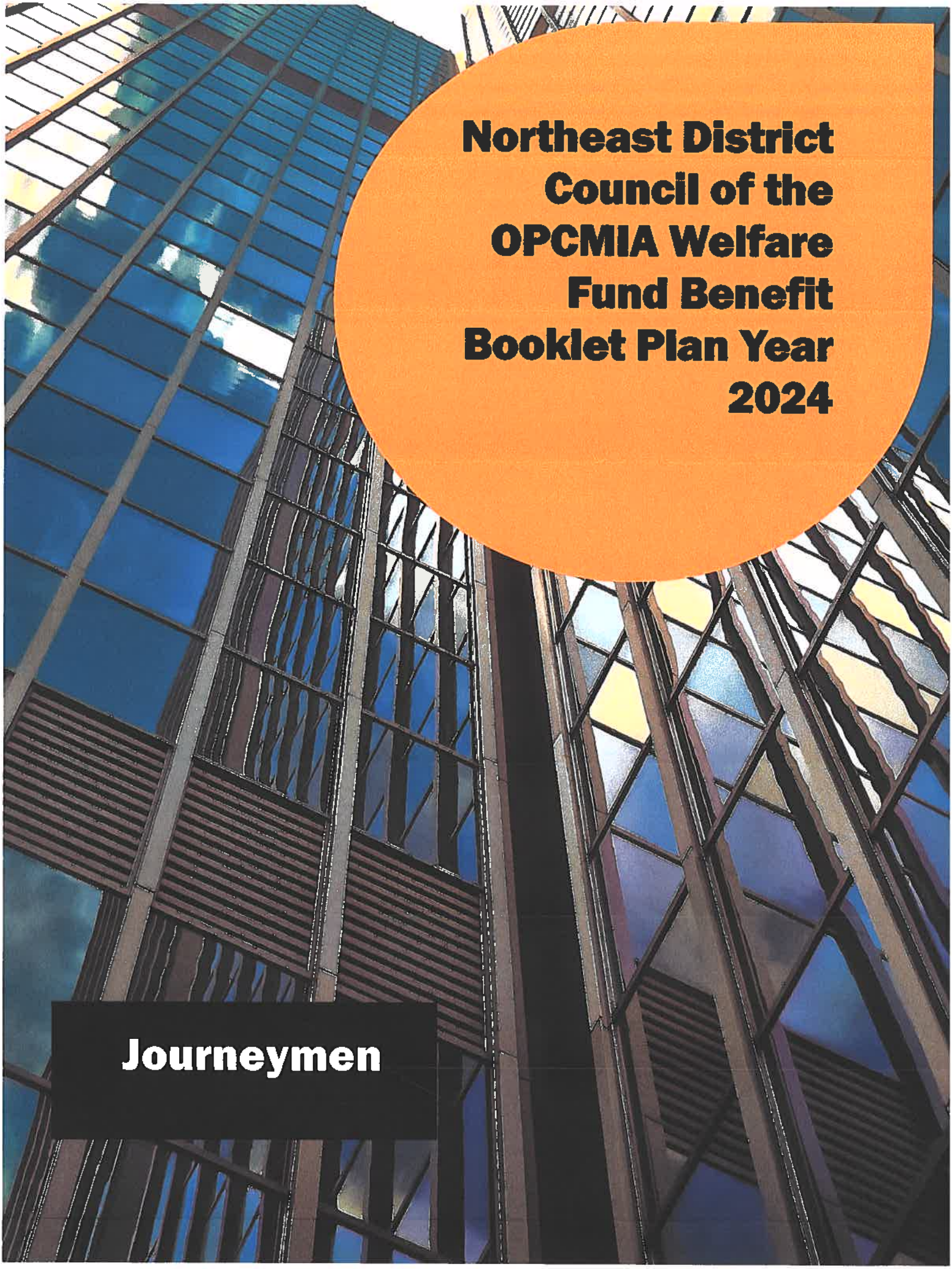

Northeast District Council of the OPCMIA Welfare Fund Benefit Booklet Plan Year 2024

Journeymen

Table of Contents

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

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

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Aetna Major Medical for Journeymen

The Northeast District Council of the OPCMIA offers a Medical Plan for Journeymen members that are eligible to enroll. Members who enroll In the Medical 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. This Medical 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.

