Northeast District Council of the OPCMIA Welfare Fund

Summary Plan Description

JANUARY 1, 2020

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INTRODUCTORY LETTER TO THE PLAN AND SUMMARY PLAN DESCRIPTION

Northeast District Council of the OPCMIA Welfare Fund
100 Merrick Road, Suite 500 West
Rockville Centre, New York 11570
P: (516) 775-2280
F: (516) 775-4064

To all Participants:

We are pleased to present you with this updated booklet of the benefits provided by the Northeast District Council of the OPCMIA Welfare Fund (the "Welfare Fund" or "Fund") under the Northeast District Council of the OPCMIA Welfare Plan (the "Plan"). The Plan is funded through a collective bargaining agreement based upon contributions from obligated employers for each hour of covered employment work. You may obtain a copy of the appropriate collective bargaining agreement from the Fund or Union. A list of obligated employers under the collective bargaining agreement is also available from the Fund.

This booklet constitutes your Summary Plan Description ("SPD") and plan document for the Plan. The Plan is administered by a Board of Trustees consisting of an equal number of representatives of the Union and of representatives of employers. As you read through this booklet you will learn how you become a Participant, what the benefits are and how to claim them. Be sure to share this booklet with your family since the benefits may affect them as well. We urge you to read this booklet carefully. It summarizes the most important features of the Plan and presents the Plan provisions.

To make this information as clear as possible, this booklet has been written in today's English. Please read this booklet carefully and keep it in a safe place for easy reference. You will notice that some of the terms used in your booklet are capitalized. These terms have a special meaning under the Plan and are defined in this booklet. If you have any questions regarding any of the material presented within, please contact the Fund office at (516) 775-2280 during regular business hours. The Fund office is open Monday through Friday from 8:00 a.m. to 3:30 p.m.

Sincerely,

The Board of Trustees

IMPORTANT ERISA INFORMATION

Northeast District Council of the OPCMIA Welfare Fund
100 Merrick Road, Suite 500 West
Rockville Centre, New York 11570
P: (516) 775-2280
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EMPLOYER TRUSTEES	UNION TRUSTEES
Michael Salgo	Gino Castignoli
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Michael Patti	Eddie Barbaria
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ALTERNATE EMPLOYER TRUSTEES	ALTERNATE UNION TRUSTEES
Sal DiLorenzo	Frank Martorano Jr.
Matthew Stevens	Joseph Ferri

FUND MANAGER
Lisa Parisi

CO-COUNSEL
Proskauer Rose LLP

CO-COUNSEL
Markowitz & Richman

PLAN NUMBER: 501
E.I.N: 13-1567895
TYPE OF PLAN: Health and Welfare

PLAN ADMINISTRATOR:

Board of Trustees of the
Northeast District Council of the OPCMIA
Welfare
100 Merrick Road, Suite 500 West
Rockville Centre, New York 11570
P: (516) 775-2280

The plan administrator has authority to control and manage the operation and administration of the Plan and is the agent for service of legal process. Service of process upon the Plan may also be made by serving its trustee.

FISCAL YEAR: The Fund's records are kept on a calendar year basis, ending December 31st.

TYPE OF ADMINISTRATION: Trusteed and Self-Administered.

SOURCE OF CONTRIBUTIONS TO THE PLAN: Employer contributions are used to pay the premium costs for the health insurance coverage provided to Participants of the Plan, to reimburse participants for certain medical or hospital costs, and to provide vacation benefits. Funds are held in trust and invested until needed to pay for benefits under the Plan.

ERISA NOTICE

INFORMATION AND ASSISTANCE AVAILABLE TO YOU

Your ERISA Rights

As a Participant in the Northeast District Council of the OPCMIA Welfare Plan (the "Plan"), you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that all Plan Participants shall be entitled to:

Receive Information about Your Plan and Benefits

- Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements and copies of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

- Obtain, upon written request to the plan administrator, copies of all documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements and copies of the latest annual report (Form 5500 Series) and updated SPD. The plan administrator may make a reasonable charge for the copies.

- Receive a summary of the Plan's annual financial report. The plan administrator is required by law to furnish each Participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

- Continue health care coverage for yourself, and your covered dependents if there is loss of coverage under the Plan as a result of a Qualifying Event. You or your covered dependents may have to pay for such coverage. Review this SPD and the documents governing the Plan on the rules governing your COBRA coverage rights.

Prudent Actions by Plan Fiduciaries

- In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit Plan. The people who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the best interest of you and other Plan Participants and beneficiaries. No one, including your employer, your Union, or any other person may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

- If your claim for a Welfare Fund benefit is denied in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

- Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the plan administrator.

- If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim frivolous.

Assistance with Your Questions

- If you have any questions about your Plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor which is listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

IMPORTANT TO REMEMBER

- You are a Participant in this Plan if you are working in covered employment established by the collective bargaining agreement by and between contributing employers and Cement Masons' Union Local 780, OPCMIA Local 262, or Local 40, or if you are a certain Northeast District Council of the OPCMIA Fund and Union employee. However, to actually receive benefits made available by the Welfare Fund, you must meet certain eligibility requirements.

- Save this booklet and store it in a safe place. If you have lost your copy, you may ask the Fund office for another; however, you may be required to cover reasonable replacement costs. If you do not understand something in this booklet, you can request an explanation in writing from the Trustees. The Trustees will reply to your request.

- Health and hospital coverage for active and retired members under this Plan is provided by Aetna Healthcare. Life and Accidental Dismemberment Insurance is provided by Anthem Life. State Mandated Disability Insurance is provided by Shelter Point Life Insurance Co. Vision care is provided by National Vision Associates (NVA) sponsored through Shelter Point. Dental care and a Hospital Indemnity Plan are provided by Aetna Healthcare. These companies are third party providers, and the extent of their services are determined by their contracts with the Fund. You are a beneficiary of those contracts, and the benefits specified in those contracts are hereby provided under this Plan.

- Importantly, if you are an OPCMIA Local 262 Tier II or Cement Masons' Union Local 780 Residential Worker, your medical and prescription benefits are described only in the Aetna EPO – Low Plan which is attached Exhibit I—you may disregard Exhibit II. Exhibit II only describes Active Journeymen and Retired Members' medical and prescription benefits which are provided under the Aetna Medicare PPO – High Plan.

- A person must be eligible under this Plan to receive a benefit for any period. If a person is not eligible, including having lost eligibility, no benefits are available under this Plan. In addition, if requested by a provider or third party provider, you must have submitted a proper application to that provider or third party provider previous to any period for which you are claiming benefits.

- COBRA continuation coverage options are available under this Plan.

- If a change occurs in your marital status or dependent status (*i.e.*, birth, adoption of a child, unmarried children between ages 19 and 26), please notify the Fund office immediately.

- Benefits terminate upon the death of the Participant unless otherwise provided herein under death benefits, loss of active coverage, or COBRA coverage.

- Your spouse is your inevitable death benefit beneficiary unless your spouse waives the entitlement on the appropriate forms. Be sure to request these forms from the Fund office and file the appropriate form(s) designating your beneficiary(ies) with the Fund office.

- The Fund office at the very least will provide you with a statement annually indicating your total hours worked for the year. You have a period of three months to protest the correctness of this report; otherwise it will be considered your final permanent record of your hours worked for the year. If you have worked hours during the year and do not receive this annual statement, notify the Fund office. You will only receive this statement if the Fund office has received a contribution on your behalf for that year.

- Retirees of age 65 or older and disabled retirees under 65 years of age must submit a copy of their Medicare health insurance card to the Fund office as one condition to secure or maintain retiree eligibility for benefits under this Plan.

- Retirees of age 65 or older and disabled retirees under 65 years of age must possess Medicare A (Hospital) and B (Medical) as one condition to secure or maintain retiree eligibility for coverage under this Plan.

- Benefits provided under this Plan are in no event assignable to another person. A Covered Person does not have the right to assign, alienate, transfer, sell, hypothecate, mortgage, encumber, pledge, commute, or anticipate any benefit payment under this Plan to a third party. However, a Covered Person may, in writing, authorize the plan administrator to pay a benefit directly to a provider of medical care, treatment, or services instead of the Covered Person as a convenience to the Covered Person; when this is done, all of the Welfare Fund's obligation to the Covered Person with respect to that benefit is discharged by payment to the medical services provider. The Welfare Fund reserves the right to not honor any assignment to a third party, including but not limited to, any provider.

- Coordination of Benefits: The rapid growth of group insurance in the past few years has produced a situation whereby an individual might be insured under two or more health plans or programs. In the event of accident or illness, this individual could possibly submit claims to each of the different insurance companies or entities underwriting his plan of insurance. To avoid duplication of payment or over insurance, coordination of benefits must occur. Benefits under this Plan will be coordinated with all other types of plans you or your dependents may be insured under so that the total amount payable under all plans will not exceed 100% of medical expenses incurred. For further information, please refer to the procedures described under the heading **"Coordination of Benefits"** on page 29 of this booklet.

- Rights of Recovery: This Plan or third party providers may pay benefits that should be paid by another benefit plan or program or that are later found to be greater than the allowable charge. In such a case, the Board of Trustees (or the Fund office or any other designee duly authorized by the Board of Trustees) shall have full authority, in their sole

and absolute discretion, to recover the amount of any overpayment (plus interest, attorney's fees and costs). Such authority shall include, but not be limited to:

- The right to seek the overpayment in a lump sum from the other benefit plan or the Covered Person;
- The right to reduce benefits payable in the future to the person who received the overpayment;
- The right to reduce benefits payable to a beneficiary who is, or may become, entitled to receive payments under the Plan; and
- The right to initiate a lawsuit or take such other legal action as may be necessary to recover any overpayment (plus interest, attorney's fees and costs) against the other benefit plan or the Covered Person.

- Subrogation: If a Participant or his covered dependent suffers an injury or illness that is caused by the negligence or fault of a third party, a reimbursement or subrogation agreement may have to be signed by the Participant or his legal representative before Plan benefits will be paid. In the event of refusal to sign or your failure to notify the Plan of such an occurrence, the Plan is also automatically entitled to these reimbursement or subrogation rights. These reimbursement or subrogation rights allow the Plan to proceed and recover against the third party or hold you the Participant responsible for repayment if you receive payment from the third party.

- Claims: If you are submitting a claim to a third party provider, you must follow the procedures of that provider as has been presented in materials sent to you. If you are presenting a claim to the Fund, the claim must be in writing and on a proper form as provided by the Fund. For further information, please refer to the procedures described under the heading **"Claims and Appeals Procedure"** on page 24 of this booklet.

- Denial and Rights of Appeal: If your claim involving coverage provided by a third party provider is denied, you must submit an appeal to the third party provider in the manner prescribed by the third party provider in the materials you have received from that provider. If your claim relating to your eligibility or a claim involving coverage directly provided by the Fund is denied, you have the right to appeal the denial to the Trustees in strict compliance with the Plan. For further information, please refer to the procedures described under the heading **"Claims and Appeals Procedure"** on page 24 of this booklet.

- Participant Fraud: If a Participant engages in fraud against the Welfare Fund, the Trustees have the right to provide further Welfare Fund benefits and take such other actions which are necessary to protect the assets of the Welfare Fund.

- Effective Date: This Plan governs the right to the payment of benefits arising after the effective date of this Plan. Previous benefits are governed by the right to the payment of

benefits for the plan then in effect. This restatement of the Plan shall become effective on January 1, 2020.

- Gender: The masculine pronoun whenever used shall include the feminine gender, the singular number whenever used shall include the plural as well as the plural the singular unless the context clearly indicates a different meaning.

- The Trustees reserve the right to interpret this Plan and to amend, change, modify, eliminate or terminate its provisions from time to time at their discretion. There are no vested benefits under this Plan, and any amendment, change, modification, elimination or termination of its provisions or any provision shall be effective at a time in accordance with such action.

- Be sure to ascertain that any employer for whom you are working as a cement mason is a signed, contributing employer and does not become delinquent in the submission of your benefit contributions.

- This group health plan believes that it is a "grandfathered health plan" under the Affordable Care Act. As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

  Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at (516) 775-2280. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

ELIGIBILITY FOR BENEFIT COVERAGE

Who can Obtain Eligibility for Coverage?

- Participants

  Participants are employees working in covered employment established by the collective bargaining agreement by and between contributing employers and the Cement Masons' Union Local 780, OPCMIA Local 262, and OPCMIA Local 40 as well as certain Northeast District Council of the OPCMIA Fund and union employees. As a Participant, or a "member," you may obtain eligibility for Welfare Fund benefits, including coverage for Eligible Dependents; however, you must be working in covered employment. Covered employment means doing the work covered by these agreements as an employee for whom benefits are received from the signed employer. **To be eligible for a benefit, you must meet eligibility requirements as presented below under the headings "Eligibility Requirements for Working Participants", "Eligibility Requirements for Active Members" and "Eligibility Requirements for Retirees"** (pages 11-13)**.**

- Retirees

  In addition, retirees who meet and comply with the specified criteria, which includes work hour requirements and paying required premiums, can obtain Welfare Fund benefits, including coverage for Eligible Dependents.

- Coverage for Eligible Dependents

  If you, the working participant, active member, or Covered Retiree, become or are eligible for coverage, this eligibility extends to certain dependents for health and medical benefits, but not for disability or Life and Accidental Dismemberment Insurance. These dependents are your lawful spouse and your unmarried children under the age of 26. To be eligible, your spouse must not be legally separated from you (unless coverage is required by law). Unmarried children of an eligible member or retiree are eligible for medical and dental coverage up to age 26 (end of year age 26). An unmarried child whose insurance would otherwise terminate solely due to reaching the age of 19 shall continue to be eligible until the end of year age 26 by law as approved by the Affordable Care Act.

  Child includes step-child, adopted children, a proposed adopted child during any waiting period prior to the finalization of the child's adoption and foster children. However, that child must be dependent upon you for support and maintenance. Child also includes any child for whom the plan administrator determines coverage must be provided under a recognized Qualified Medical Child Support Order that has been accepted by the Plan.

  If a newborn dependent child incurs charges (over and above nursery charges) for services because of injury, illness, congenital defects, birth abnormalities or premature birth, coverage will begin at birth.

If an Eligible Dependent is on Medicare, the dependent must have both Medicare A (Hospital) and B (Medical) to remain eligible.

- Eligibility Requirements for Working Participants

Working Participants are those Participants eligible for basic New York State mandated disability benefits, including Participants who incur a non-work related disability or sickness while employed in covered employment or within 4 weeks of termination of that employment.

- Eligibility Requirements for Active Members

You, as a Participant, will be considered eligible for Welfare Fund benefits for a current year as an active member provided that you have worked at least 1,000 hours in covered employment during the previous year and contributions for those hours were made to the Fund on your behalf as an employee. As presented below under the heading **"Obtaining Eligibility Hours for Benefit Coverage When Not Working"** (pg. 19), certain hours may be credited to your account if you were receiving payments on disability or workman's compensation or you were in the military.

However, if you are working for the first time as a Participant in the Plan (apprentices, residential worker, etc.), you will be considered eligible for Welfare Fund benefits starting the month after you work 1,000 hours in covered employment and contributions for those hours were made to the Fund on his or her behalf as an employee within 12 months of your first hour of work. After you work in covered employment for longer than the initial 12-month period of employment, your eligibility for Welfare Fund benefits shall be determined according to regular Plan rules for eligibility, *i.e.*, for eligibility in any given Plan Year you must have worked at least 1,000 hours in covered employment during the prior Plan Year and contributions for those hours were made to the Fund on your behalf as an employee.

★ **NOTE**: The hours required for eligibility are subject to change for any future year at the discretion of the Trustees.

***Example**: Participant Jack works his first hour in covered employment in February of 2020. In September of 2020, Jack works his 1,000th hour in covered employment and his employer has made all the required contributions to the Fund for those hours worked. Jack's medical coverage will begin under the Plan in October of 2020. He will remain eligible for coverage until December 31, 2020. For eligibility in 2021, he must have worked at least 1,000 hours in covered employment during 2020. In this case, Jack would be eligible.*

***Example**: Participant Mary works her first hour in covered employment in October of 2020. In June of 2021, Mary works her 1,000th hour in covered employment and her employer has made all the required contributions to the Fund for those hours worked.*

Mary's medical coverage will begin under the Plan in July of 2021. She will remain eligible for coverage until December 31, 2021. For eligibility in 2022, she must have worked at least 1,000 hours in covered employment during 2021.

***Example**: Participant John works his first hour in covered employment in June of 2020. In July of 2021, John works his 1,000th hour in covered employment and his employer has made all the required contributions to the Fund for those hours worked. John's eligibility under the Plan will be determined under the Plan's regular eligibility rules because John failed to work 1,000 hours in covered employment within 12 months of his first hour worked. John may be eligible for medical coverage for Plan Year 2022, if he works at least 1,000 hours in covered employment during 2021.*

Suspension of Active Member Medical Coverage

a) Suspension of Active Member Medical Coverage

If you as an active member are otherwise eligible to receive medical coverage, and are receiving such medical coverage for yourself and/or your Eligible Dependents under the Plan, but you are engaged in fraud, misrepresentation or misconduct, which means attempting, either directly or indirectly, to undermine the financial integrity and health of the Fund by his actions, including, without limitation:

i) engaging in covered employment for an employer that does not have an obligation to make contributions to the Fund pursuant to a written agreement and/or acknowledgment;

ii) engaging in covered employment for a contributing employer and agreeing to an arrangement by which payment for wages is made in cash, but contributions are not made to the Fund;

iii) submitting false claims to the Fund and/or the insurance provider for the Fund; or

iv) seeking medical coverage for individuals who are not otherwise eligible through deception, fraud or misleading information;

then such medical coverage shall be suspended for such a time deemed reasonable by the Trustees.

b) Notice

The Plan shall inform you of any suspension of your medical coverage by notice given by first class mail ten (10) days prior to the first calendar month in which your coverage is suspended. Such notice shall *include* a description of the specific reasons for the suspension, copy of the relevant provisions of the Plan, and a statement of the procedure for securing a review of the suspension.

c) Review

You shall be entitled to review of a determination suspending your medical coverage if you file a written request with the Trustees within 60 days of your receipt of the notice of suspension. The written request will be reviewed by the Trustees at the next regularly-scheduled meeting of the Trustees, as long as the written request is received more than 30 days before the next scheduled meeting. If your written request is received within 30 days of the next scheduled meeting, the written request will be reviewed by the Trustees at the subsequent regularly-scheduled meeting.

d) Resumption of Medical Coverage

The Trustees shall have the sole and absolute discretionary authority to determine whether you attempted, engaged in or committed fraud, misrepresentation or misconduct and whether such activity has ceased.

Your medical coverage shall be suspended for such periods of time as set forth below, based on the number of offenses committed by you:

Number of Offenses	Medical Coverage Suspension Period
First offense	One (1) month
Second offense	Three (3) months
Third offense	One (1) year

Any decision of the Trustees will be final, conclusive and binding.

e) Suspension Policies and Procedures

The Trustees shall have the sole and absolute discretionary authority to establish policies and procedures to implement the foregoing.

- Eligibility Requirements for Retirees

As a retiree, you and your potential Eligible Dependents will remain eligible for the Welfare Fund health, medical, dental and vision care benefits if, and only if:

1. You are receiving a regular, early retirement, disability or Joint and Survivor Annuity from the Cement Masons' Local 780 Pension Fund, the Local 262 Pension Fund or the Local 40 Pension Fund; **and**

2. You must have 20 years of having worked in covered employment for the required amount of hours (*i.e.*, 1,000 hours per year). However, if you are age 62 or older at the time of your retirement you will be eligible for retiree medical coverage if you have 15 years of having worked in covered employment for the required amount of hours (*i.e.*, 1,000 hours per year); **and**

3. You were eligible as an active member for Welfare Fund benefits on the effective date of your pension **or** you were eligible as an active member for Welfare Fund benefits for three of the past five Plan Years prior to the effective date of your retirement and pension commencement under the Cement Masons' Local 780 Pension Plan, the Local 262 Pension Plan or the Local 40 Pension Plan.

***Example**: Participant Joseph is 57 years of age, has 26 years of having worked in covered employment for the required amount of hours (i.e., 1,000 hours per year), and he is a member of Local 780. Joseph seeks retiree coverage under the Plan. Is he eligible? No. Participant Joseph is not eligible for retiree coverage under the terms of the Plan because he is not currently receiving a pension from either the Local 780 Pension Plan, Local 262 Pension Plan or the Local 40 Pension Plan, as required as #1 above.*

***Example**: Participant Peter is 63 years of age, has 19 years of having worked in covered employment for the required amount of hours (i.e., 1,000 hours per year), and he is an active member participant of the Welfare Fund set to receive a pension benefit from the Local 780 Pension Fund. Joseph seeks retiree coverage under the Plan. Is he eligible? Yes. Participant Joseph is eligible for retiree coverage under the terms of the Plan because he is starting to receive a pension from the Local 780 Pension Plan, he is an active participant with coverage under the Welfare Fund, he is over 62 years of age and has more than 15 years of having worked in covered employment for the required amount of hours (i.e., 1,000 hours per year).*

★ **IMPORTANT NOTE REGARDING RETIREE COVERAGE:** When you become eligible for retiree coverage under the Plan, you have only a one-time election. That is, when you retire and are otherwise eligible, you must elect whether or not to enter the Plan and receive retiree coverage. If you choose not to receive coverage at that time, you may not change that election later. For example, if you retire at age 62 and are otherwise eligible, but decline coverage, you may not elect coverage in the future (e.g., when you reach age 65).

Suspension of Retiree Medical Coverage

a) Suspension of Retiree Medical Coverage Upon Re-employment

If a retiree, who otherwise is eligible to receive medical coverage, and is receiving such medical coverage for himself and/or his Eligible Dependents under the Plan, is re-employed in "Disqualifying Employment," which means employment in:

i) an industry in which employees covered by the Plan were employed and accrued benefits under the Plan as a result of such employment at the time that the retiree commenced medical coverage;

ii) a trade or craft in which the employees covered by the Plan were employed at any time under the Plan; **and**

iii) the geographic area covered by the Plan, then such medical coverage shall be suspended during the period of such re-employment for each calendar month in which he or she is re-employed in Disqualifying Employment. The retiree shall be deemed as participating in Disqualifying Employment until such time that he or she complies with the notice requirements as set forth in subsections (c) and (e) below.

b) Definitions

i) "Industry" means the business activities of the types engaged in by any employees maintaining the Plan.

ii) "Trade or craft" is a skill or skills, learned during a significant period of training or practice, which is applicable in occupations in this Industry and/or supervisory activities relating thereto.

iii) "The geographic area covered by the Plan" shall include the Greater New York Metropolitan Area and any area covered by a Plan which, under a reciprocal agreement in effect when the retiree (then Participant) first commenced benefits under the Plan, had forwarded contributions to this Plan, on the basis of which this Plan accrued benefits to the Participant.

c) Notice

i) A retiree whose medical coverage has been suspended shall notify the Plan when Disqualifying Employment has ended.

ii) The Trustees shall have the right to continue the suspension of medical coverage until such notice is filed with the Plan. A retiree may ask the Plan whether a particular employment will be disqualifying. The Plan shall provide the retiree with its determination.

iii) The Plan shall inform a retiree of any suspension of his medical coverage by notice given by first class mail fifteen (15) days prior to the first calendar month in which his coverage is suspended. Such notice shall include a description of the specific reasons for the suspension, copy of the relevant provisions of the Plan, and a statement of the procedure for securing a review of the suspension. In addition, the notice shall describe the procedure for the retiree to notify the Plan when his Disqualifying Employment ends.

d) Review

i) A retiree shall be entitled to review of a determination suspending his medical coverage by written request filed with the Trustees within 60 days his receipt of the notice of suspension.

ii) The same right of review shall apply, under the same terms, to a determination by or on behalf of the Trustees that the contemplated employment will be disqualifying.

e) Resumption of Benefit Payments

Medical coverage shall resume beginning the first day of the month after the notice that Disqualifying Employment has ended has been received and accepted by the Trustees and provided the retiree has complied with the notice requirements set forth above.

★ **IMPORTANT NOTE REGARDING RETIREE COVERAGE:** Benefits for retirees and their Eligible Dependents may be modified or terminated at any time and for any reason, in the sole and absolute discretion of the Board of Trustees. Similarly, the required contribution for retiree coverage may change at any time, as determined in the sole and absolute discretion of the Board of Trustees. Retirees and their family members are not vested in, or guaranteed, any level of benefits under the Fund.

➢ <u>Covered Retirees Under Age 65</u>

After January 1, 2020, all retirees between the ages of 58 and 64 will also be placed on the Aetna medical benefit plan. The contributions for these members are as follows:

- All members retiring between the ages of 58 and 62 on or after January 1, 2020 will have a contribution of 40% of the total premium cost for primary subscriber, Eligible Spouse and Eligible Dependents. These retirees will pay a percentage share of the total premium cost (as determined by the Board of Trustees of the Fund at their sole and absolute discretion) as described above, until they reach age 65. Failure to make the premium payments as required will result in termination of coverage for you and your Dependents.

- Retirees between 62 and 64 years of age who retire on or after January 1, 2020 will be required to pay the following monthly contributions:

    - $250 for primary subscriber per month

    - $150 for Eligible Spouse per month

    - $150 for Eligible Dependents per month

- *In the event the primary subscriber reaches age 65 and enrolls in Medicare A and B as described below under the heading* ***"Covered Retirees 65 Years of Age and Over"*** *on page 17, an Eligible Spouse or Dependent that remains on the Aetna Plan will then have to pay the amount required for the primary subscriber (i.e., $250 per month).*

- $250 *for* newly disabled retirees receiving a disability pension per month

★ **NOTE:** Participants under the age of 58 are not eligible for retiree coverage under the Plan.

➢ Covered Retirees 65 Years of Age and Over

To maintain coverage, covered retirees who are 65 years of age or over must timely apply in advance of their 65th birthday for both Medicare A (Hospital) and Medicare B (Medical) and pay premiums at rates established by the Trustees of the Fund. Failure to make the premium payments as required will result in termination of coverage for you and your dependents.

Pension eligible members who retire after January 1, 2020 and are receiving both Medicare A and B benefits and start coverage under the Aetna Medicare Advantage PPO Plan. These retirees are required to pay the following amounts starting January 1, 2020:

- $125 for primary subscriber per month
- $125 for Eligible Spouse per month
- $125 for newly disabled retirees receiving a disability pension per month

➢ Termination of Eligibility for Active Members

Your eligibility for benefits will terminate the first day of January following a calendar year during which you were not in covered employment for the minimum hours required for benefits eligibility. This has been explained under the heading **"Eligibility Requirements for Active Members"** (page 11)**.**

➢ Reinstatement of Active Member Eligibility for Benefits

As an active member, if you lose your eligibility for benefits under the termination rule, you shall again be insured on the first day of January following a calendar year during which you worked the minimum amount of required hours to qualify for benefits.

➢ Termination of Eligibility for Covered Retirees

Your eligibility for benefits will terminate if you fail to pay in a timely manner any required premium payment to maintain your coverage. You or your dependents' coverage will not be reinstated unless you comply with eligibility requirements for retirees who do not have coverage or lost coverage as previously stated.

➢ Obtaining Eligibility Hours for Benefit Coverage When Not Working

- **Disability**- If you are out on disability, you will be granted twenty (20) hours per week towards your hours of eligibility for each week that you receive either weekly disability (which by law provides and is limited to 26 weeks) from the Fund or disability

payments from worker's compensation (which by law provides and is limited to 26 weeks).

- **Military Service**- Employees who lose eligibility because of their entrance in the Armed Forces shall be reinstated as eligible for benefits provided they make themselves available for work by a contributing employer within ninety (90) days after release from their active duty or ninety (90) days after recovery from a disability continuing after their release from active duty.

➢ Dependents' Termination of Eligibility

Coverage for your Eligible Dependent ends:

- On the date your own coverage ends.
- On the date a dependent no longer qualifies as a dependent.
- On the date a dependent becomes a member of Cement Masons' Union Local 780, OPCMIA Local 262, or OPCMIA Local 40.

If termination of your coverage is due to your entrance into the Armed Forces, the insurance of your dependents will continue for a period of six (6) months following the date of actual entrance in the service.

➢ Dependents' Termination of Eligibility Due to Death of the Eligible Member or Retiree

The existing coverage of your Eligible Dependents will be paid by the Fund for a period of one year (12 months) following the month of your death, provided you were:

- An active member; or
- A retiree who had coverage at the time of death

Exception: All benefits for your dependents will cease immediately upon your spouse's remarriage if the termination was due to your death.

GENERAL BENEFIT INFORMATION

In general, the Welfare Fund provides you and your eligible dependents with a range of hospital and medical benefits through contracts between the Fund and the individual insurance carriers or third party providers. The Fund then pays for the benefits provided by the contracts on your behalf. As such, you are a beneficiary of those contracts. Therefore, the actual benefits available to you are governed by those contracts; the information provided hereafter with respect to the various insurance carriers and third parties is intended as a summary and reference to the benefits provided for in the contracts.

Except in the two instances described immediately below (**"Reimbursement of Deductibles and Copayments" & "Vacation Program"**), the Welfare Fund itself does not provide any benefits in addition to those which the insurance carrier or third party administrator supplies through their contracts.

