

**Northeast District
Council of the
OPCMIA Welfare
Fund Benefit
Booklet Plan Year
2021**

Journeyman

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Overview

The Northeast District Council of the OPCMIA Welfare Fund has put together this booklet of information for all eligible active members and their eligible dependents.

Core Benefits

Major Medical

Dental

Vision

Disability

Basic Life/ AD&D

Supplemental Insurance (Hospital Indemnity Plan)



Enrollment

The Northeast District Council of the OPCMIA provides a number of resources that will assist members with the enrollment process. Please be sure to check with your Fund Office to find out what your eligibility status is.

You may also enroll eligible dependents. Eligible dependents are:

- Your Legal Spouse
- Your Children age 26 and under
- Court ordered eligible dependents
- Disabled children over age 26 with required documentation

Changing Benefit Options

You may only change your benefit plan elections throughout the year due to a life change event. Examples of a life change event are:

- Change in marital status
- Change in number of dependents (birth, adoption, child support order)
- Change in employment status for you or your spouse (new employment, termination, leave of absence)
- Special enrollment rights under HIPPA
- Medicare coverage

Please note – To change benefits or add dependents throughout the plan year, you must contact your Fund Office and provide documentation to support these changes. Acceptable documentation can be:

- Copy of Marriage Certificate
- Copy of Birth Certificate
- Copy of papers showing placement of child in your home
- Copy of court order showing legal guardianship
- Copy of prior year federal tax return showing dependent is claimed on tax documents and proof of incapacity



Aetna Major Medical – High Plan

The Northeast District Council of the OPCMIA offers a High Plan for members that are eligible to enroll. Members who enroll on the High Plan must see doctors that are in the Aetna Open Access Elect Choice Network. This plan is an in-network only plan. If you see doctors that are not in this network, Aetna will not be responsible for the amount that is owed. The High Plan has a number of services that are covered, if there is a service that you do not see, contact your Benefit Administrator for clarification.

Aetna also offers online access to your coverage and claims easily with Aetna Navigator. Please refer to the following pages to see a detailed list of your Summary of Benefits and Coverage (SBC) and information on Aetna Navigator.

Note: when enrolling in the Aetna High Medical Plan, you will receive an ID card in the mail approximately 7 to 10 days after enrollment. Please keep this ID card on you and present it to your healthcare provider, or healthcare facility / hospital when receiving services.



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

Coverage Period: 01/01/2021 - 12/31/2021


 **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=080200-120020-092082> 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?	In- <u>Network</u> : Individual \$1,000 / Family \$2,000.	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your deductible?	Yes. Emergency care; plus in- <u>network</u> office visits, <u>prescription drugs</u> & <u>preventive care</u> are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	In- <u>Network</u> : Individual \$6,600 / Family \$13,200.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u> ?	<u>Premiums</u> , <u>balance-billing</u> charges & health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u> ?	Yes. See http://www.aetna.com/docfind or call 1-888-982-3862 for a list of in- <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

 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
		In-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 <u>copay</u> /visit, <u>deductible</u> doesn't apply	Not covered	None
	<u>Specialist</u> visit	\$30 <u>copay</u> /visit, <u>deductible</u> doesn't apply	Not covered	None
	<u>Preventive care /screening</u> /immunization	No charge	Not covered	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	\$30 <u>copay</u> /visit, <u>deductible</u> doesn't apply	Not covered	None
	Imaging (CT/PET scans, MRIs)	\$75 <u>copay</u> /visit, <u>deductible</u> doesn't apply	Not covered	None
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.aetnapharmacy.com/standardoptoutaetna	Generic drugs	<u>Copay</u> /prescription, <u>deductible</u> 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 <u>in-network</u> . Your cost will be higher for choosing Brand over Generics unless prescribed Dispense as Written.
	Preferred brand drugs	<u>Copay</u> /prescription, <u>deductible</u> doesn't apply: \$25 (retail), \$50 (mail order)	Not covered	
	Non-preferred brand drugs	<u>Copay</u> /prescription, <u>deductible</u> doesn't apply: \$50 (retail), \$100 (mail order)	Not covered	
	<u>Specialty drugs</u>	Applicable cost as noted above for generic or brand drugs	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$75 <u>copay</u> /visit, <u>deductible</u> 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
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	<u>Emergency room care</u>	\$200 <u>copay</u> /visit, <u>deductible</u> doesn't apply	\$200 <u>copay</u> /visit, <u>deductible</u> doesn't apply	No coverage for non-emergency use.
	<u>Emergency medical transportation</u>	0% <u>coinsurance</u>	0% <u>coinsurance</u>	Non-emergency transport: not covered, except if pre-authorized.
	<u>Urgent care</u>	\$30 <u>copay</u> /visit, <u>deductible</u> doesn't apply	Not covered	No coverage for non-urgent use.
If you have a hospital stay	Facility fee (e.g., hospital room)	\$500 <u>copay</u> /stay	Not covered	None
	Physician/surgeon fees	0% <u>coinsurance</u>	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office: \$30 <u>copay</u> /visit, <u>deductible</u> doesn't apply; other outpatient services: no charge	Not covered	None
	Inpatient services	\$500 <u>copay</u> /stay	Not covered	None
If you are pregnant	Office visits	No charge	Not covered	<u>Cost sharing</u> does not apply for <u>preventive services</u> . Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	0% <u>coinsurance</u>	Not covered	
	Childbirth/delivery facility services	\$500 <u>copay</u> /stay	Not covered	
If you need help recovering or have other special health needs	<u>Home health care</u>	No charge	Not covered	200 visits/calendar year.
	<u>Rehabilitation services</u>	\$30 <u>copay</u> /visit, <u>deductible</u> doesn't apply	Not covered	60 visits/calendar year for Physical, Occupational & Speech Therapy combined.
	<u>Habilitation services</u>	No charge	Not covered	None
	<u>Skilled nursing care</u>	\$500 <u>copay</u> /stay	Not covered	60 days/calendar year.
	<u>Durable medical equipment</u>	0% <u>coinsurance</u>	Not covered	Limited to 1 <u>durable medical equipment</u> for same/similar purpose. Excludes repairs for misuse/abuse.
	<u>Hospice services</u>	\$500 <u>copay</u> /stay for inpatient; no charge for outpatient	Not covered	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-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.)		
<ul style="list-style-type: none"> • Cosmetic surgery • Dental care (Adult & Child) • Glasses (Child) • Hearing aids 	<ul style="list-style-type: none"> • Long-term care • Non-emergency care when traveling outside the U.S. • Routine foot care 	<ul style="list-style-type: none"> • Weight loss programs - Except for required <u>preventive services</u>.

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
<ul style="list-style-type: none"> • Acupuncture • Bariatric surgery • Chiropractic care 	<ul style="list-style-type: none"> • Infertility treatment - For more information & exceptions, see policy document using summary box link on page 1. 	<ul style="list-style-type: none"> • Private-duty nursing - 20 visits/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 www.dol.gov/ebsa/healthreform.
- 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 on how 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 www.dol.gov/ebsa/healthreform.
- 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.

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

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	\$12,700
In this example, Peg would pay:	
<i>Cost Sharing</i>	
Deductibles	\$1,000
Copayments	\$700
Coinsurance	\$0
<i>What isn't covered</i>	
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	\$5,600
In this example, Joe would pay:	
<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$1,100
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$1,120

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	\$2,800
In this example, Mia would pay:	
<i>Cost Sharing</i>	
Deductibles	\$900
Copayments	\$400
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,300

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.

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 unlawfully discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, or disability.

We provide 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: P.O. 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.

