized agency.

Room and Board Charges: Charges made by an institution for room and board and other necessary services and supplies. The charges must be regularly made at a daily or weekly rate.

If a hospital or other health care facility doesn't identify the specific amounts charged for room and board charges and other charges, Aetna will assume that 40% of the total is the room and board charge, and 60% is other charges.

Semi-Private Room Rate: This is the room and board charge that an institution applies to the most beds in its semi-private rooms with 2 or more beds. If there are no such rooms, Aetna will figure the rate based on the rate most commonly charged by similar institutions in the same geographic area.

Skilled Nursing Facility: This is a facility whose main purpose is to provide skilled nursing care and related services for patients who need medical care or rehabilitation services because of injury, illness, or disability.

A skilled nursing facility must be licensed or approved under state or local law, and:

- Qualify as a skilled nursing facility under Medicare, or as an institution accredited by:
  - The Joint Commission on Accreditation of Health Care Organizations;
  - The Bureau of Hospitals of the American Osteopathic Association; or
  - The Commission on the Accreditation of Rehabilitative Facilities.
- Provide 24-hour-a-day nursing care by licensed nurses directed by a full-time RN, and be supervised full-time by a physician or RN.
- Keep a complete medical record for each patient.
- Have a utilization review plan.

A skilled nursing facility may be a rehabilitation hospital or a portion of a hospital designated for skilled or rehabilitation services.

The following do not qualify as skilled nursing facilities:

- Institutions that provide only minimal care, custodial care services, ambulatory services, or part-time care services.
- Institutions that mainly treat alcohol or substance abuse or mental disorders.

Specialist: A specialist is a physician who practices in any generally accepted medical or surgical sub-specialty, and provides care that is not considered routine medical care.

Surgery Center: This is a freestanding ambulatory surgical facility that is licensed, set up, equipped, and run to provide general surgery, and:

- Is directed by a staff of physicians, at least one of whom is on the premises when surgery is performed and during the recovery period.
- Has at least one certified anesthesiologist at the site when surgery that requires general or spinal anesthesia is performed, and during the recovery period.
- Extends surgical staff privileges to physicians who practice surgery in an area hospital and to dentists who perform oral surgery.
- Has at least two operating rooms and one recovery room.
- Provides or arranges with a medical facility in the area for diagnostic X-ray and laboratory services needed in connection with surgery.
- Does not have a place for patients to stay overnight.

- Provides, in the operating and recovery rooms, full-time skilled nursing services directed by an RN.
- Is equipped and has staff trained to handle medical emergencies. The facility must have:
  - A physician trained in CPR, a defibrillator, a tracheotomy set, and a blood volume expander; and
  - A written agreement with an area hospital for the immediate emergency transfer of patients.
- Provides an ongoing quality assurance program that includes reviews by physicians who do not own or direct the facility.
- Keeps a medical record for each patient.

Terminally Ill: This is a medical prognosis of six months or less to live.

Treatment Facility (Alcohol or Substance Abuse): This is a facility that mainly provides a program for diagnosis, evaluation, and effective treatment of alcohol or substance abuse, and:

- Meets licensing standards.
- Prepares and maintains a written plan of treatment for each patient. The plan must be based on medical, psychological, and social needs. It must be supervised by a physician.
- Provides, on the premises, 24 hours a day:
  - Detoxification services needed for its effective treatment program.
  - Infirmary-level medical services. Also, it provides, or arranges with a hospital in the area for, any other medical services that may be required.
  - Supervision by a staff of physicians.
  - Skilled nursing care by licensed nurses who are directed by a full-time RN.

Treatment Facility (Mental Disorder): This is a facility that mainly provides a program for the diagnosis, evaluation, and effective treatment of mental disorders, and:

- Is not mainly a school or a custodial, recreational, or training institution.
- Provides infirmary-level medical services. Also, it provides, or arranges with a hospital in the area for, any other medical service that may be required.
- Is supervised full-time by a psychiatrist who is responsible for patient care and is there regularly.
- Is staffed by psychiatric physicians involved in care and treatment.
- Has a psychiatric physician present during the whole treatment day.
- Provides, at all times, psychiatric social work and nursing services, and skilled nursing care by licensed nurses who are supervised by a full-time RN.
- Prepares and maintains a written plan of treatment for each patient based on medical, psychological, and social needs. The plan must be supervised by a psychiatric physician.
- Meets licensing standards.