- Reimbursement of Certain Deductibles and Copayments

  As of November 1, 2018, the Welfare Fund cancelled the contract with Colonial/Paul Revere to provide supplemental benefits and replaced it with the Aetna Hospital Indemnity Plan. As a result of that change, if you are an active member, the Welfare Fund will reimburse you as follows:

  - For reimbursements ***not*** covered by the Aetna Hospital Indemnity Plan, the Welfare Fund will provide deductible reimbursements at the rates specified below:

    - **Family = $1,000.00**
    - **Parent/Child = $1,000.00**
    - **Couple = $1,000.00**
    - **Single = $ 500.00**

  Some examples of those deductibles that may be reimbursed according to the above rates are those incurred in connection with the use of allergy injections, emergency ambulances, convalescent facilities, hospice care, and durable medical equipment.

  In addition, for Covered Retirees, the Welfare Fund will offer a **$250.00** reimbursement of your copayment per hospital admission.

  In order for the Fund to provide you with these reimbursements, you must submit verification of your claim in the form of an explanation of benefits ("EOB") received from Aetna. Please submit your EOB concerning your claim for reimbursement of deductibles directly to the Praetorian Guard Group, LLC using the contact information provided below:

- **By mail:** Praetorian Guard Group, LLC
  140 Adams Ave., Suite B11
  Hauppauge, NY 11788

- **By e-mail:** nicoledpgg@optimum.net
  emilylpgg@optonline.net

- **By fax:** 1-631-656-5514
  1-980-444-0711

➢ Vacation Benefits Program

As of December 31, 2015, the Cement Masons' Local 780 Vacation Fund merged into the Welfare Fund. As a result of that merger, effective December 31, 2015, vacation benefits previously available and paid out of the Cement Masons Local 780 Vacation Fund are available and paid out of this Vacation Program in the Welfare Fund.

The OPCMIA Local 40, Local 262, and employers have arranged for certain employer contributions to the Welfare Fund for this Vacation Program on behalf of Local 40 and 262 members as well. As a result of those agreements, vacation benefits for Local 40 and 262 members are available and paid out of this Vacation Program in the Welfare Fund.

As such, if you are a Cement Masons' Union Local 780, OPCMIA Local 40, or Local 262 member and are otherwise eligible for benefits under the Welfare Fund, you may receive vacation benefits. Under this Program, an account is set up in your name. Contributions made on your behalf by a contributing employer are in the form of after-tax dollars and are credited to your account. The amount of the employer's contribution is collectively bargained and may change from time to time.

Contributions accumulated under this Program are automatically distributed either quarterly or annually depending which Local the member belongs to and/or the form of payment. You do not have to take a vacation in order to receive payment.

- *For all Local 40 members*, regardless of whether you select direct deposit, vacation benefits are to be distributed annually on December 1.

- *For Local 262 and 780 members* ***who decline direct deposit***, vacation benefits for hours posted between July 1 and June 30 will be distributed annually on July 15.

- *For Local 262 and 780 members **who elect direct deposit***, vacation benefits are to be distributed quarterly according to the following schedule:

Hours posted between:	**Deposit Date:**
January 1 – March 31	April 15
April 1 – June 30	July 15
July 1 – September 30	October 15
October 1 – December 31	January 15

Once contributions are received, they are invested by the Board of Trustees. Any earnings and interest accumulations are used to cover administrative costs, but if the administrative costs are less than those earnings and interest, any excess will be distributed amount Program participant accounts as dividends.

If you die with a vacation balance, any remaining distribution will be made to your designated Beneficiary as designated under the Welfare Fund generally (or to your spouse if no designated Beneficiary or to your estate if you are unmarried and did not designate a Beneficiary).

★ **NOTE**: Because contributions made to this Vacation Program on your behalf are *after* tax dollars, employer contributions to the Welfare Fund that are earmarked for the Vacation Program are taxable to you. As such, those contributions will be added to your wages and taxed accordingly.

★ **NOTE**: Your account may be deemed "unclaimed" if you do not claim it after the Fund office makes every reasonable effort to find and distribute the money to you. Accounts that remain unclaimed for a period of more than two (2) years will be allocated the Fund's general account used to defray administrative expenses. You have the responsibility to contact the Fund office to claim any contributions made on your behalf to the Program which have not been distributed for a period of two (2) years from the distribution date immediately following the contribution. If you do not contact the Fund office and claim such contributions, your money will be lost.

SUMMARY OF BENEFITS AS PROVIDED BY: INSURANCE CARRIER OR THIRD PARTY ADMINISTRATOR

Benefits are supplied by the following insurance carriers or third party administrators. A summary of benefits offered by these carriers are available at the Exhibit indicated. For full coverage details and information, refer to the full carrier plans (not included under this general benefit information here but contained in the Exhibits).

Benefit	Insurance Carrier	Exhibit
MAJOR MEDICAL & PRESCRIPTION (Tier II & Residential Workers)	Aetna EPO – Low Plan (in-network only)	I
MAJOR MEDICAL & PRESCRIPTION (Active Journeymen & Retired Members)	Aetna Medicare PPO – High Plan (in- and out-of-network)	II
DENTAL & COMPREHENSIVE CARE (Active Members & Retirees)	Aetna DMO or PPO (in-network only)	III
VISION (Active & Retired Members)	Shelter Point Life (National Vision Administrators) Gold Plan	IV
DISABILITY BENEFIT & NEW YORK PAID FAMILY LEAVE Statutory New York State Benefit (Active Members)	Shelter Point Life (26 week benefit)	V
HOSPITAL INDEMNITY BENEFIT (Active Members)	Aetna Hospital Indemnity	VI

BENEFIT HIGHLIGHTS

- Disability Benefits

  - Working Participant Benefits (Dependents not Covered) [1]
    - Disability Weekly Benefit: 50% of weekly salary up to $410
    - Maximum Benefit: 26 weeks
  - Active Member Benefits (Dependents not Covered)[2]
    - (Summary for complete coverage from this Carrier see Exhibit V)

- Life Insurance and Accidental Death and Dismemberment Benefits

  - (Summary for complete coverage from this Carrier see Exhibit VI)

Life Insurance and Accidental Death and Dismemberment (Certain rights of Conversion and extended benefits option to accelerate payment).	Members who worked at least 1000 but less than 1400 hours receive $30,000 loss of life plus $30,000 of accidental.
	Members who worked 1400 hours or more receive $50,000 loss of life plus $50,000 accidental.
	Retired Members who retired as an eligible employee receive $15,000 loss of life.[3]

★ **NOTE**: Your beneficiary will be your spouse (or your estate if you are not married) unless you specifically designate another beneficiary or beneficiaries on a form provided by the Fund.

[1] A "Working Participant" eligible for disability benefits is a Participant who, as an employee in covered employment, incurs a non-work related disability or sickness while employed in covered employment or within 4 weeks of termination of that employment. Refer to the heading **"Eligibility Requirements for Working Participants"** (page 11).

[2] An "Active Member" is one who acquires eligibility by working in covered employment with sufficient hours in the prior year to qualify for Welfare Fund Benefit Eligibility. Refer to the heading "**Eligibility Requirements for Active Members"** (page 11).

[3] This retiree life benefit is provided for by the Cement Masons' Local 780 Pension Plan, but is paid out of this Welfare Fund. As such it is only available for members who retire under the Cement Masons' Local 780 Pension Plan.

CLAIMS AND APPEALS PROCEDURE

As previously stated, various welfare coverage is provided to you by the Welfare Fund through third party providers. For claims relating to services of these third party providers of which they have advised you, the third party providers are required by ERISA to advise you of these procedures. If you require further information, please contact the Fund office or Aetna, where applicable.

For purposes of the Plan and services undertaken directly by the Plan, a claim for a benefit is a written application, submitted on an appropriate Fund form, for benefit filed with the Plan. This written application must be made to the Welfare Fund even though the original claim, which was denied, for the benefit was not in writing. You can appoint an authorized representative to act on your behalf in filing a claim. You must, however, notify the Fund office in advance in writing of the name, address, and phone number of the authorized representative.

- In the event that any Participant or other person claims to be entitled to services provided directly by the Plan, and the Plan determines that such claim should be denied in whole or in part, the Plan shall, in writing, notify such claimant within 60 days of receipt of such claim that his claim has been denied in whole or in part, setting forth the specific reasons for such denial. Expedited review is required by ERISA, subject to different regulations, for urgent care claims and pre-service claims.

<u>Such notification shall provide:</u>

- The specific reason(s) for denial.
- Reference to the Plan provision(s) upon which the decision is based.
- What additional material or information you need to provide to process your application and an explanation of why the material or information is needed.
- What procedures you need to follow to get your application reviewed and any applicable time frames.
- A statement of your right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on review.

Upon request and free of charge, you or your duly authorized representative will be allowed to review relevant documents and submit issues and comments to the Fund office in writing. A document, record or other information is “relevant” and is required to be made available to you only if:

- It was relied upon by the plan administrator in making the benefit determination.
- It was submitted, considered or generated in the course of making the benefit determination.

- It demonstrates compliance with the Plan's administrative processes and safeguards required under federal law.

You can appoint an authorized representative to act on your behalf in appealing a claim. You must, however, notify the Fund office in advance in writing of the name, address and phone number of the authorized representative.

Within 180 days after the mailing or delivery by the Plan of a notice denying a claim, such claimant may request, by mailing or delivery of a written notice to the Trustees, a review by the Trustees. If the claimant fails to request such a review within a 180 day period, it shall be conclusively determined for all purposes of this Plan that the denial of such a claim by the Plan is correct, binding and conclusive. If a review is requested, the Participant or other person shall have 30 days after filing a request for review to submit additional written material in support of the claim. After such review, the Trustees shall determine whether such denial of the claim was correct and shall notify such claimant in writing of its determination.

<u>Such notification shall provide:</u>

- The specific reason for the denial.
- The Plan provision(s) upon which the decision is based.
- A statement that upon request and free of charge, you or your duly authorized representative will be allowed to review relevant documents.
- A statement of your right to bring civil action under Section 502(a) of ERISA following an adverse benefit determination on review.

If such determination is favorable to the claimant, it shall be binding and conclusive. If such determination is adverse to the claimant, it shall be binding and conclusive unless the claimant notifies the Trustees within 90 days after the mailing or delivery to him/her by the Trustees of its determination that he/she intends to institute legal proceedings challenging the determination of the Trustees, and actually institutes such legal proceedings within 180 days after such mailing or delivery.

No interest shall be payable with respect to any favorable determination or reward regarding a claim for benefit under the Plan.

COBRA CONTINUATION COVERAGE

(Consolidated Omnibus Budget Reconciliation Act of 1986)

Under the federal law known as "COBRA," a Participant or Covered Retiree under this Plan and his eligible dependents may continue Welfare Fund (health, vision, and dental) coverage at your own expense (direct pay) after you or your dependents cease to be otherwise eligible for welfare coverage.

In general, COBRA continuation coverage may be available after the occurrence of a certain life event which causes a loss in coverage; this is called a Qualifying Event. Specific Qualifying Events are listed below. After a Qualifying Event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the Qualifying Event.

- You, the Participant or Covered Retiree, will only become a qualified beneficiary if you lose your coverage under the Plan because of the following Qualifying Events:
    - Your employment ends for any reason other than your gross conduct, or
    - You worked too few hours to remain eligible for coverage as a Participant under the Welfare Fund.
- Your spouse will become a qualified beneficiary if he or she loses coverage under the Plan because of the following Qualifying Events:
    - You (*i.e.*, the Participant or Covered Retiree) die;
    - You worked too few hours to remain eligible for coverage as a Participant under the Welfare Fund;
    - Your employment ends for any reason other than your gross misconduct;
    - You becomes entitled to Medicare benefits (under Part A, Part B, or both); or
    - Your spouse becomes divorced or legally separated from you.
- Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following Qualifying Events:
    - You (i.e., the Participant or Covered Retiree) die;
    - You worked too few hours to remain eligible for coverage as a Participant under the Welfare Fund;
    - Your employment ends for any reason other than your gross misconduct;

- You become entitled to Medicare A and/or B;
- You and your spouse become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as an Eligible Dependent.

Once the Fund office receives notice that a qualifying event has occurred (see below), COBRA continuation coverage will be offered to each qualified beneficiary. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage generally only lasts for 18 months when the Qualifying Event is that you have been terminated (for reasons other than gross misconduct) or that you merely have not worked enough hours to remain eligible for coverage under the Welfare Fund.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

- If you or anyone in your family covered by the Welfare Fund is determined by Social Security to be disabled and you notify the plan administrator in a timely fashion, then COBRA coverage may continue for an additional 11 months.

- If a qualified beneficiary experiences another Qualifying Event (i.e., your death, your becoming entitled to Medicare benefits under Part A and/or Part B, divorce/legal separation of you and your spouse, or your child stops being eligible under the Plan as a dependent) during the initial 18 months of COBRA continuation coverage, then the qualified beneficiary(ies) may continue COBRA coverage for an additional 18 months (for a maximum of 36 months. However, this extension is only available if the second Qualifying Event would have caused your spouse or dependent child to lose coverage under the Welfare Fund had the first Qualifying Event not occurred.

  - **NOTE:** You or another family member must inform the Fund office of a divorce, legal separation, or a child losing dependent status under this Plan NOT MORE THAN 30 DAYS after a Qualifying Event in order for the qualified beneficiary(ies) to be eligible for COBRA continuation coverage.

Notification and Filings

- In the event your coverage is scheduled to be terminated for any reason other than gross misconduct, you will be notified as to your right to make direct payment to continue your benefits of coverage. In all other cases, you or a family member are responsible for giving notice to the plan administrator of any divorce, legal separation or change in a dependent child status (attainment of maximum age, change in student classification, etc.) which results in a loss of benefit coverage. Under the law, you or one of your family members

have up to 60 days to file an election with the plan administrator for continuation of benefits of coverage on a direct payment basis and another 45 days to pay the required premium.

Termination of Benefits

- The benefits coverage will automatically cease if:
    - Self-payments are not received when due.
    - You or any of your dependents become covered under another group health plan (including Medicare)
    - A divorced spouse or widow remarries and becomes covered under another group health plan.

Benefit Coverage

- There will be no continuation of the Employee Weekly Disability Benefits or Life Insurance and Accidental Dismemberment benefits under COBRA.
- COBRA coverage will be retroactive to the date that coverage would otherwise have terminated.
- The amount of the direct payment will be based on the group rate as determined by the Fund's actuary. These costs may change from time to time, based on the actual claim experience of the group. In any event, the amount of the monthly direct payment required to maintain the health benefits will be furnished upon request. Annually, the Fund office establishes the COBRA rates pursuant to statue, which rates are directly related to the actual cost of your coverage.

COORDINATION OF BENEFITS

This Coordination of Benefits section sets out rules for the order of payment of covered charges when two or more plans including Medicare are paying. When a Covered Person is covered by this Plan and another plan, or the Covered Person's spouse is covered by this Plan and by another plan or the couple's covered children are covered under two or more plans, the plans will coordinate benefits when a claim is received.

The plan that pays first according to the rules will pay as if there were no other plans involved. The secondary and subsequent plans will pay the balance due up to each one's plan formula. The total reimbursement will never be more than the secondary (or subsequent) plan's formula, 50% or 80% or 100%, whatever it may be. The balance due, if any, is the responsibility of the Covered Person.

Benefit Plan

- The provision will coordinate the medical and dental benefits of a benefit plan. The term "benefit plan" means this Plan or any one of the following plans:

    1. Group or blanket benefit plans.

    2. Group practice and other group repayment plans.

    3. Federal government plans or programs, including Medicare.

    4. Other plans required or provided by law. This does not include Medicaid or any benefit plan similar to it, by its terms, does not allow coordination.

    5. No fault auto insurance, by whatever name it is called, when not prohibited by law.

Allowable Charge

- For a charge to be allowable, it must be a usual and reasonable charge and at least part of it must be covered under this Plan.

- In the case of Extended Provider Organization ("EPO") plans, this Plan will not consider any charges in excess of what an EPO provider has agreed to accept as payment in full. Also, when an EPO pays its benefits first, this Plan will not consider as an allowable charge any charge that would have been covered by the EPO had the Covered Person used the service of an EPO provider.

- In the case of service type plans where services are provided as benefits, the reasonable cash value of each service will be the allowable charge.

Automobile Limitations

- This Plan shall always be considered the secondary carrier regardless of the individual's election under Personal Injury Protection ("PIP") coverage with the auto carrier.

Benefit Plan Payment Order

- When two or more plans provide benefits for the same allowable charge, benefit payment will follow these rules:

    1. Plans that do not have a coordination provision, or one like it, will pay first. Plans with such a provision will be considered after those without one.

    2. Plans with a coordination provision will pay their benefits by these rules up to the allowable charge:

        A. The benefit plan that covers the patient as an employee or member will be considered before a benefit plan that covers the patient as a dependent.

        B. The benefits of a benefit plan which covers a person as an employee who is neither laid off nor retired are determined before those of a benefit plan which covers that person as laid off or an eligible retiree. The benefits of a benefit plan which covers a person as a dependent of an employee who is neither laid off nor retired are determined before those of a benefit plan which covers a person as a dependent of a laid off or retired employee. If the other benefit plan does not have this rule, and if as a result, the plans do not agree on the order of benefits, this rule does not apply.

- Dependent children of parents not separated or divorced:

    1. Birthday: The plan covering the parent whose birthday falls earlier in the year pays first. The plan covering the parent whose birthday falls later in the year pays second. If both parents have the same birthday, the plan that covered the parent longer pays first. The plan that covered the other parent for a shorter time pays second. A person's year of birth is not relevant in applying this rule.

    2. The Transition Rule: This provides that if one coordinating plan uses the birthday rule and the other uses the male/female rule, both plans will follow the birthday rule.

- Dependent children of parents who are divorced or separated:

    1. The benefit plan of the parent with custody will be considered before the benefit plan of the parent without custody. This rule applies when the parent with custody of the child has not remarried.

2. The benefit plan of the parent with custody will be considered first. The benefit plan of the step parent that covers the child as a dependent will be considered next. The benefit plan of the parent without custody will be considered last. This rule applies when the parent with custody of the child has been remarried.

3. A court decree may state which parent is financially responsible for medical and dental benefits of the child. In this case, the benefit plan of that parent will be considered before other plans that cover the child as a dependent. This rule will be in place of items (1) and (2) above when it applies.

4. If the specific terms of the court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined above when a child is covered as a dependent and the parents are not separated.

- If there is still a conflict after these rules have been applied, the benefit plan which has covered the patient for the longer time will be considered first.

- Medicare will pay last to the extent stated in federal law. When Medicare pays first, this Plan will base its payment upon benefits that would have been paid by Medicare under Parts A and B, regardless of whether or not the person was enrolled under both of these parts.

- <u>Claims Determination Period</u>

  Benefits will be coordinated on a calendar year basis. This is called the "claims determination period."

- <u>Right to Receive or Release Necessary Information</u>

  To make this provision work, this Plan may give or obtain needed information from another insurer or any other organization or person. This information may be given or obtained without the consent of or notice to any other person. A Covered Person will give this Plan the information it asks for about other plans and their payment of allowable charges.

- <u>Facility of Payment</u>

  This Plan may repay other plans for benefits paid that the plan administrator determines it should have paid. That repayment will count as a valid payment under this Plan.

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION ("PHI")

- Use and Disclosure of PHI

The Plan will use PHI to the extent and in accordance with the uses and disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Specifically the Plan will use and disclose PHI for purposes related to health care treatment, payment for health care, and health care operations. As relates to the Welfare Fund, the term "PHI" includes all individually identifiable health information related to your past, present or future physical or mental health condition or payment for health care. PHI includes information maintained by the Plan in oral, written, or electronic form.

- "Payment" includes activities undertaken by the Plan to obtain premiums or determine or fulfill its responsibility for coverage and provision of Plan benefits that relate to an individual to whom health care is provided. These activities include, but are not limited to the following:

    1. Determination of eligibility, coverage and cost sharing amounts (e.g. cost of a benefit, Plan maximums and copayments as determined for an individual's claim).

    2. Coordination of benefits.

    3. Adjudication of health benefit claims (including appeals and other payment disputes).

    4. Subrogation of health benefit claims.

    5. Establishing employee contributions or partial payments.

    6. Risk adjusting amounts due based on enrollee health status and demographic characteristics.

    7. Billing, collection activities and related health care data processing.

    8. Claims management and related health care data processing, including accounting auditing payments, investigating and resolving payment disputes and responding to Participant inquiries about payments.

    9. Obtaining payment under a contract for reinsurance (including stop-loss and excess of loss insurance).

    10. Medical necessity reviews, or reviews of appropriateness of care or justification of charges.

    11. Utilization review, including precertification, preauthorization, concurrent review and retrospective review.

12. Disclosure to consumer reporting agencies related to collection of premiums or reimbursement (the following PHI may be disclosed for payment purposes: name, address, date of birth, SSN, payment history, account number and name and address of the provider and or health plan).

13. Reimbursement to the Plan.

Health care operations include but are not limited to, the following activities:

1. Quality assessment.

2. Population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting of health care providers and patients with information about treatment alternatives and related functions.

3. Rating provider and Plan performance, including accreditation, certification, licensing or credentialing activities.

4. Underwriting, premium rating and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits and ceding, securing or placing a contract for reinsurance of risk relating to claims for health care (including stop-loss insurance and excess of loss insurance).

5. Conducting or arranging for medical review, legal services and auditing functions including fraud and abuse detection and compliance programs.

6. Business planning and development, such as conducting cost management and planning related analyses related to managing and operating the entity, including formulary development and administration, development or improvement of methods of payment or coverage policies.

7. Business management and general administrative activities of the entity, including but not limited to:

    A. Management activities relating to implementation of and compliance with the requirements of HIPAA administrative simplification.

    B. Customer service, including the provision of data analyses for policy holders, plan sponsors or other customers.

    C. Resolution of internal grievances.

    D. Due diligence in connection with the sale or transfer of assets to a potential successor in interest if the potential successor in interest is a covered entity or, following completion of the sale or transfer will become a covered entity.

8. Compliance with and preparation of all documents as required by law and as permitted by authorization of the Participant or beneficiary. With an authorization, the Plan will disclose PHI to other plans to which information may be disclosed, including pension plan, disability plan, reciprocal benefit plans, worker's compensation insurers, etc. for purposes related to administration of these plans.

The Plan will use and disclose PHI as required by law and as permitted by authorization of the Participant or beneficiary. With an authorization, the Plan will disclose PHI to other plans to which information may be disclosed, including any pension plan, disability plan, reciprocal benefit plan, worker's compensation insurers, etc. for purposes related to administration of these plans.

With respect to PHI, the Welfare plan sponsor and representative Board of Trustees agree to:

1. Not use or further disclose the information other than as permitted or required by the Plan document or as required by law.

2. Ensure that any agents, including a subcontractor, to whom the plan sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the plan sponsor with respect to such information.

3. Not use or disclose the information for employment-related actions and decisions unless authorized by the individual.

4. Not use or disclose the information in connection with any other benefit or employee benefit plan of the plan sponsor unless authorized by the individual.

5. Make PHI available to the individual in accordance with the access requirements of HIPAA.

6. Make PHI available for amendment and incorporate any amendments to PHI, but only to the extent as legally required.

7. Make available the information required to provide an accounting of disclosures.

8. Make internal practices, books and records relating to the use and disclosure of PHI received from the group health plan available to the secretary of HHS for the purposes of determining compliance by the Plan with HIPAA.

9. If feasible, return or destroy all PHI received from the Plan that the plan sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made. If return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible.

Adequate separation between the Plan and the plan sponsor and representative Board of Trustees must be maintained. Therefore, in accordance with HIPAA, only the following employees or classes of employees may be given access to PHI:

- The plan administrator

- Staff designated by the plan administrator who are designated in the course of their everyday activities to conduct the work and affairs and business of the Welfare Fund. As well, the consultants and business associates are designated who in the ordinary course of their business regarding the function of the Welfare Fund are required to render assistance relating to health care treatment, payment for health care and health care operations.

The persons described above may only have access to and use and disclose PHI for plan administration functions that the plan sponsor and representative Board of Trustees perform for the Plan.

If the persons described above do not comply with terms set forth in this booklet, the plan sponsor and representative Board of Trustees shall provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

This Plan is in compliance with the Woman's Health and Cancer Rights Act of 1998, which amends existing federal law (ERISA and the Public Health Service Act). The act requires health insurance carriers of group and individual policies that cover mastectomies to also cover reconstructive surgery or related services following a mastectomy.

Essentially, the act guarantees coverage to any Plan member who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with that mastectomy. The insurer that issues the policy is required to provide coverage for:

A. Reconstruction of the breast on which the mastectomy has been performed.

B. Surgery and reconstruction of the other breast to produce a symmetrical appearance.

C. Prostheses and physical complications for all stages of mastectomy, including lymphedemas.

The law specifically states that these services may be subject to annual deductibles and coinsurance under the Plan's normal terms. Such coverage must be provided in a manner determined in consultation with the attending physician and the patient.

A patient may not be denied eligibility (or continued eligibility) to enroll or to renew coverage under the terms of the Plan solely for the purpose of avoiding the requirements of this section. Further, a provider may not be given incentives or penalized to induce such provider to provide care inconsistent with this section.

FAMILY AND MEDICAL LEAVE ACT OF 1993 ("FMLA")

You may be entitled to health coverage required by the FMLA if you take family or medical leave.

The FMLA requires that unpaid leave from work must be granted for up to twelve (12) weeks for any of the following reasons:

- To care for the employee's child after birth, or placement for adoption or foster care.
- To care for the employee's spouse, son or daughter, or parent who has a serious health condition.
- For a serious health condition that makes the employee unable to perform the employee's job.

Pursuant to the FMLA, an employer must maintain group health benefits that an employee was receiving at the time leave begins during periods of FMLA leave, at the same level and in the same manner as if the employee had continued to work. Under most circumstances, an employee may elect, or the employer may require the use of any accrued paid leave (vacation, sick, personal, etc.) for periods of unpaid FMLA leave. FMLA leave may be taken in blocks of time less than the full twelve (12) weeks on an intermitted or reduced leave basis. Taking of intermitted leave for the birth, placement or adoption or foster care of a child must be approved by the employer.

You may be liable for the employee share of group health premiums during leave.

Please inquire with the Fund office regarding your continuing Plan coverage during this twelve (12) week period.

MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT OF 2008 ("MHPAEA")

MHPAEA requires group health plans and health insurance issuers to ensure that financial requirements and treatment limitations for mental health and substance use disorder benefits are no more restrictive than the requirements and limitations applied to medical or surgical benefits.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT ("NMHPA")

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

ADDITIONAL PROVISIONS OF THE PLAN

A. Incorporation of all Previous Substantive Provisions

- All of the previous substantive provisions are incorporated into and are part of the Plan.

B. Administration of the Plan

- Responsibility of Trustees: The Trustees shall have the authority and responsibility for the management and administration of the Plan and shall be considered the "named fiduciary" for the Plan within the meaning of Section 402(a) of ERISA.

- Maintenance of Records: The Trustees shall keep a record of the hours worked of each employee (as reported by, or otherwise obtained from, an employer) and shall maintain accounts showing the fiscal transactions of the Plan.

- Reliance by Trustees: The Trustees may rely upon all certificates and reports made by an accountant designated or otherwise authorized by the Trustees, upon all opinions given by legal counsel and investment consultants selected by the Trustees, upon all tables, valuations, certificates and reports furnished by an actuary engaged by or otherwise authorized by the Trustees; upon medical opinion submitted by a doctor acceptable to the Trustees and shall be fully protected in respect of any action taken or suffered by them in good faith in reliance upon any accountant, counsel, actuary or doctor and such action shall be conclusive upon employees, employers, Participants and others having anything to do with the Trustees, the Plan or the Fund.

- Indemnification: Except as otherwise provided by applicable law, the Plan shall identify and save harmless each member of the Board of Trustees against any cost or expense (including attorney's fees and disbursements) or liability arising out of any act or omission to act as a Trustee except for any liability arising out of a Trustee's own gross and wanton negligence or willful misconduct.

- Powers and Duties of Trustees: In addition to the foregoing and the powers granted in the Trust Agreement, the Trustees shall have the following additional powers and duties:

    1. To establish a welfare benefit policy and method as well as specific benefits and to meet as necessary to review such funding for the policy and method and specific benefits.

    2. To authorize specifically by a resolution in writing the allocation of their collective responsibilities for the operation and administration of the Plan to one or more Trustees acting as a committee, provided that the resolution creating such committee shall specify its powers and purposes. If the Trustees have allocated

specific responsibilities, obligations or duties among the Trustees, a Trustee to whom certain responsibilities, obligations or duties have not been allocated shall not be liable wither individually or as a Trustee for any loss resulting to the Plan arising from the acts or omissions on the part of another Trustee to whom such responsibilities, obligations or duties have been allocated.

3. To amend, modify, terminate and interpret in their discretion the Plan, benefits as provided by the Plan and governing rules and regulations.

