Your Health Benefits Program

DENTAL PLAN

Summary Plan Description

The Department of Defense
Nonappropriated Fund
Health Benefits Program

Contents

Welcome

Your health and well being are important. That's why the Department of Defense Nonappropriated Fund (DoD NAF) employers offer you a flexible benefits package that helps you maintain good health. This book provides important information about the PPO Dental Plan (the Plan) that is part of the DoD NAF Health Benefits Program (HBP).

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 Dependents for more information about eligible dependents.

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 enrolled in a DoD NAF medical plan (including an HMO plan that does not have a dental rider);
- Is scheduled to work at least 20 hours per week;
- Is 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 dental 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 dental plan.

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 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:

- 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.
- 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.

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

Open enrollment periods are held every two years (biennial). During an 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 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. The Plan does, however, allow a retired employee who is enrolled in TRICARE-for-Life and eligible for Medicare to return immediately to the DoD NAF HBP if there is an involuntary loss of TRICARE-for-Life coverage.

Status Changes

Once enrolled, you may make changes only:

- During 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 have a qualifying life event such as marriage, birth, or adoption.

You must request any change within 31 days after 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 dependent 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 dental 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 may pay your share of the cost of Plan coverage 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 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 dental providers before receiving services.

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

Your Dental Plan at a Glance

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 ***necessary***, as determined by Aetna.
- The Plan covers only expenses related to ***non-occupational injury*** and ***non-occupational disease*.**
- 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:
  - Oral exams and cleanings;
  - Problem-focused exams;
  - X-rays, including bitewings;
  - Fluoride applications;
  - Sealants;
  - Orthodontia;
  - Oral surgery; and
  - Treatment of temporomandibular joint (TMJ) disorder.

  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.

  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.
- In-network providers have agreed to charge no more than the ***negotiated charge*** for a service or supply that is covered by the Plan. You are not responsible for amounts that exceed the negotiated charge when you obtain care from an in-network provider, and your provider cannot bill you for the balance.
- The Plan pays out-of-network benefits only for the part of a covered expense that is reasonable and customary. If your out-of-network 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.

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

Keep in Mind

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

Cost Sharing

Plan Feature	You Pay
Deductible Applies to Basic and Major Restorative Services.	
Individual	$100 per calendar year
Family of 2	$200 per calendar year
Family of 3 or more	$300 per calendar year
Calendar Year Maximum Benefit Applies to Diagnostic and Preventive, Basic, and Major Restorative Services. Oral surgery, orthodontia, and TMJ treatment are not subject to the calendar year maximum.	
Individual	$2,500
Orthodontia Lifetime Maximum Benefit	
Individual	$2,000
TMJ Lifetime Maximum Benefit	
Individual	$750

Covered Services

Covered Services	Benefit Level • in-network: based on negotiated charge • out-of-network based on reasonable and customary charge
Diagnostic and Preventive Services	
Diagnostic and Preventive Services include: • Oral exams (2 per calendar year) • Cleanings (2* per calendar year) • Fluoride applications (2 treatments per calendar year) • Sealants for children under age 18 (1 application to permanent bicuspids and molars per 3-year period) • Diagnostic X-rays • Problem-focused exams (2 per calendar year) * 3 cleanings per calendar year are covered if you have certain medical conditions such as pregnancy, diabetes or heart disease. See Diagnostic and Preventive Services for more information.	The Plan pays 100% No deductible

Covered Services

Covered Services	Benefit Level • in-network: based on negotiated charge • out-of-network: based on reasonable and customary charge
Basic Services	
Basic Services include: • Simple extractions • Fillings • Periodontal care • Endodontic care • Space maintainers for children under age 19 • Dentures	You pay deductible, then the Plan pays 80%
Oral surgery	The Plan pays 100% of the first $1,000, then 80% of the balance No deductible
Major Restorative Services	
Major Restorative Services include: • Inlays, onlays, gold fillings, and crowns • Fixed bridgework	You pay deductible, then the Plan pays 50%
Treatment of TMJ disorder	The Plan pays 50%, up to the TMJ lifetime maximum No deductible
Orthodontia	
Orthodontic Treatment	The Plan pays 50%, up to the orthodontia lifetime maximum No deductible

How the Plan Works

The Plan pays benefits for covered expenses. You must be covered by the Plan on the date when you incur a covered dental expense. The Plan does not pay benefits for expenses incurred before your coverage starts or after it ends, except as described in Ordered but Undelivered Rule.