Urgent Care Provider: This is a freestanding medical facility that provides unscheduled medical services to treat an urgent condition if your physician is not reasonably available, and:

- Routinely provides ongoing unscheduled medical services for more than 8 consecutive hours;
- Is licensed and certified as required by state or federal law or regulation;
- Keeps a medical record for each patient;
- Provides an ongoing quality assurance program, including reviews by physicians other than those who own or run the facility;
- Is run by a staff of physicians, with one physician on call at all times; and
- Has a full-time administrator who is a physician.

A hospital emergency room or outpatient department is not considered to be an urgent care provider.

Urgent Condition: This is a sudden illness, injury, or condition that:

- Is severe enough to require prompt medical attention to avoid serious health problems;
- Includes a condition that could cause you severe pain that cannot be managed without urgent care or treatment;
- Does not require the level of care provided in a hospital emergency room; and
- Requires immediate outpatient medical care that can't be postponed until your physician becomes reasonably available.

Walk-In Clinic: A free-standing health care facility that treats unscheduled and/or non-emergency illnesses and injuries, and administers certain immunizations.

A walk-in clinic must be licensed and certified as required by any state or federal law or regulation, and:

- Provide unscheduled and/or non-emergency medical services;
- Be staffed by independent practitioners, such as Nurse Practitioners, licensed in the state where the clinic is located;
- Keep a medical record on each patient;
- Provide an ongoing quality assurance program;
- Have at least one physician on call at all times; and
- Have a physician who sets protocol for clinical policies, guidelines and decisions.

A hospital emergency room or outpatient department is not considered a walk-in clinic.

Resources and Tools

Resources

When you have questions or need more information, here are some of the resources available to you.

Resource	Situation	How to Contact
Human Resources Office	Contact your local NAF Human Resources Office (HRO) or use the online enrollment and address change service (where available) when: • You have a qualifying life event (for example: a change in marital status or the addition of a dependent) • You need to report a change in your name, address, or telephone number	Contact your local NAF HRO or see the servicing HRO at your local installation.
Aetna Member Services	Contact Member Services when: • You have questions about the Plan's benefits • You are required to obtain prior approval for a service (precertification) • You have a question about a claim	Phone: 1-888-506-2278 (toll free) 1-813-775-0189 (direct) Address: Aetna International P.O. Box 981543 El Paso, TX 79998-1543 Online: send an email to **www.DODNAF@aetna.com**
International Health Advisory Team (IHAT)	IHAT can help you with: • Emergencies • Finding medical devices and prescription medicines	Phone: call Aetna Member Services at the number shown above and ask to speak to an IHAT nurse Online: click on *Contact IHAT* on the Aetna International home page at **www.aetnainternational.com**
Aetna Navigator®	Use Aetna Navigator when you need: • Eligibility or claim status information • A replacement ID card • Copies of claim forms • Access to tools that help you manage your health care	Online: **www.aetna.com**

International Health Advisory Team (IHAT)

The International Health Advisory Team (IHAT) gives you a single point of contact for routine and special health care needs. The team has extensive experience with health care delivery systems throughout the world and can help with emergencies, medical case management, finding medical devices and prescription medications, and other needs. You can contact IHAT by calling Aetna Member Services at **1-888-506-2278** (toll-free) or **1-813-775-0189** (direct).

Aetna International Online

You can find online tools at **www.aetnainternational.com** that help you locate health care providers and give you other useful information when you are overseas, such as:

- A database of international direct pay hospitals;
- An international directory of physicians;
- CityHealth℠ profiles, with information about health risks, vaccinations, local health systems, emergency phone numbers, and currencies in hundreds of locations; and
- Translation databases for drug names and medical terms and phrases.