4. To withdraw monies from the Welfare Fund by means of checks, drafts, vouchers or other withdrawals signed by designated Trustees. The Trustees may be reimbursed or receive advances for all reasonable and necessary expense of any suit or proceeding brought by or against the Trustees (including attorney's fees and disbursements) shall be paid from the Welfare Fund as incurred to the extent then permitted by applicable law.

5. To authorize any person or group of persons to serve in more than one capacity (fiduciary or otherwise) with respect to the Plan (including service both as Trustee and plan administrator).

6. To allocate fiduciary responsibilities, other than Trustee responsibilities, among Trustees.

7. To designate persons other than Trustees to carry out responsibilities, fiduciary or otherwise (other than Trustee responsibilities) under the Plan.

8. To employ one or more persons to render advice with regard to any responsibility such Trustee has under the Plan, including legal, accounting and actuarial advice and services.

9. To appoint one or more investment managers (as defined in Section 3(38) of ERISA) who shall be responsible for the management, acquisition, disposition, investing and reinvesting of such of the assets of Fund as the Trustees may specify. If an investment manager or managers or investment service provider have been appointed by the Trustees, no Trustee shall be liable for the acts or omissions of such manager or managers, or be under any obligation to invest or otherwise manage any asset of the Plan which is subject to the management of such investment manager.

10. To purchase insurance out of Welfare Fund assets for the Trustees and the Plan, which insurance shall cover liability or losses occurring by reasons of the act or an omission of a Trustee, to the fullest extent permitted by applicable law.

- <u>Requirement to File Coverage Application Form:</u> Any other provision of the Plan notwithstanding, those eligible for coverage, other than disability benefit or death

benefit coverage, will only receive coverage for those eligibility periods subsequent to the submission of the eligible active or eligible retiree application form, listing claimed Eligible Dependents, claiming eligibility for coverage.

- Action of Trustees: The Trustees shall be the sole judges of the standard of proof required in any matter relating to the Plan, or any case or appeal relating to the Plan and the application and interpretation of this Plan and the decisions of the Trustees shall be determined by their discretionary powers and shall be final and binding on all parties. Benefits or services under this Plan will be paid or provided only if the plan administrator decides in his discretion that the applicant is entitled to them. In keeping with their position as sole judge, but not being arbitrary or capricious, wherever in the plan the Trustees are given discretionary powers, they shall exercise such powers in a uniform and non-discriminatory manner. The Plan shall process a claim for benefits as speedily as is feasible, consistent with the need for adequate information and proof necessary to establish the claimant's benefit rights and to commence the payment of benefits.

C. Merger, Amendment and Termination

- Merger, Amendment: The Trustees in their sole discretion shall have the right to merge, amend, alter or modify the Plan at any time, or from time to time, in whole or in part. Any such amendment shall become effective under its terms upon adoption by the Trustees. However, no amendment shall be made to the Plan which shall:

  1. Make it possible for any part of the corpus or income of the Fund (other than such part as may be required to pay taxes and administrative expenses) to be used for or diverted to purposes other than the exclusive benefit of the Participants or their beneficiaries.

  2. Notwithstanding any provision of this section or any other provisions of the Plan, any amendment or modification of the Plan may be made and applied retroactively if necessary or appropriate to conform to or to satisfy the condition of any law, government regulation, or ruling and to meet the requirements of ERISA, as it may be amended.

- Termination of the Plan:

  The Trustees reserve the right at any time and in their sole discretion to discontinue payments under the Plan and to terminate the Plan in accordance with applicable provisions of law.

  In the event of termination of the Plan, the assets of the Plan will be used towards payment of obligations of the Plan and any remaining surplus will be distributed in the manner determined by the plan administrator to best effectuate the purposes of the Plan in accordance with the applicable regulations under ERISA.

Upon proper termination of the Fund, the Trustees shall be discharged from all obligations under the Plan and no Participant or beneficiary shall have any further right or claim therein.

D. Miscellaneous

- Uniform Administration: Whenever in the administration of the Plan, any action is required by the Trustees or other persons administering the Plan, including but not by way of limitation, action with respect to eligibility or classification of employees, Participants or benefits, such action shall be uniform in nature as applied to all persons similarly situated.

- Payment due an Incompetent or Incapacitated Person: If the Trustees determine that any person to whom a payment is due under the Plan is incompetent or incapacitated by reason of physical or mental disability, the Trustees shall have the power to cause the payments becoming due to such person to be made to the person or institution maintaining or having custody of such person, without responsibility of the Trustees to see to the application of such payment. Payments made pursuant to such power shall operate as a complete discharge of any and all liability on the part of the Trustees and the Plan.

- Identity of Payee: The determination of the Trustees as to the identity of the proper payee of any benefit under the Plan and the amount of such benefit properly payable shall be conclusive and payment in accordance with such determination shall constitute a complete discharge of all obligations on account of such benefit.

- Source of Payment, Plan does not Affect Employment: All liabilities under this Plan shall be satisfied, if at all, only out of the Fund held by the Trustees. All benefits shall be paid or provided solely from the Fund and the Trustees do not assume any liability or responsibility therefore, except to the extent required by applicable law. Participation in the Plan shall not give any Participant any right to be retained in the employ of the employer.

- Non-alienation of Benefits: No benefit under the Plan shall be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge, and any attempt so to anticipate, alienate, sell, transfer, assign, pledge, encumber or charge the same shall be void; nor shall any such benefit be in any manner liable for or subject to the debts, contracts, liabilities, engagements or torts of the person entitled to such benefits; except as specifically provided in the Plan. Notwithstanding the foregoing, the creation, assignment or recognition of a right to any benefit payable with respect to a Participant pursuant to a "qualified domestic relations order" shall not be treated as an assignment or alienation prohibited by this section.

- No Reversion of Fund Assets: In no event shall any of the corpus or assets of the Fund revert to any employer or be subject to any claims of any kind or nature by the

employers except for return of an erroneous contribution within the time limits prescribed by law.

- Location of Participant or Beneficiary Unknown: In the event that all or any portion of the distribution payable to a Participant or to a Participant's beneficiary hereunder shall, at the expiration of three (3) years after it shall become payable, remain unpaid solely by reason of the inability of the Trustees to ascertain the whereabouts of such Participant or beneficiary, after sending a registered letter, return receipt requested, to the last known address, and after further diligent effort, the amount so distributable shall be used to pay Plan expenses. A Participant or beneficiary shall be entitled to no interest or accretion beyond the previous benefit amount.

- Participant Fraud: If a Participant engages in fraud against the Welfare Fund, the Trustees have the right to provide further Welfare Fund benefits and take such other actions which are necessary to protect the assets of the Welfare Fund.

- Effective Date, Governing Documents - Restated Plan: This restatement of the Plan governs the right to the payment of benefits arising after the effective date of this Plan. A Participant's rights shall be determined under the terms of the Plan as in effect as of the date the Participant first became entitled to receive the benefits. This restatement of the Plan shall become effective on January 1, 2016.

- Headings: The article headings and section numbers or other headings are included solely for ease of reference. If there is any conflict between such headings or numbers and the text of the Plan, the text shall control.

- Applicable Law: Except to the extent governed by federal law, the Plan shall be administered and interpreted in accordance with the law of the State of New York.

- Counterparts: This Plan may be executed in any number of counterparts, each of which shall be deemed an original; said counterparts shall constitute but one and the same instrument, which may be sufficiently evidenced by any one counterpart.

DEFINITIONS

These definitions apply when the following terms are used in this booklet.

Affordable Care Act

The term "Affordable Care Act" means the Patient Protection and Affordable Care Act of 2010 and the Health Care and Education Reconciliation Act of 2010.

COBRA

The term "COBRA" means Title X of the Consolidated Omnibus Reconciliation Act of 1985, as amended.

Covered Person

The term "Covered Person" means a working participant, active member, Covered Retiree, or Eligible Dependent who meets the eligibility requirements as applicable and makes any required contributions such that he or she is covered under the terms of this Plan.

Covered Retiree

The term "Covered Retiree" means a retiree who meets the eligibility requirements under the heading **"Eligibility Requirements for Retirees"** and makes the required contributions towards premiums under the terms of this Plan under either heading **"Covered Retirees Under Age 65"** or **"Covered Retirees 65 Years of Age and Over".**

Eligible Dependent

The term "Eligible Dependent" means an individual described under the heading **"Coverage for Eligible Dependents"** on page 10 of this booklet.

Eligible Spouse

The term "Eligible Spouse" means your spouse that is not legally separated from you (unless coverage is required by law) that otherwise is described under the heading **"Coverage for Eligible Dependents"** on page 10 of this booklet.

Joint and Survivor Annuity

The term "Joint and Survivor Annuity" means a lifetime pension described under Article V of the Cement Masons' Local 780 Pension Plan, as amended and restated; Article IV of the OPCMIA Local 262 Pension Plan, as amended and restated; or Article V of the Plasterers' and Cement Masons' Local 40 Pension Plan, as amended.

Medicaid

The term "Medicaid" means the Medical Assistant program under Title XIX of the Social Security Act.

Medicare

The term "Medicare" means the Health Insurance for the Aged and Disabled program under Title XVIII of the Social Security Act.

Participant

The term "Participant" means an individual described under the heading **"Participants"** on page 10 of this booklet.

Qualified Medical Child Support Order

The term "Qualified Medical Child Support Order" ("QMCSO") means a medical child support order as defined in clause (B) of 29 U.S. Code §1169(a)(2) that meets the requirements of clause (A) of that provision, i.e., §1169(a)(2).

Upon receipt of a medical child support order, the plan administrator shall follow these procedures:

(a) The plan administrator shall promptly notify in writing the Participant, each alternative recipient covered by the order, and each representative for these parties of the receipt of the medical child support order. Such notice shall include a copy of the order and these QMSCO procedures for determining whether such order is a QMSCO.

(b) The plan administrator shall permit the alternate recipient to designate a representative to receive copies of notices sent to the alternate recipient regarding the medical child support order.

(c) The plan administrator shall, within a reasonable period after receiving a medical child support order, determine whether it is a qualified order and notify the parties indicated in subsection (a) above of such determination.

(d) The plan administrator shall ensure the alternate recipient is treated by the Plan as a beneficiary for ERISA reporting and disclosure purposes, such as by distributing to the alternate recipient a copy of the SPD and any subsequent Plan amendments.

Qualifying Event

The term "Qualifying Event" means an event described under the heading **"COBRA Rules Governing Voluntary Self Payments"** on page 26 of this booklet.

Summary Plan Description

The term "Summary Plan Description" ("SPD") means a summary of the Plan provisions and how the Plan operates.

Trust Agreement

The term "Trust Agreement" means the Agreement and Declaration of Trust establishing the Northeast District Council of the OPCMIA Welfare Fund, as amended.

Trustees/Board of Trustees

The term "Employer Trustees" means the Trustees appointed by the employers. The term "Union Trustees" means the Trustees appointed by the executive board of the Union. The term "Trustees" or "Board of Trustees" means the Employer Trustees and Union Trustees collectively and includes their successors when acting as Trustees.

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

Coverage Period: 07/01/2019 - 12/31/2020

aetna™ : NORTHEAST DISTRICT COUNCIL OF THE OPCMIA WELFARE FUND

Aetna Open Access® Elect Choice® - Low Plan

Coverage for: Individual + Family | **Plan Type:** EPO

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, https://www.aetna.com/sbcsearch/getpolicydocs?u=081800-040020-011948 or by calling 1-888-982-3862. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary/ or call 1-888-982-3862 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network: Individual $1,500 / Family $3,000.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Emergency care; plus in-network office visits, preventive care & prescription drugs are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	Yes. $100 for prescription drugs. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	Network: Individual $6,600 / Family $13,200.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges & health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See http://www.aetna.com/docfind or call 1-888-982-3862 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out–of–Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$40 copay/visit, deductible doesn't apply	Not covered	None
	Specialist visit	$40 copay/visit, deductible doesn't apply	Not covered	None
	Preventive care /screening /immunization	No charge	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	$40 copay/visit, deductible doesn't apply	Not covered	None
	Imaging (CT/PET scans, MRIs)	$75 copay/visit, deductible doesn't apply	Not covered	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.aetnapharmacy.com/premierplus	Generic drugs	Copay/prescription, after specific deductible: $15 (retail), $30 (mail order)	Not covered	Covers 30 day supply (retail), 31-90 day supply (mail order). Includes contraceptive drugs & devices obtainable from a pharmacy, oral & injectable fertility drugs. No charge for preferred FDA-approved women's contraceptives in-network. Your cost will be higher for choosing Brand over Generics unless prescribed Dispense as Written.
	Preferred brand drugs	Copay/prescription, after specific deductible: $35 (retail), $70 (mail order)	Not covered	
	Non-preferred brand drugs	Copay/prescription, after specific deductible: $65 (retail), $130 (mail order)	Not covered	
	Specialty drugs	Applicable cost as noted above for generic or brand drugs	Not covered	First prescription fill at a retail pharmacy or specialty pharmacy. Subsequent fills must be through the Aetna Specialty Pharmacy Network. Precertification required for coverage.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$75 copay/visit, deductible doesn't apply	Not covered	None
	Physician/surgeon fees	No charge	Not covered	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out–of–Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	$200 copay/visit, deductible doesn't apply	$200 copay/visit, deductible doesn't apply	No coverage for non-emergency use.
	Emergency medical transportation	0% coinsurance	0% coinsurance	Non-emergency transport: not covered, except if pre-authorized.
	Urgent care	$40 copay/visit, deductible doesn't apply	Not covered	No coverage for non-urgent use.
If you have a hospital stay	Facility fee (e.g., hospital room)	$500 copay/stay	Not covered	None
	Physician/surgeon fees	0% coinsurance	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office: $40 copay/visit, deductible doesn't apply; other outpatient services: no charge	Not covered	None
	Inpatient services	$500 copay/stay	Not covered	None
If you are pregnant	Office visits	No charge	Not covered	Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	0% coinsurance	Not covered	
	Childbirth/delivery facility services	$500 copay/stay	Not covered	
If you need help recovering or have other special health needs	Home health care	No charge	Not covered	200 visits/calendar year.
	Rehabilitation services	$40 copay/visit, deductible doesn't apply	Not covered	60 visits/calendar year for Physical, Occupational & Speech Therapy combined.
	Habilitation services	$40 copay/visit, deductible doesn't apply	Not covered	None
	Skilled nursing care	$500 copay/stay	Not covered	60 days/calendar year.
	Durable medical equipment	0% coinsurance	Not covered	Limited to 1 durable medical equipment for same/similar purpose. Excludes repairs for misuse/abuse.
	Hospice services	$500 copay/stay for inpatient; not covered for outpatient	Not covered	210 days/lifetime for inpatient.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out–of–Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	No charge	Not covered	1 routine eye exam/24 months.
	Children's glasses	Not covered	Not covered	Not covered.
	Children's dental check-up	Not covered	Not covered	Not covered.

Excluded Services & Other Covered Services:

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

- Cosmetic surgery
- Dental care (Adult & Child)
- Glasses (Child)
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine foot care
- Weight loss programs - Except for required preventive services.

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

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Infertility treatment - Limited to the diagnosis & treatment of underlying medical condition, artificial insemination, ovulation induction & oral & injectable fertility drugs.
- Private-duty nursing - 20- 8 hour shifts per calendar year.
- Routine eye care (Adult) - 1 routine eye exam/24 months.

Your Rights to Continue Coverage:

There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Financial Services, Consumer Assistance Unit, 800-342-3736, http://www.dfs.ny.gov/consumer/fileacomplaint.htm.

- For more information on your rights to continue coverage, contact the plan at 1-888-982-3862.
- If your group health coverage is subject to ERISA, you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or https://www.dol.gov/agencies/ebsa.
- For non-federal governmental group health plans, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.
- If your coverage is a church plan, church plans are not covered by the Federal COBRA continuation coverage rules. If the coverage is insured, individuals should contact their State insurance regulator regarding their possible rights to continuation coverage under State law.

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

Your Grievance and Appeals Rights:

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

- Aetna directly by calling the toll free number on your Medical ID Card, or by calling our general toll free number at 1-888-982-3862.
- Department of Financial Services, Consumer Assistance Unit, 800-342-3736, http://www.dfs.ny.gov/consumer/fileacomplaint.htm.
- If your group health coverage is subject to ERISA, you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or https://www.dol.gov/agencies/ebsa**.**
- For non-federal governmental group health plans, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.
- Additionally, a consumer assistance program can help you file your appeal. Contact Community Health Advocates, Community Service Society of New York, 633 Third Avenue 10th Floor, New York, NY 10017, 1-888-614-5400, http://www.communityhealthadvocates.org/

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

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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

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

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

About these Coverage Examples:

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

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

- **The plan's overall deductible** **$1,500**
- **Specialist copayment** **$40**
- **Hospital (facility) copayment** **$500**
- **Other coinsurance** **0%**

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

Total Example Cost	**$12,800**
In this example, Peg would pay:	
Cost Sharing	
Deductibles*	$1,500
Copayments	$800
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,360**

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

- **The plan's overall deductible** **$1,500**
- **Specialist copayment** **$40**
- **Hospital (facility) copayment** **$500**
- **Other coinsurance** **0%**

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$7,400**
In this example, Joe would pay:	
Cost Sharing	
Deductibles*	$100
Copayments	$1,700
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,820**

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

- **The plan's overall deductible** **$1,500**
- **Specialist copayment** **$40**
- **Hospital (facility) copayment** **$500**
- **Other coinsurance** **0%**

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

Total Example Cost	**$1,900**
In this example, Mia would pay:	
Cost Sharing	
Deductibles*	$600
Copayments	$400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,000**

*Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.

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

Published: 08/23/2019

Assistive Technology

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 1-888-982-3862.

Smartphone or Tablet

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

Non-Discrimination

Aetna complies with applicable Federal civil rights laws and does not discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, or disability.

Aetna provides free aids/services to people with disabilities and to people who need language assistance.

If you need a qualified interpreter, written information in other formats, translation or other services, call the number on your ID card.

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:

Civil Rights Coordinator

P.O. Box 14462, Lexington, KY 40512 (CA HMO customers: PO Box 24030, Fresno, CA 93779)

1-800-648-7817, TTY: 711, Fax: 859-425-3379 (CA HMO customers: 1-860-262-7705)

Email: CRCoordinator@aetna.com

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, or at 1-800-368-1019, 800-537-7697 (TDD).

TTY: 711

Language Assistance:

For language assistance in your language call 1-888-982-3862 at no cost.

Albanian -	Për asistencë në gjuhën shqipe telefononi falas në 1-888-982-3862.
Amharic -	ለቋንቋ እገዛ በ አማርኛ በ 1-888-982-3862 በነጻ ይደውሉ
Arabic -	للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني1-888-982-3862
Armenian -	Լեզվի ցուցաբերած աջակցության (հայերեն) զանգի 1-888-982-3862 առանց գնով:
Bahasa-Indonesia -	Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-888-982-3862 tanpa dikenakan biaya.
Bantu-Kirundi -	Niba urondera uwugufasha mu Kirundi, twakure kuri iyi nomero 1-888-982-3862 ku busa
Bengali-Bangala -	বাংলায় ভাষা সহায়তার জন্য বিনামূল্যে 1-888-982-3862-তে কল করুন।
Bisayan-Visayan -	Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawag sa 1-888-982-3862 nga walay bayad.
Burmese -	ငွေကုန်ကျခံစရာမလိုဘဲ (မြန်မာဘာသာစကား)ဖြင့် ဘာသာစကားအကူအညီရယူရန် 1-888-982-3862 ကို ခေါ်ဆိုပါ။
Catalan -	Per rebre assistència en (català), truqui al número gratuït 1-888-982-3862.
Chamorro -	Para ayuda gi fino' (Chamoru), ågang 1-888-982-3862 sin gåstu.
Cherokee -	ᎾᏍᎩᎾ ᏕᏣᏂᏯᏍᏗ ᏗᏂᏍᏕᎵᏍᎩ ᎾᏍᎢ (ᏣᎳᎩ) ᏫᏓᏔᏅᎥᏕ 1-888-982-3862 ᏅᎾᎢ Ꮭ ᎪᎱᏍᏗ ᏧᎬᏩᎶᏗ ᏂᎨᏒᎾ.
Chinese -	欲取得繁體中文語言協助，請撥打 1-888-982-3862，無需付費。
Choctaw -	(Chahta) anumpa ya apela a chi I paya hinla 1-888-982-3862.
Cushite -	Gargaarsa afaan Oromiffa hiikuu argachuuf lakkokkofsa bilbilaa 1-888-982-3862 irratti bilisaan bilbilaa.
Dutch -	Bel voor tolk- en vertaaldiensten in het Nederlands gratis naar 1-888-982-3862.
French -	Pour une assistance linguistique en français appeler le 1-888-982-3862 sans frais.
French Creole -	Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo 1-888-982-3862 gratis.
German -	Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 1-888-982-3862 an.
Greek -	Για γλωσσική βοήθεια στα Ελληνικά καλέστε το 1-888-982-3862 χωρίς χρέωση.
Gujarati -	ગુજરાતીમાં ભાષામાં સહાય માટે કોઈ પણ ખર્ચ વગર 1-888-982-3862 પર કૉલ કરો.

Hawaiian -	No ke kōkua ma ka ‘ōlelo Hawai‘i, e kahea aku i ka helu kelepona 1-888-982-3862. Kāki ‘ole ‘ia kēia kōkua nei.
Hindi -	हिन्दी में भाषा सहायता के लिए, 1-888-982-3862 पर मुफ्त कॉल करें।
Hmong -	Yog xav tau kev pab txhais lus Hmoob hu dawb tau rau 1-888-982-3862.
Ibo -	Maka enyemaka asụsụ na Igbo kpọọ 1-888-982-3862 na akwụghị ụgwọ ọ bụla
Ilocano -	Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-888-982-3862 nga awan ti bayadanyo.
Italian -	Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 1-888-982-3862.
Japanese -	日本語で援助をご希望の方は、1-888-982-3862 まで無料でお電話ください。
Karen -	လၢတၢ်မၤစၢၤတၢ်ကတိၤကျိာ်ညီအဂီၤ် ကျိာ် ကိး 1-888-982-3862 လၢတအိဉ်ဒီးတၢ်လၢာ်ဘျိာ်လၢာ်စုၤဘာ့
Korean -	한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-888-982-3862 번으로 전화해 주십시오.
Kru-Bassa -	Ɓɛ´m`ké gbo-kpá-kpá dyé piɗyi ɖé Ɓaɓɔ́ɔ̀-wuɖuǔn wɛ̃ɛ, ɖá 1-888-982-3862
Kurdish -	برای راهنمایی به زبان فارسی با شماره 1-888-982-3862 به خۆرایی پەیوەندی بکەن.
Laotian -	ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ, ກະລຸນາໂທຫາ 1-888-982-3862 ໂດຍບໍ່ເສຍຄ່າໂທ.
Marathi -	तीलभाषा(मराठी)सहाय्यासाठी 1-888-982-3862 क्रमांकावरकोणत्याहीखर्चाशविायकॉलकरा.
Marshallese -	Ñan bōk jipañ ilo Kajin Majol, kallok 1-888-982-3862 ilo ejjelok wōnān.
Micronesian - Pohnpeyan	Ohng palien sawas en soun kawewe ni omw lokaia Ponape koahl 1-888-982-3862 ni sohte isais.
Mon-Khmer, Cambodian -	សម្រាប់ជំនួយភាសាជា ភាសាខ្មែរ សូមទូរស័ព្ទទៅកាន់លេខ 1-888-982-3862 ដោយឥតគិតថ្លៃ។
Navajo -	T'áá shi shizaad k'ehjí bee shíká a'doowol nínízingo Diné k'ehjí koji' t'áá jiík'e hólne' 1-888-982-3862
Nepali -	(नेपाली) मा नःशुल्क भाषा सहायता पाउनका लागि 1-888-982-3862 मा फोन गर्नुहोस् ।
Nilotic-Dinka -	Tën kuɔɔny ë thok ë Thuɔŋjäŋ cɔl 1-888-982-3862 kecïn aɣöc.
Norwegian -	For språkassistanse på norsk, ring 1-888-982-3862 kostnadsfritt.
Panjabi -	ਪੰਜਾਬੀ ਵਿੱਚ ਭਾਸ਼ਾਈ ਸਹਾਇਤਾ ਲਈ, 1-888-982-3862 'ਤੇ ਮੁਫ਼ਤ ਕਾਲ ਕਰੋ।
Pennsylvania Dutch -	Fer Helfe in Deitsch, ruf: 1-888-982-3862 aa. Es Aaruf koschtet nix.

Persian -	برای راهنمایی به زبان فارسی با شماره 1-888-982-3862 بدون هیچ هزینه ای تماس بگیرید. انگلیسی
Polish -	Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-888-982-3862.
Portuguese -	Para obter assistência linguística em português ligue para o 1-888-982-3862 gratuitamente.
Romanian -	Pentru asistenţă lingvistică în românește telefonaţi la numărul gratuit 1-888-982-3862
Russian -	Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-888-982-3862.
Samoan -	Mo fesoasoani tau gagana I le Gagana Samoa vala'au le 1-888-982-3862 e aunoa ma se totogi.
Serbo-Croatian -	Za jezičnu pomoć na hrvatskom jeziku pozovite besplatan broj 1-888-982-3862.
Spanish -	Para obtener asistencia lingüística en español, llame sin cargo al 1-888-982-3862.
Sudanic-Fulfude -	Fii yo on heɓu balal e ko yowitii e haala Pular noddee e oo numero ɗoo 1-888-982-3862 Njodi woo fawaaki on.
Swahili -	Ukihitaji usaidizi katika lugha ya Kiswahili piga simu kwa 1-888-982-3862 bila malipo.
Syriac -	[illegible] 1-888-982-3862 [illegible].
Tagalog -	Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-888-982-3862 nang walang bayad.
Telugu -	భషతో సయంకొరకు ఎలాంటి ఖర్చు లేకుండా **1-888-982-3862** కు కల్ చేయండి. (తెలుగు)
Thai -	สำหรับความช่วยเหลือทางด้านภาษาเป็น ภาษาไทย โทร 1-888-982-3862 ฟรีไม่มีค่าใช้จ่าย
Tongan -	Kapau ‘oku fiema'u hā tokoni ‘i he lea faka-Tonga telefoni 1-888-982-3862 ‘o ‘ikai hā tōtōngi.
Trukese -	Ren áninnisin chiakú ren (Kapasen Chuuk) kopwe kékkééri 1-888-982-3862 nge esapw kamé ngonuk.
Turkish -	(Dil) çağrısı dil yardım için. Hiçbir ücret ödemeden 1-888-982-3862.
Ukrainian -	Щоб отримати допомогу перекладача української мови, зателефонуйте за безкоштовним номером 1-888-982-3862.
Urdu -	[illegible] 1-888-982-3862 [illegible]
Vietnamese -	Để được hỗ trợ ngôn ngữ bằng (ngôn ngữ), hãy gọi miễn phí đến số 1-888-982-3862.
Yiddish -	פאר שפראך הילף אין אידיש רופט 1-888-982-3862 פריי פון אפצאל.
Yoruba -	Fún ìrànlọwọ nípa èdè (Yorùbá) pe 1-888-982-3862 lái san owó kankan rárá.

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

Coverage Period: 07/01/2019 - 12/31/2020

aetna™ : NORTHEAST DISTRICT COUNCIL OF THE OPCMIA WELFARE FUND

Aetna Open Access® Elect Choice® - High Plan

Coverage for: Individual + Family | **Plan Type:** EPO

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, https://www.aetna.com/sbcsearch/getpolicydocs?u=081800-040020-011946 or by calling 1-888-982-3862. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary/ or call 1-888-982-3862 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network: Individual $1,000 / Family $2,000.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Emergency care; plus in-network office visits, prescription drugs & preventive care are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Network: Individual $6,600 / Family $13,200.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges & health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See http://www.aetna.com/docfind or call 1-888-982-3862 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out–of–Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$30 copay/visit, deductible doesn't apply	Not covered	None
	Specialist visit	$30 copay/visit, deductible doesn't apply	Not covered	None
	Preventive care /screening /immunization	No charge	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	$30 copay/visit, deductible doesn't apply	Not covered	None
	Imaging (CT/PET scans, MRIs)	$75 copay/visit, deductible doesn't apply	Not covered	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.aetnapharmacy.com/premierplus	Generic drugs	Copay/prescription, deductible doesn't apply: $10 (retail), $20 (mail order)	Not covered	Covers 30 day supply (retail), 31-90 day supply (mail order). Includes contraceptive drugs & devices obtainable from a pharmacy, oral & injectable fertility drugs. No charge for preferred FDA-approved women's contraceptives in-network. Your cost will be higher for choosing Brand over Generics unless prescribed Dispense as Written.
	Preferred brand drugs	Copay/prescription, deductible doesn't apply: $25 (retail), $50 (mail order)	Not covered	
	Non-preferred brand drugs	Copay/prescription, deductible doesn't apply: $50 (retail), $100 (mail order)	Not covered	
	Specialty drugs	Applicable cost as noted above for generic or brand drugs	Not covered	First prescription fill at a retail pharmacy or specialty pharmacy. Subsequent fills must be through the Aetna Specialty Pharmacy Network. Precertification required for coverage.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$75 copay/visit, deductible doesn't apply	Not covered	None
	Physician/surgeon fees	No charge	Not covered	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out–of–Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	$200 copay/visit, deductible doesn't apply	$200 copay/visit, deductible doesn't apply	No coverage for non-emergency use.
	Emergency medical transportation	0% coinsurance	0% coinsurance	Non-emergency transport: not covered, except if pre-authorized.
	Urgent care	$30 copay/visit, deductible doesn't apply	Not covered	No coverage for non-urgent use.
If you have a hospital stay	Facility fee (e.g., hospital room)	$500 copay/stay	Not covered	None
	Physician/surgeon fees	0% coinsurance	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office: $30 copay/visit, deductible doesn't apply; other outpatient services: no charge	Not covered	None
	Inpatient services	$500 copay/stay	Not covered	None
If you are pregnant	Office visits	No charge	Not covered	Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	0% coinsurance	Not covered	
	Childbirth/delivery facility services	$500 copay/stay	Not covered	
If you need help recovering or have other special health needs	Home health care	No charge	Not covered	200 visits/calendar year.
	Rehabilitation services	$30 copay/visit, deductible doesn't apply	Not covered	60 visits/calendar year for Physical, Occupational & Speech Therapy combined.
	Habilitation services	$30 copay/visit, deductible doesn't apply	Not covered	None
	Skilled nursing care	$500 copay/stay	Not covered	60 days/calendar year.
	Durable medical equipment	0% coinsurance	Not covered	Limited to 1 durable medical equipment for same/similar purpose. Excludes repairs for misuse/abuse.
	Hospice services	$500 copay/stay for inpatient; not covered for outpatient	Not covered	210 days/lifetime for inpatient.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out–of–Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	No charge	Not covered	1 routine eye exam/24 months.
	Children's glasses	Not covered	Not covered	Not covered.
	Children's dental check-up	Not covered	Not covered	Not covered.

