Department of Defense
Nonappropriated Fund
Health Benefits Program

Take charge of your health care costs

News and Updates on Your DoD NAF Health Benefits Program

This newsletter contains information and important changes to your DoD NAF Health Benefits Program (HBP). In order to control rising health care costs, we have made adjustments to our health plan. You can control your costs by joining the many Americans who are learning how they can spend less and still get the services they need. By educating yourself, you have the opportunity to avoid extra medical expenses.

This year Open Enrollment will take place November 10 – December 5, 2014. Eligible retirees currently enrolled in medical coverage may switch their current coverage to another NAF employer-sponsored plan available in their geographic region (if offered by your NAF employer). Standard eligibility criteria will apply. If another plan is not offered in your area, there will be no opportunity to switch at this time.

If you are adding or removing eligible dependents from your coverage, Social Security numbers are required for all dependents enrolled in the DoD NAF HBP. Please update your records with your NAF employer.

Any changes made during the enrollment period will be effective January 1, 2015. If you are not making any changes, you don't have to do anything. Your existing coverage will remain in effect for 2015. Keep in mind that there is no opportunity for retirees to enroll, or re-enroll, in a plan that was not offered at the time of retirement, or if a retiree was not eligible to enroll at the time of retirement. However, you may make changes to your coverage elections during the year if you have a qualified family status change. Please contact your NAF employer for detailed information and instructions.

Watch for your new Aetna medical ID card

In 2015, all DoD NAF employees, retirees and same-sex spouses/domestic partners enrolled in the DoD NAF HBP will receive a new Aetna ID card in the mail. Make sure your NAF employer has your correct mailing address so you will receive your card.

Your new ID card will show updated plan information, so be sure to destroy your old ID card. Bring and show your new card to your doctor during your first visit in 2015.

Remember: You can always log in to Aetna Navigator® to print off a temporary ID card or order additional cards.

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If you are enrolled in the Open Choice Plan and once you reach age 65, you will need to contact your Human Resources office to inquire about your coverage of your medical insurance after age 65. Also, remember that once you reach age 65 to enroll in Medicare Parts A and B. The Plan's benefits are calculated as though you have enrolled in Medicare Part B — whether or not you've actually enrolled.

Visit **www.nafhealthplans.com/retiree** for complete information about your health benefits.

Your DoD NAF health plan gives you the power to choose and spend wisely through its benefits, programs and services. Check out "Six ways to save money on health care" in this newsletter for more ideas on how to use your health care benefits wisely.

What's changing in 2015

More than ever, it's important to pay attention to your health care benefits to avoid paying more out-of-pocket expenses than necessary. Check out the "Six ways to save money on health care" article on page 5 – 6.

Medical and dental plan premiums

The chart below shows your 2015 monthly retiree contributions for the Aetna medical and dental plans. The good news is that by making plan changes that are described later in this newsletter, significant medical plan rate increases have been avoided and rates are only increasing by 4.35%.

2015 Monthly Premiums

Plan	Individual		Family	
	2014	2015	2014	2015
Medical (4.35% increase)	$156.19	$162.98	$363.37	$379.18
Medical and Dental	$165.65	$172.44	$385.72	$401.53

Copay changes

For the first time since 2006, copays for in-network physician office visits are changing. For 2015, copays will be as follows:

- Primary care provider (PCP; including walk-in clinics and urgent care centers): Increasing from $20 to $30
- Specialist: Increasing from $35 to $45

PCPs and specialists

PCPs include general practitioners, family practitioners, internists and pediatricians. A provider who does not meet this definition is considered a specialist.

Deductibles and out-of-pocket maximums

The chart below shows your 2015 deductible and out-of-pocket maximum amounts.