Health Information Website

Aetna Navigator® is Aetna's benefits and health information website. Aetna Navigator gives you access to secure, personalized features, allowing you to:

- Print eligibility information;
- Request a replacement ID card or print a temporary ID card;
- Download copies of claim forms;
- Check the status of a claim;
- Find benefit balances; and
- Contact Aetna Member Services.

Aetna Navigator also gives you access to useful tools that help you manage your health care:

- **Aetna InteliHealth®** lets you search a wide variety of topics, from specific health conditions and their treatment to the latest developments in disease prevention, wellness, and fitness.
- **Cost of Care***,* a tool that allows you to research the costs of office visits, medical tests, and selected medical procedures in your area.
- **DocFind®**, Aetna's online provider directory, gives you the most recent information on the providers in the Aetna U.S. network.
- **Health History Report***,* an easy-to-understand summary of doctor visits, tests, treatments, and other health-related activity, based on claim activity. You can print your Health History Report and share it with your doctor.
- **Health Topics A-Z***,* the Healthwise® Knowledgebase is a decision-support tool that provides information on thousands of health-related topics to help you make better decisions about health care and treatment options.

- **Hospital Comparison Tool**, helps you compare area hospitals on measures that are important to your health.
- **Simple Steps To A Healthier Life®**, a personalized online health and wellness program that offers resources to help you eat healthier, get in shape, relieve stress, and more. The program can help you discover convenient ways to achieve a healthier, more balanced life.

  Simple Steps features:

  - A *health assessment* to help you identify your health needs;
  - Personalized *health reports* and a one-page *health summary* to share with your doctor, all based on your completed assessment;
  - A personalized *action plan* recommending online programs in areas such as nutrition, fitness, stress relief, and smoking cessation – chosen for you based on your health needs; and
  - Interactive *tools* such as the Diet Manager, Walking Challenge, Healthy Shopping List, and Fitness Planner.

You can access Aetna Navigator at **www.aetna.com**.

Clinical Policy Bulletins

Aetna uses its Clinical Policy Bulletins (CPBs) as a resource when making benefit and claim decisions. CPBs are written on selected health care topics, such as new technologies and new treatment approaches and procedures. The CPBs describe whether Aetna has determined that a service or supply is medically necessary, based on clinical information.

You can find the CPBs at **www.aetna.com**. The language of the CPBs is technical because it was developed for use in benefit administration, so you should print a copy and review it with your doctor if you have questions.

Keep in Mind

- The CPBs define whether a service or supply is medically necessary, but they do not define whether the service or supply is covered by the Plan. This book describes what is covered and what is not covered by the Plan.
- If you have questions about your coverage, you can contact Aetna Member Services, toll-free, at **1-888-506-2278** (toll free) or **1-813-775-0189** (direct).

Health Incentive Credits

You can reduce your deductible and/or coinsurance by taking healthy actions:

- Employees, retirees and dependents age 18 or older, you can earn incentive credits when you:
  - Have a routine physical exam
  - Take or update the Simple Steps to a Healthier Life® online health assessment on Aetna Navigator at **www.aetna.com**
  - Complete an Online Wellness Program
  - Respond to items on Member Health Engagement Plan "To Do" List

  A $50 credit is applied toward your deductible and/or coinsurance after you complete each action, up to the individual and family maximums described below.

- Dependents under age 18, you can earn a $100 incentive credit by having a well-child exam.

The credit can be applied only toward your deductible and/or coinsurance – it cannot be applied to copayments.

If you have family coverage, the members of your family can also earn the incentive credit. The maximum credit depends on the number of covered family members:

- Individual (employee-only): $150 maximum per calendar year
- Family of two: $300 maximum per calendar year
- Family of three or more: $450 maximum per calendar year

The credit will roll over to the next calendar year (for up to three years) if you are unable to use it in the year earned.

Additional U.S.-Based Programs

The programs and resources described below are available when you are in the 50 states.

The National Medical Excellence Program®

The National Medical Excellence Program® (NME) helps you receive care from nationally recognized doctors and facilities experienced in performing organ transplants, bone marrow transplants, and other complicated procedures.

Travel and Lodging

When NME arranges for treatment at a facility more than 100 miles from your home, the Plan provides travel and lodging allowances for you and one companion**,** including round trip (air, train or bus) transportation costs (coach class only) or mileage, parking, and tolls if traveling by auto.