Excluded Services & Other Covered Services:

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

- Cosmetic surgery
- Dental care (Adult & Child)
- Glasses (Child)
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine foot care
- Weight loss programs - Except for required preventive services.

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

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Infertility treatment - Limited to the diagnosis & treatment of underlying medical condition, artificial insemination, ovulation induction & oral & injectable fertility drugs.
- Private-duty nursing - 20- 8 hour shifts/calendar year.
- Routine eye care (Adult) - 1 routine eye exam/24 months.

Your Rights to Continue Coverage:

There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Financial Services, Consumer Assistance Unit, 800-342-3736, http://www.dfs.ny.gov/consumer/fileacomplaint.htm.

- For more information on your rights to continue coverage, contact the plan at 1-888-982-3862.
- If your group health coverage is subject to ERISA, you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or https://www.dol.gov/agencies/ebsa.
- For non-federal governmental group health plans, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.
- If your coverage is a church plan, church plans are not covered by the Federal COBRA continuation coverage rules. If the coverage is insured, individuals should contact their State insurance regulator regarding their possible rights to continuation coverage under State law.

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

Your Grievance and Appeals Rights:

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

- Aetna directly by calling the toll free number on your Medical ID Card, or by calling our general toll free number at 1-888-982-3862.
- Department of Financial Services, Consumer Assistance Unit, 800-342-3736, http://www.dfs.ny.gov/consumer/fileacomplaint.htm.
- If your group health coverage is subject to ERISA, you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or https://www.dol.gov/agencies/ebsa**.**
- For non-federal governmental group health plans, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.
- Additionally, a consumer assistance program can help you file your appeal. Contact Community Health Advocates, Community Service Society of New York, 633 Third Avenue 10th Floor, New York, NY 10017, 1-888-614-5400, http://www.communityhealthadvocates.org/

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

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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

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

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

About these Coverage Examples:

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

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

- **The plan's overall deductible** **$1,000**
- **Specialist copayment** **$30**
- **Hospital (facility) copayment** **$500**
- **Other coinsurance** **0%**

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

Total Example Cost	**$12,800**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$1,000
Copayments	$700
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,760**

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

- **The plan's overall deductible** **$1,000**
- **Specialist copayment** **$30**
- **Hospital (facility) copayment** **$500**
- **Other coinsurance** **0%**

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$7,400**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$1,300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,320**

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

- **The plan's overall deductible** **$1,000**
- **Specialist copayment** **$30**
- **Hospital (facility) copayment** **$500**
- **Other coinsurance** **0%**

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

Total Example Cost	**$1,900**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$600
Copayments	$400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,000**

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: 1-888-982-3862.

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

Published: 08/23/2019

Assistive Technology

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 1-888-982-3862.

Smartphone or Tablet

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

Non-Discrimination

Aetna complies with applicable Federal civil rights laws and does not discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, or disability.

Aetna provides free aids/services to people with disabilities and to people who need language assistance.

If you need a qualified interpreter, written information in other formats, translation or other services, call the number on your ID card.

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:

Civil Rights Coordinator

P.O. Box 14462, Lexington, KY 40512 (CA HMO customers: PO Box 24030, Fresno, CA 93779)

1-800-648-7817, TTY: 711, Fax: 859-425-3379 (CA HMO customers: 1-860-262-7705)

Email: CRCoordinator@aetna.com

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, or at 1-800-368-1019, 800-537-7697 (TDD).

TTY: 711

Language Assistance:

For language assistance in your language call 1-888-982-3862 at no cost.

Albanian -	Për asistencë në gjuhën shqipe telefononi falas në 1-888-982-3862.
Amharic -	ለቋንቋ እገዛ በ አማርኛ በ 1-888-982-3862 በነጻ ይደውሉ
Arabic -	1-888-982-3862للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني
Armenian -	Լեզվի ցուցաբերած աջակցության (հայերեն) զանգի 1-888-982-3862 առանց գնով:
Bahasa-Indonesia -	Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-888-982-3862 tanpa dikenakan biaya.
Bantu-Kirundi -	Niba urondera uwugufasha mu Kirundi, twakure kuri iyi nomero 1-888-982-3862 ku busa
Bengali-Bangala -	বাংলায় ভাষা সহায়তার জন্য বিনামূল্যে 1-888-982-3862-তে কল করুন।
Bisayan-Visayan -	Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawag sa 1-888-982-3862 nga walay bayad.
Burmese -	ငွေကုန်ကျခံစရာမလိုဘဲ (မြန်မာဘာသာစကား)ဖြင့် ဘာသာစကားအကူအညီရယူရန် 1-888-982-3862 ကို ခေါ်ဆိုပါ။
Catalan -	Per rebre assistència en (català), truqui al número gratuït 1-888-982-3862.
Chamorro -	Para ayuda gi fino' (Chamoru), ågang 1-888-982-3862 sin gåstu.
Cherokee -	ᎾᏍᎩᎾ ᏚᏙᏂᎯᏍᏗ ᏗᏂᏍᏕᎵᏍᎩ ᎾᏓᎢ (ᏣᎳᎩ) ᎾᏏᎳᏛᎥᏍ 1-888-982-3862 ᏥᎾᎢ Ꮭ ᎪᎱᏍᏗ ᏧᎬᏩᎶᏗ ᏂᎨᏒᎾ.
Chinese -	欲取得繁體中文語言協助，請撥打 1-888-982-3862，無需付費。
Choctaw -	(Chahta) anumpa ya apela a chi I paya hinla 1-888-982-3862.
Cushite -	Gargaarsa afaan Oromiffa hiikuu argachuuf lakkokkofsa bilbilaa 1-888-982-3862 irratti bilisaan bilbilaa.
Dutch -	Bel voor tolk- en vertaaldiensten in het Nederlands gratis naar 1-888-982-3862.
French -	Pour une assistance linguistique en français appeler le 1-888-982-3862 sans frais.
French Creole -	Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo 1-888-982-3862 gratis.
German -	Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 1-888-982-3862 an.
Greek -	Για γλωσσική βοήθεια στα Ελληνικά καλέστε το 1-888-982-3862 χωρίς χρέωση.
Gujarati -	ગુજરાતીમાં ભાષામાં સહાય માટે કોઈ પણ ખર્ચ વગર 1-888-982-3862 પર કૉલ કરો.

Hawaiian -	No ke kōkua ma ka ‘ōlelo Hawai‘i, e kahea aku i ka helu kelepona 1-888-982-3862. Kāki ‘ole ‘ia kēia kōkua nei.
Hindi -	हिन्दी में भाषा सहायता के लिए, 1-888-982-3862 पर मुफ्त कॉल करें।
Hmong -	Yog xav tau kev pab txhais lus Hmoob hu dawb tau rau 1-888-982-3862.
Ibo -	Maka enyemaka asụsụ na Igbo kpọọ 1-888-982-3862 na akwụghị ụgwọ ọ bụla
Ilocano -	Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-888-982-3862 nga awan ti bayadanyo.
Italian -	Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 1-888-982-3862.
Japanese -	日本語で援助をご希望の方は、1-888-982-3862 まで無料でお電話ください。
Karen -	လၢတၢ်မၤစၢၤတၢ်ကတိၤကျိာ်အဂီၤ် ကျိာ် ကိး 1-888-982-3862 လၢတအိဉ်ဒီးတၢ်လၢာ်ဘျိာ်လၢာ်စုၤဘာ့
Korean -	한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-888-982-3862 번으로 전화해 주십시오.
Kru-Bassa -	Ɓɛ´m`ké gbo-kpá-kpá dyé piɗyi ɖé Ɓaɓɔ́ɔ̀-wuɖuǔn wɛ̃ɛ, ɖá 1-888-982-3862
Kurdish -	بۆ یارمەتی وەرگێڕان بە زمانی کوردی بە خۆڕایی پەیوەندی بکەن. 1-888-982-3862 برای راهنمایی به زبان فارسی با شماره
Laotian -	ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ, ກະລຸນາໂທຫາ 1-888-982-3862 ໂດຍບໍ່ເສຍຄ່າໂທ.
Marathi -	तीलभाषा(मराठी)सहाय्यासाठी 1-888-982-3862 क्रमांकावरकोणत्याहीखर्चाशवायकॉलकरा.
Marshallese -	Ñan bōk jipañ ilo Kajin Majol, kallok 1-888-982-3862 ilo ejjelok wōnān.
Micronesian - Pohnpeyan	Ohng palien sawas en soun kawewe ni omw lokaia Ponape koahl 1-888-982-3862 ni sohte isais.
Mon-Khmer, Cambodian -	សម្រាប់ជំនួយភាសាជា ភាសាខ្មែរ សូមទូរស័ព្ទទៅកាន់លេខ 1-888-982-3862 ដោយឥតគិតថ្លៃ។
Navajo -	T'áá shi shizaad k'ehjí bee shíká a'doowol nínízingo Diné k'ehjí koji' t'áá jiík'e hólne' 1-888-982-3862
Nepali -	(नेपाली) मा नःशुल्क भाषा सहायता पाउनका लागि 1-888-982-3862 मा फोन गर्नुहोस् ।
Nilotic-Dinka -	Tën kuɔɔny ë thok ë Thuɔŋjäŋ cɔl 1-888-982-3862 kecïn aɣöc.
Norwegian -	For språkassistanse på norsk, ring 1-888-982-3862 kostnadsfritt.
Panjabi -	ਪੰਜਾਬੀ ਵਿੱਚ ਭਾਸ਼ਾਈ ਸਹਾਇਤਾ ਲਈ, 1-888-982-3862 'ਤੇ ਮੁਫ਼ਤ ਕਾਲ ਕਰੋ।
Pennsylvania Dutch -	Fer Helfe in Deitsch, ruf: 1-888-982-3862 aa. Es Aaruf koschtet nix.

Persian -	برای راهنمایی به زبان فارسی با شماره 1-888-982-3862 بدون هیچ هزینه ای تماس بگیرید. انگلیسی
Polish -	Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-888-982-3862.
Portuguese -	Para obter assistência linguística em português ligue para o 1-888-982-3862 gratuitamente.
Romanian -	Pentru asistenţă lingvistică în românește telefonați la numărul gratuit 1-888-982-3862
Russian -	Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-888-982-3862.
Samoan -	Mo fesoasoani tau gagana I le Gagana Samoa vala'au le 1-888-982-3862 e aunoa ma se totogi.
Serbo-Croatian -	Za jezičnu pomoć na hrvatskom jeziku pozovite besplatan broj 1-888-982-3862.
Spanish -	Para obtener asistencia lingüística en español, llame sin cargo al 1-888-982-3862.
Sudanic-Fulfude -	Fii yo on heɓu balal e ko yowitii e haala Pular noddee e oo numero ɗoo 1-888-982-3862 Njodi woo fawaaki on.
Swahili -	Ukihitaji usaidizi katika lugha ya Kiswahili piga simu kwa 1-888-982-3862 bila malipo.
Syriac -	1-888-982-3862 .
Tagalog -	Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-888-982-3862 nang walang bayad.
Telugu -	భషతో సయం కోరకు ఎలంటి ఖర్చు లేకుండా **1-888-982-3862** కు కల్ చేయండి. (తెలుగు)
Thai -	สำหรับความช่วยเหลือทางด้านภาษาเป็น ภาษาไทย โทร 1-888-982-3862 ฟรีไม่มีค่าใช้จ่าย
Tongan -	Kapau ‘oku fiema'u hā tokoni ‘i he lea faka-Tonga telefoni 1-888-982-3862 ‘o ‘ikai hā tōtōngi.
Trukese -	Ren áninnisin chiakú ren (Kapasen Chuuk) kopwe kékkééri 1-888-982-3862 nge esapw kamé ngonuk.
Turkish -	(Dil) çağrısı dil yardım için. Hiçbir ücret ödemeden 1-888-982-3862.
Ukrainian -	Щоб отримати допомогу перекладача української мови, зателефонуйте за безкоштовним номером 1-888-982-3862.
Urdu -	1-888-982-3862
Vietnamese -	Đê ̉ đươ ̣c hô ̃ trơ ̣ ngôn ngư ̃ bằng (ngôn ngư ̃), hãy goi ̣ miễn phi ́ đê ́n sô ́ 1-888-982-3862.
Yiddish -	1-888-982-3862 פאר שפראך הילף אין אידיש רופט פרי פון אפצאל.
Yoruba -	Fún ìrànlọwọ nípa èdè (Yorùbá) pe 1-888-982-3862 lái san owó kankan rárá.

NORTHEAST DISTRICT COUNCIL OF THE OPCMIA WELFARE FUND

Aetna Medicare [SM] Plan (PPO)

Medicare (P01) PPO Plan

Custom Rx $10/$20/$50/$50

Benefits and Premiums are effective January 1, 2020 through December 31, 2020

PLAN DESIGN AND BENEFITS

PROVIDED BY AETNA LIFE INSURANCE COMPANY

PLAN FEATURES	This is what you pay for Network Providers	This is what you pay for Out-of-Network Providers
Annual Deductible	$0	$0
This is the amount you have to pay out of pocket before the plan will pay its share for your covered Medicare Part A and B services.		
Annual Maximum Out-of-Pocket Amount	**Network Services:**	**Network and out-of-network services:**
	$3,400	$3,400 for in and out-of-network services combined
Annual maximum out-of-pocket limit amount includes any deductible, copayment or coinsurance that you pay. It will apply to all medical expenses except Hearing Aid Reimbursement, Vision Reimbursement and Medicare prescription drug coverage that may be available on your plan.		
Primary Care Physician Selection	Optional	Not Applicable
There is no requirement for member pre-certification. Your provider will do this on your behalf.		
Referral Requirement	None	
PREVENTIVE CARE	**This is what you pay for Network Providers**	**This is what you pay for Out-of-Network Providers**
Annual Wellness Exams	$0	25%
One exam every 12 months.		
Routine Physical Exams	$0	15%
Medicare Covered Immunizations	$0	$0
Pneumococcal, Flu, Hepatitis B		

Routine GYN Care (Cervical and Vaginal Cancer Screenings)	$0	15%
One routine GYN visit and pap smear every 24 months.		
Routine Mammograms (Breast Cancer Screening)	$0	15%
One baseline mammogram for members age 35-39; and one annual mammogram for members age 40 & over.		
Routine Prostate Cancer Screening Exam	$0	15%
For covered males age 50 & over, every 12 months.		
Routine Colorectal Cancer Screening	$0	15%
For all members age 50 & over.		
Routine Bone Mass Measurement	$0	15%
Medicare Diabetes Prevention Program (MDPP)	$0	15%
12 months of core session for program eligible members with an indication of pre-diabetes.		
Routine Eye Exams	$0	15%
One annual exam every 12 months.		
Routine Hearing Screening	$0	15%
One exam every 12 months.		
Additional Medicare Preventive Services	$0	25%

- Ultrasound screening for abdominal aortic aneurysm (AAA)
- Cardiovascular disease screening
- Diabetes screening tests and diabetes self-management training (DSMT)
- Medical nutrition therapy
- Glaucoma screening
- Screening and behavioral counseling to quit smoking and tobacco use
- Screening and behavioral counseling for alcohol misuse
- Adult depression screening

- Behavioral counseling for and screening to prevent sexually transmitted infections
- Behavioral therapy for obesity
- Behavioral therapy for cardiovascular disease
- Behavioral therapy for HIV screening
- Hepatitis C screening
- Lung cancer screening

PHYSICIAN SERVICES	This is what you pay for Network Providers	This is what you pay for Out-of-Network Providers
Primary Care Physician Visits	$10	25%
Includes services of an internist, general physician, family practitioner for routine care as well as diagnosis and treatment of an illness or injury and in-office surgery.		
Physician Specialist Visits	$10	25%
DIAGNOSTIC PROCEDURES	**This is what you pay for Network Providers**	**This is what you pay for Out-of-Network Providers**
Outpatient Diagnostic Laboratory	$0	25%
Outpatient Diagnostic X-ray	$0	25%
Outpatient Diagnostic Testing	$0	25%
Outpatient Complex Imaging	$0	25%
EMERGENCY MEDICAL CARE	**This is what you pay for Network Providers**	**This is what you pay for Out-of-Network Providers**
Urgently Needed Care; Worldwide	$15	$15
Emergency Care; Worldwide (waived if admitted)	$65	$65
Ambulance Services	$0	$0
Observation Care		
Your cost share for Observation Care is based upon the services you receive.		

HOSPITAL CARE	This is what you pay for Network Providers	This is what you pay for Out-of-Network Providers
Inpatient Hospital Care	$250 per stay	25% per stay
The member cost sharing applies to covered benefits incurred during a member's inpatient stay.		
Outpatient Surgery	$0	25%
Blood	All components of blood are covered beginning with the first pint.	
MENTAL HEALTH SERVICES	**This is what you pay for Network Providers**	**This is what you pay for Out-of-Network Providers**
Inpatient Mental Health Care	$250 per stay	25% per stay
The member cost sharing applies to covered benefits incurred during a member's inpatient stay.		
Outpatient Mental Health Care	$10	25%
ALCOHOL/DRUG ABUSE SERVICES	**This is what you pay for Network Providers**	**This is what you pay for Out-of-Network Providers**
Inpatient Substance Abuse	$250 per stay	25% per stay
The member cost sharing applies to covered benefits incurred during a member's inpatient stay.		
Outpatient Substance Abuse	$10	25%
OTHER SERVICES	**This is what you pay for Network Providers**	**This is what you pay for Out-of-Network Providers**
Skilled Nursing Facility (SNF) Care	$0 copay per day, day(s) 1-20; $20 copay per day, day(s) 21-100	25%
Limited to 100 days per Medicare Benefit Period*.		
The member cost sharing applies to covered benefits incurred during a member's inpatient stay.		

*A benefit period begins the day you go into a hospital or skilled nursing facility. The benefit period ends when you haven't received any inpatient hospital care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a skilled nursing facility after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods.

Home Health Agency Care	$0	25%
Hospice Care	Covered by Original Medicare at a Medicare certified hospice.	
Outpatient Rehabilitation Services (Speech, Physical, and Occupational therapy)	$0	25%
Cardiac Rehabilitation Services	$0	25%
Pulmonary Rehabilitation Services	$15	25%
Radiation Therapy	$0	25%
Chiropractic Services	$15	25%
Limited to Original Medicare - covered services for manipulation of the spine.		
Durable Medical Equipment/ Prosthetic Devices	$0	25%
Podiatry Services	$10	25%
Limited to Original Medicare covered benefits only.		
Diabetic Supplies Includes supplies to monitor your blood glucose from LifeScan.	$0	25%
Diabetic Eye Exams	$0	15%
Outpatient Dialysis Treatments	$0	$0
Medicare Part B Prescription Drugs	$0	25%
Medicare Covered Dental Non-routine care covered by Medicare.	$10	25%

ADDITIONAL NON-MEDICARE COVERED SERVICES	
Fitness Benefit	Silver Sneakers
Resources for Living	Covered
For help locating resources for every day needs.	

See next page for Pharmacy-Prescription Drug Benefits.

NORTHEAST DISTRICT COUNCIL OF THE OPCMIA WELFARE FUND

Aetna Medicare [SM] Plan (PPO)

Medicare (P01) PPO Plan

Custom Rx $10/$20/$50/$50

PHARMACY - PRESCRIPTION DRUG BENEFITS

Calendar-year deductible for prescription drugs $0

Prescription drug calendar year deductible must be satisfied before any Medicare Prescription Drug benefits are paid. Covered Medicare Prescription Drug expenses will accumulate toward the pharmacy deductible.

Pharmacy Network S2

Your Medicare Part D plan is associated with pharmacies in the above network. To find a network pharmacy, you can visit our website (http://www.aetnaretireeplans.com).

Formulary (Drug List) GRP B2

Your cost for generic drugs is usually lower than your cost for brand drugs. However, Aetna in some instances combines higher cost generic drugs on brand tiers.

Initial Coverage Limit (ICL) $4,020

The Initial Coverage Limit includes the plan deductible, if applicable. This is your cost sharing until covered Medicare prescription drug expenses reach the Initial Coverage Limit (and after the deductible is satisfied, if your plan has a deductible):

4 Tier Plan	Retail cost-sharing up to a 30 -day supply	Retail cost-sharing up to a 90 -day supply	Preferred mail order cost-sharing up to a 90 -day supply
Tier 1 - Generic Generic Drugs	$10	$20	$20
Tier 2 - Preferred Brand Includes some high-cost generic and preferred brand drugs	$20	$40	$40

4 Tier Plan	Retail cost-sharing up to a 30 -day supply	Retail cost-sharing up to a 90 -day supply	Preferred mail order cost-sharing up to a 90 -day supply
Tier 3 - Non-Preferred Drug Includes some high-cost generic and non-preferred brand drugs	$50	$100	$100
Tier 4 - Specialty Includes high-cost/unique generic and brand drugs	$50	Limited to one-month supply	Limited to one-month supply

Coverage Gap

The Coverage Gap starts once covered Medicare prescription drug expenses have reached the Initial Coverage Limit. Here's your cost-sharing for covered Part D drugs after the Initial Coverage Limit and until you reach $6,350 in prescription drug expenses:

Your former employer/union/trust provides additional coverage during the Coverage Gap stage for covered drugs. This means that you will generally continue to pay the same amount for covered drugs throughout the Coverage Gap stage of the plan as you paid in the Initial Coverage stage. Coinsurance-based cost-sharing is applied against the overall cost of the drug, prior to the application of any discounts or benefits.

NORTHEAST DISTRICT COUNCIL OF THE OPCMIA WELFARE FUND

Aetna Medicare [SM] Plan (PPO)

Medicare (P01) PPO Plan

Custom Rx $10/$20/$50/$50

Catastrophic Coverage:	Greater of 5% of the cost of the drug - or - $3.60 for a generic drug or a drug that is treated like a generic and $8.95 for all other drugs.

Catastrophic Coverage benefits start once $6,350 in true out-of-pocket costs is incurred.

Requirements:	
Precertification	Applies
Step-Therapy	Does Not Apply

Non-Part D Drug Rider

- Not Covered

For more information about Aetna plans, go to **www.aetna.com** or call Member Services at toll-free at 1-888-267-2637 (TTY: 711) for additional information. Hours are 8 a.m. to 6 p.m. local time, Monday through Friday.

Medical Disclaimers

Not all PPO Plans are available in all areas

Participating physicians, hospitals and other health care providers are independent contractors and are neither agents nor employees of Aetna. The availability of any particular provider cannot be guaranteed, and provider network composition is subject to change.

In case of emergency, you should call 911 or the local emergency hotline. Or you should go directly to an emergency care facility.

The following is a partial list of what isn't covered or limits to coverage under this plan:

- Services that are not medically necessary unless the service is covered by Original Medicare or otherwise noted in your Evidence of Coverage
- Plastic or cosmetic surgery unless it is covered by Original Medicare
- Custodial care
- Experimental procedures or treatments that Original Medicare doesn't cover
- Outpatient prescription drugs unless covered under Original Medicare Part B

You may pay more for out-of-network services. Prior approval from Aetna is required for some network services. For services from a non-network provider, prior approval from Aetna is recommended. Providers must be licensed and eligible to receive payment under the federal Medicare program and willing to accept the plan.

Out-of-network/non-contracted providers are under no obligation to treat Aetna members, except in emergency situations. Please call our Customer Service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.

Aetna will pay any non contracted provider (that is eligible for Medicare payment and is willing to accept the Aetna Medicare Plan) the same as they would receive under Origional Medicare for Medicare covered services under the plan.

Pharmacy Disclaimers

Aetna's retiree pharmacy coverage is an enhanced Part D Employer Group Waiver Plan that is offered as a single integrated product. The enhanced Part D plan consists of two components: basic Medicare Part D benefits and supplemental benefits. Basic Medicare Part D benefits are offered by Aetna based on our contract with CMS. We receive monthly payments from CMS to pay for basic Part D benefits. Supplemental benefits are non-Medicare benefits that provide enhanced coverage beyond basic Part D. Supplemental benefits are paid for by plan sponsors or

members and may include benefits for non-Part D drugs. Aetna reports claim information to CMS according to the source of applicable payment (Medicare Part D, plan sponsor or member).

You must use network pharmacies to receive plan benefits except in limited, non-routine circumstances as defined in the EOC. In these situations, you are limited to a 30 day supply. To find a network pharmacy, you can visit our website (http://www.aetnaretireeplans.com). Quantity limits and restrictions may apply.

If you reside in a long-term care facility, your cost share is the same as at a retail pharmacy and you may receive up to a 31 day supply.

Members who get "extra help" don't need to fill prescriptions at preferred network pharmacies to get Low Income Subsidy (LIS) copays.

Specialty pharmacies fill high-cost specialty drugs that require special handling. Although specialty pharmacies may deliver covered medicines through the mail, they are not considered "mail-order pharmacies." Therefore, most specialty drugs are not available at the mail-order cost share.

For mail-order, you can get prescription drugs shipped to your home through the network mail-order delivery program. Typically, mail-order drugs arrive within 7-10 days. You can call 1-888-792-3862, (TTY users should call 711) 24 hours a day, seven days a week, if you do not receive your mail-order drugs within this timeframe. Members may have the option to sign-up for automated mail-order delivery.

Aetna receives rebates from drug manufacturers that may be taken into account in determining Aetna's preferred drug list. Rebates do not reduce the amount a member pays the pharmacy for covered prescriptions. Pharmacy participation is subject to change.

There are three general rules about drugs that Medicare drug plans will not cover under Part D. This plan cannot:

- Cover a drug that would be covered under Medicare Part A or Part B.
- Cover a drug purchased outside the United States and its territories.

- Generally cover drugs prescribed for “off label” use, (any use of the drug other than indicated on a drug's label as approved by the Food and Drug Administration) unless supported by criteria included in certain reference books like the American Hospital Formulary Service Drug Information, the DRUGDEX Information System and the USPDI or its successor.

Additionally, by law, the following categories of drugs are not normally covered by a Medicare prescription drug plan unless we offer enhanced drug coverage for which additional premium may be charged. These drugs are not considered Part D drugs and may be referred to as “exclusions” or “non-Part D drugs”. These drugs include:

- Drugs used for the treatment of weight loss, weight gain or anorexia
- Drugs used for cosmetic purposes or to promote hair growth
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
- Outpatient drugs that the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer as a condition of sale
- Drugs used to promote fertility
- Drugs used to relieve the symptoms of cough and colds
- Non-prescription drugs, also called over-the-counter (OTC) drugs
- Drugs when used for the treatment of sexual or erectile dysfunction

Plan Disclaimers

Aetna Medicare is a PDP, HMO, PPO plan with a Medicare contract. Enrollment in our plans depends on contract renewal.

This information is not a complete description of benefits. Call 1-888-267-2637 (TTY: 711) for more information.

Plans are offered by Aetna Health Inc., Aetna Health of California Inc., and/or Aetna Life

Insurance Company (Aetna).

Your coverage is provided through a contract with your former employer/union/trust. The plan benefits administrator will provide you with information about your plan premium (if applicable).

You must be entitled to Medicare Part A and continue to pay your Part B premium and Part A, if applicable.

See Evidence of Coverage for a complete description of plan benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by service area.

If there is a difference between this document and the Evidence of Coverage (EOC), the EOC is considered correct.

You can read the *Medicare & You 2020* Handbook. Every year in the fall, this booklet is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. If you don't have a copy of this booklet, you can get it at the Medicare website (http://www.medicare.gov) or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

ATTENTION: If you speak another language, language assistance services, free of charge, are available to you. Call 1-888-267-2637 (TTY: 711). Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-267-2637 (TTY: 711). Traditional Chinese: 注意：如果您使用中文，您可以免費獲得語言援助服務。請致電 1-888-267-2637 (TTY: 711).