Open Choice Plan

Coverage	2014 Deductible	2015 Deductible	2014 Out-of-pocket maximum	2015 Out-of-pocket maximum
Individual	$400 in-network $1,000 out-of-network	**$500 in-network** **$1,500 out-of-network**	$3,000 in-network $4,000 out-of-network	$3,000 in-network **$6,000 out-of-network**
Family of 2	$800 in-network $2,000 out-of-network	**$1,000 in-network** **$3,000 out-of-network**	$6,000 in-network $8,000 out-of-network	$6,000 in-network **$12,000 out-of-network**
Family of 3 or more	$1,200 in-network $3,000 out-of-network	**$1,500 in-network** **$4,500 out-of-network**	$9,000 in-network $12,000 out-of-network	$9,000 in-network **$18,000 out-of-network**

Traditional Choice Plan (including Aetna International)

Coverage	2014 deductible	2015 deductible
Individual	$400 in-network	**$500 in-network**
Family of 2	$800 in-network	**$1,000 in-network**
Family of 3 or more	$1,200 in-network	**$1,500 in-network**

Removal of deductible and out-of-pocket maximum crossover

Currently, your in-network and out-of-network expenses are combined to meet annual health plan deductibles and out-of-pocket limits. Starting in 2015, in-network expenses and out-of-network expenses will no longer be combined. In-network expenses will be applied to the in-network deductible only, and the same will be true for out-of-network expenses.

This means you will need to meet the full in-network deductible before benefits are paid at the applicable coinsurance for in-network care. Likewise, you must meet the full out-of-network deductible before benefits are paid at the applicable coinsurance for out-of-network care.

It is important to always try to use in-network providers to avoid unnecessary out-of-pocket costs.

Pharmacy costs

Currently, your pharmacy plan has different tiers of benefits. How much you pay for prescriptions depends on the type of drug used — generic, preferred brand-name drugs and non-preferred brand-name drugs. You pay a flat amount (copay) for generic drugs (Tier One) and preferred brand-name drugs (Tier Two). For non-preferred brand-name drugs (Tier Three), you pay a percentage of the cost and there is a minimum and maximum cost per prescription. A fourth tier for specialty drugs is being added for 2015.

For the first time since 2009, pharmacy copays and/or coinsurance will change. In 2015, the tiers will be as follows:

- The Tier One copay will remain the same at $10 for generic drugs.
- The Tier Two copay will increase from $20 to $35 for brand-name drugs on the preferred drug list.
- The Tier Three percentage will remain the same at 35%. However, the per-prescription minimum will increase from $35 to $60, and the maximum will increase from $100 to $125.
- A new Tier Four will be added for specialty pharmacy. The percentage you pay will be 40%, with a minimum of $60 and a maximum of $125. Specialty medications are generally injectables that require special shipping and handling (such as refrigeration). Aetna Specialty Pharmacy® fills prescriptions for specialty drugs.

It is very important to talk to your physician about the prescription options available to you, in order to minimize your cost. Always use less expensive generic prescriptions, if possible. Learn how you can save money with mail order on page 7.

New: Anti-obesity drug coverage

Medications used to control weight will be added at the applicable pharmacy tier cost to the prescription drug plan in 2015. Some examples are Belviq (Lorcaserin) and Qsymia (Phentermine/topiramate ER). Learn more about this category of drug at **www.aetna.com/products/rxnonmedicare/data/2014/MISC/antiobesity.html.**

Maximum allowable amount

The cost of medical procedures can vary from one facility to another — and while costs may vary widely, quality will not. To address these differences, Aetna has established a standard price called the **maximum allowable amount** for certain outpatient services. Effective January 1, 2015, there will be a maximum allowable amount for certain outpatient procedures, including but not limited to:

- Scope procedures (colonoscopy, endoscopy)
- CT scans and MRIs
- Hernia surgery
- Tonsillectomy
- Carpal tunnel surgery
- Cataract surgery, and more*

*To view a complete list of outpatient procedures and their maximum allowable amounts, log in at **www.aetna.com** and click "I want to . . . View Deductibles & Plan Limits." Scroll to the bottom of the page and look for the "Maximum Allowable Amount" box. This information will be available beginning January 1, 2015.

What does this mean for you? When you have one of these procedures, the plan will pay up to the maximum allowable amount toward facility costs for the service. You pay any facility costs above the maximum allowable amount and this does not apply toward your plan's out-of-pocket maximum.

Why not get the best price? Verify your medical facility costs are within the cost of the maximum allowable amount before you schedule your procedure. Keep in mind that just because your physician refers you to a particular provider for an outpatient procedure that provider may not necessarily cover the total cost even if they accept Aetna insurance. Talk to your doctor and ask questions.