Benefits for travel and lodging expenses are subject to a maximum of $10,000 per transplant or procedure. Lodging expenses are subject to a $50 per night maximum per person, or $100 per night total.

The Plan will pay for travel and lodging expenses beginning on the day you become a participant in the National Medical Excellence Program. Coverage ends either:

- One year after the day a covered procedure was performed; or
- On the date you cease to receive any services from the program provider in connection with the covered procedure; or
- On the date your coverage terminates under the Plan.

The Plan covers only those services, supplies, and treatments considered necessary for your medical condition. The Plan does ***not*** cover treatment considered experimental or investigational (as determined by Aetna).

> *Keep in Mind*
>
> Travel and lodging expenses must be approved in advance by Aetna. The Plan does not cover expenses that are not approved.

The Institutes of Excellence™ Network

Through the Institutes of Excellence™ (IOE) network, you have access to a provider network that specializes in transplants. Each facility in the IOE network has been selected to perform only certain types of transplants, based on quality of care and successful clinical outcomes. Through the IOE Program, you can receive care for the following transplants:

- Bone marrow
- Heart
- Heart and lung
- Kidney
- Kidney and pancreas
- Liver
- Lung
- Pancreas

You are encouraged to use an IOE facility when you need a transplant in the 50 states because of their experience with this highly specialized care.

Discount Programs

When you are in the 50 states, you can take advantage of discounts on health and wellness services and supplies. To learn more about the following, log on to Aetna Navigator at **www.aetna.com**.

If you'd like to learn more about discounts on:	Go to www.aetna.com and read about:
■ fitness services	Aetna Fitness℠ discount program
■ hearing services and supplies	Aetna Hearing℠ discount program
■ savings on natural therapies and products	Aetna Natural Products and Services℠ program
■ vision services and supplies	Aetna Vision℠ discount program
■ weight loss products and programs	Aetna Weight Management℠ discount program

HIPAA Privacy Rights

Protecting Your Privacy

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) protects the privacy of health information that is related to your coverage under the Plan. This information is called Protected Health Information (PHI). PHI is information about you that is related to your past, present, or future health care treatment or payment for health care services. The HIPAA rules:

- Govern how employers may use and disclose PHI;
- Require employers to provide participants in a health care plan with a notice that explains the practices that are in place to protect PHI; and
- Require employers to abide by the terms of the privacy notice.

This notice describes how the DoD NAF employers may use and disclose your PHI. It also describes your rights with respect to your PHI and how you can exercise those rights.

The DoD NAF employers may, at times, update this notice. Changes to the notice will apply to both current and future PHI that the DoD NAF employers have about you.

Use and Disclosure of Your Health Information

The DoD NAF employers sponsor the DoD NAF Health Benefits Program (HBP). The medical benefits described in this book and referred to as “the Plan” are part of the DoD NAF HBP. The DoD NAF employers hire business associates, such as Aetna, to help in the administration of the Plan. Each business associate of the Plan must agree in writing to ensure the continuing confidentiality and security of your PHI.

In the course of providing and administering health care benefits, the DoD NAF employers and business associates receive and maintain information about you. HIPAA allows the use and sharing of your PHI, without your consent or authorization, for the following purposes:

- *Treatment*: PHI may be shared with health care providers for coordination and management of health care. Health care providers include physicians, hospitals, and other caregivers who provide health care services.
  For example, the Plan may give PHI to your physician, upon request, when related to your medical care.
- *Payment*: PHI may be shared to determine eligibility, coordinate care, review medical necessity, pay claims, obtain external review, and respond to complaints.
  For example, information from your health care provider may be used to help process your claims. Your personal information may also be used and shared to obtain payment from others that may be responsible for such costs.
- *Health care operations and services*: Personal information may be used and shared as part of Plan operations and services such as credentialing of providers; quality improvement activities; grievance or external review programs; and disease management, case management, and care coordination. This may also include general administrative activities such as detection and investigation of fraud, auditing, and underwriting.
  For example, the Plan may use or share your personal information to inform you about a disease management program.