You can also visit our website at www.aetnaretireeplans.com. As a reminder, our website has the most up-to-date information about our provider network (Provider Directory) and our list of covered drugs (Formulary/Drug List).

Information is believed to be accurate as of the production date; however, it is subject to change. For more information about Aetna plans, go to www.aetna.com.

Please contact Customer Service toll-free at 1-888-267-2637 (TTY: 711) for additional information. Hours are 8 a.m. to 6 p.m. local time, Monday through Friday.

This document is not intended to be member-facing as it does not include the required disclosures.

*****This is the end of this plan benefit summary*****

GRP_0009_661

Northeast District Council of the OPCMIA
Effective Date: 07/01/2019
Expire Date: 12/31/2020

Dental Benefits Summary

	Active PPO MAX With PPOII Network	
	Participating	Non-participating
Annual Deductible*		
Individual	$50	$100
Family	$100	$200
Preventive Services	100%	100%
Basic Services	80%	50%
Major Services	50%	50%
Annual Benefit Maximum	$2,000	$2,000
Office Visit Copay	N/A	N/A
Orthodontic Services**	50%	50%
Orthodontic Deductible	None	None
Orthodontic Lifetime Maximum	$2,000	$2,000

*The deductible applies to: Basic & Major services only
**Orthodontia is covered only for children (appliance must be placed prior to age 20).

Partial List of Services	Active PPO MAX With PPOII Network	
Preventive	Participating	Non-participating
Oral examinations (a)	100%	100%
Cleanings (a) Adult/Child	100%	100%
Fluoride (a)	100%	100%
Sealants (permanent molars only) (a)	100%	100%
Bitewing Images (a)	100%	100%
Full mouth series Images (a)	100%	100%
Space Maintainers	100%	100%
Basic		
Root canal therapy		
Anterior teeth / Bicuspid teeth	80%	50%
Scaling and root planing (a)	80%	50%
Gingivectomy (a)*	80%	50%
Amalgam (silver) fillings	80%	50%
Composite fillings	80%	50%
Stainless steel crowns	80%	50%
Incision and drainage of abscess*	80%	50%
Uncomplicated extractions	80%	50%
Surgical removal of erupted tooth*	80%	50%
Surgical removal of impacted tooth (soft tissue)*	80%	50%
Major		
Inlays	50%	50%
Onlays	50%	50%
Crowns	50%	50%
Crown lengthening	50%	50%
Full & partial dentures	50%	50%
Pontics	50%	50%
Root canal therapy, molar teeth	50%	50%
Osseous surgery (a)*	50%	50%
Surgical removal of impacted tooth (partial bony/ full bony)*	50%	50%
General anesthesia/intravenous sedation*	50%	50%
Denture repairs	50%	50%
Crown Build-Ups	50%	50%
Implants	50%	50%

*Certain services may be covered under the Medical Plan. Contact Member Services for more details.
(a) Frequency and/or age limitations may apply to these services. These limits are described in the booklet/certificate.

EXHIBIT III

Dental Benefits Summary

Other Important Information

This Aetna Dental® Preferred Provider Organization (PPO) MAX benefits summary is provided by Aetna Life Insurance Company for some of the more frequently performed dental procedures. Under the Dental Preferred Provider Organization (PPO) MAX plan, you may choose at the time of service either a PPO participating dentist or any nonparticipating dentist. With the PPO MAX plan, savings are possible because the participating dentists have agreed to provide care for covered services at negotiated rates. Non-Participating coverage is limited to a maximum allowable charge (MAX) of the plan's payment, which is based on the contracted maximum fee for participating providers in the particular geographic area.

Emergency Dental Care

If you need emergency dental care for the palliative treatment (pain relieving, stabilizing) of a dental emergency, you are covered 24 hours a day, 7 days a week.

When emergency services are provided by a participating PPO dentist, your co-payment/coinsurance amount will be based on a negotiated fee schedule. When emergency services are provided by a non-participating dentist, you will be responsible for the difference between the plan payment and the dentist's usual charge. Refer to your plan documents for details. Subject to state requirements. Out-of-area emergency dental care may be reviewed by our dental consultants to verify appropriateness of treatment.

Partial List of Exclusions and Limitations* - Coverage is not provided for the following:

1. Services or supplies that are covered in whole or in part:
   (a) under any other part of this Dental Care Plan; or
   (b) under any other plan of group benefits provided by or through your employer.
2. Services and supplies to diagnose or treat a disease or injury that is not:
   (a) a non-occupational disease; or
   (b) a non-occupational injury.
3. Services not listed in the Dental Care Schedule that applies, unless otherwise specified in the Booklet-Certificate.
4. Those for replacement of a lost, missing or stolen appliance, and those for replacement of appliances that have been damaged due to abuse, misuse or neglect.
5. Those for plastic, reconstructive or cosmetic surgery, or other dental services or supplies, that are primarily intended to improve, alter or enhance appearance. This applies whether or not the services and supplies are for psychological or emotional reasons. Facings on molar crowns and pontics will always be considered cosmetic.
6. Those for or in connection with services, procedures, drugs or other supplies that are determined by Aetna to be experimental or still under clinical investigation by health professionals.
7. Those for dentures, crowns, inlays, onlays, bridgework, or other appliances or services used for the purpose of splinting, to alter vertical dimension, to restore occlusion, or to correct attrition, abrasion or erosion.
8. Those for any of the following services (Does not apply to the DMO plan in TX):
   (a) an appliance or modification of one if an impression for it was made before the person became a covered person;
   (b) a crown, bridge, or cast or processed restoration if a tooth was prepared for it before the person became a covered person; or
   (c) root canal therapy if the pulp chamber for it was opened before the person became a covered person.
9. Services that Aetna defines as not necessary for the diagnosis, care or treatment of the condition involved. This applies even if they are prescribed, recommended or approved by the attending physician or dentist.
10. Those for services intended for treatment of any jaw joint disorder, unless otherwise specified in the Booklet-Certificate.

11. Those for space maintainers, except when needed to preserve space resulting from the premature loss of deciduous teeth.

12. Those for orthodontic treatment, unless otherwise specified in the Booklet-Certificate.
13. Those for general anesthesia and intravenous sedation, unless specifically covered. For plans that cover these services, they will not be eligible for benefits unless done in conjunction with another necessary covered service.
14. Those for treatment by other than a dentist, except that scaling or cleaning of teeth and topical application of fluoride may be done by a licensed dental hygienist. In this case, the treatment must be given under the supervision and guidance of a dentist.

15. Those in connection with a service given to a person age 5 or older if that person becomes a covered person other than:

   (a) during the first 31 days the person is eligible for this coverage, or
   (b) as prescribed for any period of open enrollment agreed to by the employer and Aetna. This does not apply to charges incurred:
      (i) after the end of the 12-month period starting on the date the person became a covered person; or
      (ii) as a result of accidental injuries sustained while the person was a covered person; or

(iii) for a primary care service in the Dental Care Schedule that applies as shown under the headings Visits and Exams, and X-rays and Pathology.

16. Services given by a nonparticipating dental provider to the extent that the charges exceed the amount payable for the services shown in the Dental Care Schedule that applies.
17. Those for a crown, cast or processed restoration unless:
    (a) it is treatment for decay or traumatic injury, and teeth cannot be restored with a filling material; or
    (b) the tooth is an abutment to a covered partial denture or fixed bridge.
18. Those for pontics, crowns, cast or processed restorations made with high-noble metals, unless otherwise specified in the Booklet-Certificate.
19. Those for surgical removal of impacted wisdom teeth only for orthodontic reasons, unless otherwise specified in the Booklet-Certificate.
20. Services needed solely in connection with non-covered services.
21. Services done where there is no evidence of pathology, dysfunction or disease other than covered preventive services.

Any exclusion above will not apply to the extent that coverage of the charges is required under any law that applies to the coverage.
*This is a partial list of exclusions and limitations, others may apply. Please check your plan booklet for details.

Your Dental Care Plan Coverage Is Subject to the Following Rules:

Replacement Rule
The replacement of; addition to; or modification of: existing dentures; crowns; casts or processed restorations; removable denture; fixed bridgework; or other prosthetic services is covered only if one of the following terms is met:

The replacement or addition of teeth is required to replace one or more teeth extracted after the existing denture or bridgework was installed. This coverage must have been in force for the covered person when the extraction took place.

The existing denture, crown; cast or processed restoration, removable denture, bridgework, or other prosthetic service cannot be made serviceable, and was installed at least 5 years before its replacement.

The existing denture is an immediate temporary one to replace one or more natural teeth extracted while the person is covered, and cannot be made permanent, and replacement by a permanent denture is required. The replacement must take place within 12 months from the date of initial installation of the immediate temporary denture.

The extraction of a third molar does not qualify. Any such appliance or fixed bridge must include the replacement of an extracted tooth or teeth.

Tooth Missing But Not Replaced Rule
Coverage for the first installation of removable dentures; fixed bridgework and other prosthetic services is subject to the requirements that such removable dentures; fixed bridgework and other prosthetic services are (i) needed to replace one or more natural teeth that were removed while this policy was in force for the covered person; and (ii) are not abutments to a partial denture; removable bridge; or fixed bridge installed during the prior 5 years.

Alternate Treatment Rule: If more than one service can be used to treat a covered person's dental condition, Aetna may decide to authorize coverage only for a less costly covered service provided that all of the following terms are met:
    (a) the service must be listed on the Dental Care Schedule;
    (b) the service selected must be deemed by the dental profession to be an appropriate method of treatment; and
    (c) the service selected must meet broadly accepted national standards of dental practice.

If treatment is being given by a participating dental provider and the covered person asks for a more costly covered service than that for which coverage is approved, the specific copayment for such service will consist of:
    (a) the copayment for the approved less costly service; plus
    (b) the difference in cost between the approved less costly service and the more costly covered service.

Finding Participating Providers

Consult Aetna Dental's online provider search for the most current provider listings. Participating providers are independent contractors in private practice and are neither employees nor agents of Aetna Dental or its affiliates. The availability of any particular provider cannot be guaranteed, and provider network composition is subject to change without notice. For the most current information, please contact the selected provider or Aetna Member Services at the toll-free number on your online ID card, or use our Internet-based provider search available at www.aetna.com.

Specific products may not be available on both a self-funded and insured basis. The information in this document is subject to change without notice. In case of a conflict between your plan documents and this information, the plan documents will govern.

In the event of a problem with coverage, members should contact Member Services at the toll-free number on their online ID cards for information on how to utilize the grievance procedure when appropriate.

Dental Benefits Summary

All member care and related decisions are the sole responsibility of participating providers. Aetna Dental does not provide health care services and, therefore, cannot guarantee any results or outcomes.

Dental plans are provided or administered by Aetna Life Insurance Company, Aetna Dental Inc., Aetna Dental of California Inc. and/or Aetna Health Inc.

In Texas, the Dental Preferred Provider Organization (PPO) is known as the Participating Dental Network (PDN), and is administered by Aetna Life Insurance Company.

This material is for informational purposes only and is neither an offer of coverage nor dental advice. It contains only a partial, general description of plan or program benefits and does not constitute a contract. The availability of a plan or program may vary by geographic service area. Certain dental plans are available only for groups of a certain size in accordance with underwriting guidelines. Some benefits are subject to limitations or exclusions. Consult the plan documents (Schedule of Benefits, Certificate/Evidence of Coverage, Booklet, Booklet-Certificate, Group Agreement, Group Policy) to determine governing contractual provisions, including procedures, exclusions and limitations relating to your plan.

Aetna complies with applicable Federal civil rights laws and does not discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, or disability.

Aetna provides free aids/services to people with disabilities and to people who need language assistance.

If you need a qualified interpreter, written information in other formats, translation or other services, call 877-238-6200.

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:

Civil Rights Coordinator,
P.O. Box 14462, Lexington, KY 40512 (CA HMO customers: PO Box 24030 Fresno, CA 93779),
1-800-648-7817, TTY: 711,
Fax: 859-425-3379 (CA HMO customers: 860-262-7705),
CRCoordinator@aetna.com.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, or at 1-800-368-1019, 800-537-7697 (TDD).

Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company, Coventry Health Care plans and their affiliates (Aetna).
TTY: 711

To access language services at no cost to you, call the number on your ID card. (English)

Për shërbime përkthimi falas për ju, telefononi në numrin që gjendet në kartën tuaj të identitetit. (Albanian)

የቋንቋ አገልግሎቶችን ያለክፍያ ለማግኘት፣ በመታወቂያዎት ላይ ያለውን ቁጥር ይደውሉ። (Amharic)

للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء الاتصال على الرقم الموجود على بطاقة اشتراكك.(Arabic)

Ձեր նախընտրած լեզվով ավվճար խորհրդատվություն ստանալու համար զանգահարեք ձեր բժշկական ապահովագրության քարտի վրա նշված հէռախոսահամարով (Armenian)

Kugira uronke serivisi z'indimi ata kiguzi, hamagara inomero iri ku karangamuntu kawe (Bantu-Kirundi)

আপনাকে বিনামূল্যে ভাষা পরিষেবা পেতে হলে আপনার পরিচয়পত্রে দেওয়া নম্বরে টেলিফোন করুন। (Bengali)

သင့္အေနျဖင့္ အခေၾကးေငြ မေပးရပဲ ဘာသာစကားဝန္ေဆာင္မႈမ်ား ရရွိႏုိင္ရန္၊ သင့္ ID ကတ္ေပၚတြင္ရွိေသာ ဖုန္းနံပတ္အား ေခၚဆိုပါ။ (Burmese)

Per accedir a serveis lingüístics sense cap cost per a vostè, telefoni al número indicat a la seva targeta d'identificació. (Catalan)

Aron maakses ang mga serbisyo sa lengguwahe nga wala kay bayran, tawagi ang numero nga anaa sa imong kard sa ID. (Cebuano)

Para un hago' i setbision lengguåhi ni dibåtde para hågu, ågang i numiru gi iyo-mu kard aidentifikasion. (Chamorro)

ᏩᎩᏍᏗ ᎦᏬᏂᎯᏍᏗ ᎢᏳᎾᏓᏛᏁᏗ Ꮭ ᎠᏈᏍᏗ ᏗᏣᏤᎷᏫᏁᏗ ᏑᎩ, ᏫᏚᎯᏏᏔᏛᏏ ᎾᏍᎩ ᏗᏎᏍᏗ ᏥᎦᎪᏩᏛ ᎤᎾᎢ ID ᏆᏂᏲᏍᏗ ᏟᏙᎩᎢ. (Cherokee)

如欲使用免費語言服務，請撥打您健康保險卡上所列的電話號碼（Chinese Traditional)

Anumpa tosholi i toksvli ya peh pilla ho ish i payahinla kvt chi holisso kallo iskitini holhtena takanli ma i payah (Choctaw)

Ren omw kopwe angei aninisin eman chon awewei (ese kamé), kopwe kééri ewe nampa mei mak won noum ena katen ID (Chuukese)

Tajaajiiloota afaanii gatii bilisaa ati argaachuuf,lakkoofsa fuula waraaqaa eenyummaa (ID) kee irraa jiruun bilbili. (Cushitic-Oromo)

Voor gratis taaldiensten, bel het nummer op uw ziekteverzekeringskaart. (Dutch)

Pour accéder gratuitement aux services linguistiques, veuillez composer le numéro indiqué sur votre carte d'assurance santé. (French)

Pou ou jwenn sèvis gratis nan lang ou, rele nimewo telefòn ki sou kat idantifikasyon asirans sante ou. French Creole (Haitian)

Um auf den für Sie kostenlosen Sprachservice auf Deutsch zuzugreifen, rufen Sie die Nummer auf Ihrer ID-Karte an. (German)

Για πρόσβαση στις υπηρεσίες γλώσσας χωρίς χρέωση, καλέστε τον αριθμό στην κάρτα ασφάλισής σας. (Greek)

તમારે કોઇ પણ જાતના ખર્ચ વિના ભાષા સેવાઓ મેળવવા માટે, તમારા આઇડી કાર્ડ પર રહેલ નંબર પર કૉલ કરવો. (Gujarati)

No ka wala'au 'ana me ka lawelawe 'ōlelo e kahea aku i ka helu kelepona ma kāu kāleka ID. Kāki 'ole 'ia kēia kōkua nei. (Hawaiian)

बिना किसी कीमत के भाषा सेवाओं का उपयोग करने के लिए, अपने आईडी कार्ड पर दिए नंबर पर कॉल करें। (Hindi)

Yuav kom tau kev pab txhais lus tsis muaj nqi them rau koj, hu tus naj npawb ntawm koj daim npav ID. (Hmong)

aetna™

Dental Benefits Summary

Inweta enyemaka asụsụ na akwughi ụgwọ obụla, kpọọ nọmba nọ na kaadi njirimara gị (Igbo)

Tapno maakses dagiti serbisio ti pagsasao nga awanan ti bayadna, awagan ti numero nga adda ayan ti ID kardmo. (Ilocano)

Untuk mengakses layanan bahasa tanpa dikenakan biaya, silakan hubungi nomor telepon di kartu asuransi Anda. (Indonesian)

Per accedere ai servizi linguistici senza alcun costo per lei, chiami il numero sulla tessera identificativa. (Italian)

無料の言語サービスは、IDカードにある番号にお電話ください。(Japanese)

vXw>urRM>usdmw>rRpXRtw>zH;w>rRwz.

무료 다국어 서비스를 이용하려면 보험 ID 카드에 수록된 번호로 전화해 주십시오. (Korean)

I nyuu kosna mahola ni language services ngui nsaa wogui wo, sebel i nsinga i ye ntilga i kat yong matibla (Kru-Bassa)

(Kurdish).کارتی خوت (ID)بۆ دەستپێراگەیشتن بە خزمەتگوزاری زمان بەبێ تێچوون بۆ تۆ، پەیوەندی بکە بە ژمارەی سەر ئای دی

ເພື່ອເຂົ້າເຖິງບໍລິການພາສາທີ່ບໍ່ເສຍຄ່າ, ໃຫ້ໂທຫາເບີໂທຢູ່ໃນບັດປະຈຳຕົວຂອງທ່ານ. (Lao)

आपल्याला कोणत्याही शुल्काशिवाय भाषा सेवांपर्यंत पोहोचण्यासाठी, आपल्या ID कार्डावरील क्रमांकावर फोन करा. (Marathi)

Ṇan bōk jipañ kōn kajin ilo an ejjeḷọk wōṇean ñan kwe, kwōn kallok nōṃba eo ilo kaat in ID eo aṃ. (Marshallese)

Pwehn alehdi sawas en lokaia kan ni sohte pweipwei, koahlih nempe nan amhw doaropwe en ID. (Micronesian-Ponapean)

ដើម្បីទទួលបានសេវាកម្មភាសាដែលឥតគិតថ្លៃសម្រាប់លោកអ្នក សូមហៅទូរសព្ទទៅកាន់លេខដែលមាននៅលើបណ្ណសម្គាល់ខ្លួនរបស់លោកអ្នក។ (Mon-Khmer, Cambodian)

T'11 ni nizaad k'ehj7 bee n7k1 a'doowo[doo b33h 7l7n7g00 naaltsoos bee atah n7l98go nanitin7g77 bee n44ho'd0lzin7g77 b44sh bee hane'7 bik1'7g77 1aj8' h0lne'. (Navajo)

भाषासम्बन्धी सेवाहरूमाथि निःशुल्क पहुँच राख्न आफ्नो कार्डमा रहेको नम्बरमा कल गर्नुहोस्। (Nepali)

Të kɔɔr yïn ran de wëër de thokic ke cïn wëu kɔr keek tënɔŋ yïn. Ke yïn cɔl ran ye kɔc kuɔny në namba de abac tɔ̈ në ID kard duɔ̈n de tïït de nyin de panakim kɔ̈u. (Nilotic-Dinka)

For tilgang til kostnadsfri språktjenester, ring nummeret på ID-kortet ditt. (Norwegian)

Um Schprooch Services zu griege mitaus Koscht, ruff die Nummer uff dei ID Kaart. (Pennsylvanian-Dutch)

(Persian Farsi) .برای دسترسی به خدمات زبان به طور رایگان، با شماره قید شده روی کارت شناسایی خود تماس بگیرید

Aby uzyskać dostęp do bezpłatnych usług językowych, należy zadzwonić pod numer podany na karcie identyfikacyjnej. (Polish)

Para aceder aos serviços linguísticos gratuitamente, ligue para o número indicado no seu cartão de identificação. (Portuguese)

ਤੁਹਾਡੇ ਲਈ ਬਿਨਾਂ ਕਿਸੇ ਕੀਮਤ ਵਾਲੀਆਂ ਪੰਜਾਬੀ ਸੇਵਾਵਾਂ ਦੀ ਵਰਤੋਂ ਕਰਨ ਲਈ, ਆਪਣੇ ਆਈਡੀ ਕਾਰਡ 'ਤੇ ਦਿੱਤੇ ਨੰਬਰ 'ਤੇ ਫ਼ੋਨ ਕਰੋ। (Punjabi)

Pentru a accesa gratuit serviciile de limbă, apelați numărul de pe cardul de membru. (Romanian)

Для того чтобы бесплатно получить помощь переводчика, позвоните по телефону, приведенному на вашей идентификационной карте. (Russian)

Mō le mauaina o 'au'aunaga tau gagana e aunoa ma se totogi, vala'au le numera i luga o lau pepa ID. (Samoan)

Za besplatne prevodilačke usluge pozovite broj naveden na Vašoj identifikacionoj kartici. (Serbo-Croatian)

Para acceder a los servicios lingüísticos sin costo alguno, llame al número que figura en su tarjeta de identificación. (Spanish)

Heeɓa a naasta nder ekkitol jaangirde woldeji walla yoɓugo, ewnu lamba je ɗon windi ha do ɗerowol maaɗa. (Sudanic Fulfulde)

Kupata huduma za lugha bila malipo kwako, piga nambari iliyo kwenye kadi yako ya kitambulisho. (Swahili)

ܟܝ ܡܣܩܐ ܠܗܘܢ ܚܠ ܝܠܚܝܐ ܕܡܢܝܢܐ ܠܠܫܢܐ ܡܓܢܐܝܬ، ܡܚܝܬܘܢ ܡܢܝܢܐ ܥܠ ܦܬܩܐ ܕܗܘܝܬܐ ܕܝܠܘܟܘܢ. (Syriac-Assyrian)

Kupata huduma za lugha bila malipo kwako, piga nambari iliyo kwenye kadi yako ya kitambulisho. (Swahili)

Upang ma-access ang mga serbisyo sa wika nang walang bayad, tawagan ang numero sa iyong ID card. (Tagalog)

భాష సేవలను మీకు ఖర్చు లేకుండా అందుకునేందుకు, మీ ఐడి కార్డుపై ఉన్న నంబరుకు కాల్ చేయండి. (Telugu)

หากท่านต้องการเข้าถึงการบริการทางด้านภาษาโดยไม่มีค่าใช้จ่าย โปรดโทรหมายเลขที่แสดงอยู่บนบัตรประจำตัวของท่าน

Kapau ‘oku ke fiema’u ta’etōtōngi ‘a e ngaahi sēvesi kotoa pē he ngaahi lea kotoa, telefoni ki he fika ‘oku hā atu ‘i ho’o ID kaati. (Tongan)

Dil hizmetlerine ücretsiz olarak erişmek için kimlik kartınızdaki numarayı arayın. (Turkish)

Щоб безкоштовнj отримати мовні послуги, задзвоніть за номером, вказаним на вашій ідентифікайній картці. (Ukrainian)

لسانی خدمات تک مُفت رسائی کے لیے، اپنے بیمہ کے ID کارڈ پر درج نمبر پر کال کریں۔ (Urdu)

Để sử dụng các dịch vụ ngôn ngữ miễn phí, vui lòng gọi số điện thoại ghi trên thẻ ID của quý vị. (Vietnamese)

צו באקומען שפראך סערוויסעס פריי פון אפצאל, רופט דעם נומער אויף אייער ID קארטל. (Yiddish)

Láti ráyèsí àwọn iṣẹ́ èdè fún ọ lọ́fẹ̀ẹ́, pe nọ́mbà tó wà lórí káàdì ìdánimọ̀ rẹ. (Yoruba)

aetna™

Northeast District Council of the OPCMIA Welfare Fund
Plan 75
Effective Date: 07/01/2019
Expire Date: 12/31/2020

DMO® Dental Benefits Summary

CODE	PROCEDURE	PATIENT PAYS	CODE	PROCEDURE	PATIENT PAYS
	Office Visit Copay	$0			
			DIAGNOSTIC		
D0120-D0180	Oral Evaluations	No Charge	D0277	Vertical Bitewings - 7 to 8 Films	No Charge
D0210	Full mouth series Images	No Charge	D0330	Panoramic Image	No Charge
D0220-D0230	Periapicals	No Charge	D0391	Interpretation of Diagnostic Image	No Charge
D0240	Intraoral, Occlusal Image	No Charge	D0470	Diagnostic Casts	No Charge
D0250-D0251	Extraoral Images	No Charge	D0472-D0474	Accession of Tissue	No Charge
D0270-D0274	Bitewings	No Charge			
			PREVENTIVE		
D1110	Prophy - Adult	No Charge	D1510	Space Maintainer - Fixed Unilateral	No Charge
D1120	Prophy - Child	No Charge	D1516-17	Space Maintainer - Fixed Bilateral	No Charge
D4346	Scaling in presence of generalized moderate/severe gingival inflammation, full mouth, after oral evaluation	$35	D1520	Space Maintainer - Removable Unilateral	No Charge
D1208	Fluoride - Child	No Charge	D1526-27	Space Maintainer - Removable Bilateral	No Charge
D1206	Application of Topical Fluoride Varnish	No Charge	D1550	Recement Space Maintainer	$12
D1330	Oral Hygiene Instruction	No Charge	D1555	Removal of Space Maintainer	$12
D1351, D1354	Sealant	No Charge	D1575	Distal shoe space maintainer - fixed - unilateral	No Charge
D1352	Preventive Resin Restoration	No Charge	D2990	Resin Infiltration of Lesion	No Charge
D1353	Sealant Repair - Per Tooth	No Charge			
Diagnostic and Preventive services may be subject to age and frequency limitations. See your booklet for details.					
			RESTORATIVE		
			PRIMARY OR PERMANENT TEETH		
D2140	Amalgam - 1 Surf Primary or Permanent	No Charge	D2391	Resin-Based Composite 1 Surf, Posterior	$49
D2150	Amalgam - 2 Surf Primary or Permanent	No Charge	D2392	Resin-Based Composite 2 Surf, Posterior	$63
D2160	Amalgam - 3 Surf Primary or Permanent	No Charge	D2393	Resin-Based Composite 3 Surf, Posterior	$77
D2161	Amalgam - 4+ Surf Primary or Permanent	No Charge	D2394	Resin-Based Composite 4+ Surf, Posterior	$106
D2330	Resin-Based Composite 1 Surf, Anterior	No Charge	D2921	Reattachment of tooth fragment, incisal edge or dusp	$7
D2331	Resin-Based Composite 2 Surf, Anterior	No Charge	D2940	Protective Restoration	$8
D2332	Resin-Based Composite 3 Surf, Anterior	No Charge	D2941	Interim therapeutic restoration - primary dentition	$4
D2335	Resin-Based Composite 4+ Surf; Anterior (or involving Incisal angle)	$72	D2951	Pin Retention - In Addition to Restoration	$14
D2390	Resin-Based Composite Crown, Anterior	$72			
			CROWNS/BRIDGES		
D2510	Inlay - Metallic 1 Surf	$236	D6076	Implant Supported Retainer for Porcelain Fused to Metal FPD (Titanium, Titanium Alloy or High Noble Metal)	$362
D2520	Inlay - Metallic 2 Surf	$236	D6077	Implant Supported Retainer for Cast Metal FPD (Titanium, Titanium Alloy or High Noble Metal)	$362
D2530	Inlay - Metallic 3 Surf	$236	D6094	Abutment Supported Crown - (Titanium)	$362
D2542	Onlay - Metallic 2 Surf	$253	D6110	Implant Abut Sup Removable Dent-MaxCom	$318
D2543	Onlay - Metallic 3 Surf	$253	D6111	Implant Abut Sup Removable Dent-Mand Com	$318
D2544	Onlay, Metallic - 4 or More Surf	$253	D6112	Implant Abut Sup Removable Dent-Max Par	$318
D2610	Inlay, Porcelain/Ceramic - 1 Surf	$236	D6113	Implant Abut Sup Removable Dent-Mand Par	$318
D2620	Inlay, Porcelain/Ceramic - 2 Surf	$236	D6114	Implant Abut Sup Fixed Dent-Max Com	$318
D2630	Inlay, Porcelain/Ceramic - 3 or More Surf	$236	D6115	Implant Abut Sup Fixed Dent-Mand Com	$318
D2642	Onlay, Porcelain/Ceramic - 2 Surf	$253	D6116	Implant Abut Sup Fixed Dent-Max Par	$318
D2643	Onlay, Porcelain/Ceramic - 3 Surf	$253	D6117	Implant Abut Sup Fixed Dent-Mand Par	$318
D2644	Onlay, Porcelain/Ceramic - 4 or More Surf	$253	D6205	Pontic - Indirect Resin Based Composite	$362
D2650	Inlay, Composite/Resin - 1 Surf	$236	D6210	Pontic - Cast High Noble Metal	$362
D2651	Inlay, Composite/Resin - 2 Surf	$236	D6211	Pontic - Cast Predominantly Base Metal	$362
D2652	Inlay, Composite/Resin - 3 Surf	$236	D6212	Pontic - Cast Noble Metal	$362
D2662	Onlay, Composite/Resin - 2 Surf	$253	D6214	Pontic - Titanium	$362
D2663	Onlay, Composite/Resin - 3 Surf	$253	D6240	Pontic - Porcelain Fused to High Noble Metal	$362
D2664	Onlay, Composite/Resin - 4 or More Surf	$253	D6241	Pontic - Porcelain Fused to Predominantly Base Metal	$362
D2710	Crown - Resin-Based Composite, Indirect	$362	D6242	Pontic - Porcelain Fused to Noble Metal	$362