To help make sure you don't pay more than you need to for your care:

- Use Aetna's Member Payment Estimator tool. This online tool provides personalized cost estimates for common procedures, including procedures that have a maximum allowable amount.

To use the Member Payment Estimator, log in at **www.aetna.com**, click on "Use Member Payment Estimator" in the Cost of Care box to see a list of facilities in your area that perform the procedure, and their cost. If there is a maximum allowable amount for the procedure, you'll see estimates that can perform the procedure at or below the maximum allowable amount. This information will be available on January 1, 2015.

- **Contact Aetna Members Services at 1-800-367-6276** before scheduling your procedure to ensure that you understand what your costs will be.

For more information about the maximum allowable amount, visit **www.nafhealthplans.com/retiree**.

Health care reform changes for 2015

As a result of health care reform, dependent eligibility will change. As of January 1, 2015, coverage will be extended through the entire month of a dependent's 26th birthday. Currently, your dependents, regardless of marital or employment status, are covered up to the date of their 26th birthday.

Due to reporting requirements under the Accountable Care Act, certain information, such as Social Security numbers and dates of births, is required for all dependents enrolled in the DoD NAF HBP. Please update your records with your NAF employer.

Visit **www.nafhealthplans.com/retiree** for more information about health care reform and how it could affect you.

Six ways to save money on health care

As health care costs reach new highs, it's more important than ever to think like a well-informed health care consumer and shop for the best quality care at the best price. Here are six ways you can have more control over what you spend for care:

1 Stay in the network

You save two ways with in-network providers. First, your plan pays a higher percentage of the cost when you visit an in-network provider vs. an out-of-network provider. Second, Aetna negotiates a lower rate with in-network providers. To find in-network providers, use DocFind, the searchable provider directory at **www.aetna.com/docfind**.

2 Know before you go

You can use the Member Payment Estimator to compare rates for common health care procedures among in-network providers. You can search for a particular doctor or facility, or find area providers based on ZIP code. Log in to **www.aetna.com** and click on "Use Member Payment Estimator."

3 Use Quest Diagnostics® and other affiliated* labs

You can save money when you use Quest Diagnostics and other affiliated labs for blood tests and other lab services. You'll pay even less than you would at an in-network lab. Take a look:

	Quest Diagnostics	In-network hospital lab	Out-of-network lab
Cost of lab tests	$75	$150	$225
Your coinsurance	10%	10%	40%
You pay	$7.50	$15	$90

4 Work on your wellness

When you take action for better health, you enjoy a better quality of life — and lower health care costs. You also earn incentives that will reduce your out-of-pocket expenses by reducing your annual deductible. Here are some ways to get started:

- **Get preventive screenings.** Your plan covers preventive care at 100%, with no deductible and no copay if you stay in-network. Preventive services include routine physical exams and cancer screenings. This kind of care can catch problems in their early stages, when treatment is more effective and less costly. *Earn a $50 health incentive for a routine physical or well-woman exam.*
- **Complete or update your health assessment.** In just 20 minutes you can learn more about your current health and risks, and what you can do to improve. Just log in at **www.aetna.com** and click "I want to . . . Take a health assessment." *Earn a $50 health incentive for completing or updating the assessment.*
- **Reach your healthy weight.** Your plan offers weight management discounts on programs from Jenny Craig®, CalorieKing™ and Nutrisystem®. Log in to **www.aetna.com** and click the Health Programs tab, then "Get Discounts."

Earn up to $150 (individual) or up to $450 (family) by completing certain healthy actions. There are up to eight ways to earn these rewards. Learn more at www.nafhealthplans.com/retiree.

5 Use the emergency room (ER) for emergencies only

Save the hospital ER for true medical emergencies. When you are not experiencing a life threatening condition, consider going to a walk-in clinic or urgent care center instead of the ER. Use DocFind to search for facilities near you. You will save yourself money and time.