The Provider Network

The Plan gives you the freedom to choose any licensed **dentist** or other dental care provider (in- or out-of-network) when you need dental care. How much you pay out of your own pocket depends on whether the expense is covered by the Plan and whether you choose an **in-network provider** or an **out-of-network provider**.

Providers who belong to Aetna's network are called in-network providers. The providers in the network represent a wide range of services, from routine care to specialized dental treatment. When they join the network, providers agree to provide services or supplies at **negotiated charges**.

To find an in-network provider in your area:

- **Use DocFind at www.aetna.com**. Follow the prompts to select the type of search you want, the area in which you want to search, and the number of miles you're willing to travel. For more about DocFind, turn to Resources and Tools.
- **Call Member Services**. A Member Services representative can help you find an in-network provider in your area. You can also request a printed listing of network providers in your area without charge. The toll-free number for Member Services is **1-800-367-6276**.

It's Your Choice

When you need dental care, you have a choice. You can select a dental provider that belongs to the network (an in-network provider) or one that does not belong (an out-of-network provider). The Plan's benefit level is the same for network care and out-of-network care, but there are advantages to choosing a network provider:

- *If you use an in-network provider*, you will probably save money because your share of the cost is based on the network provider's negotiated charge – you are not responsible for any amounts that are above the negotiated charge. You won't have to fill out claim forms, because your in-network provider will file claims for you.
- *If you use an out-of-network provider,* you may pay more out of your own pocket for your care. The Plan pays benefits for out-of-network care based on the **reasonable and customary charge**. If your dental care provider charges more than the reasonable and customary charge, you are responsible for the excess amount. You may be required to file your own claims for out-of-network care.

When You Need Dental Care

The Plan's annual deductible applies to most Basic and Major Restorative Services. You must meet the applicable deductible before the Plan begins to pay benefits for covered dental expenses.

> *Keep in Mind*
>
> The annual deductible does not apply to Diagnostic and Preventive Services, orthodontia, oral surgery, or treatment of TMJ disorder.

The Plan pays a percentage of your covered dental expenses (the Plan's coinsurance) and you pay the rest (your coinsurance). The percentage paid by the Plan depends on the type of expense, as shown in the Summary of Benefits.

The Plan's benefits for Diagnostic and Preventive Services, Basic Services (except oral surgery), and Major Restorative Services are subject to a calendar year maximum. There are separate lifetime maximum benefits for treatment of TMJ disorder and orthodontic treatment. These calendar year and lifetime maximums are shown in the Summary of Benefits.

> *Keep in Mind*
>
> The calendar year maximum is the most the Plan will pay for all of the dental expenses you incur in a calendar year. It applies even when there is a break in coverage.

Advance Claim Review

The advance claim review is a voluntary service that gives you information that you and your dentist can consider when deciding on a course of treatment.

The purpose of the advance claim review is to determine – in advance – the benefits (if any) that the Plan will pay for proposed services. Knowing ahead of time which services are covered by the Plan, and the benefit amount payable, helps you and your **dentist** make informed decisions about the care you are considering.

> *Keep in Mind*
>
> The advance claim review process is not a guarantee of benefit payment. It is an estimate of the amount or scope of benefits to be paid.

When to Get a Voluntary Advance Claim Review

An advance claim review is not required, but you are strongly encouraged to request one whenever a course of dental treatment is likely to cost more than $200. Ask your dentist to write down a full description of the treatment you need, using the Dental Benefits Request form. The form is available online at **www.aetna.com**. Then, ***before*** treating you, your dentist should send the form to Aetna. Aetna may ask for supporting X-rays and other diagnostic records. Once all of the information has been gathered, Aetna will review the proposed treatment plan and provide you and your dentist with a statement that outlines how the Plan will cover the treatment. You and your dentist can then decide how to proceed.

To determine the benefits payable, Aetna will consider alternate procedures, services, or courses of treatment for the dental condition concerned in order to accomplish the appropriate result. (See Alternate Treatment Rule for more information about alternate dental procedures.)