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DMO® Dental Benefits Summary

D2712	Crown - 3/4 Resin-Based Composite, Indirect	$265	D6245	Pontic - Porcelain/Ceramic	$362
D2720	Crown - Resin With High Noble Metal	$362	D6250	Pontic - Resin With High Noble Metal	$362
D2721	Crown - Resin With Predominantly Base Metal	$362	D6251	Pontic - Resin With Predominantly Base Metal	$362
D2722	Crown - Resin With Noble Metal	$362	D6252	Pontic - Resin With Noble Metal	$362
D2740	Crown - Porcelain/Ceramic Substrate	$362	D6545	Retainer - Cast Metal for Resin-Bonded Fixed	$236
D2750	Crown - Porcelain Fused to High Noble Metal	$362	D6548	Retainer - Porcelain/Ceramic for Resin-Bonded Fixed Prosthesis	$236
D2751	Crown - Porcelain Fused to Predominantly Base Metal	$362	D6549	Resin Retainer - Resin Bonded Prosthesis	$130
D2752	Crown - Porcelain Fused to Noble Metal	$362	D6600	Inlay - Porcelain/Ceramic, 2 Surf	$236
D2780	Crown - 3/4 Cast High Noble Metal	$362	D6601	Inlay - Porcelain/Ceramic, 3+ Surf	$236
D2781	Crown - 3/4 Cast Predominantly Based Metal	$362	D6602	Inlay - Cast High Noble Metal, 2 Surf	$269
D2782	Crown - 3/4 Cast Noble Metal	$362	D6603	Inlay - Cast High Noble Metal, 3+ Surf	$269
D2783	Crown - 3/4 Porcelain/Ceramic	$362	D6604	Inlay - Cast Predominantly Base Metal, 2 Surf	$236
D2790	Crown - Full Cast High Noble Metal	$362	D6605	Inlay - Cast Predominantly Base Metal, 3+ Surf	$236
D2791	Crown - Full Cast Predominantly Base Metal	$362	D6606	Inlay - Cast Noble Metal, 2 Surf	$257
D2792	Crown - Full Cast Noble Metal	$362	D6607	Inlay - Cast Noble Metal, 3+ Surf	$257
D2794	Crown - Titanium	$362	D6608	Onlay - Porcelain/Ceramic, 2 Surf	$253
D2910	Recement Inlay, Onlay or Partial Coverage Restoration	$15	D6609	Onlay - Porcelain/Ceramic, 3+ Surf	$253
D2915	Recement Cast or Prefab Post and Core	$8	D6610	Onlay - Cast High Noble Metal, 2 Surf	$285
D2920	Recement Crown	$15	D6611	Onlay - Cast High Noble Metal, 3+ Surf	$285
D2929	Prefab Porcelain/Ceramic Crown - Primary Tooth	$76	D6612	Onlay - Cast Predominantly Base Metal, 2 Surf	$253
D2930	Prefab, Stainless Steel Crown - Primary Tooth	$54	D6613	Onlay - Cast Predominantly Base Metal, 3+ Surf	$253
D2931	Prefab, Stainless Steel Crown - Permanent Tooth	$65	D6614	Onlay - Cast Noble Metal, 2 Surf	$274
D2934	Prefabricated Esthetic Coated Stainless Steel Crown - Primary Tooth	$54	D6615	Onlay - Cast Noble Metal, 3+ Surf	$274
D2950	Core Buildup, Including Any Pins	$141	D6624	Inlay - Titanium	$269
D2952	Post & Core in Addition to Crown	$140	D6634	Onlay - Titanium	$285
D6058	Abutment Supported Porcelain/Ceramic Crown	$362	D6710	Crown - Indirect Resin Based Composite	$362
D6059	Abutment Supported Porcelain Fused to Metal Crown (High Noble Metal)	$362	D6720	Crown - Resin With High Noble Metal	$362
D6060	Abutment Supported Porcelain Fused to Metal Crown (Predominantly Base Metal)	$362	D6721	Crown - Resin With Predominantly Base Metal	$362
D6061	Abutment Supported Porcelain Fused to Metal Crown (Noble Metal)	$362	D6722	Crown - Resin With Noble Metal	$362
D6062	Abutment Supported Cast Metal Crown (High Noble Metal)	$362	D6740	Crown - Porcelain/Ceramic	$362
D6063	Abutment Supported Cast Metal Crown (Predominantly Base Metal)	$362	D6750	Crown - Porcelain Fused to High Noble Metal	$362
D6064	Abutment Supported Cast Metal Crown (Noble Metal)	$362	D6751	Crown - Porcelain Fused to Predominantly Base Metal	$362
D6065	Implant Supported Porcelain/Ceramic Crown	$362	D6752	Crown - Porcelain Fused to Noble Metal	$362
D6066	Implant Supported Porcelain Fused to Metal Crown (Titanium, Titanium Alloy or High Noble Metal)	$362	D6780	Crown - 3/4 Cast High Noble Metal	$362
D6067	Implant Supported Metal Crown (Titanium, Titanium Alloy or High Noble Metal)	$362	D6781	Crown - 3/4 Cast Predominantly Base Metal	$362
D6068	Abutment Supported Retainer for Porcelain/Ceramic FPD	$362	D6782	Crown - 3/4 Cast Noble Metal	$362
D6069	Abutment Supported Retainer for Porcelain Fused to Metal FPD (High Noble Metal)	$362	D6783	Crown - 3/4 Porcelain/Ceramic	$362
D6070	Abutment Supported Retainer for Porcelain Fused to Metal FPD (Predominantly Base Metal)	$362	D6790	Crown - Full Cast High Noble Metal	$362
D6071	Abutment Supported Retainer for Porcelain Fused to Metal FPD (Noble Metal)	$362	D6791	Crown - Full Cast Predominantly Base Metal	$362
D6072	Abutment Supported Retainer for Cast Metal FPD (High Noble Metal)	$362	D6792	Crown - Full Cast Noble Metal	$362
D6073	Abutment Supported Retainer for Cast Metal FPD (Predominantly Base Metal)	$362	D6794	Crown - Titanium	$362

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D6074	Abutment Supported Retainer for Cast Metal FPD (Noble Metal)	$362	D6930	Recement Fixed Partial Denture	$25
D6075	Implant Supported Retainer for Ceramic FPD	$362	Additional Charge per Unit for Full Mouth Rehabilitation.		$125
Full mouth rehabilitation is defined as 6 or more units of covered crowns and/or pontics under one treatment plan.					
Charges for crowns and bridgework are per unit. There will be additional charges for the actual cost for gold/high noble metal.					
ENDODONTICS					
D3110	Pulp Cap - Direct (excluding final restoration)	No Charge	D3333	Internal Root Repair of Perforation Defects	$110
D3120	Pulp Cap - Indirect (excluding final restoration)	No Charge	D3346	Retreatment of Previous Root Canal Therapy - Anterior	$242
D3220	Therapeutic Pulpotomy (excluding final restoration)	$77	D3347	Retreatment of Previous Root Canal Therapy - Bicuspid	$308
D3221	Pulpal Debridement, Primary and Permanent Teeth	$14	D3348	Retreatment of Previous Root Canal Therapy - Molar	$433
D3222	Partial Pulpotomy	$70	D3410 (1)	Apicoectomy/Periradicular Surgery - Anterior	$179
D3230	Pulpal Therapy (Resorbable Filling) - Anterior, Primary Tooth	$77	D3421 (1)	Apicoectomy/Periradicular Surgery - Bicuspid (First Root)	$179
D3240	Pulpal Therapy (Resorbable Filling) - Posterior, Primary Tooth	$77	D3425 (1)	Apicoectomy/Periradicular Surgery - Molar (First Root)	$179
D3310	Root Canal Therapy - Anterior (excluding final restoration)	$135	D3426 (1)	Apicoectomy/Periradicular Surgery- Each Additional Root	$110
D3320	Root Canal Therapy - Bicuspid (excluding final restoration)	$216	D3427 (1)	Periradicular surgery without apicoectomy	$134
D3330	Root Canal Therapy - Molar (excluding final restoration)	$331	D3430 (1)	Retrograde Filling - Per Root	$80
D3331	Treatment of Root Canal Obstruction, Nonsurgical Access	$135	D3450 (1)	Root Amputation - Per Root	$88
D3332	Incomplete Endodontic Therapy; Inoperable, Unrestorable or Fractured Tooth	$99			
(1) Certain services may be covered under the Medical Plan. Contact Member Services for more details.					
PERIODONTICS					
D4210 (1)	Gingivectomy or Gingivoplasty - 4 or More Teeth - Per Quadrant	$105	D4275 (1)	Soft Tissue Allograft	$342
D4211 (1)	Gingivectomy or Gingivoplasty - 1-3 Teeth - Per Quadrant	$39	D4276 (1)	Connective Tissue/Pedicle Graft, Per Tooth	$200
D4212 (1)	Gingivectomy to allow access, per tooth	$13	D4277 (1)	Free soft tissue graft - first tooth	$86
D4240 (1)	Gingival Flap Procedure, Including Root Planing - 4 or More Teeth - Per Quadrant	$116	D4278 (1)	Free soft tissue graft - each additional tooth	$43
D4241 (1)	Gingival Flap Procedure, Including Root Planing - 1-3 Teeth - Per Quadrant	$69	D4283 (1)	Autogenous connective tissue graft	$67
D4245 (1)	Apically Positioned Flap	$95	D4285 (1)	Non-autogenous connective tissue graft	$188
D4249	Clinical Crown Lengthening, Hard Tissue	$158	D4341	Periodontal Scaling and Root Planing - 4 or More Teeth - Per Quadrant	$53
D4260 (1)	Osseous Surgery (Including Flap Entry and Closure) - 4 or More Teeth - Per Quadrant	$263	D4342	Periodontal Scaling and Root Planing - 1-3 Teeth - Per Quadrant	$32
D4261 (1)	Osseous Surgery (Including Flap Entry and Closure) - 1-3 Teeth - Per Quadrant	$158	D4355	Debridement	$70
D4268 (1)	Surgical Revision Procedure, Per Tooth	$105	D4910	Periodontal Maintenance	$33
D4270 (1)	Pedicle Soft Tissue Graft Procedure	$200	D4920	Unscheduled Dressing Change (By Someone Other Than Treating Dentist)	$11
D4273 (1)	Subepithelial Connective Tissue Graft, Per Tooth	$121			
(1) Certain services may be covered under the Medical Plan. Contact Member Services for more details.					
PROSTHODONTICS-REMOVABLE (2)					
D5110	Complete Denture - Maxillary	$318	D5223-D5224	Immediate max/mand partial denture - cast base framework w/resin denture base (including any conventional clasps, rests and teeth)	$393
D5120	Complete Denture - Mandibular	$318	D5225	Maxillary Partial Denture - Flexible Base (including any clasps, rests and teeth)	$363

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D5130	Immediate Denture - Maxillary	$342	D5226	Mandibular Partial Denture - Flexible Base (including any clasps, rests and teeth)	$363
D5140	Immediate Denture - Mandibular	$342	D5282-83	Removable Unilateral Partial Denture - One Piece Cast Metal (including clasps and teeth)	$318
D5211	Maxillary Partial Denture - Resin Base (including any conventional clasps, rests and teeth)	$318	D5410	Adjust Complete Denture - Maxillary	$11
D5212	Mandibular Partial Denture - Resin Base (including any conventional clasps, rests and teeth)	$318	D5411	Adjust Complete Denture - Mandibular	$11
D5213	Maxillary Partial Denture - Cast Metal Framework with Resin Denture Bases (including any conventional clasps, rests and teeth)	$342	D5421	Adjust Partial Denture - Maxillary	$11
D5214	Mandibular Partial Denture - Cast Metal Framework with Resin Denture Bases (including any conventional clasps, rests and teeth)	$342	D5422	Adjust Partial Denture - Mandibular	$11
D5221-D5222	Immediate max/mand partial dental - resin base (including any conventional clasps, rests and teeth)	$366			
(2) Includes relines, adjustments, rebases within the 1st six months. Adjustments to dentures that are done within six months of placement of the denture, are limited to no more than four adjustments.					
REPAIRS TO PROSTHETICS					
D5511-D5512	Repair Broken Complete Denture Base	$45	D5730	Reline Complete Maxillary Denture (Chairside)	$66
D5520	Replace Missing or Broken Teeth - Complete Denture (each tooth)	$45	D5731	Reline Complete Mandibular Denture (Chairside)	$66
D5611-D5612	Repair Resin Partial Denture Base	$45	D5740	Reline Maxillary Partial Denture (Chairside)	$66
D5621-D5622	Repair Cast Partial Framework	$45	D5741	Reline Mandibular Partial Denture (Chairside)	$66
D5630	Repair or Replace Broken Clasp	$45	D5750	Reline Complete Maxillary Denture (Lab)	$110
D5640	Replace Broken Teeth - Per Tooth	$50	D5751	Reline Complete Mandibular Denture (Lab)	$110
D5650	Add Tooth to Existing Partial Denture	$45	D5760	Reline Maxillary Partial Denture (Lab)	$110
D5660	Add Clasp to Existing Partial Denture	$50	D5761	Reline Mandibular Partial Denture (Lab)	$110
D5670	Replace All Teeth and Acrylic on Cast Metal Framework (Maxillary)	$110	D5820	Interim Partial Denture (Maxillary) (3)	$132
D5671	Replace All Teeth and Acrylic on Cast Metal Framework (Mandibular)	$110	D5821	Interim Partial Denture (Mandibular) (3)	$132
D5710	Rebase Complete Maxillary Denture	$110	D5850	Tissue Conditioning, Maxillary	$61
D5711	Rebase Complete Mandibular Denture	$110	D5851	Tissue Conditioning, Mandibular	$61
D5720	Rebase Maxillary Partial Denture	$110	D5876	Add metal substructure to acrylic full denture (per arch)	$40
D5721	Rebase Mandibular Partial Denture	$110			
(3) Eligible on Anterior Teeth only.					
ORAL SURGERY					
D7111	Extraction, Coronal Remnants - Deciduous Tooth	No Charge	D7285 (1)	Biopsy of Oral Tissue - Hard (Bone, Tooth)	$88
D7140	Extraction, Erupted Tooth or Exposed Root (Elevation and/or Forceps Removal)	No Charge	D7286 (1)	Biopsy of Oral Tissue - Soft	$88
D7210 (1)	Surgical Removal of Erupted Tooth	$57	D7287 (1)	Cytological Sample Collection	$44
D7220 (1)	Removal of Impacted Tooth - Soft Tissue	$65	D7310 (1)	Alveoloplasty in Conjunction With Extractions - 4 or More Teeth or Tooth Spaces - Per Quadrant	$66
D7230 (1)	Removal of Impacted Tooth - Partially Bony	$94	D7311 (1)	Alveoloplasty in Conjunction With Extractions - 1 to 3 Teeth or Tooth Spaces - Per Quadrant	$33
D7240 (1)	Removal of Impacted Tooth - Completely Bony	$145	D7320 (1)	Alveoloplasty Not in Conjunction With Extractions - 4 or More Teeth or Tooth Spaces - Per Quadrant	$83
D7241 (1)	Removal of Impacted Tooth - Completely Bony, With Unusual Surgical Complications	$145	D7321 (1)	Alveoloplasty Not in Conjunction With Extractions - 1-3 Teeth or Tooth Spaces - Per Quadrant	$42
D7250 (1)	Surgical Removal of Residual Tooth Roots	$59	D7510 (1)	Incision and Drainage of Abcess - Intraoral Soft Tissue	$33
D7251	Coronectomy - intentional partial tooth removal	$66	D7511 (1)	Incision and Drainage of Abcess - Intraoral Soft Tissue - Complicated	$36

"Patient Pays" applies to procedures provided by the member's Primary Care Dentist or approved specialty dentist.

DMO® Dental Benefits Summary

D7280 (1)	Surgical Access of Unerupted Tooth	$62	D7960 (1)	Frenulectomy (Frenectomy, Frenotomy) Separate Procedure	$99
D7282 (1)	Mobilization of Erupted or Malpositioned Tooth to Aid Eruption	$77	D7963 (1)	Frenuloplasty	$105
D7283	Placement of Device to Facilitate Eruption of Impacted Tooth	$15			
(1) Certain services may be covered under the Medical Plan. Contact Member Services for more details.					
OTHER (ADJUNCTIVE) SERVICES					
D9110	Palliative (Emergency) Treatment of Dental Pain - minor procedure	$11	D9942	Repair and/or Reline of Occlusal Guard	$22
D9222	Deep sedation/general anesthesia - 1st 15 min	$109	D9943	Occlusal guard adjustment	$19
D9223	Deep sedation/general anesthesia - each 15 minute increment	$87	D9944	Occlusal guard – hard appliance, full arch	$173
D9239	Intravenous conscious sedation/analgesia - 1st 15 min	$109	D9945	Occlusal guard – soft appliance, full arch	$150
D9243	Intravenous conscious sedation/analgesia - each 15 minute increment	$87	D9946	Occlusal guard – hard appliance, partial arch	$90
D9310	Consultation - Diagnostic Service Provided by Dentist or Physician Other Than Requesting Dentist or Physician	No Charge	D9951	Occlusal Adjustment - limited	$35
D9311	Consultation with a medical health care professional	No Charge	D9952	Occlusal Adjustment - complete	$96
D9932-D9935	Denture cleaning and inspection	$25			
ORTHODONTICS					
	Orthodontic Screening Exam	$30			
	Diagnostic Records	$150			
	Comprehensive Orthodontic Treatment				
	Adolescent (appliance must be placed prior to age 20)	$1,545			
	Adult	N/A			
	Orthodontic Retention	$275			

Other Important Information

This Benefit summary of the Aetna Dental Maintenance Organization (DMO®) provides information on benefits provided when services are rendered by a participating dentist. In order for a covered person to be eligible for benefits, dental services must be provided by a primary care dentist selected from the network of participating DMO dentists. Out of network benefits may apply. Please refer to your Schedule of Benefits.

Employees in AZ, CA, GA, MA, MD, MO, NC, NJ and TX must either live or work within the approved DMO® service area to be eligible to enroll in the DMO®

Due to state law, limited (varying by state) DMO® benefits for non-emergency services rendered by non-participating providers are available for plan contracts written in: CT, IL, KY, MA and OH and for members residing in OK (regardless of contract situs state).

Attention Massachusetts residents: Before enrolling, you should be aware that our network of preferred providers in Massachusetts has providers mainly in the following counties: Barnstable, Berkshire, Bristol, Essex, Hampden, Hampshire, Middlesex, Norfolk, Plymouth, Suffolk and Worcester. Your out of pocket expenses will be higher if you do not see an in-network provider and, in some plans, benefits may not be available at all for out-of-network providers.

PLAN EXCLUSIONS AND LIMITATIONS*

Some Services Not Covered Under the Plan Are:

1. Services or supplies that are covered in whole or in part:
(a) under any other part of this Dental Care Plan; or
(b) under any other plan of group benefits provided by or through your employer.

2. Services and supplies to diagnose or treat a disease or injury that is not:
(a) a non-occupational disease; or
(b) a non-occupational injury.

3. Services not listed in the Dental Care Schedule that applies, unless otherwise specified in the Booklet-Certificate.

4. Those for replacement of a lost, missing or stolen appliance, and those for replacement of appliances that have been damaged due to abuse, misuse or neglect.

"Patient Pays" applies to procedures provided by the member's Primary Care Dentist or approved specialty dentist.

DMO® Dental Benefits Summary

5. Those for plastic, reconstructive or cosmetic surgery, or other dental services or supplies, that are primarily intended to improve, alter or enhance appearance. This applies whether or not the services and supplies are for psychological or emotional reasons. Facings on molar crowns and pontics will always be considered cosmetic.

6. Those for or in connection with services, procedures, drugs or other supplies that are determined by Aetna to be experimental or still under clinical investigation by health professionals.

7. Those for dentures, crowns, inlays, onlays, bridgework, or other appliances or services used for the purpose of splinting, to alter vertical dimension, to restore occlusion, or to correct attrition, abrasion or erosion. Does not apply to CA contracts.

8. Those for any of the following services (Does not apply to TX contracts):
(a) An appliance or modification of one if an impression for it was made before the person became a covered person;
(b) A crown, bridge, or cast or processed restoration if a tooth was prepared for it before the person became a covered person;
(c) Root canal therapy if the pulp chamber for it was opened before the person became a covered person.

9. Services that Aetna defines as not necessary for the diagnosis, care or treatment of the condition involved. This applies even if they are prescribed, recommended or approved by the attending physician or dentist.

10. Those for services intended for treatment of any jaw joint disorder, unless otherwise specified in the Booklet-Certificate.

11. Those for space maintainers, except when needed to preserve space resulting from the premature loss of deciduous teeth.

12. Those for orthodontic treatment, unless otherwise specified in the Booklet-Certificate.

13. Those for general anesthesia and intravenous sedation, unless specifically covered. For plans that cover these services, they will not be eligible for benefits unless done in conjunction with another necessary covered service.

14. Those for treatment by other than a dentist, except that scaling or cleaning of teeth and topical application of fluoride may be done by a licensed dental hygienist. In this case, the treatment must be given under the supervision and guidance of a dentist.

15. Those in connection with a service given to a dependent age 5 or older if that dependent becomes a covered dependent other than:
(a) during the first 31 days the dependent is eligible for this coverage, or
(b) as prescribed for any period of open enrollment agreed to by the employer and Aetna. This does not apply to charges incurred:
(i) after the end of the 12-month period starting on the date the dependent became a covered dependent; or
(ii) as a result of accidental injuries sustained while the dependent was a covered dependent; or
(iii) for a primary care service in the Dental Care Schedule that applies as shown under the headings Visits and Exams, and X-rays and Pathology.

16. Services given by a nonparticipating dental provider to the extent that the charges exceed the amount payable for the services shown in the Dental Care Schedule that applies.

17. Those for a crown, cast or processed restoration unless:
(a) It is treatment for decay or traumatic injury and teeth cannot be restored with a filling material; or
(b) The tooth is an abutment to a covered partial denture or fixed bridge.

18. Those for pontics, crowns, cast or processed restorations made with high-noble metals, unless otherwise specified in the Booklet-Certificate.

19. Those for surgical removal of impacted wisdom teeth only for orthodontic reasons, unless otherwise specified in the Booklet-Certificate.

20. Services needed solely in connection with non-covered services.

21. Services done where there is no evidence of pathology, dysfunction or disease other than covered preventive services. Does not apply to CA contracts.

Any exclusion above will not apply to the extent that coverage of the charge is required under any law that applies to the coverage.

*This is a partial list of exclusions and limitations, others may apply. Please check your plan booklet for details.

A partial list of what your plan doesn't cover* – some eligible dental service exceptions and exclusions

1. Charges for services or supplies
• Provided by a network provider in excess of the negotiated charge.
• Provided by an out-of-network provider in excess of the recognized charge.
• Provided for your personal comfort or convenience, or the convenience of any other person, including a dental provider
• Provided in connection with treatment or care that is not covered under the plan
• Cancelled or missed appointment charges or charges to complete claim forms
• Charges for which you have no legal obligation to pay
• Charges that would not be made if you did not have coverage, including:
  - Care in charitable institutions
  - Care for conditions related to current or previous military service
  - Care [illegible]

2. Any charge in excess of any benefit, dollar, visit, or frequency limit stated in the schedule of benefits.

3. Cosmetic services and supplies including:
• Plastic surgery
• Reconstructive surgery
• Cosmetic surgery
• Personalization or characterization of dentures or other services and supplies which improve, alter or enhance appearance
• Augmentation and vestibuloplasty and other services to protect, clean, whiten, bleach or alter the appearance of teeth whether or not for psychological or emotional reasons
• Facings on molar crowns and pontics will always be considered cosmetic.

"Patient Pays" applies to procedures provided by the member's Primary Care Dentist or approved specialty dentist.

DMO® Dental Benefits Summary

4. Court-ordered services and supplies - Includes those court-ordered services and supplies, or those required as a condition of parole, probation, release or as a result of any legal proceeding.
5. Acupuncture, acupressure and acupuncture therapy
6. Crown, inlays and onlays, and veneers unless for one of the following: • It is treatment for decay or traumatic injury and teeth cannot be restored with a filling material • The tooth is an abutment to a covered partial denture or fixed bridge.
7. Dental implants, false teeth, prosthetic restoration of dental implants, plates, dentures, braces, mouth guards, and other devices to protect, replace or reposition teeth and removal of implants.
8. Dentures, crowns, inlays, onlays, bridges, or other prosthetic appliances or services used for the purpose of splinting, to alter vertical dimension, to restore occlusion, or correcting attrition, abrasion, or erosion. (Does not apply to California residents covered under the DMO plan)
9. Dental work that began before you were covered by the plan. This means that the following dental work is not covered (Does not apply to Texas residents covered under the DMO plan): • An appliance, or modification of an appliance, if an impression for it was made before you were covered by the plan • A crown, bridge, or cast or processed restoration, if a tooth was prepared for it before you were covered by the plan • Root canal therapy, if the pulp chamber for it was opened before you were covered by the plan
10. First installation of a denture or fixed bridge, and any inlay and crown that serves as an abutment to replace congenitally missing teeth or to replace teeth, all of which were lost while you were not covered.
11. General anesthesia and intravenous sedation, unless specifically covered and done in connection with another eligible dental service.
12. Instruction for diet, tobacco counseling and oral hygiene.
13. Orthodontic treatment except as covered in the Eligible Dental Services section of the schedule of benefits.
14. Dental services and supplies made with high noble metals (gold or titanium) except as covered in the Eligible Dental Services section of the schedule of benefits.
15. Services and supplies provided in connection with treatment or care that is not covered under the plan.
16. Replacement of a device or appliance that is lost, missing or stolen, and for the replacement of appliances that have been damaged due to abuse, misuse or neglect and for an extra set of dentures.
17. Replacement of teeth beyond the normal complement of 32.
18. Services and supplies provided where there is no evidence of pathology, dysfunction or disease, other than covered preventive services. (Does not apply to California residents covered under the DMO plan)
19. Space maintainers except when needed to preserve space resulting from the premature loss of deciduous teeth.
20. Surgical removal of impacted wisdom teeth when removed only for orthodontic reasons.
21. Temporomandibular joint dysfunction/disorder
22. Dental services and supplies that are covered in whole or in part: • Under any other part of this plan • Under any other plan of group benefits provided by the policyholder
23. Experimental or investigational drugs, devices, treatments or procedures. (Does not apply toTexas residents covered under the DMO plan)
24. Services, including but not limited to, those treatments, services, prescription drugs and supplies which are not medically necessary (as determined by Aetna) for the diagnosis and treatment of illness, injury, restoration of physiological functions, or covered preventive services. This applies even if they are prescribed, recommended or approved by your physician or dentist.
25. Payment for a portion of the charge that another party is responsible for as the primary payer.
26. Prescribed drugs, pre-medication or analgesia.
27. Treatment by other than a dentist. However, the plan will cover some services provided by a licensed dental hygienist under the supervision and guidance of a dentist. These are: • Scaling of teeth • Cleaning of teeth • Topical application of fluoride.
28. Work related illness or injuries.

Any exclusion above will not apply to the extent that coverage of the charges is required under any law that applies to the coverage.
*This is a partial list of exclusions and limitations, others may apply. Please check your plan booklet for details.

Specialty Referrals

1. Under the DMO dental plan, services performed by specialists are eligible for coverage only when prescribed by the primary care dentist and authorized by Aetna Dental. If Aetna's payment to the specialty dentist is based on a negotiated fee, then the member's copayment for the service will be based on the same negotiated fee.

2. DMO members may visit an orthodontist without first obtaining a referral from their primary care dentist. In an effort to ease the administrative burden on both participating Aetna dentists and members, Dental has opened direct access for DMO members to orthodontic services.

Emergency Dental Care

"Patient Pays" applies to procedures provided by the member's Primary Care Dentist or approved specialty dentist.