	Walk-in Clinic $	Urgent Care Center $	ER $$$
	Ear infections, colds, allergies, strep throat, bronchitis	Sprained ankles, broken arms, fevers, and minor cuts and burns	True emergencies including trouble breathing, uncontrollable bleeding, chest pain and unconsciousness
Open Choice Plan	$30 copay	$30 copay	$350 copay, plus 10% of total cost of visit*
Traditional Choice and Aetna International Plans	80% of total cost of visit, after deductible	80% of total cost of visit, after deductible	80% of total cost of visit, after deductible*

*If you visit the ER for a non-emergency care, you will pay 50% of the total cost of the visit after any copays or deductibles.

6 Save on prescription drugs

Ask your doctor or pharmacist about generic drugs. If you currently take a brand-name medication, you can save when you switch to its generic equivalent (if available). Your pharmacist may be able to make the switch for you, depending on how your doctor wrote the original prescription.

Here's an few example of how you can save with mail-order and generic drugs:

Nexium® 20 mg	Mail order (90-day supply)	Retail pharmacy (3 fills for 90-day supply)
Total Cost	$690.30	$734.16 ($244.72 x 3 months)
You pay	$70	$105 ($35 x 3 months)

Save even more with other generic medications in the same therapeutic category as Nexium such as Pantoprazole and Lansoprazole. You'll pay only $20 with mail order or $30 with a retail pharmacy for a 90-day supply. Total costs vary based on member ZIP code and retail location. Example provided for illustrative purposes only.

If you take medication on a regular basis, you can save money by using the **mail-order pharmacy**. When you use mail order, you not only have the convenience of your medication shipping free-of-charge to your door but you also will only pay a 2-month copay for a 90-day supply. For that same medication, you will pay a 3-month copay if you purchase it at a retail pharmacy.

To get started, ask your doctor for two prescriptions for each medication you use — one for an immediate supply from your local pharmacy and one to include with your first mail order. Then call **1-888-792-3862** or log in at **www.aetna.com** to download an order form.

To estimate the cost of a prescription drug from your local retail pharmacy or a mail-order pharmacy, or to compare the costs of generic vs. brand-name drugs, visit **www.aetna.com** and log in to your member website. Click "Aetna Pharmacy" from the top of the page. Then click "Get Drug Prices." Using this cost estimator tool as well as taking advantage of mail order and generics, you can begin saving on your medications today.

Dental reasonable and customary rates

Dental benefits are based on a percentage of "reasonable and customary" (R&C) charges when you use out-of-network providers. An R&C charge is determined as the most common charge for a service in a given geographical area. Currently, the percentile "allowed" for out-of-network dental services is 95% of R&C charges. **In 2015, this will change to 85% of R&C charges.** This means that 85% of dentists in a given area charge that fee or less for that specific dental service. Your plan benefits are then applied to this R&C amount. The charts below shows examples of this change.

Example 1	2014 (95%)	2015 (85%)
Dentist charges	$120	$120
Allowed amount	$100	$90
Aetna would pay	$100 ($100 x 100%)	$90 ($90 x 100%)
Member would pay	$20 ($120 - $100)	$30 ($120 - $90)
This example assumes that this is a preventive care visit that is covered at 100% under the plan.		

Example 2	2014 (95%)	2015 (85%)
Dentist charges	$1,000	$1,000
Allowed amount	$920	$840
Aetna would pay	$736 ($920 x 80%)	$672 ($840 x 80%)
Member would pay	$264 ($1,000 - $736)	$328 ($1,000 - $672)
This example assumes that this is a basic visit that is covered at 80% under the plan, and the patient has already met their deductible.		

How can you save money? The most cost effective way is by using in-network dentists. R&C charges don't apply to in-network providers. Instead, benefits are based on the provider's actual charges, which (by agreement with Aetna) are equal to or less than established R&C charges. Because the current dental plans do not require you to use in-network providers, it is important that you understand that the R&C restriction may apply to you if your dentist is not an in-network provider.

To find Aetna network dentists, use DocFind by logging in to Aetna Navigator at **www.aetna.com** and clicking "I want to . . . Find a Doctor, Dentist or Facility" on your home page.

Visit the DoD NAF Health Benefits Program website at **www.nafhealthplans.com/retiree**.

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