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 -** ለጽንዖት እና በ አማርኛ በ 1-888-982-3862 በነጻ ይደውሉ
- Arabic -** للمساعدة في اللغة العربية، الرجاء الاتصال على الرقم المجاني 1-888-982-3862
- 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, rwakure kuri iyi numero 1-888-982-3862 ku busa
- Bengali-Bangala -** বাংলা 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 -** ဓမ္မကုန်တုံ့ပေးမှုအတွက် (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), ágang 1-888-982-3862 sin gástu.
- Cherokee -** ოცნებ 50ᄃᄂᄃᄂ ᄂᄃᄂᄃᄂᄃ ᄂᄃᄂᄃᄂᄃ ᄂᄃᄂᄃᄂᄃ (Cᄂᄃ) ᄂᄃᄂᄃᄂᄃ 1-888-982-3862 ᄂᄃᄂᄃ ᄂᄃᄂᄃᄂᄃ ᄂᄃᄂᄃᄂᄃ.
- Chinese -** 欲取得繁體中文語言協助，請撥打 1-888-982-3862，無需付費。
- Choctaw -** (Chahᄃ) anumpa ya apela a chi l paya hinla 1-888-982-3862.
- Cushite -** Gargaarsa afaan Oromiffa hiikuu argachuuf iakkokkofsa 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 કોલ 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 - လာဘ်မစာတော်တော်တော်တော်တော် တိုက် ကိ: 1-888-982-3862 လာဘ်မစာတော်တော်တော်တော်တော်
- Korean - 한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-888-982-3862 번으로 전화해 주십시오.
- Kru-Bassa - Be'm'ké gbo-kpá-kpá dyé pídyi dé Baśóó-wuđúúń wéé, dé 1-888-982-3862
- Kurdish - برای راهنمایی به زبان فارسی با شماره 1-888-982-3862 به خورانی پیموهندی بکن.
- Laotian - ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ, ກະລຸນາໂທຫາ 1-888-982-3862 ໂດຍບໍ່ເສຍຄ່າໃຫ້.
- Marathi - कोणत्याही शुल्कशुल्क भाषा सेवा प्राप्त करण्यासाठी, 1-888-982-3862 वर फोन करा.
- Marshallese - Ñan bōk jipañ ilo Kajin Majol, kallok 1-888-982-3862 ilo ejjelok wōnān.
- Micronesian - Ohng palien sawas en soun kawewe ni omw lokaia Ponape koahl 1-888-982-3862 ni sohte isais.
- Pohnpeyan - សម្រាប់ជំនួយភាសាជា ភាសាខ្មែរ សូមទូរស័ព្ទទទួលបានការជំនួយ 1-888-982-3862 ដោយឥតគិតថ្លៃ។
- Mon-Khmer, Cambodian -
- Navajo - T'áá shi shizaad K'ehji bee shíká a'doowol ninizingo Diné K'ehji koji' t'áá jílk'e hótne' 1-888-982-3862
- Nepali - (नेपाली) मा नःशुल्क भाषा सहायता पाउनका लागि 1-888-982-3862 मा फोन गर्नुहोस् ।
- Nilotic-Dinka - Tën kuwoony è thok è Thuwojäng ɗal 1-888-982-3862 kecīn ayōc.
- Norwegian - For språkassistanse på norsk, ring 1-888-982-3862 kostnadsfritt.
- Panjabi - ਪੰਜਾਬੀ ਵੈੱਬ ਡਾਝਾਈ ਸਹਾਇਤਾ ਲਈ, 1-888-982-3862 'ਤੇ ਮੁਫਤ ਕਾਲ ਕਰੋ।
- Pennsylvania Dutch - Fer Hefle in Deutsch, 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 asistență 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 tologi.
- Serbo-Croatian - Za jezičnu pomoć na hrvatskom jeziku pozovite besplatno 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 hebu balal e ko yowitii e haala Pular noddee e oo numero doo 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 - ܟܠܗܘܢܐ ܕܡܘܨܪܝܐ ܕܡܘܨܪܝܐ ܕܡܘܨܪܝܐ ܕܡܘܨܪܝܐ ܕܡܘܨܪܝܐ ܕܡܘܨܪܝܐ ܕܡܘܨܪܝܐ ܕܡܘܨܪܝܐ ܕܡܘܨܪܝܐ ܕܡܘܨܪܝܐ ܕܡܘܨܪܝܐ ܕܡܘܨܪܝܐ 1-888-982-3862 ܗܘܢܐ ܗܘܢܐ.
- Tagalog - Para sa tulong sa wika na nasa Tagalog, rawagan ang 1-888-982-3862 nang walang bayad.
- Telugu - భషితీ సాయం కోరకు ఎలాంటి ఖర్చు లేకుండా 1-888-982-3862 కు కాల్ చేయండి. (తీలుగు)
- 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 ánninnisn chiakú ren (Kapasen Chuuk) kopwe kékkéeri 1-888-982-3862 nge csapw kamé ngonuk.
- Turkish - (Dil) çağrısı dil yardım için. Hiçbir ücret ödemedi 1-888-982-3862.
- Ukrainian - Щоб отримати допомогу перекладача української мови, зателефонуйте за безкоштовним номером 1-888-982-3862.
- Urdu - بلائیت زبان سے منطقتہ خدمت حاصل کرنے کے لیے ، 1-888-982-3862 پر بات کریں
- 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 פון אפצאל.
- Yoruba - Fún iranlọwọ nípa èdè (Yorùbá) pẹ 1-888-982-3862 láì san owó kankan rárá.

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- **See what you owe.** Look up claims to see how much the plan paid and what you may have to pay.
- **Know your plan.** Check who is covered by your plan and what it covers.
- **Get valuable information.** See which doctors and hospitals have met extra standards for quality and efficiency.
- **Know costs before you go.** See cost estimates before you make an appointment for an office visit, test or procedure.
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She can help you sign up for Aetna Navigator. She can even help you find a doctor, estimate the cost of services, answer questions about claims, ID cards and more. Ann never sleeps, so chat with her anytime.

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*Health savings accounts are currently not available to health maintenance organization (HMO) members in Illinois and California.

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Policy forms issued in Oklahoma include: HMO OK COC-5 09/07, HMO/OK GA-3 11/01, HMO OK POSRIDER 08/07, GR-23 and/or GR-29/GR-29N.

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Dental Insurance – Aetna Dental DMO Plan

The Northeast District Council of the OPCMIA offers a Dental DMO Plan for members and their dependents that are eligible to enroll. The plan offers various benefits for different dental services and procedures. Prior to receiving services, you may download an ID card as indicated on page 31.

Members who enroll in the Aetna Dental DMO Plan must see doctors that are in the Aetna DMO Network. This plan is an **in-network** only plan. If you see doctors that are not in this network, Aetna will not be responsible for the amount that is owed. Most expenses are subject to a copay or fee amount and there is no annual maximum. Orthodontic Care is covered for dependents age 20 or under. The lifetime maximum copay amount of the Orthodontic benefit is \$1,545. If there is a service you do not see, contact your Benefit Administrator for clarification. Please refer to the following pages to see a detailed list of your Summary of Dental Benefits.





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	Recent 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

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



DMO[®] Dental Benefits Summary

D2710	Crown - Resin-Based Composite, Indirect	\$362	D6242	Pontic - Porcelain Fused to Noble Metal	\$362
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

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DMO[®] Dental Benefits Summary

D6073	Abutment Supported Retainer for Cast Metal FPD (Predominantly Base Metal)	\$362	D6794	Crown - Titanium	\$362
D6074	Abutment Supported Retainer for Cast Metal FPD (Noble Metal)	\$362	D6930	Reccement 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)

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



DMO® Dental Benefits Summary

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
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

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



DMO® Dental Benefits Summary

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 Abscess - Intraoral Soft Tissue	\$33
D7251	Coronectomy - intentional partial tooth removal	\$66	D7511 (1)	Incision and Drainage of Abscess - Intraoral Soft Tissue - Complicated	\$36
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

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



DMO® Dental Benefits Summary

(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. 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

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



DMO® Dental Benefits Summary

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: <ul style="list-style-type: none">• 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.
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: <ul style="list-style-type: none">• 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): <ul style="list-style-type: none">• 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: <ul style="list-style-type: none">• 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 to Texas 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: <ul style="list-style-type: none">• 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.

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

**DMO® Dental Benefits Summary**

*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

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.

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



DMO[®] Dental Benefits Summary

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

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.



Dental Insurance – Aetna Dental PPO Plan

The Northeast District Council of the OPCMIA offers a Dental PPO Plan for members and their dependents that are eligible to enroll. The plan offers various benefits for different dental services and procedures. Prior to receiving services, you may download an ID card as indicated on page 31.

Members who enroll in the Aetna Dental PPO Plan can see a doctor of their choice. Most services are subject to an annual deductible and have an annual maximum of \$2,000. The Orthodontic benefit is available to dependents age 20 and under with a lifetime maximum of \$2,000. This plan offers out of network coverage too, however when seeing an out of network provider you are subject to a higher annual deductible amount. The most liberal benefits are paid when you use a network provider. If there is a service that you do not see, contact your Benefit Administrator for clarification. Please refer to the following pages to see a detailed list of your Summary of Benefits for the Aetna PPO Dental Plan.

Note: Preventive care and Orthodontic care are not subject to the annual deductible.





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	
	Participating	Non-participating
Preventive		
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.

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

Dental Benefits Summary

(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 ያለከፍያ ለማግኘት፣ በመታወቂያዎ ላይ ያለውን ቁጥር ይደውሉ። (Amharic)

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

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

Quality health plans & benefits
Healthier living
Financial well-being
Intelligent solutions



Good news to smile about Aetna Dental® plans

You don't need a dental ID card to get dental care

We want to make doing business with us easier than ever.

How will my dentist know I'm an Aetna Dental member?

When you visit your dentist, simply tell the office your name, date of birth and member ID number (or your Social Security number).

But what if I want a card?

Easy — use our mobile app or go online. Log in to your secure member website at www.aetna.com. Your ID card will appear on your personal benefits page. You can print out an ID card for you and your dependents by clicking on "Get an ID card." If your electronic ID card says "No Election" or "Invalid Choice," then your plan requires you to choose a primary care dentist (PCD) who is in our network. Until you choose one, your benefits and claims may be affected.*

Here's what else you can do online:

- Find or select a dentist
- View claims and claim address
- Manage your health care spending

Aetna Mobile—find what you need, wherever, whenever

There are two ways to download the free Aetna Mobile app to access your ID card or dental benefits information when you're on the go.

- Text "Apps" to 44040 to download now.**
- Scan the code with your mobile device.

To learn more, visit us at www.aetna.com/mobile.