What Is a Course of Dental Treatment?

A course of dental treatment is a planned program of dental services or supplies. The services or supplies are provided by one or more dentists to treat a dental condition that was diagnosed by the attending dentist as a result of an oral examination. A course of treatment starts on the date your dentist first renders a service to correct or treat the diagnosed dental condition.

Alternate Treatment Rule

Sometimes there are several ways to treat a dental problem, all of which provide acceptable results. When this is the case, the Plan's coverage is limited to the least expensive service or supply that:

- Is customarily used nationwide for treatment;
- Is considered by the dental profession to be appropriate for treatment; and
- Meets broadly accepted national standards of dental practice, taking into account your current oral condition, as determined by Aetna.

Here are some examples of alternate treatment and the benefit limits that apply:

- *Reconstruction.* The Plan covers only charges for the procedure needed to eliminate oral disease and replace missing teeth. The Plan does not cover an **appliance** or **restoration** needed to increase vertical dimension or restore occlusion.
- *Partial dentures*. The Plan covers only charges for a cast chrome or acrylic **denture** if this satisfactorily restores an arch. This limit applies even if you and your dentist choose a more elaborate or precision appliance.
- *Complete dentures*. The Plan covers only charges for a standard procedure. This limit applies even if you and your dentist choose personalized or specialized treatment.

Ordered but Undelivered Rule

Your dental coverage may end while you are in the middle of treatment. The Plan does not cover any dental services that are given after your coverage terminates. There is an exception, however. The Plan will cover the following eligible services if they were ordered while you were covered by the Plan and installed within 60 days after your coverage ends:

- Dentures;
- Fixed **bridgework**;
- Removable bridges;
- Cast or process restorations;
- Root canals; and
- **Inlays, onlays,** and **crowns**.

"Ordered" means:

- For dentures: the **impressions** from which the denture will be made were taken.
- For a root canal: the pulp chamber was opened.
- For the other services listed above: the teeth which will serve as retainers or supports, or the teeth which are being restored:
  - Have been fully prepared to receive the item; and
  - Impressions have been taken from which the item will be prepared.

Dental Emergency

You have coverage 24 hours a day, 7 days a week, if you need emergency dental care to relieve pain or treat a condition that will get worse if you wait for treatment.

In general, a dental emergency:

- Occurs suddenly;
- Requires immediate treatment; and
- Has symptoms of severe pain, swelling, or bleeding.

The voluntary advance claim review process does not apply to dental emergencies.

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	The plan that covers you as an employee 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.

Coordination With Medicare

Medicare Parts A and B do not cover routine dental care or most dental procedures such as cleanings, fillings, tooth extractions, dentures, dental plates, or other dental devices. Medicare may pay for certain dental services that you get when you're in a hospital or for services related to accidental injury. In general, such expenses are not covered by the Dental Plan described in this book, but may be covered by a DoD NAF HBP medical plan option. For information about coverage for oral surgery and coordination with Medicare, refer to the separate book describing your medical plan option.

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 a dental condition. 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 **1-800-367-6276**.

Diagnostic and Preventive Services

Taking care of teeth now can prevent serious problems later. The Plan covers the following diagnostic and preventive care, without a deductible, up to the annual maximum:

- Two routine oral exams per calendar year. This includes prophylaxis, **scaling**, and cleaning of teeth.

  Maintaining good dental health is especially important for people with certain medical conditions. If you are pregnant or have diabetes, coronary artery disease or cerebrovascular disease (stroke), the Plan covers three cleanings per calendar year.

- Two problem-focused exams per calendar year.
- Two topical applications of sodium or stannous **fluoride** per calendar year.
- One application of sealants to permanent bicuspids and molars every three years for dependents under age 18.
- Diagnostic X-rays and other X-rays, but no more than:
  - One full mouth series per three-year period;
  - One set of **bitewing** X-rays per 6-month period; and
  - One set of vertical bitewings per three-year period.