- *As required by law.* PHI may be disclosed when required by federal, state, or local law. For example, the Plan must allow the U.S. Department of Health and Human Services to audit Plan records. The Plan may also disclose your PHI as authorized by, and to the extent necessary to comply with, Workers' Compensation or other similar laws.

PHI may also be used or shared for the following (this is not an inclusive list):

- *Health care oversight and law enforcement*: to comply with federal or state oversight agencies. These may include your state Department of Insurance or the U.S. Department of Labor.
- *Legal proceedings*: to comply with a court order or other lawful process.
- *Treatment options*: to inform you about treatment options or health related benefits or services.
- *Plan sponsors*: to permit health plan sponsors to administer your benefits.
- *Research*: to researchers where all procedures required by law have been taken to protect the privacy of the data.
- *Others involved in your health care*: certain personal information may be shared with a relative, such as your spouse, close personal friend, or others whom you have identified as being authorized to receive information about your health care.
- *Personal representatives*: personal information may be shared with people you have authorized to act on your behalf. Examples include parents of an unemancipated minor or those having a Power of Attorney.
- *Business associates*: to persons providing services to the DoD NAF employers, and who have agreed in writing that they will protect the information.
- *Other situations*: personal health information may also be shared in certain public interest situations. Examples include protecting victims of abuse or neglect, preventing a serious threat to health or safety, and tracking diseases or medical devices as required by law.

Other Sharing of Information and Treatment of Information If You Are No Longer Enrolled

The DoD NAF employers and business associates will obtain your written permission to use or share your health information for reasons not identified by this notice. If you withdraw your permission, your health information will not be used or shared in the future for those reasons.

Your information is not destroyed when your coverage ends. It may be necessary to use and share your information, for many of the purposes described above, even after your coverage ends. However, your information will continue to be protected regardless of your coverage status.

Your Rights

HIPAA provides you with certain rights. You must make a written request to exercise these rights:

- *Requesting restrictions*: You have the right to request a restriction on the use or sharing of your health information for treatment, payment, or health care operations. The DoD NAF employers are not legally required to agree to a requested restriction. However, if your requested restriction is agreed to, it will be treated as if it is part of the HIPAA Privacy Rule.
- *Confidential communications*: You can request that the DoD NAF employers communicate with you about your health and related issues in a certain way, or at a certain location. For example, you may ask that the DoD NAF employers contact you by mail, rather than by

telephone, or at work, rather than at home. The DoD NAF employers will accommodate reasonable requests.

- *Access and copies*: You can obtain a copy of your PHI. There may be a fee for the costs of copying, mailing, labor, and supplies related to your request. Your request for PHI may be refused in some situations. If your request is denied, the denial may be reviewed. The review will be done by someone who was not involved in the original decision to deny your request.
- *Amendment*: You may ask to have PHI amended if you believe it is incorrect or incomplete. You must provide your request and the reason for your request in writing. Your request may be denied if the information you want to amend:
  - Is accurate and complete;
  - Was not created by the DoD NAF employers, unless the person or entity that created the PHI is no longer available to make the amendment;
  - Is not part of the PHI kept by the DoD NAF employers; or
  - Is not part of the Protected Health Information that you would be permitted to inspect and copy.
- *Accounting of disclosures*: You may request a list of the disclosures made by the DoD NAF employers or business associates. All requests for an accounting of disclosures must state a time period that cannot be more than 6 years prior to the date of the request and may not include dates before April 14, 2003. You do not have to pay for the list, unless you requested a similar list within the previous 12 months. In that situation, you'll be told the cost for an additional request, and you may withdraw your request before you incur any costs.

Filing a Complaint or Receiving Additional Information

If you have any questions about this notice, please contact your NAF employer or.

Department of Defense/DCPAS/HROPS
NAF Personnel Policy Division
Attn: DoD NAF HBP Privacy Officer
4800 Mark Center Drive, Suite 05G21
Alexandria, VA 22350-1100

If you believe your privacy rights have been violated, you may contact your NAF employer or:

Secretary of the Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue S.W.
Washington, DC 20201.

You will not be retaliated against for filing a complaint.

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