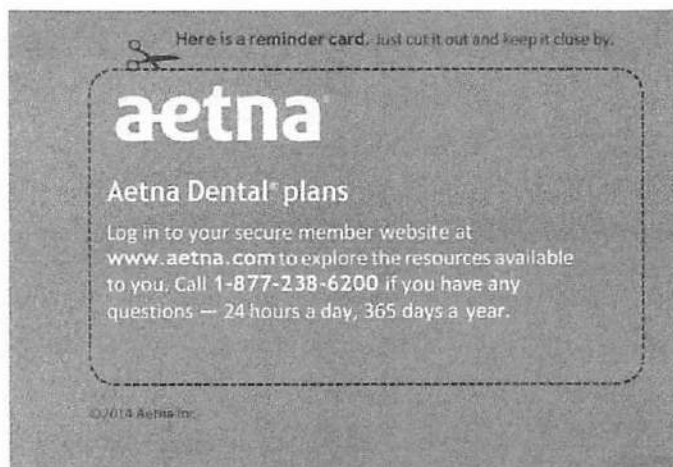


*CA/AZ DMO participants: If you have not selected a PCD, one may have been selected for you. View your electronic ID card to determine if one was selected on your behalf.

**Standard text messaging rates may apply.

DMO dental benefits and dental insurance plans are underwritten by Aetna Dental Inc., Aetna Health Inc. and/or Aetna Life Insurance Company. Dental preferred provider organization (PPO) and dental indemnity insurance plans are underwritten and/or administered by Aetna Life Insurance Company. Each insurer has sole financial responsibility for its own products.

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.



www.aetna.com



Empire

Blue Cross/Blue Shield

Vision Insurance – Empire Blue View Vision

The Northeast District Council of the OPCMIA also offers a Vision Plan through Empire Blue View Vision for members and their dependents that are eligible to enroll. The plan offers various benefits for different vision services. Most services are covered 100% or are covered up to an allowable amount.

Please see the following pages to see a detailed list of your Vision Summary of Benefits for the Empire Blue Cross/Blue Shield Vision Plan and instruction on how to find a Vision Provider Online.



Welcome to your Blue View Vision plan!

You have many choices when it comes to using your benefits. As a Blue View Vision plan member, you have access to one of the nation's largest vision networks. You may choose from many private practice doctors, local optical stores, and national retail stores including LensCrafters®, Target Optical®, and most Pearle Vision® locations. You may also use your in-network benefits to order eyewear online at Glasses.com and ContactsDirect.com. To locate a participating network eye care doctor or location, log in at empireblue.com, or from the home page menu under Care, select **Find a Doctor**. You may also call member services for assistance at 1-866-723-0515.

Out-of-Network – If you choose to, you may instead receive covered benefits outside of the Blue View Vision network. Just pay in full at the time of service, obtain an itemized receipt, and file a claim for reimbursement up to your maximum out-of-network allowance.

YOUR BLUE VIEW VISION PLAN BENEFITS	IN-NETWORK	OUT-OF-NETWORK	FREQUENCY
Routine Eye Exam			
A comprehensive eye examination	\$0 copay	Up to \$70 allowance	Once every 12 months
Eyeglass Frames			
One pair of eyeglass frames	\$175 allowance, then 20% off any remaining balance	Up to \$100 allowance	Once every 12 months
Eyeglass Lenses (instead of contact lenses)			
One pair of standard plastic prescription lenses:			
<ul style="list-style-type: none"> o Single vision lenses o Bifocal lenses o Trifocal lenses o Lenticular lenses 	<ul style="list-style-type: none"> \$0 copay \$0 copay \$0 copay \$0 copay 	<ul style="list-style-type: none"> Up to \$45 allowance Up to \$115 allowance Up to \$190 allowance Up to \$190 allowance 	Once every 12 months
Eyeglass Lens Enhancements			
When obtaining covered eyewear from a Blue View Vision provider, you may choose to add any of the following lens enhancements at no extra cost.			
<ul style="list-style-type: none"> o Transitions Lenses (for a child under age 19) o Standard polycarbonate (for a child under age 19) o Factory scratch coating 	<ul style="list-style-type: none"> \$0 copay \$0 copay \$0 copay 	No allowance when obtained out-of-network	Same as covered eyeglass lenses
Contact Lenses (instead of eyeglass lenses)			
Contact lens allowance will only be applied toward the first purchase of contacts made during a benefit period. Any unused amount remaining cannot be used for subsequent purchases in the same benefit period, nor can any unused amount be carried over to the following benefit period.			
<ul style="list-style-type: none"> o Elective conventional (non-disposable) <p>OR</p> <ul style="list-style-type: none"> o Elective disposable <p>OR</p> <ul style="list-style-type: none"> o Non-elective (medically necessary) 	<ul style="list-style-type: none"> \$175 allowance, then 15% off any remaining balance \$175 allowance (no additional discount) Covered in full 	<ul style="list-style-type: none"> Up to \$175 allowance Up to \$175 allowance Up to \$290 allowance 	Once every 12 months

This is a primary vision care benefit intended to cover only routine eye examinations and corrective eyewear. Blue View Vision is for routine eye care only. If you need medical treatment for your eyes, visit a participating eye care doctor from your medical network. Benefits are payable only for expenses incurred while the group and insured person's coverage is in force. This information is intended to be a brief outline of coverage. All terms and conditions of coverage, including benefits and exclusions, are contained in the member's policy, which shall control in the event of a conflict with this overview. This benefit overview is only one piece of your entire enrollment package.

EXCLUSIONS & LIMITATIONS (not a comprehensive list – please refer to the member Certificate of Coverage for a complete list)

Combined Offers. Not to be combined with any offer, coupon, or in-store advertisement.

Excess Amounts. Amounts in excess of covered vision expense.

Sunglasses. Plano sunglasses and accompanying frames.

Safety Glasses. Safety glasses and accompanying frames.

Not Specifically Listed. Services not specifically listed in this plan as

Lost or Broken Lenses or Frames. Any lost or broken lenses or frames are not eligible for replacement unless the insured person has reached his or her normal service interval as indicated in the plan design.

Non-Prescription Lenses. Any non-prescription lenses, eyeglasses or contacts. Plano lenses or lenses that have no refractive power.

Orthoptics. Orthoptics or vision training and any associated supplemental

covered services.

testing.

OPTIONAL SAVINGS AVAILABLE FROM BLUE VIEW VISION IN-NETWORK PROVIDERS ONLY		In-network Member Cost (after any applicable copay)
Retinal Imaging - at member's option can be performed at time of eye exam		Not more than \$39
Eyeglass lens upgrades When obtaining eyewear from a Blue View Vision provider, you may choose to upgrade your new eyeglass lenses at a discounted cost. Eyeglass lens copayment applies.	<ul style="list-style-type: none"> • Transitions lenses (Adults) \$0 • Standard Polycarbonate (Adults) \$0 • Tint (Solid and Gradient) \$0 • UV Coating \$0 • Progressive Lenses¹ <ul style="list-style-type: none"> • Standard \$0 • Premium Tier 1 \$30 • Premium Tier 2 \$40 • Premium Tier 3 \$55 • Premium Tier 4 \$120 • Anti-Reflective Coating² <ul style="list-style-type: none"> • Standard \$35 • Premium Tier 1 \$57 • Premium Tier 2 \$68 • Premium Tier 3 \$85 • Other Add-ons 20% off retail price 	
Additional Pairs of Eyeglasses Any time from any Blue View Vision network provider.	<ul style="list-style-type: none"> • Complete Pair 40% off retail price • Eyeglass materials purchased separately 20% off retail price 	
Eyewear Accessories	<ul style="list-style-type: none"> • Items such as non-prescription sunglasses, lens cleaning supplies, contact lens solutions, eyeglass cases, etc. 20% off retail price 	
Contact lens fit and follow-up A contact lens fitting and up to two follow-up visits are available to you once a comprehensive eye exam has been completed.	<ul style="list-style-type: none"> • Standard contact lens fitting³ Up to \$0 • Premium contact lens fitting⁴ 10% off retail price 	
Conventional Contact Lenses	<ul style="list-style-type: none"> • Discount applies to materials only 15% off retail price 	

¹ Please ask your provider for his/her recommendation as well as the available progressive brands by tier.

² Please ask your provider for his/her recommendation as well as the available coating brands by tier.

³ Standard fitting includes spherical clear lenses for conventional wear and planned replacement. Examples include but are not limited to disposable and frequent replacement.

⁴ Premium fitting includes all lens designs, materials and specialty fittings other than standard contact lenses. Examples include but are not limited to toric and multifocal.

Discounts are subject to change without notice. Discounts are not 'covered benefits' under your vision plan and will not be listed in your certificate of coverage. Discounts will be offered from in-network providers except where state law prevents discounting of products and services that are not covered benefits under the plan. Discounts on frames will not apply if the manufacturer has imposed a no discount policy on sales at retail and independent provider locations. Some of our in-network providers include:



ADDITIONAL SAVINGS AVAILABLE THROUGH EMPIRE'S SPECIAL OFFERS PROGRAM *

Savings on items like additional eyewear after your benefits have been used, non-prescription sunglasses, hearing aids and even LASIK laser vision correction surgery are available through a variety of vendors. Just log in at empireblue.com, select discounts, then Vision, Hearing & Dental.