Basic Services

The Plan covers basic restorative care, including:

- Emergency treatment for pain.
- Endodontic treatment, including **root canal therapy**.
- Fillings (except gold fillings).
- First installation of removable dentures to replace one or more natural teeth that were extracted while you were covered by the Plan. Coverage includes relines, rebases, and adjustments after the dentures are installed.
- General anesthesia and intravenous sedation when provided in conjunction with a covered surgical procedure.
- Injection of antiobiotic drugs.

- Oral surgery that is dental in nature. Dental-in-nature surgery involves the teeth, such as bone replacement grafts and surgical removal of impacted teeth.

  The calendar year deductible and maximum do not apply to oral surgery.
- Osseous surgery, limited to one per quadrant or per site in a three-year period.
- Partial and bony impactions.
- Relining or rebasing of dentures after six months.
- Repair or recementing of **crowns**, **inlays**, **bridgework**, or **dentures**.
- Replacement of an existing removable denture or fixed bridgework with a new denture, or the addition of new teeth to a partial removable denture, if you meet the Prosthesis Replacement Rule (see below).
- Simple extractions.
- Soft tissue grafts.
- Space maintainers needed to preserve space resulting from premature loss of deciduous (baby) teeth for children under age 19, including all adjustments within six months after installation.
- Treatment of periodontal and other diseases of the gums and tissues of the mouth.

Major Restorative Services

Major restorative care includes the replacement of natural teeth with bridgework or dentures. The Plan covers the following services:

- Inlays, **onlays**, gold fillings, and crowns, including precision attachments for dentures, when:
  - Needed to treat decay or traumatic injury, and the tooth cannot be restored with a filling material; or
  - The tooth is an abutment to a covered partial veneer or fixed bridge.
- First installation of fixed bridgework (including inlays and crowns as abutments) to replace one or more natural teeth that were extracted while you were covered by the Plan.
- Replacement of an existing removable denture or fixed bridgework with new fixed bridgework, or the addition of new teeth to existing fixed bridgework, if you meet the Prosthesis Replacement Rule (see below).
- Treatment of temporomandibular joint dysfunction or myofascial pain dysfunction, as follows:
  - Diagnostic oral exams and X-rays;
  - Restorative procedures to restore occlusion;
  - Auto repositioning appliances; and
  - Joint manipulation and other physical therapy involving structures of the jaw.

Keep in Mind

Treatment of temporomandibular joint dysfunction or myofascial pain dysfunction is limited to the TMJ lifetime maximum shown in the Summary of Benefits. The maximum applies even when there is a break in coverage.

Prosthesis Replacement Rule

Dentures and bridgework are subject to the Plan's prosthesis replacement rule. In order for the Plan to cover certain replacements or additions, you must give Aetna proof that:

- You or your covered dependent had a tooth (or teeth) extracted after the existing denture or bridgework was installed and while you were covered by the Plan. As a result, you need to have teeth replaced or added to your denture or bridgework.
- The present denture or bridgework was installed at least five years before its replacement and cannot be made serviceable.
- The present denture is an immediate temporary one that replaces a tooth (or teeth) extracted while you were covered by the Plan. A permanent denture is needed and the temporary denture cannot be used as a permanent denture. Replacement must occur within 12 months from the date the immediate temporary one was first installed.

Missing and Unreplaced Rule

The first installation of dentures, removable bridges, and fixed bridges will be covered if:

- The dentures or bridges are needed to replace one or more natural teeth that were removed while you were covered by the Plan; and
- They are not an abutment to a partial denture, removable bridge, or fixed bridge installed during the prior five years.

Orthodontic Treatment

Orthodontia benefits cover the straightening of teeth with braces or other methods. Coverage for **orthodontic treatment** includes:

- Comprehensive and limited orthodontic treatment;
- Post-treatment stabilization;
- Interceptive orthodontic treatment;
- Occlusal guard for bruxism, limited to one per three-year period; and
- Fixed and removable appliance therapy for harmful habits.

Benefits are limited to the lifetime maximum for orthodontic treatment shown in the Summary of Benefits. The maximum applies even when there is a break in coverage.

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

- Changes in treatment because of an accident.
- Invisible aligners (removable acrylic aligners).
- Invisible braces (lingually placed direct bonded appliances and arch wires).
- Maxillofacial surgery.
- Myofunctional therapy.
- Replacement of broken appliances.