DMO® Dental Benefits Summary

If you need emergency dental care for the palliative treatment (pain relieving, stabilizing) of a dental emergency, you are covered 24 hours a day, 7 days a week. You should contact your Primary Care Dentist to receive treatment. If you are unable to contact your PCD, contact Member Services for assistance in locating a dentist. Refer to your plan documents for details. Subject to state requirements. Out-of-area emergency dental care may be reviewed by our dental consultants to verify appropriateness of treatment.

Your Dental Care Plan Coverage Is Subject to the Following Rules:

Replacement Rule
The replacement of; addition to; or modification of:
existing dentures;
crowns;
casts or processed restorations;
removable denture;
fixed bridgework; or
other prosthetic services
is covered only if one of the following terms is met:

The replacement or addition of teeth is required to replace one or more teeth extracted after the existing denture or bridgework was installed. This coverage must have been in force for the covered person when the extraction took place.

The existing denture, crown; cast or processed restoration, removable denture, bridgework, or other prosthetic service cannot be made serviceable, and was installed at least 5 years before its replacement.

The existing denture is an immediate temporary one to replace one or more natural teeth extracted while the person is covered, and cannot be made permanent, and replacement by a permanent denture is required. The replacement must take place within 12 months from the date of initial installation of the immediate temporary denture.

The extraction of a third molar does not qualify. Any such appliance or fixed bridge must include the replacement of an extracted tooth or teeth.

Tooth Missing But Not Replaced Rule (Does not apply to TX and CA contracts.)
Coverage for the first installation of removable dentures; fixed bridgework and other prosthetic services is subject to the requirements that such removable dentures; fixed bridgework and other prosthetic services are (i) needed to replace one or more natural teeth that were removed while this policy was in force for the covered person; and (ii) are not abutments to a partial denture; removable bridge; or fixed bridge installed during the prior 5 years.

Alternate Treatment Rule: If more than one service can be used to treat a covered person's dental condition, Aetna may decide to authorize coverage only for a less costly covered service provided that all of the following terms are met:

(a) the service must be listed on the Dental Care Schedule;
(b) the service selected must be deemed by the dental profession to be an appropriate method of treatment; and
(c) the service selected must meet broadly accepted national standards of dental practice.

If treatment is being given by a participating dental provider and the covered person asks for a more costly covered service than that for which coverage is approved, the specific copayment for such service will consist of:

(a) the copayment for the approved less costly service; plus
(b) the difference in cost between the approved less costly service and the more costly covered service.

Alternate treatment rule: Sometimes there are several ways to treat a dental problem, all of which provide acceptable results.

• If a charge is made for a non-eligible dental service or supply and an eligible dental service that would provide an acceptable result, then your plan will pay a benefit for the eligible dental service or supply.

• If a charge is made for an eligible dental service but another eligible dental service that would provide an acceptable result is less expensive, the benefit will be for the least expensive eligible dental service.

• You should review the differences in the cost of alternate treatment with your dental provider. Of course, you and your dental provider can still choose the more costly treatment method. You are responsible for any charges in excess of what your plan will cover.

Replacement rule: Some eligible dental services are subject to your plan's replacement rule. The replacement rule applies to replacements of, or additions to existing:

• Crowns
• Inlays
• Onlays
• Veneers
• Complete dentures
• Removable partial dentures
• Fixed partial dentures (bridges)
• Other prosthetic services

DMO® Dental Benefits Summary

These eligible dental services are covered only when you give us proof that:
• While you were covered by the plan:
– You had a tooth (or teeth) extracted after the existing denture or bridge was installed.
– As a result, you need to replace or add teeth to your denture or bridge.

• The present item cannot be made serviceable, and is:
– A crown installed at least 5 years before its replacement.
– An inlay, onlay, veneer, complete denture, removable partial denture, fixed partial denture (bridge), or other prosthetic item installed at least 5 years before its replacement.

• While you were covered by the plan:
– You had a tooth (or teeth) extracted.
– Your present denture is an immediate temporary one that replaces that tooth (or teeth).
– 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 that the temporary denture was installed.

Tooth missing but not replaced rule: (Does not apply to California and Texas residents covered under the DMO plan)

The first installation of complete dentures, removable partial dentures, fixed partial dentures (bridges), and other prosthetic services will be covered if:

• The dentures, bridges or other prosthetic items are needed to replace one or more natural teeth. (The extraction of a third molar tooth does not qualify.)

• The tooth that was removed was not an abutment to a removable or fixed partial denture installed during the prior 5 years

Any such appliance or fixed bridge must include the replacement of an extracted tooth or teeth.

Late entrant rule: The plan does not cover services and supplies given to a person age 5 or older if that person did not enroll in the plan during one of the following:

• The first 31 days the person is eligible for this coverage or
• Any period of open enrollment agreed to by the employer and us

This does not apply to charges incurred for any of the following:

• After the person has been covered by the plan for 12 months
• As a result of injuries sustained while covered by the plan
• Diagnostic and preventive services such as exams, cleanings, fluoride, and images (excludes services related to orthodontia).

Finding Participating Providers

Consult Aetna Dental's online provider search for the most current provider listings. Participating providers are independent contractors in private practice and are neither employees nor agents of Aetna Dental or its affiliates. The availability of any particular provider cannot be guaranteed, and provider network composition is subject to change without notice. Not every provider listed in the directory will be accepting new patients. Although Aetna Dental has identified providers who were not accepting patients in our DMO plan as known to Aetna Dental at the time the provider directory was created, the status of a provider's practice may have changed. For the most current information, please contact the selected provider or Aetna Member Services at the toll-free number on your online ID card, or use our Internet-based provider search available at www.aetna.com.

Specific products may not be available on both a self-funded and insured basis. The information in this document is subject to change without notice. In case of a conflict between your plan documents and this information, the plan documents will govern. In the event of a problem with coverage, members should contact Member Services at the toll-free number on their online ID cards for information on how to utilize the grievance procedure when appropriate. All member care and related decisions are the sole responsibility of participating providers. Aetna Dental does not provide health care services and, therefore, cannot guarantee any results or outcomes.

Dental plans are provided or administered by Aetna Life Insurance Company, Aetna Dental Inc., Aetna Dental of California Inc. and/or Aetna Health Inc.
In Arizona, DMO Dental Plans are provided or administered by Aetna Health Inc.

In Virginia, Aetna DMO® is called Aetna DNO. It is not an HMO. To receive maximum benefits, members must choose a participating primary care dentist to coordinate their care with in-network providers.

This material is for informational purposes only and is neither an offer of coverage nor dental advice. It contains only a partial, general description of plan or program benefits and does not constitute a contract. Aetna does not provide dental services and, therefore, cannot guarantee any results or outcomes. The availability of a plan or program may vary by geographic service area. Certain dental plans are available only for groups of a certain size in accordance with underwriting guidelines. Some benefits are subject to limitations or exclusions. Consult the plan documents (Schedule of Benefits, Certificate/Evidence of Coverage, Booklet, Booklet-Certificate, Group Agreement, Group Policy) to determine governing contractual provisions, including procedures, exclusions and limitations relating to your plan.

Aetna complies with applicable Federal civil rights laws and does not discriminate, exclude or treat people differently based on their race, color,

DMO® Dental Benefits Summary

Aetna provides free aids/services to people with disabilities and to people who need language assistance.

If you need a qualified interpreter, written information in other formats, translation or other services, call 877-238-6200.

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:

Civil Rights Coordinator,
P.O. Box 14462, Lexington, KY 40512 (CA HMO customers: PO Box 24030 Fresno, CA 93779),
1-800-648-7817, TTY: 711,
Fax: 859-425-3379 (CA HMO customers: 860-262-7705),
CRCoordinator@aetna.com.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, or at 1-800-368-1019, 800-537-7697 (TDD).

Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company, Coventry Health Care plans and their affiliates (Aetna).
TTY: 711

To access language services at no cost to you, call the number on your ID card. (English)

Për shërbime përkthimi falas për ju, telefononi në numrin që gjendet në kartën tuaj të identitetit. (Albanian)

የቋንቋ አገልግሎቶችን ያለክፍያ ለማግኘት፣ በመታወቂያዎት ላይ ያለውን ቁጥር ይደውሉ። (Amharic)

للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء الاتصال على الرقم الموجود على بطاقة اشتراكك.(Arabic)

Ձեր նախընտրած լեզվով ավվճար խորհրդատվություն ստանալու համար զանգահարեք ձեր բժշկական ապահովագրության քարտի վրա նշված հէռախոսահամարով (Armenian)

Kugira uronke serivisi z'indimi ata kiguzi, hamagara inomero iri ku karangamuntu kawe (Bantu-Kirundi)

আপনাকে বিনামূল্যে ভাষা পারিষেবা পেতে হলে আপনার পরিচয়পত্রে দেওয়া নম্বরে টেলিফোন করুন। (Bengali)

သင့်အနေဖြင့် အခမဲ့ ဘာသာစကား ဝန်ဆောင်မှုများ ရရှိနိုင်ရန်၊ သင့် ID ကတ်ပေါ်တွင်ရှိသော ဖုန်းနံပါတ်အား ခေါ်ဆိုပါ။
(Burmese)

Per accedir a serveis lingüístics sense cap cost per a vostè, telefoni al número indicat a la seva targeta d'identificació. (Catalan)

Aron maakses ang mga serbisyo sa lengguwahe nga wala kay bayran, tawagi ang numero nga anaa sa imong kard sa ID. (Cebuano)

Para un hago' i setbision lengguåhi ni dibåtde para hågu, ågang i numiru gi iyo-mu kard aidentifikasion. (Chamorro)

ᎶᎩᏍᏗ ᏕᏬᏂᎯᏍᏗ ᎢᏳᎾᎵᏍᏓᏁᏗ Ꮭ ᎠᏒᏍᏗ ᏗᏣᎬᏩᏁᏗ ᏗᏱ, ᏫᏘᎯᏏᏔᏅᏍᎬ ᎾᏍᎩ ᏗᏎᏍᏗ ᏥᏕᎠᏒᏅ ᎤᎾᎢ ID ᏆᏂᏲᏍᏗ ᏣᏤᎵᏛ. (Cherokee)

如欲使用免費語言服務，請撥打您健康保險卡上所列的電話號碼（Chinese Traditional)

Anumpa tosholi i toksvli ya peh pilla ho ish i payahinla kvt chi holisso kallo iskitini holhtena takanli ma i payah (Choctaw)

Ren omw kopwe angei aninisin eman chon awewei (ese kamé), kopwe kééri ewe nampa mei mak won noum ena katen ID (Chuukese)

Tajaajiiloota afaanii gatii bilisaa ati argaachuuf,lakkoofsa fuula waraaqaa eenyummaa (ID) kee irraa jiruun bilbili. (Cushitic-Oromo)

"Patient Pays" applies to procedures provided by the member's Primary Care Dentist or approved specialty dentist.

SHELTERPOINT Life Insurance Company

Vision Insurance - Gold Plan Summary

Offering Vision benefits does a lot more than provide employees with access to discounted eye wear. Regular eye exams can provide early detection of eye diseases, as well as health conditions like diabetes and high blood pressure. Our plans provide the freedom to choose any Vision care provider, but members may save more at a participating network provider. Plus, **examinations, and single or bifocal lenses are covered at 100%** when using a participating provider.

Benefit Amounts

This is a partial listing only. Please refer to the policy for details.

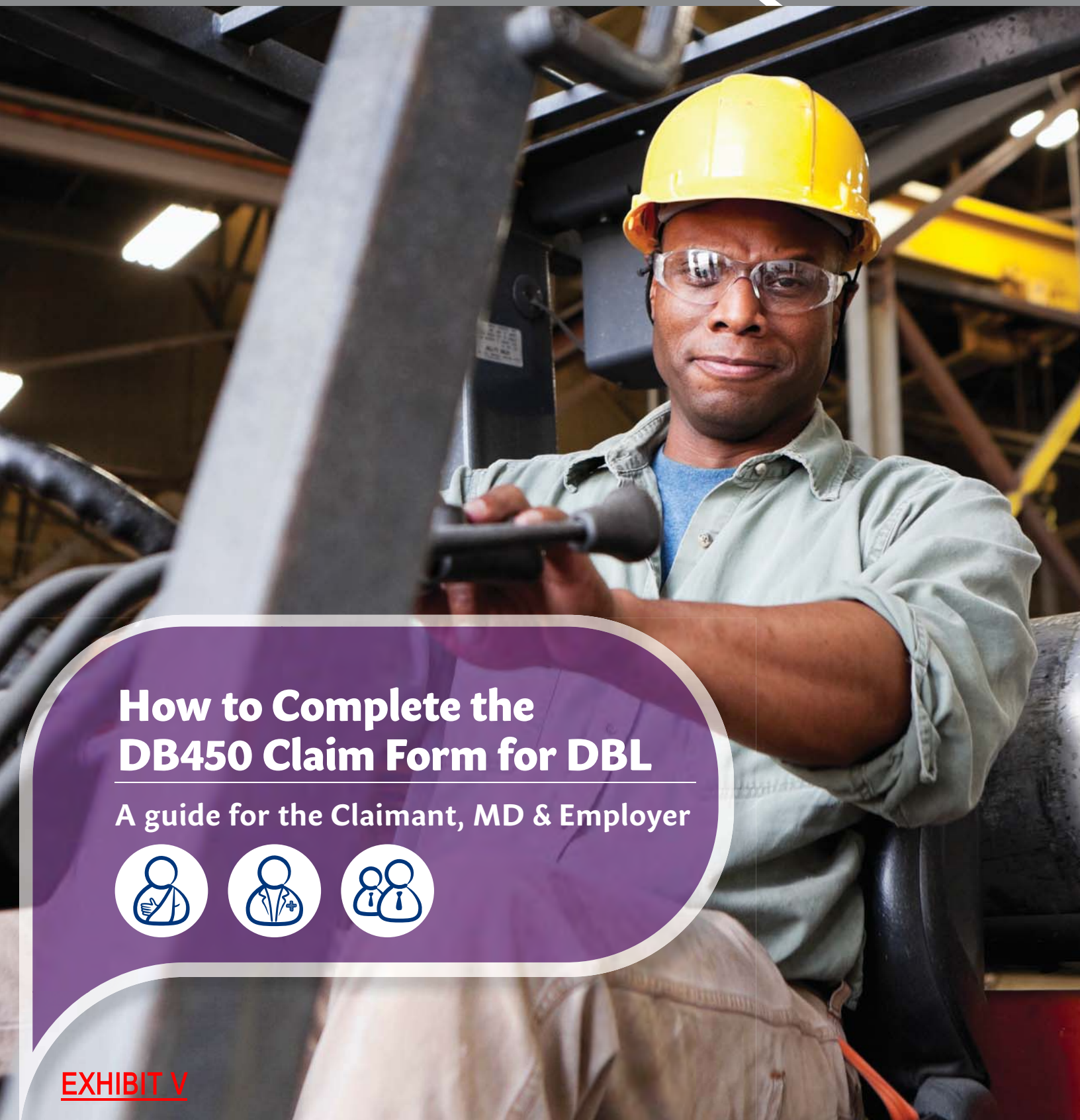
		In-network benefits	Out-of-network reimbursements
Examination	**Once every 12 months[1]**		
		Covered 100%	**Up to $70**
Lenses	**Once every 12 months[1]**		
	Single vision	**Covered 100%**	**Up to $45**
	Bifocal vision	**Covered 100%**	**Up to $115**
	Intermediate vision	**Covered 100%**	**Up to $115**
	Trifocal	**Covered 100%**	**Up to $190**
	Lenticular	**Covered 100%**	**Up to $190**
Lens Options	**Once every 12 months[1]**		
	Scratch resistant coating	**Covered 100%**	
	Fashion/gradient tint	**Covered 100%**	
	Solid tint	**Covered 100%**	
	Glass photogrey single vision lens	**Covered 100%**	
	Glass photogrey bifocal and trifocal lens	**Covered 100%**	
	Ultraviolet (UV) coating	**Covered 100%**	**N/A**
	Standard anti-reflective (AR) coating	**Covered 100% after $35 copay**	
	Polarized lenses	**Discounted to $75[2]**	
	Polycarbonate lenses	**Covered 100%**	
	Standard progressive lenses	**Covered 100%**	
	Premium progressive lenses	**Covered 100% after $40 copay**	
Frames	**Once every 12 months[1]**		
	Frame allowance	**$175 retail allowance[5] (20% overage discount)**	**Up to $100**
Contacts *(In lieu of eyeglasses)*	**Once every 12 months[1]**		
	Maximum allowance for conventional lenses	**$175 retail allowance[3] (10% overage discount)**	
	Maximum allowance for disposable lenses	**$175 retail allowance[3] (10% overage discount)**	**Up to $290[6]**
	Medically necessary contact lenses[4]	**Covered 100%**	
	Evaluation, fitting, and follow-up care - standard lens	**Covered 100%**	
		Covered 100%	**N/A**
	Evaluation, fitting, and follow-up care - specialty lens	**Covered 100%**	

[1] *Benefit year is based on an enrollee's last date of service.*
[2] *Actual discounted amounts may vary.*
[3] *Does not apply at Contact Fill or Cole corporate locations (if applicable) and where prohibited by law. Prohibited by some manufacturers.*
[4] *Prior authorization required.*
[5] *Does not apply for certain proprietary frame brands and where prohibited by law.*
[6] *Only covered if member chooses contact lenses.*

EXHIBIT IV

SHELTERPOINT

www.shelterpoint.com | 800.365.4999



How to Complete the DB450 Claim Form for DBL

A guide for the Claimant, MD & Employer

EXHIBIT V

Part A - Claimant's Statement

What is the DB450 Claim Form?

The DB450 Claim Form is the initial form used to file a disability benefits claim for individuals who have a non work-related injury or illness while employed, or within 4 weeks after termination of employment. If you are sick or disabled after being unemployed more than 4 weeks, you must use form DB300.

To ensure your claim is handled in a timely fashion, it is important that this claim form is legibly filled out in its entirety with all sections completed. **Missing, incomplete, or illegible information will result in a delay in processing your claim.**

Before submitting this Claim Form for processing, be sure each section is **fully completed**. There are 3 sections on the DB450:

- **Part A** is for the **Claimant (Employee)**
- **Part B** is for the treating **Physician/Medical Practitioner**
- **Part C** is for the **Employer**

Each Part must be fully completed, signed, and dated by the appropriate party.

Be sure to make a copy of the completed Claim Form and retain for your records. A detailed outline of each section is below.

Your privacy and security is important to us - none of your information is distributed to 3rd parties without your express consent.

In this section you will enter your First and Last Name, Social Security Number, Mailing Address and other details which will aid in processing this claim.

All information should be printed & legible.

EXAMPLE FORM

PART A - CLAIMANT'S STATEMENT (Please Print or Type) ANSWER ALL QUESTIONS

1. My name is ..... (First / Middle / Last) Social Security Number ☐☐☐ ☐☐ ☐☐☐☐

2. Address..... (Number / Street / City or Town / State / Zip Code / Apt. No.)

3. Tel. No..... 4. Date of Birth..... 5. Married (Check one) ☐Yes ☐No

6. My disability is (if injury, also state how, when and where it occurred) .....

.....

7. I became disabled on ..... (Month / Day / Year) a. I worked on that day ☐Yes ☐No

b. I have since worked for wages or profit. ☐Yes ☐No If "Yes", give dates .....

8. Give name of last employer. If more than one employer during the last eight (8) weeks, name all employers.

EMPLOYER'S			DATES OF EMPLOYMENT						AVERAGE WEEKLY WAGES (Include Bonuses, Tips, Commissions, Reasonable Value of Board, Rent, etc)
BUSINESS NAME	BUSINESS ADDRESS	TELEPHONE NO.	FROM Mo.	FROM Day	FROM Yr.	THROUGH Mo.	THROUGH Day	THROUGH Yr.	

9. My job is or was ..... (Occupation) ..... (Name of Union and Local Number, if Member)

10. For the period of disability covered by this claim
    a. Are you receiving wages, salary or separation pay:..... ☐Yes ☐No
    b. Are you receiving or claiming:
    (1) Workers' compensation for work-connected disability..... ☐Yes ☐No
    (2) Unemployment Insurance Benefits..... ☐Yes ☐No
    (3) Damages for personal injury..... ☐Yes ☐No
    (4) Benefits under the Federal Social Security Act for long-term disability..... ☐Yes ☐No

    IF "YES" IS CHECKED IN ANY OF THE ITEMS IN 10a OR 10b, COMPLETE THE FOLLOWING:
    I have ☐ received ☐ claimed from ..... for the period ..... (Date) to ..... (Date)

11. I have received disability benefits for another period or periods of disability within the 52 weeks immediately before my present disability began ..... ☐ Yes ☐ No
    If "Yes", fill in the following: I have been paid by ..... From ..... (Date) To ..... (Date)

12. I have read the instructions above. I hereby claim Disability Benefits and certify that for the period covered by this claim I was disabled; and that the foregoing statements, including any accompanying statements, are to the best of my knowledge true and complete.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD PRESENTS, CAUSES TO BE PRESENTED, OR PREPARES WITH KNOWLEDGE OR BELEIF THAT IT WILL BE PRESENTED TO OR BY AN INSURER, OR SELF-INSURER, ANY INFORMATION CONTAINING ANY FALSE MATERIAL STATEMENT OR CONCEALS ANY MATERIAL FACT SHALL BE GUILTY OF A CRIME AND SUBJECT TO SUBSTANTIAL FINES AND IMPRISONMENT.

Claim signed on .... (Claimant's Signature) ..... (Claimant's Email Address)

If signed by other than claimant, print below: name, address, and relationship of representative.

Part A - Claimant's Statement

Question 1:
PRINT your full first and last name in the space provided and enter your nine digit social security number in the boxes provided. This information is required for tax reporting purposes.

Question 2:
PRINT your current mailing address (Street # and name, apartment #, City, State, Zip). We will use the address provided when mailing correspondence and/or benefit checks to you. An incomplete or incorrect address could result in returned or lost mail and delay in processing your claim.

Question 3 – Tel. No:
This is the contact phone where we may reach you, should there be any questions on your claim.

Question 4 – Date of Birth:
Enter the month, day, and year in which you were born.

Question 5 – Marital Status:
Enter "yes" if you are married and "no" if you are not.

Question 6:
Enter a brief description of your disability. If you were injured, please also provide details on when (date) and where (location of incident) the incident occurred, as well as how you came to be injured.

Question 7:
Enter the date you became disabled, whether or not you worked on that day, and if you have since worked for wages.

Question 8:
Enter your **Employer's information**, including business name, address, phone#, dates employed (when you started working through your last day worked prior to the disability) and your average weekly wages.

IMPORTANT: If you have more than one job, be sure to complete for ALL employers. Each employer will need to complete their own Part C.

Question 9:
Tell us your job title. If you are a member of a union that **provides DBL benefits**, please enter union name and local number.

Question 10 – Provide us additional detail on your disability:

a) After being disabled, have you received any wages, salary, or other pay? If so, enter YES. If your wages have ceased, enter NO.
b) Have you received OR claimed any other types of benefits? Check Yes or No where applicable
   (1) Workers Comp (On the Job Accident or Illness) Benefits
   (2) Unemployment Insurance Benefits
   (3) Damages for Personal Injury
   (4) Social Security Disability (Federal Long Term Disability Benefits)

*If you have marked YES to any of the options in question 10, you must also provide additional detail regarding the period of time in which you are receiving or claiming these benefits. *

Question 11:
Answer Yes or No to the question "Have you received disability benefits within the past year (52 week period)". If yes, provide from whom the benefit was collected, and the period of time during which you received benefits.

Part A must be signed by claimant and/or authorized representative. End of Part A.

Part B - Healthcare Provider's Statement

Instructions for the Claimant:

This section must be completed by your treating Healthcare provider or Practitioner, providing all details of your disabling condition. Be sure all questions are answered, the information is legible, and your provider/practitioner has signed and dated Part B. This section must be completed, signed and dated **after** the date you became disabled and stopped working.

Be sure your form is completed and signed by an authorized practitioner.

Please be advised **the following medical professionals are NOT Authorized** to complete and sign part B of the DB450 form:

- RN (Registered Nurse)
- CSW (Certified Social Worker)
- PT (Physical Therapist)
- LPN (Licensed Practical Nurse)

Instructions for the Health Care Provider:

IMPORTANT: Part B must be fully and legibly completed to process this claim in a timely fashion. In addition to providing the medical details necessary to examine the claim, **this statement MUST be signed by the treating practitioner and dated to be considered acceptable.**

You must select the appropriate professional degree, enter your license number and state in which you are licensed to practice. Finally, we must have your practice name and mailing address in case additional medical documentation is required.

EXAMPLE FORM

PART B - HEALTH CARE PROVIDER'S STATEMENT (Please Print or Type)
THE HEALTH CARE PROVIDER'S STATEMENT MUST BE FILLED IN COMPLETELY AND THE FORM MAILED TO THE INSURANCE CARRIER OR SELF-INSURED EMPLOYER, OR RETURNED TO THE CLAIMANT WITHIN SEVEN DAYS OF THE RECEIPT OF THE FORM. For item 7d, give approximate date. Make some estimate. If disability is caused by or arising in connection with pregnancy, enter estimated delivery date under "Remarks".

1. Claimant's Name ..... 2. Date of Birth ..... 3. Sex ☐ Male ☐ Female
4. Diagnosis/Analysis .....
   a. Claimant's Symptoms .....
   .....
   .....
   b. Objective Findings .....
   .....
5. Claimant Hospitalized? ☐ Yes ☐ No From ..... To .....
6. Operation Indicated? ☐ Yes ☐ No a. Type ..... b. Date .....
7. Enter Dates for the Following:

	Month	Day	Year
a. Date of your first treatment for this disability			
b. Date of your most recent treatment for this disability			
c. Date claimant was unable to work because of this disability			
d. Date claimant will be able to perform usual work			

   (Even if considerable question exists, estimate date. Avoid use of terms such as unknown or undetermined.)
8. In your opinion, is this disability the result of injury arising out of and in the course of employment or occupational disease? ☐ Yes ☐ No
   If yes, has form C-4 been filed with the Workers' Compensation Board? ☐ Yes ☐ No
   Remarks (attach additional sheet, if necessary) .....
   (if disability is pregnancy related, please enter estimated delivery)

I affirm that I am a					Licensed in the State of	License Number
	☐ Chiropractor	☐ Physician	☐ Psychologist			
	☐ Dentist	☐ Podiatrist	☐ Nurse-Midwife			

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD PRESENTS, CAUSES TO BE PRESENTED, OR PREPARES WITH KNOWLEDGE OR BELEIF THAT IT WILL BE PRESENTED TO OR BY AN INSURER, OR SELF-INSURER, ANY INFORMATION CONTAINING ANY FALSE MATERIAL STATEMENT OR CONCEALS ANY MATERIAL FACT SHALL BE GUILTY OF A CRIME AND SUBJECT TO SUBSTANTIAL FINES AND IMPRISONMENT.

Health Care Provider's Signature ..... **Date** .....
Health Care Provider's Name (Please Print) ..... **Tel.No.** .....
Office Address .....
Number Street City or Town State Zip

HIPAA NOTICE: In order to adjudicate a workers' compensation claim, WCL 13-a(4)(a) and 12 NYCRR 325-1.3 require health care providers to regularly file medical reports of treatment with the Board and the carrier or employer. Pursuant to 45 CFR 164.512 these legally required medical reports are exempt from HIPAA's restrictions on disclosure of health information.

Part B - Healthcare Provider's Statement

Question 1:
Please PRINT the claimant's (Patient) First and Last Name.

Question 2:
Please enter the claimant's date of birth (month, day, year).

Question 3– Sex:
Please indicate whether the claimant is Male or Female.

Question 4:
Please indicate the symptoms and findings of the claimant's disabling condition. Be sure to include any complications which may have exacerbated the disabling condition and provide applicable diagnosis codes if possible.
If this is a pregnancy claim, please enter the estimated date of delivery in this section.
If claimant has already delivered, please provide actual delivery date and type.

Question 5:
Please indicate if the claimant was hospitalized. If hospitalized, provide the confinement dates (from/to).

Question 6:
Please indicate whether or not an operation was performed. If yes, provide type of surgery and the date it took place.

Question 7:

IMPORTANT: YOU MUST PROVIDE DATES for questions 7A through 7D.

a) Date of claimant's **FIRST (Initial)** treatment for their disability (print date in Month, Day, Year format in the boxes provided)

b) Date of claimant's **MOST RECENT** treatment for their disability (print date in Month, Day, Year format in the boxes provided)

c) Date claimant was medically **UNABLE TO WORK (ONSET DATE)** due to this disability (print date in Month, Day, Year format in the boxes provided). This is not necessarily a working day, but the actual day that you certified the claimant disabled.

d) Date claimant will be able to perform usual work **(PROGNOSIS)** (print date in Month, Day, Year format in the boxes provided). This may be an estimated date.

Question 8:
Please indicate whether or not this disabling condition may be WORK RELATED.
If Yes, indicate whether a C-4 Doctor's Initial Report has been filed with the Workers' Compensation Board.

Remarks: Please enter any additional comments needed.

Practitioner Information (Type of Practitioner, License State, License #, Signature, Date, Practice Name, Mailing address etc). **Please legibly print all information.**

End of Part B.

Part C - Employer's Statement

Instructions For the Claimant:

In this section **your Employer** will provide details of your employment. Be sure all questions are answered, the information is legible, and your employer has signed and dated Part C.