* Discounts cannot be used in conjunction with your covered benefits.

OUT-OF-NETWORK

If you choose to receive covered services or purchase covered eyewear from an out-of-network provider, network discounts will not apply and you will be responsible for payment of services and/or eyewear materials at the time of service. Please complete an out-of-network claim form and submit it along with your itemized receipt to the fax number, email address, or mailing address below. To download a claim form, log in at empireblue.com, or from the home page menu under Support select Forms, click Change State to choose your state, and then scroll down to Claims and select the Blue View Vision Out-of-Network Claim Form. You may instead call member services at 1-866-723-0515 to request a claim form.

To Fax: 866-293-7373
 To Email: oonclaims@eyewearspecialoffers.com
 To Mail: Blue View Vision
 Attn: OON Claims
 P.O. Box 8504
 Mason, OH 45040-7111

Vision

How to Find a Vision Provider Online



An Anthem Company

STEP 1

Visit empireblue.com/findadoctor (or visit empireblue.com, click Menu and then click "Find a Doctor")

- **Search as a Guest:** click on "search by selecting a plan/network"

Search as a Member

Log in or use your Member ID card to make sure you find a doctor or hospital in your network, which will help keep your cost down.

Username Password

Search using your ID Number or Alpha Prefix

Identification Number or Alpha Prefix (first three values)

Note: If you are a member with Medicaid or other state-sponsored programs, search with the prefix after three values of your identification number or search by selecting government.

Search as a Guest by Selecting a Plan

Search by Selecting a Plan or Network.

STEP 2

When searching as guest, complete the following fields:

- What type of care are you searching for? Select "Vision"
- What state do you want to search in? Select a state
- What type of plan? Select "Vision"
- Select a plan/network – Blue View Vision

What type of care are you searching for?

What state do you want to search in?

What type of plan do you want to search with?

Select a plan/network

STEP 3

Select your search criteria and click "Search".

Empire Find a Doctor Search

Medicare Individual & Family Employers Producers Providers Medicaid

I want to search this plan/network: **Blue View Vision**

I'm looking for a Vision Professional (0)

Who specializes in:

Show specialty details

Located near:

Within a distance of:

Whose name is:

STEP 4

View your search results.

Empire Find:

Medicare Individual & Family Employers Producers Providers Medicaid

Modify Search Search Results

Vision Professional

1778 results in the Blue View Vision plan within 20 miles of 11375.
 Refine your search results using any combination of filters.

List View

MICHAŁ S ZYLINSKI O.D.

Male
 Ophthalmology
EMPIRE VISION CENTER
 11.64 miles away
 2133 86TH ST
 BROOKLYN, NY 11214
 County: Kings
 (718) 499-1525
[View More Addresses](#)

Services available:
 Exams And Materials, Discounts
 on non-covered services

JOSEPH ZUPNICK O.D.

Male
 Ophthalmology
VISITING EYECARE SERVICE
 10.41 miles away
 300 HEMPSTEAD AVE
 WEST HEMPSTEAD, NY 11552
 County: Nassau
 (516) 565-2616

Services available:
 Exams And Materials, Discounts
 on non-covered services

UNICARE

Life and Health Insurance Company

Disability Insurance – NY DBL and PFL Plans

The Northeast District Council of the OPCMIA offers a NY Disability Plan through UniCare Life and Health Insurance Company for their members. The DBL plan pays out a weekly benefit amount of 50% up to a maximum of \$450 for a total of 26 weeks.

The PFL Plan pays out a weekly benefit amount of 67% up to a maximum of \$971.61 for a total of 12 weeks.



New York State Short Term Disability

Important Information	You have 30 days from the date of disability to file a claim
Weekly Benefit	50%
Maximum Weekly Amount for 2021	\$450
Total Weeks Paid	26 Weeks

New York State Paid Family Leave (PFL) 2021

Weekly Benefit	67%
Maximum Weekly Amount for 2021	\$971.61
Total Weeks Paid	12 Weeks

New York Paid Family Leave

What you need to know for 2021

If you're a New York worker, the New York Paid Family Leave law (PFL) gives you paid time off to bond with a new child, care for a seriously ill family member or attend to family matters associated with a qualifying military exigency. Your job is protected while you're on approved Paid Family Leave. For 2021, the PFL benefit is 67% of your average weekly wage or the state average weekly wage, whichever is less, for up to 12 weeks.

Do you have questions about PFL coverage? We're here to help you understand your benefit.

Do I have to participate in the Paid Family Leave program?

Yes. Paid Family Leave is not optional for most employees. The exception is if you are in a job that will not allow you to attain the 26 continuous weeks or 175 days needed to qualify for Paid Family Leave (for example a seasonal worker).

Does Paid Family Leave cost me anything?

Yes. New York's Paid Family Leave is entirely paid for by employees. Employers may collect the cost of Paid Family Leave through payroll deductions. The maximum annual employee contribution in 2021 is \$385.34, which is 0.511% of an employee's wages up to the New York State Average Weekly Wage of \$1,450.17 for 2021.

I am pregnant. Will I be able to receive Paid Family Leave during my pregnancy?

No, Paid Family Leave only begins after birth. It is not available for pre-natal conditions. You may be eligible for DBL benefits if you are disabled.

Will I be able to use Paid Family Leave to take care of an eligible relative living outside New York?

Yes, as long as you are caring for an eligible family member and provide the medical certification for a serious health condition.

I am not a US citizen. Will I still be eligible for Paid Family Leave?

Yes. Your citizenship status has no impact on your Paid Family Leave eligibility.

I am an undocumented worker. Can I take Paid Family Leave?

Your immigration status has no impact on your Paid Family Leave eligibility.

Will I be able to use Paid Family Leave if I work part-time?

Yes. If you work less than 20 hours a week you will become eligible after 175 days of work. If you work 20 or more hours a week you will become eligible after 26 consecutive weeks of work.

I am collecting workers' compensation. Will I be able to use Paid Family Leave?

If you are not working and are collecting workers' compensation, you may not use Paid Family Leave.

I am a freelance worker. Am I eligible for Paid Family Leave?

If you do not have a regular employer and work as an independent contractor, you will not have Paid Family Leave benefits unless you purchase coverage for yourself.

I am a farm laborer. Am I eligible for Paid Family Leave?

If you work in service as a farm laborer, you are not eligible for disability or Paid Family Leave benefits.

Will I have to take all of my sick time and/or vacation before I use Paid Family Leave?

An employer may permit you to use vacation or sick leave for full salary but may not require you to use either.

Can I take Paid Family Leave and use my sick and/or vacation time together so that I receive my full salary?

Yes, if your employer allows you to use your sick and/or vacation time during Paid Family Leave, so that you receive your full salary for all or part of the leave, then you can do so.

Will my spouse and I be able to use Paid Family Leave at the same time?

If you and your spouse have different employers, you are both eligible to take Paid Family Leave at the same time.

However, if you and your spouse work for the same employer, your employer can deny Paid Family Leave to more than one employee at the same time to care for the same family leave recipient, or to bond with a child.

Anthem

Basic Life/AD&D Insurance – Anthem Group Life Plan High Plan

The Northeast District Council of the OPCMIA also offers a Group Life/AD&D plan for eligible members only, dependents are eligible to enroll. The plan offers a benefit if you were to pass away. The benefit is paid out to your designated beneficiary on file to help with the hardships during such a difficult time.

The following Group Life / AD&D plan is for those members who have worked 1,399 or more hours in the prior calendar year.

Note: Please update any beneficiary information to ensure that your benefit is paid to the correct person of your choice.





Disability and Life

Group Name: Northeast District Council of the OPCMIA Welfare Fund

Plan Design

Basic Group Term Life, Accidental Death and Dismemberment

Class 1: All Eligible Members who worked 1399 hours or more

Eligibility: All Eligible Employees Working 30 Hours Per Week

Benefit Schedule

Basic Life benefits	
Basic life benefit	\$50,000
Guaranteed issue limit	\$50,000
Living benefit (accelerated death benefit)	50% up to \$500,000
Waiver of premium	Premiums can be waived for employees who become totally disabled before age 60, after the 6 month elimination period. Coverage terminates at age 65 or retirement, whichever is earlier.
Conversion	Included
Portability	Not included
Age reductions	Benefit reduces by 50% at age 70. All coverage terminates at retirement.
Employee contribution	Non-contributory
Participation requirement	100% of eligible employees must be enrolled for coverage
Accidental Death and Dismemberment benefits	
AD&D benefit	Same as basic life
Guaranteed issue limit	All amounts are guaranteed issue
Age reductions	Same as basic life
Table of losses	Standard table included
Airbag benefit	10% of AD&D benefit, up to \$10,000 maximum
Seatbelt benefit	10% of AD&D benefit, up to \$15,000 maximum
Repatriation benefit	Up to \$5,000 for transportation and related expenses
Child education benefit	5% of AD&D benefit per year for each child's post-secondary education expenses; annual maximum of \$5,000 or actual expense. \$40,000 combined maximum for all children.
Coma benefit	1% of AD&D benefit for each full month of coma, up to 96%
Common carrier benefit	25% of AD&D benefit
General Provisions	
Resource Advisor	Included
Travel Assistance	Included
Special Offers	Included
Rate guarantee	Rates in this Proposal are guaranteed for 24 months

Anthem

Basic Life/AD&D Insurance – Anthem Group Life Plan Low Plan

The Northeast District Council of the OPCMIA also offers a Group Life/AD&D plan for eligible members only, dependents are eligible to enroll. The plan offers a benefit if you were to pass away. The benefit is paid out to your designated beneficiary on file to help with the hardships during such a difficult time.