- Retreatment of orthodontic cases.
- Surgical removal of impacted wisdom teeth when done for orthodontic reasons only.
- Treatment of cleft palate, micrognathia, or macroglossia.

When Orthodontic Treatment Starts

Your dentist or orthodontist must submit a claim for the orthodontic treatment plan. The plan should include the type and length of treatment, the total fee, and the date bands were placed.

Based on the banding date, the Plan's benefits for the treatment will be calculated and paid in installments, as follows:

- **Initial allowance**: 25% of the covered fee (based on the negotiated charge for in-network care or the reasonable and customary charge for out-of-network care) times 50% (the Plan's orthodontia coinsurance); then
- **Automatic quarterly reimbursement**: the remaining 75% of the total covered fee times 50% (the Plan's orthodontia coinsurance), prorated over the treatment period, up to the orthodontia lifetime maximum benefit shown in the Summary of Benefits.

Here is an example of the benefit calculation and payments for orthodontic treatment by an in-network provider:

Orthodontic Treatment Plan	
• Total fee	$4,000
• Covered fee (in-network negotiated charge)	$3,000
• Length of treatment	15 months (5 quarters)
• Date banded	March 1, 2013
How Benefits Are Calculated	
Initial allowance:	
• 25% of the covered fee, times 50% benefit level	$375 (.25 X $3,000 X .50)
Automatic quarterly reimbursement:	
• Remaining 75% of the covered fee, times 50% benefit level	$1,125 (.75 X $3,000 X .50)
• Monthly payment	$75 ($1,125 ÷ 15 months)
• Quarterly payment	$225 ($75 X 3)
• Total quarterly payments	$1,125 ($225 X 5 quarters in the treatment plan)
Total paid by the Plan	**$1,500 ($375 + $1,125)**

Keep in Mind

If your orthodontic treatment stops before it is complete, the Plan will cover only the services and supplies that were provided before treatment ended.

If Your Dental Coverage Ends Before Orthodontic Treatment Is Completed

When your dental coverage ends, the Plan's benefits will continue through the last month of active coverage.

Here is an example of how the benefits shown above would be different if coverage ends before the 15-month treatment plan is over:

Orthodontic Treatment Plan	
• Total fee	$4,000
• Covered fee (in-network negotiated charge)	$3,000
• Date banded	March 1, 2013
• Date coverage ends	August 31, 2013
How Benefits Are Calculated	
Initial allowance (March, 2013):	$375
Quarterly payments:	
• First quarterly payment (April, May, June, 2013)	$225
• Final payment (July and August, 2013) (monthly payment times 2 months)	$150 ($75 X 2 months).
Total paid by the Plan	**$750 ($375 + $225 + $150)**

What the Plan Does Not Cover

The Plan does not cover all dental 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:

- An illness, injury, or condition that is related to your employment or self-employment.
- Care in charitable institutions.
- Charges for cancelled or missed appointments.
- Charges made only because you have dental coverage.
- Charges that exceed the **reasonable and customary charge** for an out-of-network dental service, as determined by Aetna.
- Charges that exceed your in-network provider's **negotiated charge** for a given service or supply.
- Charges you are not legally obligated to pay.
- Claim form completion.
- Court-ordered services, including those required as a condition of parole or release.
- Dental services and supplies that are covered, in whole or in part, under any other part of this Plan or any other plan of group benefits provided by the DOD NAF employers.
- Examinations provided for employment, licensing, insurance, school, camp, sports, adoption, or other purposes that are not **necessary**, and related expenses for reports, including report presentation and preparation.
- Services and supplies Aetna determines are not necessary for the diagnosis, care, or treatment of the condition – even if they are prescribed, recommended, or approved by a **physician** or **dentist**.
- Treatment that is not given by a dentist. The Plan will cover cleaning and **scaling** by a licensed **dental hygienist** if supervised by a dentist.
- Work that was begun before the effective date of your coverage. For example:
  - If an impression was made for an appliance or a modification to an appliance before you were covered by the Plan, the appliance or modification is not covered.
  - If a tooth was prepared for a crown or bridge before you were covered by the Plan, the prosthetic is not covered.
  - If the pulp chamber was opened for root canal therapy before you were covered by the Plan, the therapy is not covered.