When enrolling in the Aetna 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.

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Northeast District Council of the OPCMIA – Low Plan
Proposed Effective Date: 01-01-2024
Open Access® Elect Choice® - New York

PLAN DESIGN & BENEFITS
PROVIDED BY AETNA LIFE INSURANCE COMPANY

PLAN FEATURES	IN-NETWORK
Deductible (per calendar year)	$2,000 Individual $4,000 Family
Member cost sharing for certain services, as indicated in the plan, are excluded from charges to meet the Deductible. The family Deductible is a cumulative Deductible for all family members. The family Deductible can be met by a combination of family members; however no single individual within the family will be subject to more than the individual Deductible amount.	
Member Coinsurance	Covered 100%
Applies to all expenses unless otherwise stated.	
Payment Limit (per calendar year)	$6,600 Individual $13,200 Family
Certain member cost sharing elements may not apply toward the Payment Limit. Pharmacy expenses apply towards the Payment Limit. Only those out-of-pocket expenses resulting from the application of coinsurance percentage, copays, and deductibles (except any penalty amounts) may be used to satisfy the Payment Limit. The family Payment Limit is a cumulative Payment Limit for all family members. The family Payment Limit can be met by a combination of family members; however no single individual within the family will be subject to more than the individual Payment Limit amount.	
Lifetime Maximum	
Unlimited except where otherwise indicated.	
Primary Care Physician Selection	Optional
Referral Requirement	None
PREVENTIVE CARE	**IN-NETWORK**
Routine Adult Physical Exams/ Immunizations	Covered 100%; deductible waived
1 exam per calendar year up to age 65, 1 exam per calendar year age 65 and older	
Routine Well Child Exams/Immunizations	Covered 100%; deductible waived
7 exams in the first 12 months of life, 3 exams in the 13th-24th months of life, 3 exams 25-36 months, 1 exam per calendar year thereafter to age 22.	
Routine Gynecological Care Exams	Covered 100%; deductible waived
2 exams per calendar year. Includes routine tests and related lab fees.	
Routine Mammograms	Covered 100%; deductible waived
Women's Health	Covered 100%; deductible waived
Includes: Screening for gestational diabetes, HPV (Human- Papillomavirus) DNA testing, counseling for sexually transmitted infections, counseling and screening for human immunodeficiency virus, screening and counseling for interpersonal and domestic violence, breastfeeding support, supplies and counseling. Contraceptive methods, sterilization procedures, patient education and counseling. Limitations may apply.	
Routine Digital Rectal Exam	Covered 100%; deductible waived
Prostate-specific Antigen Test	Covered 100%; deductible waived
Colorectal Cancer Screening	Covered 100%; deductible waived
Recommended: For all members age 50 and over.	
Routine Eye Exams	Covered 100%; deductible waived
1 routine exam per 24 months.	
PHYSICIAN SERVICES	**IN-NETWORK**
Office Visits to Non-Specialist	$40 office visit copay
Includes services of an internist, general physician, family practitioner or pediatrician.	