The following Group Life / AD&D plan is for those members who have worked 1,000 to 1,399 or more hours in the prior calendar year.

Note: Please update any beneficiary information to ensure that your benefit is paid to the correct person of your choice.

AnthemLife

Disability and Life

Plan Design

Group Name: Northeast District Council of the OPCMIA Welfare Fund

Plan Design

Basic Group Term Life, Accidental Death and Dismemberment

Class 2: All Eligible Members who worked 1000 to 1399 hours

Eligibility: All Eligible Employees Working 30 Hours Per Week

Benefit Schedule

Basic Life benefits	
Basic life benefit	\$30,000
Guaranteed issue limit	\$30,000
Living benefit (accelerated death benefit)	50% up to \$500,000
Waiver of premium	Premiums can be waived for employees who become totally disabled before age 60, after the 6 month elimination period. Coverage terminates at age 65 or retirement, whichever is earlier.
Conversion	Included
Portability	Not included
Age reductions	Benefit reduces by 50% at age 70. All coverage terminates at retirement.
Employee contribution	Non-contributory
Participation requirement	100% of eligible employees must be enrolled for coverage
Accidental Death and Dismemberment benefits	
AD&D benefit	Same as basic life
Guaranteed issue limit	All amounts are guaranteed issue
Age reductions	Same as basic life
Table of losses	Standard table included
Airbag benefit	10% of AD&D benefit, up to \$10,000 maximum
Seatbelt benefit	10% of AD&D benefit, up to \$15,000 maximum
Repatriation benefit	Up to \$5,000 for transportation and related expenses
Child education benefit	5% of AD&D benefit per year for each child's post-secondary education expenses; annual maximum of \$5,000 or actual expense. \$40,000 combined maximum for all children.
Coma benefit	1% of AD&D benefit for each full month of coma, up to 96%
Common carrier benefit	25% of AD&D benefit
General Provisions	
Resource Advisor	Included
Travel Assistance	Included
Special Offers	Included
Rate guarantee	Rates in this Proposal are guaranteed for 24 months



Aetna Hospital Indemnity Plan (reimbursement plan)

The Northeast District Council of the OPCMIA also offers a Hospital Indemnity Plan provided by Aetna.

As a participant in the Aetna Major Medical Plan, the Fund provides you and your eligible dependents with a range of hospital and medical reimbursement benefits with respect to your out-of-pocket deductible costs for certain hospital and other ancillary medical benefits.

Enclosed is a summary of the Aetna Hospital Indemnity Plan Benefits.

Note: As a member of Aetna Medical if you have a covered hospital stay, you do not need to file a claim. Aetna will use the information from your medical claim to automatically process the hospital claim.



Additionally, for those deductible costs that are NOT covered under the Aetna Hospital Indemnity Plan, the Fund will provide the following deductible reimbursements at the rates specified below:

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

In order for the Fund to provide you with the reimbursement, 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 e-mail:

tdimattinapgg@optonline.net

emilylpgg@optonline.net

By fax:

1-980-444-0711

1-631-656-5514

As always, the Fund Office is available to assist you with any other questions that you may have. If you have questions, please contact the Fund Office at 516-775-2280.





Less stress

Aetna Hospital Indemnity Plan

Be prepared for what lies ahead

Maybe you're expecting to have a hospital stay — or maybe not. Either way, you can plan ahead to give yourself an extra financial cushion.

What is the Hospital Indemnity Plan?

The plan pays benefits when you have a planned, or unplanned hospital stay for an illness, injury, surgery or having a baby. The plan pays a lump-sum benefit for admission and a daily benefit for a covered hospital stay. You can use the benefits to help pay out-of-pocket medical costs or personal expenses.

How is this different from a major medical plan?

Medical plans help pay providers for services and treatment. But, they don't cover unexpected costs that might come with a stay in the hospital.

The Aetna Hospital Indemnity Plan pays benefits directly to **you**, giving you extra cash when you need it most. It can help fill in the gaps, making it a great companion to your major medical plan.

How can you use the cash benefits?

It's completely up to you. You can use the money any way you want, like:

- deductibles or copays
- mortgage or rent
- groceries or utility bills

...or for anything else you choose.

Rest assured

Enrollment is easy. And, you get benefits paid directly to you by check or direct deposit.

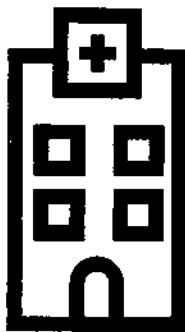
Aetna.com

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Because it happens

More than 35 million Americans were hospitalized in 2016¹. The average hospital stay in the U.S. costs \$10,700².



Ready...or not

Carter* is a hard worker, so he doesn't always slow down to listen to his body. Before he knew it, a little cough turned into pneumonia — and a hospital stay.

Good thing he had the Aetna Hospital Indemnity Plan. He filed his claim and the benefits were deposited right into his bank account.

That money helped make up for the time he missed while recovering, and paid some of his deductible. Now, he can focus more on his health.

One less worry

If you're an Aetna Medical member and have a covered hospital stay, you don't need to file a claim**. We'll use the information from your medical claim to automatically process the hospital claim.

If you don't have Aetna Medical, filing a claim is easy with our **Simplified Claims Experience™**. Just register on the **My Aetna Supplemental** app or at **Myaetnasupplemental.com**. Click "Report New Claim", answer a few quick questions, and upload or take a picture of your medical bill. You can also print and mail a paper claim form to Aetna Voluntary Plans.

Visit the app or portal to view plan documents, submit and track claims, and sign up for direct deposit.



¹American Hospital Association. Fast facts on U.S. hospitals, 2018. February 2018. Available at: aha.org/research/rc/stat-studies/fastfacts.shtml. Accessed April 25, 2018.

²Michaels M. The 35 most expensive reasons you might have to visit a hospital in the US — and how much it costs if you do. Business Insider. March 1, 2018. Available at: businessinsider.com/most-expensive-health-conditions-hospitalcosts-2018-2. Accessed April 25, 2018.

*This is a fictional example of how the plan could work.

** In some circumstances, you may have to submit a separate supplemental health claim, if the benefit does not generate a medical claim.

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.

The Aetna Hospital Indemnity Plan is underwritten by Aetna Life Insurance Company (Aetna). The Aetna Hospital Indemnity Plan is a hospital confinement indemnity plan. This plan provides limited benefits. It pays fixed dollar benefits for covered services without regard to the health care provider's actual charges. The benefits payments are not intended to cover the full cost of medical care. 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 material is for information only. Insurance plans contain exclusions and limitations. Not all health services are covered, and coverage is subject to applicable laws and regulations, including economic and trade sanctions. See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Plan features, rates, eligibility and availability may vary by location and are subject to change. For more information about Aetna plans, refer to **Aetna.com**.

Policy forms issued in Missouri and Oklahoma include: GR-96172 01, AL VOL HPOL-Hosp 01 and AL VOL HCOC-Hosp 01.



BENEFIT SUMMARY

Northeast District Council of the OPCMIA Welfare Fund
802405

Aetna Hospital Indemnity

Insurance plans are underwritten by Aetna Life Insurance Company.

Unless otherwise indicated, all benefits and limitations are per covered person.

The Aetna Hospital Indemnity Plan is a hospital confinement indemnity plan with other fixed indemnity benefits. THESE PLANS DO NOT COUNT AS MINIMUM ESSENTIAL COVERAGE UNDER THE AFFORDABLE CARE ACT. THESE PLANS ARE A SUPPLEMENT TO HEALTH INSURANCE AND ARE 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. These plans provide limited benefits. They pay fixed dollar benefits for covered services without regard to the health care provider's actual charges. These benefit payments are not intended to cover the full cost of medical care. 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 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.

Covered Benefit for Inpatient Stays

Plan 2

Hospital stay - Admission

\$1,500

Provides a lump sum benefit for the initial day of your stay in a hospital.

Maximum 1 stay per plan year

Hospital stay - Daily

\$100

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

Hospital stay - (ICU) Daily

\$150

Pays a daily benefit, beginning on day two of your stay in an ICU room of a hospital.

Maximum 30 days per plan year

Nursery admission (non-NICU)

\$100

Provides a lump-sum benefit after the birth of your newborn. This will not pay for an outpatient birth.

Substance abuse stay - Daily

\$100

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

Mental disorder stay - Daily

\$100

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

Rehabilitation unit stay - Daily

\$50

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

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

\$50

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

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.

Do I need to file a claim?