Services and Supplies

The Plan does not cover:

- Acupuncture, acupuncture therapy, or acupressure, except when performed by a **physician** as a form of anesthesia for surgery covered by the Plan.
- Braces, mouth guards, and other devices to protect, replace or reposition teeth, except as described in Orthodontic Treatment.
- Instruction in diet, plaque, and oral hygiene.
- Prescribed drugs, pre-medication, and analgesia.
- Pontics, crowns, and cast or processed restorations made with high noble metals such as gold or titanium.
- Replacement of a lost, missing, stolen, or damaged device or **appliance**, including the replacement of appliances that have been damaged due to abuse, misuse, or neglect.
- Services and supplies given for your personal comfort or convenience, or the convenience of another person (including a provider).
- Services and supplies given as part of treatment or care that is not covered by the Plan.
- Services or appliances to increase vertical dimension or restore occlusion.
- Services or appliances used for splinting or to correct attrition, abrasion, or erosion.
- Services to treat a jaw joint disorder or to alter the bite or the alignment or operation of the jaw, except as described in What the Plan Covers. The Plan does not cover:
  - Orthognathic surgery;
  - Treatment of malocclusion; or
  - Devices to alter bite or alignment.

Cosmetic Services and Supplies

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

- Services or supplies that are cosmetic in nature, including personalization or characterization of **dentures**.
- Cosmetic, reconstructive, or plastic surgery to improve, alter, or enhance appearance, even if the surgery is performed for psychological or emotional reasons. The Plan covers such surgery only when it is needed to repair an injury, as long as the surgery is done in the calendar year of the accident or in the following calendar year.
- Augmentation and vestibuloplasty, and other substances to protect, clean, whiten, bleach, or alter the appearance of teeth.

Keep in Mind

Facings on molar **crowns** and pontics are always considered cosmetic.

Experimental or Investigational

The Plan does ***not*** cover charges for drugs, devices, treatments, or procedures that are **experimental or investigational**, as determined by Aetna.

Government and Armed Forces

The Plan does ***not*** cover charges (to the extent allowed by law) for services and supplies:

- Provided while you are in the care of a government authority.
- To care for conditions related to past or present military service.
- Provided, paid for, or for which benefits are provided or required:
  - Under any government law: or
  - Because of your past or present service in the armed forces of a government.

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 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 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

When you receive care in the United States from a dentist who participates in Aetna's dental network, the dentist will file your claim. You may be responsible for filing claims when care is provided by an out-of-network provider. You must file a claim to be reimbursed for covered expenses when you receive dental care overseas. You must use a claim form to submit your claim. You can obtain a claim form from Aetna Member Services by calling **1-800-367-6276**, or by going online at **www.aetna.com**.

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 benefits have been requested. The exam will be done at any reasonable time while a claim for benefits is pending or under review. The exam may be performed by a doctor or dentist Aetna has chosen, at no cost to you.

Claim Processing

Aetna will make a decision on your claim.

- **If Aetna approves the claim**, Aetna will provide an Explanation of Benefits that shows how benefits were determined. Benefits are payable to you. Aetna has the right, however, to pay any benefits directly to your dentist 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 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.

Three Steps in the Appeal Process

The Plan provides for two levels of appeal to Aetna, followed by an 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.
- You can file an appeal with the employee's NAF employer after you have exhausted the level one and level two appeal process. You have 30 days to submit the appeal to the NAF employer after you receive the final denial notice under the standard appeal process.

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 **1-800-367-6276**.

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 dentist familiar with the case may represent you in the appeal.

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. This level of appeal is voluntary, so you are not required to pursue it.

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 treatment is, or is not, 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 a voluntary review by the employee's NAF employer. 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.

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 under this Plan or any other group plan offered by your employer; or
- All dependent coverage under the Plan ends.

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 (TCC) Program. See the separate book describing your medical plan benefits 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; and
- In the event of the employee's death.

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, including his or her domestic partner, may continue Plan coverage if the employee dies while covered by the DOD NAF HBP. 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. Refer to the separate book describing your medical plan for more information about the TCC Program.
  - **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 4-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 4-month period will be paid by the NAF employer.