PLAN DESIGN & BENEFITS
PROVIDED BY AETNA LIFE INSURANCE COMPANY

Specialist Office Visits	$40 copay
Includes services of an internist, general physician, family practitioner or pediatrician if the physician is not the member's selected PCP.	
Pre-Natal Maternity	Covered 100%; deductible waived
E-visit to Non-Specialist	Not Covered
An E-visit is an online internet consultation between a physician and an established patient about a non-emergency healthcare matter. This visit must be conducted through our authorized internet E-visit service vendor.	
E-visit to Specialist	Not Covered
An E-visit is an online internet consultation between a physician and an established patient about a non-emergency healthcare matter. This visit must be conducted through our authorized internet E-visit service vendor.	
Walk-in Clinics	$40 office visit copay
Walk-in Clinics are network, free-standing health care facilities. They are an alternative to a physician's office visit for treatment of unscheduled, non-emergency illnesses and injuries and the administration of certain immunizations. It is not an alternative for emergency room services or the ongoing care provided by a physician. Neither an emergency room, nor the outpatient department of a hospital, shall be considered a Walk-in Clinic.	
Allergy Testing	Member cost sharing is based on the type of service performed and the place of service where it is rendered
Allergy Injections	Covered 100% after deductible
Routine Hearing Exams	Not Covered
DIAGNOSTIC PROCEDURES	**IN-NETWORK**
Diagnostic X-ray	$40 copay; deductible waived
(other than Complex Imaging Services)	
If performed as a part of a physician office visit and billed by the physician, expenses are covered subject to the applicable physician's office visit member cost sharing.	
Diagnostic Laboratory	$40 copay; deductible waived
If performed as a part of a physician office visit and billed by the physician, expenses are covered subject to the applicable physician's office visit member cost sharing.	
Diagnostic Outpatient Complex Imaging	$75 copay; deductible waived
EMERGENCY MEDICAL CARE	**IN-NETWORK**
Urgent Care Provider	$40 copay; deductible waived
Non-Urgent Use of Urgent Care Provider	Not Covered
Emergency Room	$200 copay; deductible waived
Non-Emergency Care in an Emergency Room	Not Covered
Emergency Use of Ambulance	Covered 100% after deductible
Non-Emergency Use of Ambulance	Not Covered
HOSPITAL CARE	**IN-NETWORK**
Inpatient Coverage	Covered 100% after deductible, after $500 per confinement copay
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	
Inpatient Maternity Coverage	$40 copay for Physician maternity services
(includes delivery and postpartum care)	100% after $500 per stay copay for Facility services; deductible applies
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	
Outpatient Hospital Expenses	Covered 100% after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.	
Outpatient Surgery	$75 copay; deductible waived
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.	

PLAN DESIGN & BENEFITS
PROVIDED BY AETNA LIFE INSURANCE COMPANY

MENTAL HEALTH SERVICES	**IN-NETWORK**
Inpatient The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	Covered 100% after deductible, after $500 per confinement copay
Outpatient The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.	$40 copay; deductible waived
Crisis Intervention Services	$40 copay; deductible waived
ALCOHOL/DRUG ABUSE SERVICES	**IN-NETWORK**
Inpatient The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	Covered 100% after deductible, after $500 per confinement copay
Residential Treatment Facility	Covered 100% after deductible, after $500 per confinement copay
Outpatient The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.	$40 copay; deductible waived
OTHER SERVICES	**IN-NETWORK**
Convalescent Facility Limited to 60 days per calendar year. The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	Covered 100% after deductible, after $500 per confinement copay
Home Health Care Limited to 200 visits per calendar year. Each visit by a nurse or therapist is one visit. Each visit up to 4 hours by a home health care aide is one visit.	Covered 100%; deductible waived
Hospice Care The member cost sharing applies to all covered benefits incurred during a member's inpatient stay. Limited to 210 days per lifetime.	Covered 100% after deductible, after $500 per confinement copay
Private Duty Nursing – Outpatient Limited to 20 visits per calendar year.	Covered 100% after deductible
Outpatient Physical, Speech and Occupational Therapy Limited to 60 visits per calendar year combined.	$40 copay; deductible waived
Spinal Manipulation Therapy	$40 copay; deductible waived
Autism Behavioral Therapy Covered same as any other Outpatient Mental Health benefit	$30 copay; deductible waived
Autism Applied Behavior Analysis Covered same as any other Outpatient Mental Health benefit with no visit limits or age restrictions up to 680 hours per a calendar year.	$40 copay; deductible waived
Autism Physical Therapy Unlimited visits	$40 copay; deductible waived
Autism Occupational Therapy Unlimited visits	$40 copay; deductible waived
Autism Speech Therapy Unlimited visits	$40 copay; deductible waived
Durable Medical Equipment	Covered 100% after deductible
Diabetic Supplies	Covered same as PCP office visit cost sharing
Generic FDA-approved Women's Contraceptives	Covered 100%; deductible waived
Contraceptive drugs and devices not obtainable at a pharmacy	Covered 100%; deductible waived