No, if you are an Aetna medical plan member, we can retrieve your medical information to process your Hospital Indemnity claim. Your medical claim kick-starts the process. Our system grabs your medical information to start the claim, your Hospital Indemnity claim is processed and payments are sent directly to you.

How do I file a claim?

Go to myaetnasupplemental.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

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.



Non-Discrimination Notice

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 1-888-772-9682.

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
1-800-648-7817, TTY: 711, Fax: 859-425-3379, 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).

Availability of Language Assistance Services

TTY: 711

For language assistance in your language call 1-888-772-9682 at no cost. (English)

Para obtener asistencia lingüística en su idioma, llame sin cargo al 1-888-772-9682. (Spanish)

欲取得以您的語言提供的語言協助，請撥打1-888-772-9682，無需付費。(Chinese)

Pour une assistance linguistique dans votre langue, appeler le 1-888-772-9682 sans frais. (French)

Para sa tulong sa inyong wika, tumawag sa 1-888-772-9682 nang walang bayad. (Tagalog)

Hilfe oder Informationen in deutscher Sprache erhalten Sie kostenlos unter der Nummer 1-888-772-9682. (German)

للمساعدة اللغوية بلغتك الرجاء الاتصال على الرقم المجاني 1-888-772-9682. (Arabic)

Pou jwenn asistans nan lang pa w, rele nimewo 1-888-772-9682 gratis. (French Creole)

Per ricevere assistenza nella sua lingua, può chiamare gratuitamente il numero 1-888-772-9682. (Italian)

日本語で援助をご希望の方は 1-888-772-9682 (フリーダイヤル) までお電話ください。(Japanese)

본인의 언어로 통역 서비스를 받고 싶으시면 비용 부담 없이 1-888-772-9682번으로 전화해 주십시오. (Korean)

برای راهنمایی به زبان شما با شماره 1-888-772-9682 بدون هیچ هزینه ای تماس بگیرید. (Persian)

Aby uzyskać pomoc w swoim języku, zadzwoń bezpłatnie pod numer 1-888-772-9682. (Polish)

Para obter assistência no seu idioma, ligue gratuitamente para o 1-888-772-9682. (Portuguese)

Чтобы получить помощь с переводом на ваш язык, позвоните по бесплатному номеру 1-888-772-9682. (Russian)

Để được hỗ trợ ngôn ngữ bằng ngôn ngữ của bạn, hãy gọi miễn phí đến số 1-888-772-9682. (Vietnamese)



Menos estrés

Plan de indemnización hospitalaria de Aetna

Esté preparado para lo que vendrá

Quizá usted anticipa que pasará una internación... o quizá no. De cualquier manera, puede prepararse para contar con una protección financiera adicional.

¿Qué es el plan de indemnización hospitalaria?

Con este plan, se pagan beneficios cuando hay una internación planeada o imprevista debido a una enfermedad, lesión, cirugía o parto. Se paga un beneficio en una suma única por el ingreso y un beneficio diario por la internación cubierta en el hospital. Puede usar los beneficios para pagar los costos de desembolso por servicios médicos o sus gastos personales.

¿En qué se diferencia de un plan médico principal?

Con los planes médicos, se ayuda a pagarles a los proveedores los servicios y tratamientos. Sin embargo, no se cubren los costos inesperados que podría haber en caso de una internación en el hospital.

Con el plan de indemnización hospitalaria de Aetna, se le pagan beneficios directamente a **usted**, brindándole dinero adicional cuando más lo necesita. Puede ayudar a cubrir las carencias, lo que lo convierte en un gran complemento de su plan médico principal.

¿Cómo puede usar los beneficios de dinero en efectivo?

Es su decisión. Usted puede usar el dinero de la forma que quiera, por ejemplo, para lo siguiente:

- deducibles o copagos;
- hipoteca o alquiler;
- alimentos o facturas de servicios.

O puede usarlo para cualquier otra cosa que usted elija.

Quétese tranquilo

La inscripción es sencilla. Recibirá el pago de beneficios de forma directa mediante cheque o depósito directo.

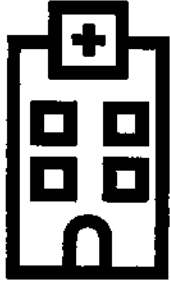
Aetna.com

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aetna™

Es algo que sucede...

En 2016, **más de 35 millones** de estadounidenses fueron hospitalizados¹. La internación promedio en los Estados Unidos cuesta **\$10,700**².



Preparado... o no

Carter* trabaja mucho, por lo que no siempre baja el ritmo para prestar atención a las señales del cuerpo. Sin darse cuenta, un poco de tos se convirtió en neumonía, y terminó internado.

Afortunadamente, contaba con el plan de indemnización hospitalaria de Aetna. Presentó su reclamo, y le depositaron el dinero por los beneficios directamente en su cuenta bancaria.

Ese dinero lo ayudó a compensar el tiempo que no trabajó durante su recuperación y a pagar parte de su deducible. Ahora puede enfocarse más en su salud.

Algo menos de qué preocuparse

Si es miembro de un plan médico de Aetna, para su internación cubierta en el hospital no hace falta presentar reclamos**. Con la información del reclamo del plan médico, procesaremos automáticamente el reclamo del plan de indemnización hospitalaria.

Si no tiene un plan médico de Aetna, le resultará fácil presentar el reclamo a través de nuestro **Simplified Claims Experience™**, el proceso de reclamos simplificado. Regístrese en la aplicación **My Aetna Supplemental**, en **Myaetnasupplemental.com**. Haga clic en "Report New Claim" (Registrar nuevo reclamo), responda algunas preguntas breves y suba el archivo o una fotografía de su factura médica. También puede imprimir y enviar por correo una forma de reclamo en papel a Aetna Voluntary Plans.

En la aplicación y en el portal podrá ver los documentos del plan, enviar reclamos y hacerles un seguimiento, y registrarse para el servicio de depósito directo.



¹ Asociación Americana de Hospitales. "Fast facts on U.S. hospitals, 2018". Febrero de 2018. Disponible en aha.org/research/rc/stat-studies/fastfacts.shtml. Consultado el 25 de abril de 2018.

² Michaels, M. "The 35 most expensive reasons you might have to visit a hospital in the US — and how much it costs if you do". Business Insider. 1.º de marzo de 2018. Disponible en businessinsider.com/most-expensive-health-conditions-hospitalcosts-2018-2. Consultado el 25 de abril de 2018.

* Este es un ejemplo ficticio de cómo podría funcionar el plan.

** En algunos casos, es posible que tenga que presentar un reclamo aparte por el seguro de salud suplementario, si es que no se genera un reclamo del plan médico por el beneficio.

ESTE PLAN NO CUENTA COMO COBERTURA ESENCIAL MÍNIMA SEGÚN LA LEY DE CUIDADO DE SALUD ASEQUIBLE. ES UN SUPLEMENTO DEL SEGURO DE SALUD Y NO REEMPLAZA LA COBERTURA MÉDICA PRINCIPAL. SI NO CUENTA CON UNA COBERTURA MÉDICA PRINCIPAL (U OTRA COBERTURA ESENCIAL MÍNIMA), ES POSIBLE QUE DEBA PAGAR UN MONTO ADICIONAL A SUS IMPUESTOS.

El plan de indemnización hospitalaria de Aetna está asegurado por Aetna Life Insurance Company (Aetna).

El plan de indemnización hospitalaria de Aetna es un plan de indemnización por internación en el hospital. Se ofrecen beneficios limitados a través de este plan. Se pagan beneficios fijos en efectivo por los servicios cubiertos sin tener en cuenta los cargos reales del proveedor del cuidado de la salud. Mediante el pago de estos beneficios no se pretende cubrir el costo total del cuidado médico. Usted es responsable de asegurarse de que se paguen las facturas del proveedor. Estos beneficios se pagan de forma adicional a cualquier otra cobertura de salud que usted tenga. Este material solo tiene fines informativos. Los planes de seguro tienen exclusiones y limitaciones. No todos los servicios de salud están cubiertos. La cobertura está sujeta a las leyes y reglamentaciones vigentes, incluidas las sanciones económicas y comerciales. Consulte los documentos del plan para obtener una descripción completa de los beneficios, las exclusiones, las limitaciones y las condiciones de cobertura. Las características, las tarifas, los requisitos que se deben cumplir y la disponibilidad del plan pueden variar según el lugar y están sujetos a cambios. Para obtener más información sobre los planes de Aetna, visite **Aetna.com**.

Las formas de póliza emitidas en Misuri y Oklahoma incluyen las siguientes: GR-96172 01, AL VOL HPOL-Hosp 01 y AL VOL HCOC-Hosp 01.

Resumen de Beneficios

Northeast District Council of the OPCMIA Welfare Fund
802405

Indemnización hospitalaria de Aetna

Los planes de seguro están suscritos por Aetna Life Insurance Company.

A menos que se indique lo contrario, todos los beneficios y limitaciones son por cada persona cubierta.