If you have more than 1 employer, be sure **each** employer completes their own Part C, and all pages are included with your claim submission.

Instructions For the Employer:

Part C must be **fully and legibly** completed to process this claim in a timely fashion. In addition to providing the employee's details of their employment necessary to examine the claim, **this statement MUST be signed, titled, and dated to be considered acceptable**. We must also have your business name and mailing address in case additional information is required.

PLEASE NOTE:
Part C cannot be completed or signed by the claimant. If you (the claimant) are the owner and sole employee, a Schedule C Form 1040 must be included with your claim submission, and Part C must be completed and signed by your bookkeeper or accountant.

EXAMPLE FORM

PART C - EMPLOYERS STATEMENT

1. Employee's Name: _____ **POLICY NUMBER: DBL-** _____
2. Employee's Occupation: _____ S.S. No.: _____ Age ____
3. Date Employee Last Worked: _____ DATE EMPLOYED: / /20 FULL TIME ☐ PART TIME ☐
4. Date Employee's Wages Ceased: _____ CHECK DAYS NORMALLY WORKED

Mon	Tues.	Wed.	Thurs.	Fri.	Sat.	Sun

5. Date Employee Returned To Work: _____
6. Wages Continued During Disability? _____
7. Is Reimbursement Requested? _____
8. Is Disability Due To Job? _____
9. Name of Workers' Compensation Carrier: _____
10. Indicate Weekly Value of Board, Lodging, Tips $ _____
11. Is Employee A Member of a Union Which Provides N.Y. State Disability Benefits? _____
12. If Employee is no longer in your employ, check reason
    Labor Dispute ☐ Lack of Work ☐ Discharged ☐ Quit ☐
    Explain _____
13. Is Claimant a ☐ Proprietor ☐ Owner ☐ Partner ☐ High School Student
14. Has Employee made a claim for Disability Benefits in the past 52 weeks?
    ☐ Yes ☐ No. If Yes, Date _____ 20 ____
15. Last Date Employee Received Unemployment Benefits: _____
16. Does Employee Work For Anyone Other Than You ☐ Yes ☐ No
17. Do Employees contribute toward their Disability premium? _____

EARNINGS 8 WEEKS PRIOR TO DISABILITY
(Including the week in which the disability began)

MONTH	DAY	YEAR	NO. DAYS WORKED	AMOUNT
			TOTAL	

EMPLOYER'S NAME: _____
ADDRESS: _____
DATE: _____ **TELEPHONE: ( )** _____
SIGNED BY: _____ **TITLE:** _____

MAIL COMPLETED FORMS TO:
ShelterPoint Life Insurance Company
600 Northern Blvd, Great Neck, NY 11021
by email: claimforms@shelterpoint.com
by fax: 516-504-6414

Question 1:

Please print the employee's first and last name.

Question 2:

Indicate the employee's job title.

Question 3:

Please enter the exact date the employee last worked (print date in Month, Day, Year format).

Part C - Employer's Statement

Question 4:
Please enter the exact date the employee's wages ceased. If wages are still being continued, enter "N/A". You will reaffirm this in question 6.

Question 5:
Please enter the date the employee returned to work, if applicable.

Question 6:
Please indicate if wages were continued during disability (Respond with YES or NO). Note, if wages were continued, we will need to know the type of wages (Sick Time, Vacation Time, PTO) and dates collected. You can provide a breakdown on a separate piece of paper to be submitted at same time.

Question 7:
Please indicate whether or not YOUR BUSINESS is requesting reimbursement for continued wages (sick time only).

Question 8:
Please indicate if the employee's disability is work related (respond with Yes or No).

Question 9:
Print the name of your Workers' Comp (on the Job Accident or Illness) insurer. ShelterPoint does not write Workers' Comp insurance.

Question 10:
If this employee receives additional remuneration in the form of tips, Board, Lodging, or Rent, indicate the average weekly amount here.

Question 11:
Please indicate if the employee is a member of a union that provides NYS Disability benefits (respond with Yes or No). If yes, provide the Union Name and Number.

Question 12:
If the employee no longer works for you, indicate **why** (check the applicable box) and provide detail on their termination/separation.

Question 13:
Select the appropriate employee designation.

Question 14:
Indicate whether the claimant has received or claimed Disability Benefits within the past 52 weeks. If yes, please provide dates of claim.

Question 15:
Enter the last date the employee received unemployment benefits, if applicable.

Question 16:
Indicate whether the employee works for anyone other than you. This is important as liability may be split amongst multiple employers.

Question 17:
Indicate whether the employee contributes to disability premium or not. (Respond with Yes or No). If yes, indicate the dollar amount of weekly contribution, or percentage of premium employee contributes.

Part C - Employer's Statement

Additional Required Info on Part C:

Policy Number:
Enter your current ShelterPoint Disability Benefits policy #. If you are completing this form as a concurrent employer, and are insured with another Carrier, you can enter your disability policy # and insurance carrier's name here.

SS No:
Print the employee's 9 digit social security number here.

Age:
Enter the employee's age.

Check Days Normally Worked:
Select boxes indicating which days the employee normally works. If employee's schedule varies, provide average days worked per week.

Wages Grid:
Enter the last 8 weeks GROSS (pre-tax) wages prior to the employee's last day worked in the boxes provided. You may also submit the same information as a separate page.

Employer's Name:
Print your Business name here.

Address:
Print your Business's mailing address here.

Date:
Enter the date you received and completed the form here.

Telephone:
Enter your phone number here, including area code.

Signed By:
Sign your name here

Title:
Print your job title here.

End of Part C.

Once the DB450 form is fully completed, make a copy for your records, and submit one copy to ShelterPoint for processing. The completed claim should be mailed within 30 days of becoming disabled.

Disability Benefits Claims Division:
Email: claimforms@shelterpoint.com
Fax: 516-504-6414
Mail: ShelterPoint, 600 Northern Boulevard, Ste 310, Great Neck NY 11021.

Questions?
dblclaims@ShelterPoint.com or 800.365.4999

New York State

NOTICE AND PROOF OF CLAIM FOR DISABILITY BENEFITS

DB-450 5-19

Read instructions on page 2 carefully to avoid a delay in processing. You must answer all questions in Part A and questions 1 through 3 in Part B. Health care providers must complete Part B on page 2.

PART A - CLAIMANT'S INFORMATION (Please Print or Type)

1. Last Name: _____ First Name: _____ MI: ___

2. Mailing Address (Street & Apt #): _____

City: _____ State: _____ Zip: _____ Country: _____

3. Daytime Phone #: _____ Email Address: _____

4. Social Security #: _____ - _____ - _____ 5. Date of Birth: ___ - ___ - _____ 6. Gender: ☐ Male ☐ Female

7. Describe your disability (if injury, also state how, when and where it occurred): _____

_____

8. Date you became disabled: ____ / ____ / _____ Did you work on that day?: ☐ Yes ☐ No

Have you recovered from this disability? ☐ Yes ☐ No If Yes, date you were able to return to work: ____ / ____ / _____

Have you since worked for wages or profit? ☐ Yes ☐ No If Yes, list dates: _____

9. Name of last employer prior to disability. If more than one employer in previous eight (8) weeks, name all employers. Average Weekly Wage is based on all wages earned in last eight (8) weeks worked.

LAST EMPLOYER PRIOR TO DISABILITY			PERIOD OF EMPLOYMENT		**Average Weekly Wage** (Include Bonuses, Tips, Commissions, Reasonable Value of Board, Rent, etc.)
Firm or Trade Name	Address	Phone Number	First Day	Last Day Worked	
			Mo. Day Yr.	Mo. Day Yr.	
OTHER EMPLOYER (during last eight (8) weeks)			**PERIOD OF EMPLOYMENT**		**Average Weekly Wage** (Include Bonuses, Tips, Commissions, Reasonable Value of Board, Rent, etc.)
Firm or Trade Name	Address	Phone Number	First Day	Last Day Worked	
			Mo. Day Yr.	Mo. Day Yr.	
			Mo. Day Yr.	Mo. Day Yr.	

10. My job is or was: _____ (Occupation) 11. Union Member: ☐ Yes ☐ No If "Yes": _____ (Name of Union or Local Number)

12. Were you claiming or receiving unemployment prior to this disability? ☐ Yes ☐ No

If you did **not** claim or if you claimed but did **not** receive unemployment insurance benefits *after* LAST DAY WORKED, explain reasons fully: _____

_____

If you did receive unemployment benefits, provide all periods collected: _____

_____

13. For the period of disability covered by this claim:

A. Are you receiving wages, salary or separation pay: ☐ Yes ☐ No

B. Are you receiving or claiming:

1. Workers' compensation for work-connected disability: ☐ Yes ☐ No
2. Paid Family Leave: ☐ Yes ☐ No
3. No-Fault motor vehicle accident?: ☐ Yes ☐ No **or** personal injury involving third party?: ☐ Yes ☐ No
4. Long-term disability benefits under the Federal Social Security Act for *this* disability: ☐ Yes ☐ No

IF "YES" IS CHECKED IN ANY OF THE ITEMS IN 13, COMPLETE THE FOLLOWING:

I have: ☐ received ☐ claimed from: _____ for the period: ____ / ____ / _____ to: ____ / ____ / _____

14. In the year (52 weeks) before your disability began, have you received disability benefits for other periods of disability? ☐ Yes ☐ No

If yes, Paid by: _____ from: ____ / ____ / _____ to: ____ / ____ / _____

15. In the year (52 weeks) before your disability began, have you received Paid Family Leave? ☐ Yes ☐ No

If yes, Paid by: _____ from: ____ / ____ / _____ to: ____ / ____ / _____

16. If you became disabled while employed or within four weeks of your last day worked, did your employer provide you with your rights under Disability Law within 5 days of your notice or request for disability forms? ☐ Yes ☐ No

I hereby claim Disability Benefits and certify that for the period covered by this claim I was disabled. I have read the instructions on page 2 of this form and that the foregoing statements, including any accompanying statements are, to the best of my knowledge, true and complete.

Claimant's Signature _____ **Date** _____ **Claimant's email address** _____

An individual may sign on behalf of the claimant only if he or she is legally authorized to do so and the claimant is a minor, mentally incompetent or incapacitated. If signed by other than claimant, print information below and complete and submit Form OC-110A, Claimant's Authorization to Disclose Workers' Compensation Records.

On behalf of Claimant _____ **Address** _____ **Relationship to Claimant** _____

PART B - HEALTH CARE PROVIDER'S STATEMENT (Please Print or Type)

T**HE HEALTH CARE PROVIDER'S STATEMENT MUST BE FILLED IN COMPLETELY. THE ATTENDING HEALTH CARE PROVIDER SHALL COMPLETE AND RETURN TO THE CLAIMANT WITHIN SEVEN (7) DAYS OF RECEIPT OF THIS FORM.** For item 7-d, you must give estimated date. If disability is caused by or arising in connection with pregnancy, enter estimated delivery date in item 7-e. **INCOMPLETE ANSWERS MAY DELAY PAYMENT OF BENEFITS.**

1. Last Name: _____ First Name: _____ MI: ___

2.Gender: ☒ Male ☒ Female 3. Date of Birth: ___ / ___ / _____

4. Diagnosis/Analysis: _____ Diagnosis Code: _____

a. Claimant's symptoms: _____

_____

b. Objective findings: _____

_____

5. Claimant hospitalized?: ☐ Yes ☐ No From: ____ / ____ / _____ To: ____ / ____ / _____

6. Operation indicated?: ☐ Yes ☐ No a. Type _____ b. Date ____ / ____ / _____

7. ENTER DATES FOR THE FOLLOWING	MONTH	DAY	YEAR
a Date of your first treatment for this disability			
b. Date of your most recent treatment for this disability			
c. Date Claimant was unable to work because of this disability			
d. Date Claimant will again be able to perform work (Even if considerable question exists, estimate date. Avoid use of terms such as unknown or undetermined.)			
e. If pregnancy related, please check box and enter the date ☐ estimated delivery date OR ☐ actual delivery date			

8. In your opinion, is this disability the result of injury arising out of and in the course of employment or occupational disease?:
☐ Yes ☐ No If "Yes", has Form C-4 been filed with the Board? ☐ Yes ☐ No

I certify that I am a:

_____ _____ _____
(Physician, Chiropractor, Dentist, Podiatrist, Psychologist, Nurse-Midwife) **Licensed or Certified in the State of** **License Number**

_____ _____ _____
Health Care Provider's Printed Name **Health Care Provider's Signature** **Date**

_____ _____
Health Care Provider's Address **Phone #**

IMPORTANT NOTICE TO CLAIMANT- READ THESE INSTRUCTIONS CAREFULLY

PLEASE NOTE: Do not date and file this form prior to your first date of disability. In order for your claim to be processed, Parts A and B must be completed.

1. If you are using this form because you became disabled **while employed** or you became disabled **within four (4) weeks after termination of employment**, your completed claim should be mailed **within thirty (30) days to your employer or your last employer's insurance carrier**. You may find your employer's disability insurance carrier on the Workers' Compensation Board's website, www.wcb.ny.gov, using Employer Coverage Search.

2. If you are using this form because you became **disabled after having been unemployed for more than four (4) weeks**, your completed claim should be mailed to: **Workers' Compensation Board, Disability Benefits Bureau, PO Box 9029, Endicott, NY 13761-9029.** If you answered "Yes" to question 13.B.3, please complete and attach Form DB-450.1.

If you do not receive a response within 45 days or if you have questions about your disability benefits claim, please call your employer's insurance carrier. For general information about disability benefits, please visit www.wcb.ny.gov or call the Board's Disability Benefits Bureau at (877) 632-4996.

Notification Pursuant to the New York Personal Privacy Protection Law (Public Officers Law Article 6-A) and the Federal Privacy Act of 1974 (5 U.S.C. § 552a). The Workers' Compensation Board's (Board's) authority to request that claimants provide personal information, including their social security number, is derived from the Board's investigatory authority under Workers' Compensation Law (WCL) § 20, and its administrative authority under WCL § 142. This information is collected to assist the Board in investigating and administering claims in the most expedient manner possible and to help it maintain accurate claim records. Providing your social security number to the Board is voluntary. There is no penalty for failure to provide your social security number on this form; it will not result in a denial of your claim or a reduction in benefits. The Board will protect the confidentiality of all personal information in its possession, disclosing it only in furtherance of its official duties and in accordance with applicable state and federal law

HIPAA NOTICE - In order to adjudicate a workers' compensation claim or disability benefits claim, WCL 13-a(4)(a) and 12 NYCRR 325-1.3 require health care providers to regularly file medical reports of treatment with the Board and the insurance carrier or employer. Pursuant to 45 CFR 164.512 these legally required medical reports are exempt from HIPAA's restrictions on disclosure of health information.

Disclosure of Information: The Board will not disclose any information about your case to any unauthorized party without your consent. If you choose to have such information disclosed to an unauthorized party, you must file with the Board an original signed Form OC-110A, "Claimant's Authorization to Disclose Workers' Compensation Records". This form is available on the WCB website (www.wcb.ny.gov) and can be accessed by clicking the "Forms" link. If you do not have access to the internet please call (877) 632-4996 or visit our nearest Customer Service Center to obtain a copy of the form. In lieu of Form OC-110A, you may also submit an original signed, notarized authorization letter.

An employer or insurer, or any employee, agent, or person acting on behalf of an employer or insurer, who KNOWINGLY MAKES A FALSE STATEMENT OR REPRESENTATION as to a material fact in the course of reporting, investigation of, or adjusting a claim for any benefit or payment under this chapter for the purpose of avoiding provision of such payment or benefit SHALL BE GUILTY OF A CRIME AND SUBJECT TO SUBSTANTIAL FINES AND IMPRISONMENT.

PART C- EMPLOYER'S STATEMENT

Instructions: Complete this form in its entirety for your employee claiming disability benefits. Any missing or incomplete information could result in delays processing their claim.

1. Employee's full name: _____
2. Employee's Social Security Number:___ ___ ___ - ___ ___- ___ ___ ___ ___ Age: _____
3. Their occupation:_____
4. Their role: □ Employee □ Proprietor □ Partner □ Spouse of Employer □ Owner □ Co-owner
5. Date they last worked: ____/____/_____ 5.1Date they returned to work: ____/____/_____
6. Date employee's wages ceased: ____/____/_____
7. Were wages continued during disability? □ Yes □ No Date/Type: _____
   Note: If wages continued were a result of the employee using accrued sick time, vacation time, or paid time off, please indicate the type and date used, and attach to this sheet.
8. If wages were continued, is reimbursement requested to the employer? □ Yes □ No
   Note: Employers may only be reimbursed if the employee used sick time, or if you continued their salary during leave.
9. Is the disability due to their job (work-related)? □ Yes □ No
10. Is the employee a member of a union that provides NYS disability benefits? □ Yes □ No
    if yes, please provide Union name and address:

11. Provide a breakdown of this employee's 8 weeks wages immediately **PRIOR** to their disability, starting with the week the disability began.

Date	# of Days Worked	Amount (gross wages) *wages includes tips, value of board/lodging, and commissions*
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
	Total:	

12. Employee's date of hire: _____/____/_____
13. Status: □ Full-time □ Part-time
14. Is employee a full-time High School Student?
    □ Yes □ No
15. Days usually worked:
    □ Mon □ Tue □ Wed □ Thu □ Fri □ Sat □ Sun
16. Does employee contribute to their disability premium?
    □ Yes:_____ □ No
    if yes, please specify dollar amount or specific percentage. If you leave this question blank we will assume they do not contribute.
17. Does employee work for anyone else besides your company?
    □ Yes □ No
18. Has employee made a claim for disability benefits or paid family leave within the past 52 weeks prior to the date this disability began? □ Yes □ No *If yes, please provide details below:*
    Disability Benefits: from _____/____/_____ to _____/____/_____
    Paid Family Leave: from _____/____/_____ to _____/____/_____
19. If this employee received unemployment benefits, date the benefit was last received? _____/____/_____
20. If this employee is no longer in your employment, select reason: □ labor dispute □ lack of work □ discharged □ resigned
    Please provide detail:

Business name (including any DBA/trade name):

Business address:

I have read and acknowledge the fraud warning in the instructions on page 2 of the DB450 form.

Signature:_____ Title: _____

Phone: ( ) _____ Date: _____/_____/_____

Email: _____ Policy Number:_____

Return completed claim form (including Parts A and B) to ShelterPoint Life one of 3 ways:
Fax: 516-504-6414 **Email:** claimforms@shelterpoint.com **Mail:** ShelterPoint, 1225 Franklin Ave-Ste. 475, Garden City, NY 11530

BENEFIT SUMMARY

Northeast District Council of the OPCMIA Welfare Fund

802405

Aetna Hospital Indemnity

Insurance plans are underwritten by Aetna Life Insurance Company.

Here's how the plan works:

Unless otherwise indicated, all benefits and limitations are per covered person.

THIS PLAN DOES NOT COUNT AS MINIMUM ESSENTIAL COVERAGE UNDER THE AFFORDABLE CARE ACT. THIS IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMUM ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES.

THIS IS NOT A MEDICARE SUPPLEMENT (MEDIGAP) PLAN. If you are or will become eligible for Medicare, review the free Guide to Health Insurance for People with Medicare available at **www.medicare.gov.**

This policy, alone, does not meet Massachusetts Minimum Creditable Coverage standards.

The insurance evidenced by this certificate provides limited benefits health insurance only. It does NOT provide basic hospital, basic medical, major medical, Medicare supplement, long term care insurance, nursing home insurance only, home care insurance only, or nursing home and home care insurance as defined by the New York State Department of Financial Services.

EXHIBIT VI

Covered Benefit for Inpatient Stays	Plan 2
Hospital stay - Admission Provides a lump sum benefit for the initial day of your stay in a hospital. *Maximum 1 stay per plan year*	$1,500
Hospital stay - Daily Pays a daily benefit, beginning on day two of your stay in a non-ICU room of a hospital. *Maximum 30 days per plan year*	$100
Hospital stay - (ICU) Daily Pays a daily benefit, beginning on day two of your stay in an ICU room of a hospital. *Maximum 30 days per plan year*	$150
Nursery admission (non-NICU) Provides a lump-sum benefit after the birth of your newborn. This will not pay for an outpatient birth.	$100
Substance abuse stay - Daily Pays a daily benefit for each day you have a stay in a hospital or substance abuse treatment facility for the treatment of substance abuse. *Maximum 30 days per plan year*	$100
Mental disorder stay - Daily Pays a daily benefit for each day you have a stay in a hospital or mental disorder treatment facility for the treatment of mental disorders. *Maximum 30 days per plan year*	$100
Rehabilitation unit stay - Daily Pays a benefit each day of your stay in a rehabilitation unit immediately after your hospital stay due to an illness or accidental injury. *Maximum 30 days per plan year*	$50

Important Note:
All inpatient stays begin on day two and count toward the plan year maximum.

Inpatient Benefits	Plan 2
Skilled nursing facility stay - Daily Pays a daily benefit for each day you have a stay in a skilled nursing facility due to an illness or accidental injury. *Maximum 30 days per plan year*	$50

Important Note:
Plan year maximums for inpatient stay daily benefits, including skilled nursing facility and hospice care, start counting on day two of the inpatient stay.

Waiver of premium

If you are in a hospital for more than 30 days in a row, we will waive the premium beginning on the first premium due date that occurs after the 30th day of your stay, through the next 6 months of coverage. During your stay, you must remain employed with the policyholder.

Exclusions and Limitations

This plan has exclusions and limitations. Refer to the actual policy and certificate to determine which benefits are not payable. The following is a partial list of services and supplies that are generally not covered. However, the plan may contain exceptions to this list based on state mandates or the plan design purchased.

Benefits will not be paid for any stay or other service for an illness or accidental injury related to the following:

1. Engaging in extra-hazardous activities meaning aviation and related activities
2. Participating as a professional in athletics or sports
3. Act of war, riot, war
4. Operating, learning to operate or serving as a pilot or crew member of any aircraft, whether motorized or not
5. Assault, felony, illegal occupation, or other criminal act
6. Care provided by a spouse, parent, child, or sibling
7. Cosmetic services and plastic surgery, with certain exceptions
8. Custodial Care
9. Hospice services, except as specifically provided in the Benefits under your plan section of the certificate;
10. Self-harm, suicide, except when resulting from a diagnosed disorder
11. Violating any cellular device use laws of the state in which the accident occurred, while operating a motor vehicle
12. Care or services received outside the United States, its possessions or the countries of Canada and Mexico
13. Accidental injury sustained while under the influence of any narcotic unless administered on the advice of a physician and taken in the prescribed dose
14. Dental and orthodontic care and treatment
15. Any care, prescription drugs, and medicines related to infertility
16. Outpatient cognitive rehabilitation, physical therapy, occupational therapy, or speech therapy for any reason
17. Vision-related care

Questions and Answers

Do I have to be actively at work to enroll in coverage?

Yes, you must be actively at work in order to enroll and for coverage to take effect. You are actively at work if you are working, or are available to work, and meet the criteria set by your employer to be eligible to enroll.

Can I enroll in the Aetna Hospital Indemnity plan even though I have a Health Savings Account (HSA)?

Yes, you can still enroll in the Aetna Hospital Indemnity plan if you have a Health Savings Account.

What is considered a hospital stay?

A stay is a period during which you are admitted as an inpatient; and are confined in a hospital, non-hospital residential facility, skilled nursing facility or rehabilitation facility; and are charged for room, board and general nursing services. A stay does not include time in the hospital because of custodial or personal needs that do not require medical skills or training. A stay specifically excludes time in the hospital for observation or in the emergency room unless this leads to a stay.

How do I file a claim?

Go to **www.aetnavoluntaryforms.com** to find your benefit claim form. Use the "Online claims process" link to fill out the form and submit your claim. You can also print/mail in form(s) to: Aetna Voluntary Plans, PO Box 14079, Lexington, KY 40512-4079, or you can ask us to mail a printed form.

What should I do in case of an emergency?

In case of emergency, call 911 or your local emergency hotline, or go directly to an emergency care facility.

What if I don't understand something I've read here, or have more questions?

Please call us. We want you to understand these benefits before you decide to enroll. You may reach one of our Customer Service representatives **Monday through Friday, 8 a.m. to 6 p.m.,** by calling **1-800-607-3366.** We're here to answer questions before and after you enroll.

Important information about your benefits

The Aetna Hospital Indemnity Plan is a hospital confinement indemnity plan with other fixed indemnity benefits. This plan provides LIMITED BENEFITS. This plan pays you fixed dollar amounts regardless of the amount that the provider charges. You are responsible for making sure the provider's bills get paid. These benefits are paid in addition to any other health coverage you may have. This disclosure provides a very brief description of the important features of the benefits being considered. It is not an insurance contract and only the actual policy provisions will control.

IN ORDER FOR THE HOSPITAL INDEMNITY BENEFITS TO BE PAYABLE, THE INITIAL DAY OF YOUR STAY AND OTHER SERVICES MUST BE ON OR AFTER YOUR EFFECTIVE DATE OF COVERAGE.

Complaints and appeals

Please tell us if you are not satisfied with a response you received from us or with how we do business. Call Member Services to file a verbal complaint or to ask for the address to mail a written complaint. You can also e-mail Member Services through the secure member website. If you're not satisfied after talking to a Member Services representative, you can ask us to send your issue to the appropriate department.

If you don't agree with a denied claim, you can file an appeal. To file an appeal, follow the directions in the letter or explanation of benefits statement that explains that your claim was denied. The letter also tells you what we need from you and how soon we will respond.

We protect your privacy

We consider personal information to be private. Our policies protect your personal information from unlawful use. By "personal information," we mean information that can identify you as a person, as well as your financial and health information. Personal information does not include what is available to the public. For example, anyone can access information about what the plan covers. It also does not include reports that do not identify you.

When necessary for your care or treatment, the operation of our health plans or other related activities, we use personal information within our company, share it with our affiliates and may disclose it to: your doctors, dentists, pharmacies, hospitals and other caregivers, other insurers, vendors, government departments and third-party administrators (TPAs).

We obtain information from many different sources —particularly you, your employer or benefits plan sponsor if applicable, other insurers, health maintenance organizations or TPAs, and health care providers.

These parties are required to keep your information private as required by law. Some of the ways in which we may use your information include: Paying claims, making decisions about what the plan covers, coordination of payments with other insurers, quality assessment, activities to improve our plans and audits.

We consider these activities key for the operation of our plans. When allowed by law, we use and disclose your personal information in the ways explained above without your permission. Our privacy notice includes a complete explanation of the ways we use and disclose your information. It also explains when we need your permission to use or disclose your information.

We are required to give you access to your information. If you think there is something wrong or missing in your personal information, you can ask that it be changed. We must complete your request within a reasonable amount of time. If we don't agree with the change, you can file an appeal.

If you'd like a copy of our privacy notice, call **1-800-607-3366** or visit us at **www.aetna.com**.

If you require language assistance, please call Member Services at 1-800-607-3366 and an Aetna representative will connect you with an interpreter. If you're deaf or hard of hearing, use your TTY and dial 711 for the Telecommunications Relay Service. Once connected, please enter or provide the Aetna telephone number you're calling.

Si usted necesita asistencia lingüística, por favor llame al Servicios al Miembro a 1-800-607-3366, y un representante de Aetna le conectará con un intérprete. Si usted es sordo o tiene problemas de audición, use su TTY y marcar 711 para el Servicio de Retransmisión de Telecomunicaciones (TRS). Una vez conectado, por favor entrar o proporcionar el número de teléfono de Aetna que está llamando.

ATTENTION MASSACHUSETTS RESIDENTS: As of January 1, 2009, the Massachusetts Health Care Reform Law requires that Massachusetts residents, eighteen (18) years of age and older, must have health coverage that meets the Minimum Creditable Coverage standards set by the Commonwealth Health Insurance Connector, unless waived from the health insurance requirement based on affordability or individual hardship. For more information call the Connector at **1-877-MA-ENROLL (1-877-623-6765)** or visit the Connector website **(www.mahealthconnector.org)**. THIS POLICY, ALONE, DOES NOT MEET MINIMUM CREDITABLE COVERAGE STANDARDS. If you have questions about this notice, you may contact the Division of Insurance by calling **1-617-521-7794** or visiting its website at **www.mass.gov/doi.**

Financial Sanctions Exclusions Clause

If coverage provided by this policy violates or will violate any US economic or trade sanctions, the coverage is immediately considered invalid. For example, Aetna companies cannot make payments or reimburse for health care or other claims or services if it violates a financial sanction regulation. This includes sanctions related to a blocked person or entity, or a country under sanction by the United States, unless permitted under a valid written Office of Foreign Assets Control (OFAC) license. For more information on OFAC, visit **http://www.treasury.gov/resource-center/sanctions/Pages/default.aspx.**

Plans are underwritten by Aetna Life Insurance Company (Aetna).

This material is for information only and is not an offer or invitation to contract. Information is believed to be accurate as of the production date; however, it is subject to change. For more information about Aetna plans, refer to **www.aetna.com**.

Hospital Indemnity Policy forms issued in Idaho, Oklahoma and Missouri include:

AL VOL HPOL-Hosp 01 and AL VOL HCOC-Hosp 01.