Fertility Drugs (oral and injectable)	Covered 100%; deductible waived
Vision Eyewear	Not Covered
Transplants	Covered 100% after deductible, after $500 per confinement copay Preferred coverage is provided at an IOE contracted facility only.
Bariatric Surgery	Covered 100% after deductible, after $500 per confinement copay
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	
Out of Area Dependents	No coverage for non-emergency care received outside the service area.
FAMILY PLANNING	**IN-NETWORK**
Infertility Treatment	Member cost sharing is based on the type of service performed and the place of service where it is rendered
Diagnosis and treatment of the underlying medical condition.	
Comprehensive Infertility Services	Applicable cost sharing based on the type of service performed and place of service where rendered
Coverage includes Artificial Insemination and Ovulation Induction.	
Advanced Reproductive Technology (ART)	Not Covered
Vasectomy	Member cost sharing is based on the type of service performed and the place of service where it is rendered
Tubal Ligation	Covered 100%; deductible waived
PHARMACY	**IN-NETWORK**
Pharmacy Plan Type	Aetna Standard Plan Opt Out ACSF
Pharmacy Deductible	$100 Deductible
Retail	$15 copay for generic drugs, $35 copay for formulary brand-name drugs, and $65 copay for non-formulary brand-name drugs up to a 30 day supply at participating pharmacies.
Mail Order	$30 copay for generic drugs, $70 copay for formulary brand-name drugs, and $130 copay for non-formulary brand-name drugs up to a 31-90 day supply from Aetna Rx Home Delivery®.
Aetna Specialty CareRx	$15 copay for formulary generic drugs, $35 copay for formulary brand-name drugs, and $65 copay for non-formulary brand-name and generic drugs up to a 30 day supply at participating pharmacies.
Choose Generics with Dispense as Written (DAW) override - The member pays the applicable copay. If the physician requires brand-name, member would pay brand-name copay. If the member requests brand-name when a generic is available, the member pays the applicable copay plus the difference between the generic price and the brand-name price.	
Plan Includes: Diabetic supplies and medication covered at PCP cost sharing and Contraceptive drugs and devices obtainable from a pharmacy. Performance Enhancing Drugs limited to 6 tablets per month. Oral and injectable fertility drugs included (physician charges for injections are not covered under RX, medical coverage is limited). Precert for growth hormones included. Expanded Precert included with 90 day Transition of Care. Formulary Generic & Brand FDA-approved Women's Contraceptives and certain over-the-counter preventive medications covered 100% in network.	
GENERAL PROVISIONS	
Dependents Eligibility	Spouse, children from birth to age 26 regardless of student status.

Pre-existing Conditions Exclusion On effective date: Waived
After effective date: Waived

Plans are provided by: Aetna Health Inc. While this material is believed to be accurate as of the production date, it is subject to change.

Health benefits and health insurance plans contain exclusions and limitations. Not all health services are covered. See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by location and are subject to change. You may be responsible for the health care provider's full charges for any non-covered services, including circumstances where you have exceeded a benefit limit contained in the plan. Providers are independent contractors and are not our agents. Provider participation may change without notice. We do not provide care or guarantee access to health services.

If you are in a plan that requires the selection of a primary care physician and your primary care physician is part of an integrated delivery system or physician group, your primary care physician will generally refer you to specialists and hospitals that are affiliated with the delivery system or physician group.