El Plan de Indemnización hospitalaria de Aetna es un plan de indemnización por confinamiento en el hospital con otros beneficios de indemnización fijos. ESTOS PLANES NO CUENTA COMO COBERTURA ESENCIAL MÍNIMA BAJO LA LEY DE CUIDADO DE SALUD A BAJO PRECIO. ESTOS PLANES SON UN SUPLEMENTO DEL SEGURO MÉDICO Y NO SUSTITUYEN LA COBERTURA MÉDICA PRINCIPAL. FALTA DE COBERTURA MÉDICA PRINCIPAL (U OTRA COBERTURA ESENCIAL MÍNIMA) PUEDE RESULTAR EN UN PAGO ADICIONAL CON SUS IMPUESTOS. Estos planes proporcionan beneficios limitados; estos beneficios pagan los servicios cubiertos con sumas fijas en dólares independientemente de los cargos reales emitidos por el proveedor médico. Estos pagos por beneficios no pretenden cubrir la totalidad del costo de la atención médica. Usted es responsable de asegurarse de que las facturas del proveedor se salden. Estos beneficios se pagan en adición a cualquier otra cobertura médica que usted tenga.

ESTO NO ES UN PLAN SUPLEMENTARIO DE MEDICARE (MEDIGAP). Si es o será elegible para recibir Medicare, revise la Guía de Seguro de Salud para Personas con Medicare gratuita disponible en www.medicare.gov. **Este es un resumen de sus beneficios. Consulte los documentos del plan para obtener una descripción completa de los beneficios, las exclusiones, las limitaciones y las condiciones de cobertura.**

Esta póliza, en sí, no cumple con las normas de Cobertura mínima comprobable de Massachusetts.

El seguro evidenciado por este certificado brinda beneficios limitados de seguro médico solamente. NO proporciona seguro hospitalario básico, seguro médico básico, seguro médico principal, suplemento de Medicare, seguro médico a largo plazo, seguro de hogar de ancianos solamente, seguro de cuidado en el hogar o seguro en un hogar de ancianos y cuidado en el hogar como lo define el Departamento de Servicios Financieros del estado de New York.

Beneficios de paciente hospitalizado**Plan 2****Admisión hospitalaria: admisión**

Paga el beneficio de una suma global por el día inicial de su admisión en un centro médico designado por el empleador.

\$1,500

Máximo de 1 admisión hospitalaria por año del plan

Estadía hospitalaria: diario

Paga un beneficio diario a partir del día dos de su estadía en una habitación que no sea de la UCI de un hospital.

\$100

Máximo de 30 días por año del plan

Estadía hospitalaria: diario (UCI)

Paga un beneficio diario a partir del día dos de su estadía en una habitación de la UCI de un hospital. *Máximo de 30 días por año del plan*

\$150

Cuidado rutinario del recién nacido

Paga un beneficio de suma global después del nacimiento de su recién nacido. Esto no pagaría por un nacimiento ambulatorio.

\$100

Estadía por abuso de sustancias: diario

Paga un beneficio diario por cada día de una estadía en un centro médico para el tratamiento de abuso de sustancias tóxicas.

\$100

Máximo de 30 días por año del plan

Estadía por trastorno mental: diario

Paga un beneficio diario por cada día de una estadía en un centro médico para el tratamiento de trastornos mentales.

\$100

Máximo de 30 días por año del plan

Estadía en una unidad de rehabilitación: diario

Paga un beneficio cada día de su estadía en una unidad de rehabilitación inmediatamente después de su estadía hospitalaria debido a una enfermedad o lesión accidental.

\$50

Máximo de 30 días por año del plan

Nota importante:

Todas las estadías para pacientes hospitalizados cuentan para el máximo del año del plan.

Beneficios de la establecimiento de enfermería especializada**Plan 2****Admisión en un establecimiento de enfermería especializada: por día**

Paga un beneficio diario por cada día que pasa en un establecimiento de enfermería especializada debido a una enfermedad o lesión accidental.

\$50

Máximo de 30 días por año del plan

Nota importante:

Todas las estadías para pacientes hospitalizados comienzan cuentan para el máximo del año del plan.

Renuncia de la prima

Si su estadía en un hospital dura más de 30 días consecutivos, vamos a renunciar a la prima a partir de la primera fecha de vencimiento de la prima que se produce después del día 30 de su estadía, durante los próximos 6 meses de cobertura. Durante esta estadía, usted debe permanecer empleado con el asegurado.

Exclusiones y limitaciones

Este plan tiene exclusiones y limitaciones. Consulte la póliza actual y el folleto certificado para determinar qué servicios de atención médica están cubiertos y en qué medida. La siguiente, es una lista parcial de servicios y suministros que generalmente no están cubiertos. **No obstante, el plan puede contener excepciones a esta lista basadas en mandatos estatales o en el diseño del plan adquirido. No se pagarán beneficios por ningún servicio por una enfermedad o lesión accidental relacionada con lo siguiente:**

1. Participar en actividades extra peligrosas que significan las actividades de aviación y afines
2. Participando como profesional en atletismo o deportes
3. Acto de guerra, motín, guerra
4. Operar, aprender a operar o servir como piloto o tripulante de cualquier aeronave, ya sea motorizada o no
5. Asalto, delito, ocupación ilegal u otro acto criminal
6. La atención prestada por un cónyuge, padre, hijo o hermano
7. Servicios estéticos y cirugía plástica con ciertas excepciones
8. Cuidado de custodia
9. Servicios de cuidados paliativos, a excepción como se especifica en los beneficios bajo la sección del certificado del plan
10. Autolesionarse, suicidio, excepto cuando resulte de un trastorno diagnosticado
11. Violación de las leyes de uso del estado de cualquier dispositivo celular en el que ocurrió el accidente, mientras se conduce un vehículo de motor
12. Atención o servicios recibidos fuera de los Estados Unidos, sus posesiones o los países de Canadá o México
13. Lesiones accidentales sufridas mientras está bajo la influencia de cualquier narcótico a menos que se administren siguiendo el consejo de un médico y se tomen en la dosis prescrita
14. Atención y tratamiento dental y ortodóntico
15. Cualquier cuidado, medicamentos bajo receta y medicinas relacionadas con la infertilidad
16. Rehabilitación cognitiva ambulatoria, fisioterapia, terapia ocupacional o terapia del habla por cualquier motivo
17. Cuidado relacionado con la visión

Preguntas frecuentes sobre los planes de indemnización hospitalaria

¿Tengo que estar activamente en el trabajo para inscribirme en la cobertura?

Sí, debe estar activamente en el trabajo a fin de inscribirse y para que la cobertura esté en vigor. Usted está activamente en el trabajo si está trabajando, o está disponible para trabajar, y cumple con los criterios establecidos por su empleador para ser elegible para inscribirse.

¿Puedo inscribirme en el plan de Indemnización hospitalaria de Aetna aunque tenga una Cuenta de ahorros médica (en inglés. HSA)?

Sí, aún puede inscribirse en el plan de Indemnización hospitalaria de Aetna si tiene una Cuenta de ahorros médicos.

¿Qué se considera una estadía de hospital?

Una estadía es un período durante el cual usted es admitido como paciente hospitalizado y está confinado en un hospital, un centro médico residencial no hospitalario, establecimiento de enfermería especializada o centro médico de rehabilitación y se cobra por habitación, comida y servicios generales de enfermería. Una estadía no incluye el tiempo en el hospital debido a necesidades de custodia o personales que no requieren habilidades médicas o capacitación. Una estadía excluye específicamente el tiempo en el hospital para observación o en la sala de emergencias a menos que esto conduzca a una estadía en el hospital.

¿Necesito presentar un reclamo?

No; si usted es miembro del plan médico de Aetna, podemos recuperar su información médica para procesar su reclamo de hospital. Su reclamo médico inicia el proceso. Nuestro sistema toma su información médica para iniciar el reclamo, su reclamo de hospital se procesa y los pagos se envían directamente a usted.

¿Cómo presento un reclamo?

Inicie sesión en myaetnasupplemental.com para encontrar su formulario de reclamo de beneficios. Utilice el enlace "Online claims process" (Proceso de reclamos en Internet) para completar el formulario y presentar su reclamo. También tiene la opción de imprimir o enviar el formulario a: Aetna Voluntary Plans, PO Box 14079, Lexington, KY 40512-4079, o puede solicitarnos enviar el formulario impreso.

¿Qué debo hacer en caso de una emergencia?

En caso de emergencia, llame al 911 o a su línea directa de emergencia local, o vaya directamente a un centro médico de atención de emergencia.

¿Qué ocurre si no entiendo algo que he leído aquí, o tengo más preguntas?

Llámenos. Queremos que entienda estos beneficios antes de decidir a inscribirse. Puede comunicarse con uno de nuestros representantes de Servicios al cliente de lunes a viernes, de 8 a.m. a 6 p.m., llamando al número sin cargo **1-800-607-3366**. Estamos aquí para responder preguntas antes y después de inscribirse.

Información importante acerca de sus beneficios

PARA QUE LOS BENEFICIOS DE INDEMNIZACIÓN HOSPITALARIA SEAN PAGADEROS, EL DÍA INICIAL DE SU ESTADÍA Y OTROS SERVICIOS DEBEN SER POSTERIORES A LA FECHA DE VIGENCIA DE LA COBERTURA.