  When the 4-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.

Glossary

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

Appliance: This is a device used for functional or healing effect. A fixed appliance is cemented to the teeth or is attached by adhesive materials. A prosthetic appliance is used for replacing a missing tooth.

Bitewing: This is a dental X-ray showing approximately the crown halves of the upper and lower jaw.

Bridgework: A fixed bridge is a partial **denture** that is used as abutments, and is retained with **crowns** or **inlays** cemented to natural teeth. A fixed-removable bridge is a bridge that can be removed by a dentist but not by a patient. A removable bridge is a partial denture that is retained by attachments – usually clasps – that permits removal of the denture.

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

Crown: This is the portion of a tooth covered by enamel.

Dental Hygienist: This is someone who has been trained to provide certain dental services, such as the removal of stains and deposits on the teeth.

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

Denture: This is a device that replaces missing teeth.

Directory: This is a listing of in-network providers in the service area covered under the Plan. A current list of in-network providers may be obtained from Member Services and is also available through Aetna's online provider directory, DocFind, at **www.aetna.com**.

Domestic Partner: Refer to Dependents for the definition of a domestic partner.

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.

Fluoride: This is a solution of fluoride that is applied to the surface of teeth to prevent tooth decay.

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.

Impression: This is a reproduction of a given area of a tooth.

Inlay: This is a **restoration** which is made to fit a tooth cavity and which is cemented into place.

In-Network Provider: This is a health care provider who has contracted to furnish services or supplies for a negotiated charge, but only if the provider is, with Aetna's consent, included in the network directory for the service or supply involved.

Necessary: A service or supply furnished by a particular provider is 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, dental 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 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.

Negotiated Charge: This is the maximum fee an in-network provider has agreed to charge for any service or supply for the purpose of benefits under this Plan.

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.

Onlay: A restoration that covers the entire surface of a tooth (often used to restore a part of a tooth or to increase the height of a tooth).

Orthodontic Treatment: This is any medical or dental service or supply that is furnished to prevent, diagnose, or correct a misalignment of:

- The teeth;
- The bite; or
- The jaws or jaw joint relationship,

. . . whether or not for the purpose of relieving pain.

Orthodontic treatment does not include:

- The installation of a space maintainer; or
- A surgical procedure to correct malocclusion.

Out-of-Network Provider: This is a health care provider who does not belong to Aetna's network and has not contracted with Aetna to furnish services or supplies at a negotiated charge**.**

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

Reasonable and Customary Charge: The Plan covers only that part of a charge that 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 95th 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.

Restoration: Any restoration of a tooth structure, tooth, or oral tissue.

Root canal therapy: The treatment of a tooth having a damaged pulp.

Scaling: Removal of tartar and stains from teeth.

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 • Your dentist has recommended a course of treatment that will cost more than $200 • You have a question about a claim	Online: send an email to **www.DODNAF@aetna.com**
	In the U.S.	Phone: 1-800-367-6276 Address: Aetna P.O. Box 14079 Lexington, KY 40512-4079
	Overseas	Phone: 1-888-506-2278 (toll free) 1-813-775-0189 (direct) Address: Aetna International P.O. Box 981543 El Paso, TX 79998-1543 USA
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**

Online Directory

DocFind® is Aetna's online provider directory. DocFind gives you the most recent information on the dentists, doctors, and other providers in the Aetna network. For each dentist or other health care provider, you can learn about his or her credentials and practice, including education, board certification, office location, and handicapped access.

To access DocFind, go to **www.aetna.com** and follow the prompts.

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 dental conditions and their treatment to the latest developments in disease prevention and wellness.
- **Cost of Care**, a tool that allows you to research the costs of cleanings, fillings, X-rays, dentures, and other common dental services in your area.
- **Health History Report**, an easy-to-understand summary of diagnostic and preventive services, dental procedures, and other dental-related activity, based on claim activity. You can print your Health History Report and share it with your dentist.

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 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 dentist if you have questions.

Keep in Mind

- The CPBs define whether a service or supply is 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 **1-800-367-6276**.

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 dental 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 dentist, upon request, when related to your dental care.
- *Payment*: PHI may be shared to determine eligibility, coordinate care, review 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.