•All medical or hospital services not specifically covered in, or which are limited or excluded by your plan documents;
• Cosmetic surgery, including breast reduction;
• Custodial care;
• Dental care and dental X-rays;
• Donor egg retrieval;
• Experimental and investigational procedures, except for coverage for medically necessary routine patient care costs for members participating in a cancer clinical trial;
• Home births;
• Immunizations for travel or work except where medically necessary or indicated;
• Implantable drugs and certain injectable infertility drugs;
• Infertility services, including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI and other related services, unless specifically listed as covered in your plan documents;
• Long-term rehabilitation therapy;
• Non-medically necessary services or supplies;
• Orthotics except diabetic orthotics;
• Outpatient prescription drugs (except for treatment of diabetes), unless covered by a prescription plan rider and over-the-counter medications (except as provided in a hospital) and supplies;
• Radial keratotomy or related procedures;
• Reversal of sterilization;
• Services for the treatment of sexual dysfunction or inadequacies, including therapy, supplies, or counseling or prescription drugs;
• Special duty nursing;
• Therapy or rehabilitation other than those listed as covered;
• Weight control services including surgical procedure, medical treatments, weight control/loss programs, dietary regimens and supplements, appetite suppressants and other medications; food or food supplements, exercise programs, exercise or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity, including Morbid Obesity, or for the purpose of weight reduction, regardless of the existence of comorbid conditions.

Aetna receives rebates from drug manufacturers that may be taken into account in determining Aetna's Preferred Drug List. Rebates do not reduce the amount a member pays the pharmacy for covered prescriptions. Aetna Rx Home Delivery refers to Aetna Rx Home Delivery, LLC, a licensed pharmacy subsidiary of Aetna Inc., that operates through mail order. The charges that Aetna negotiates with Aetna Rx Home Delivery may be higher than the cost they pay for the drugs and the cost of the mail order pharmacy services they provide. For these purposes, the pharmacy's cost of purchasing drugs takes into account discounts, credits and other amounts that they may receive from wholesalers, manufacturers, suppliers and distributors.

In case of emergency, call 911 or your local emergency hotline, or go directly to an emergency care facility.

Translation of the material into another language may be available. Please call Member Services at **1-888-982-3862.**

PLAN DESIGN & BENEFITS
PROVIDED BY AETNA LIFE INSURANCE COMPANY

Puede estar disponible la traduccion de este material en otro idioma. Por favor llame a Servicios al Miembro al **1-888-982-3862.**
Plan features and availability may vary by location and group size.
For more information about Aetna plans, refer to **www.aetna.com.**

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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.

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 Benefits for the Aetna DMO Dental Plan.

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Northeast District Council of the OPCMIA Welfare Fund
Plan 75
Effective Date: 01/01/2024

DMO® Dental Benefits Summary

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

"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

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

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

"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.

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D7241 (1)	Removal of Impacted Tooth - Completely Bony, With Unusual Surgical Complications	$145	D7321 (1)	Alveoloplasty Not in Conjunction With Extractions - 1-3 Teeth or Tooth Spaces - Per Quadrant	$42
D7250 (1)	Surgical Removal of Residual Tooth Roots	$59	D7510 (1)	Incision and Drainage of Abcess - Intraoral Soft Tissue	$33
D7251	Coronectomy - intentional partial tooth removal	$66	D7511 (1)	Incision and Drainage of Abcess - Intraoral Soft Tissue - Complicated	$36
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

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

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

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

aetna™

Northeast District Council of the OPCMIA Welfare Fund
Plan 75
Effective Date: 01/01/2024

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

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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.

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Northeast District Council of the OPCMIA Welfare Fund
Plan 75
Effective Date: 01/01/2024

DMO® Dental Benefits Summary

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

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

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).

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TTY: 711

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

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

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

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

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

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

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

0 ID
(Burmese)

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

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

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

ᏩᎩᏍᏗ ᏕᏫᏂᎯᏍᏗ ᎢᏬᏝᏛᏁᏗ Ꮯ ᎠᎱᏍᏗ ᏗᏟᎬᏩᏁᏗ ᏱᎩ, ᎾᏢᏏᏔᏛᏏ ᎾᏍᎩ ᏗᏎᏍᏗ ᏥᏕᎪᏪᎵ ᎤᏙᎢ ID ᏆᏂᏲᏍᏗ ᏣᏤᎵᎢ. (Cherokee)

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

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

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

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Northeast District Council of the OPCMIA Welfare Fund
Plan 75
Effective Date: 01/01/2024

DMO® Dental Benefits Summary

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

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

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

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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.