Quejas y apelaciones

Díganos si usted no está satisfecho con la respuesta que recibió de nosotros o con la forma en que hacemos negocios. Llame a Servicios al Miembro para presentar una queja verbal o para pedir la dirección de correo postal para enviar una queja por escrito. También puede enviar un correo electrónico a Servicios al Miembro a través del sitio de Internet seguro del miembro. Si usted no está satisfecho después de hablar con un representante de Servicios al Miembro, puede pedirnos que enviemos su problema al departamento correspondiente.

Si usted no está de acuerdo con una denegación de reclamo, puede presentar una apelación. Para presentar una apelación, siga las instrucciones de la carta o la declaración de explicación de beneficios que explica que su reclamo fue denegado. La carta también le dice lo que necesitamos de usted y qué tan pronto le responderemos.

Protegemos su privacidad

Consideramos que la información personal es privada. Nuestras políticas protegen su información personal frente al uso ilegal. Por "información personal", nos referimos a la información que le puede identificar como una persona, así como su información financiera y de la salud. La información personal no incluye lo que está disponible para el público. Por ejemplo, toda persona puede acceder a la información acerca de lo que cubre el plan. También no incluye informes que no le identifican a usted.

Cuando sea necesario para su atención o tratamiento, la administración de nuestros planes de salud u otras actividades relacionadas, usamos la información personal dentro de nuestra empresa, la compartimos con nuestras afiliadas y podemos divulgarla a: sus médicos, dentistas, farmacias, hospitales y otros cuidadores, otras aseguradoras, proveedores de suministros, departamentos gubernamentales y administradores de terceros (TPA, por sus siglas en inglés).

Obtenemos información de muchas fuentes diferentes, en particular de usted, su empleador o patrocinador del plan de beneficios, si corresponde, otras aseguradoras, organizaciones de mantenimiento de la salud o TPA, y los proveedores de atención médica.

Dichas partes están obligados a mantener su información privada como lo requiere la ley. Algunas de las formas en las cuales podemos utilizar su información son: pagar los reclamos, tomar decisiones acerca de lo que el plan cubre, coordinación de los pagos con otras aseguradoras, evaluación de calidad, actividades para mejorar nuestros planes y auditorías.

Consideramos estas actividades clave para la administración de nuestros planes. Cuando lo permite la ley, utilizamos y divulgamos su información personal de las maneras descritas anteriormente sin su permiso.

Nuestro aviso de privacidad incluye una explicación completa de las maneras en que usamos y divulgamos su información. También explica cuando necesitamos su permiso para usar o divulgar su información.

Estamos obligados a darle acceso a su información. Si piensa que hay algo mal o falta de su información personal, usted puede pedir que se cambie. Debemos completar su solicitud dentro de un plazo razonable. Si no estamos de acuerdo con el cambio, puede presentar una apelación. Si desea una copia de nuestro aviso de privacidad, llame al **1-800-607-3366** o visítenos en **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.

ATENCIÓN RESIDENTES DE MASSACHUSETTS: A partir del 1 de enero de 2009, la Ley de Reforma de la Atención Médica de Massachusetts requiere que los residentes de Massachusetts de dieciocho (18) años o mayor, deben tener cobertura de salud que reúna las normas de Cobertura Comprobable Mínima establecidas por el Conector de Seguro de Salud del Estado, a menos que sea exonerado del requisito de seguro de salud de acuerdo con asequibilidad económica o indigencia. Para obtener más información, llame al Conector al **1-877-MA-ENROLL (1-877-623-6765)** o visite el sitio de Internet del Conector en **(www.mahealthconnector.org)**. **ESTA PÓLIZA, EN SÍ, NO CUMPLE CON LOS ESTÁNDARES DE COBERTURA COMPROBABLE MÍNIMA.** Si tiene alguna pregunta sobre este aviso, puede comunicarse con la División de Seguros llamando al **1-617-521-7794** o visite el sitio de Internet en **www.mass.gov/doi**.

Cláusula de las exclusiones de sanciones financieras

Si la cobertura proporcionada por esta póliza viola o violará las posibles sanciones económicas o comerciales de los EE.UU., la cobertura es considerada inválida inmediatamente. Por ejemplo, las compañías de Aetna no pueden realizar pagos o reembolsar para atención médica u otros reclamos o servicios si infringe un reglamento de sanciones financieras. Esto incluye las sanciones relacionadas con una persona o entidad bloqueada, o en un país en virtud de sanción por parte de los Estados Unidos, salvo que esté permitido bajo una licencia válida y por escrito de la Oficina de Control de Activos Extranjeros (Office of Foreign Assets Control u OFAC). Para obtener más información acerca de la OFAC, visite el sitio de Internet en **http://www.treasury.gov/resource-center/sanctions/Pages/default.aspx**.

Los planes están suscritos por Aetna Life Insurance Company (Aetna).

Este material es solo para fines informativos y no constituye una oferta ni invitación de contrato. Si bien se cree que la información dada en el presente documento es precisa a la fecha de producción, está sujeta a cambios. Para más información sobre los planes de Aetna, consulte **www.aetna.com**.

Los formularios de Póliza de Indemnización hospitalaria emitidos en Idaho, Oklahoma y Missouri incluyen: AL VOL HPOL-Hosp 01 and AL VOL HCOC-Hosp 01.



Aviso de no discriminación

Aetna cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo.

Aetna ofrece recursos o servicios gratuitos a las personas con discapacidades y para las personas que necesitan ayuda en el idioma. Si usted necesita un intérprete calificado, información por escrito en otros formatos, traducción u otros servicios, llame al 1-888-772-9682.

Si considera que Aetna ha fracasado en proporcionar estos servicios o, de otra manera, discriminado en base a una clase protegida como se ha indicado anteriormente, también puede presentar una queja formal ante el Coordinador de Derechos Civiles poniéndose en contacto con:

Civil Rights Coordinator, P.O. Box 14462, Lexington, KY 40512

1-800-648-7817, TTY: 711, Fax: 859-425-3379, CRCoordinator@aetna.com.

También puede presentar una queja de derechos civiles con el U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, disponible en <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, o bien, al: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, o llamar al 1-800-368-1019, 800-537-7697 (TDD).

Disponibilidad de servicios de asistencia lingüística

TTY: 711

For language assistance in your language call 1-888-772-9682 at no cost. (English)

Para obtener asistencia lingüística en su idioma, llame sin cargo al 1-888-772-9682. (Spanish)

欲取得以您的語言提供的語言協助，請撥打1-888-772-9682，無需付費。(Chinese)

Pour une assistance linguistique dans votre langue, appeler le 1-888-772-9682 sans frais. (French)

Para sa tulong sa inyong wika, tumawag sa 1-888-772-9682 nang walang bayad. (Tagalog)

Hilfe oder Informationen in deutscher Sprache erhalten Sie kostenlos unter der Nummer 1-888-772-9682. (German)

للمساعدة اللغوية بلغتك الرجاء الاتصال على الرقم المجاني 1-888-772-9682. (Arabic)

Pou jwenn asistans nan lang pa w, rele nimewo 1-888-772-9682 gratis. (French Creole)

Per ricevere assistenza nella sua lingua, può chiamare gratuitamente il numero 1-888-772-9682. (Italian)

日本語で援助をご希望の方は 1-888-772-9682 (フリーダイヤル) までお電話ください。 (Japanese)

본인의 언어로 통역 서비스를 받고 싶으시면 비용 부담 없이 1-888-772-9682번으로 전화해 주십시오. (Korean)

برای راهنمایی به زبان شما با شماره 1-888-772-9682 بدون هیچ هزینه ای تماس بگیرید. (Persian)

Aby uzyskać pomoc w swoim języku, zadzwoń bezpłatnie pod numer 1-888-772-9682. (Polish)

Para obter assistência no seu idioma, ligue gratuitamente para o 1-888-772-9682. (Portuguese)

Чтобы получить помощь с переводом на ваш язык, позвоните по бесплатному номеру 1-888-772-9682. (Russian)

Để được hỗ trợ ngôn ngữ bằng ngôn ngữ của bạn, hãy gọi miễn phí đến số 1-888-772-9682. (Vietnamese)

CONTACT INFORMATION

CARRIER CONTACT	PHONE	WEB ADDRESS
Aetna Medical & Dental	1-855-281-8858	www.aetna.com
Blue View Vision (Empire)	1-866-723-0515	www.empireblue.com
Aetna Hospital Indemnity	1-800-607-3366	www.aetnavoluntaryforms.com

NORTHEAST DISTRICT COUNCIL FO THE OPCMIA WELFARE FUND OFFICE		
CONTACT	PHONE	EMAIL
Lisa Parisi (Fund Manager)	1-516-775-2280	lisa.paris@nedcfunds.org
Diane Ferchland	1-516-775-2280	diane@nedcfunds.org
100 Merrick Road, Suite 500 West, Rockville Centre, NY 11570		

BENEFIT CONSULTANT	PHONE	EMAIL
Praetorian Guard Group	631-656-3070 ext. 2000 631-656-3070 ext. 2001	tdimattinapgg@optonline.net emilylpgg@optonline.net