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.

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Northeast District Council of the OPCMIA
Effective Date: 01-01-2024

Dental Benefits Summary

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

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

Emergency Dental Care

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

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

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

1. Services or supplies that are covered in whole or in part:
   (a) under any other part of this Dental Care Plan; or
   (b) under any other plan of group benefits provided by or through your employer.
2. Services and supplies to diagnose or treat a disease or injury that is not:
   (a) a non-occupational disease; or
   (b) a non-occupational injury.
3. Services not listed in the Dental Care Schedule that applies, unless otherwise specified in the Booklet-Certificate.
4. Those for replacement of a lost, missing or stolen appliance, and those for replacement of appliances that have been damaged due to abuse, misuse or neglect.
5. Those for plastic, reconstructive or cosmetic surgery, or other dental services or supplies, that are primarily intended to improve, alter or enhance appearance. This applies whether or not the services and supplies are for psychological or emotional reasons. Facings on molar crowns and pontics will always be considered cosmetic.
6. Those for or in connection with services, procedures, drugs or other supplies that are determined by Aetna to be experimental or still under clinical investigation by health professionals.
7. Those for dentures, crowns, inlays, onlays, bridgework, or other appliances or services used for the purpose of splinting, to alter vertical dimension, to restore occlusion, or to correct attrition, abrasion or erosion.
8. Those for any of the following services (Does not apply to the DMO plan in TX):
   (a) an appliance or modification of one if an impression for it was made before the person became a covered person;
   (b) a crown, bridge, or cast or processed restoration if a tooth was prepared for it before the person became a covered person; or
   (c) root canal therapy if the pulp chamber for it was opened before the person became a covered person.
9. Services that Aetna defines as not necessary for the diagnosis, care or treatment of the condition involved. This applies even if they are prescribed, recommended or approved by the attending physician or dentist.
10. Those for services intended for treatment of any jaw joint disorder, unless otherwise specified in the Booklet-Certificate.
11. Those for space maintainers, except when needed to preserve space resulting from the premature loss of deciduous teeth.
12. Those for orthodontic treatment, unless otherwise specified in the Booklet-Certificate.
13. Those for general anesthesia and intravenous sedation, unless specifically covered. For plans that cover these services, they will not be eligible for benefits unless done in conjunction with another necessary covered service.
14. Those for treatment by other than a dentist, except that scaling or cleaning of teeth and topical application of fluoride may be done by a licensed dental hygienist. In this case, the treatment must be given under the supervision and guidance of a dentist.
15. Those in connection with a service given to a person age 5 or older if that person becomes a covered person other than:

    (a) during the first 31 days the person is eligible for this coverage, or
    (b) as prescribed for any period of open enrollment agreed to by the employer and Aetna. This does not apply to charges incurred:
        (i) after the end of the 12-month period starting on the date the person became a covered person; or
        (ii) as a result of accidental injuries sustained while the person was a covered person; or
        (iii) for a primary care service in the Dental Care Schedule that applies as shown under the headings Visits and Exams, and X-rays and Pathology.
16. Services given by a nonparticipating dental provider to the extent that the charges exceed the amount payable for the services shown in the Dental Care Schedule that applies.
17. Those for a crown, cast or processed restoration unless:
    (a) it is treatment for decay or traumatic injury, and teeth cannot be restored with a filling material; or
    (b) the tooth is an abutment to a covered partial denture or fixed bridge.
18. Those for pontics, crowns, cast or processed restorations made with high-noble metals, unless otherwise specified in the Booklet-Certificate.

19. Those for surgical removal of impacted wisdom teeth only for orthodontic reasons, unless otherwise specified in the Booklet-Certificate.
20. Services needed solely in connection with non-covered services.
21. Services done where there is no evidence of pathology, dysfunction or disease other than covered preventive services.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

▯

ID (Burmese)

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

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

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

ᏩᎩᏍᏗ ᏕᏬᏂᎯᏍᏗ ᎢᎤᎾᏓᏛᏁᏗ Ꮳ ᎪᎱᏍᏗ ᏗᏣᎬᏩᎳᏁᏗ ᎹᎩ, ᎾᎵᎯᏏᎳᏛᏏ ᎾᏍᎩ ᏧᏐᏍᏗ ᏥᏚᎪᏪᎵ ᎤᎾᎢ ID ᏆᏂᏲᏍᏗ ᏣᏙᎵᎢ. (Cherokee)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

ເພື່ອເຂົ້າເຖິງບໍລິການພາສາທີ່ບໍ່ເສຍຄ່າ, ໃຫ້ໂທຫາເບີໃຫຍ່ໃນບັດປະຈຳຕົວຂອງທ່ານ. (Lao)

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

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

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

ដើម្បីទទួលបានសេវាកម្មភាសាដែលគ្មានតម្លៃសម្រាប់លោកអ្នក សូមហៅទូរស័ព្ទទៅកាន់លេខដែលមាននៅលើបណ្ណសម្គាល់ខ្លួនរបស់លោកអ្នក។ (Mon-Khmer, Cambodian)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Heeba a naasta nder ekkitol jaangirde woldeji walla yobugo, ewnu lamba je don windi ha do derowol maada. (Sudanic Fulfulde)

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

(Syriac-Assyrian) ܟܕ ܡܣܝܒܪܐ ܬܠܘܢ ܥܠ ܡܢܝܢܐ ܕܠܫܢܐ ܡܫܡܫܢܘܬܐ ܥܠ ܡܣܟܢܘܬܐ ܒܠܫܢܐ ܕܒܓܝܢ.

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

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

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

หากท่านต้องการเข้าถึงการบริการทางด้านภาษาโดยไม่มีค่าใช้จ่าย โปรดโทรหมายเลขที่แสดงอยู่บนบัตรประจำตัวของท่าน (Thai)

Kapau ʻoku ke fiemaʻu taʻetōtōngi ʻa e ngaahi sēvesi kotoa pē he ngaahi lea kotoa, telefoni ki he fika ʻoku hā atu ʻi hoʻo ID kaati. (Tongan)

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

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

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

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

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

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

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Vision Insurance – Aetna Vision Preferred

The Northeast District Council of the OPCMIA also offers a Vision Plan through Aetna Vision Preferred 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 Aetna Vision Preferred Plan.

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Summary of Benefits for Northeast District Council Of The Opcmia Welfare Fund

Aetna Vision℠ Preferred

www.aetnavision.com

Effective Date: 01/01/2024 Frequency (Exam/Frame/Lens): 12/12/12 Enhanced Plan CURRENT PLAN 823238 - Package A	In Network Member Cost Aetna Vision Network	Out of Network Member Reimbursement*
Exam		
Use your Exam Coverage once every Calendar Year		
Eye Exam with Dilation as Necessary	$0 Copay	$75 Reimbursement
Retinal Imaging	Member pays discounted fee of $39	Not Covered
Standard Contact Lens Fit /Follow Up[1]	$0 Copay	$35 Reimbursement
Premium Contact Lens Fit /Follow Up	Member pays 90% of retail	Not Covered
Frames		
Use your Frame Coverage once every Calendar Year		
Any Frame available, including frames for prescription sunglasses	$0 Copay; $175 Allowance**, 20% off balance over allowance	$100 Reimbursement
Standard Plastic Lenses		
Use your Lens/Lens Option Coverage once every Calendar Year to purchase 1 pair of eyeglass lenses OR 1 order of contact lenses		
Single Vision	$0 Copay	$45 Reimbursement
Bifocal	$0 Copay	$120 Reimbursement
Trifocal	$0 Copay	$130 Reimbursement
Lenticular	$0 Copay	$182 Reimbursement
Standard Progressive Lens	$0 Copay	$120 Reimbursement
Premium Progressive Lens Tier 1[2]	$30 Copay	$120 Reimbursement
Premium Progressive Lens Tier 2[2]	$40 Copay	$120 Reimbursement
Premium Progressive Lens Tier 3[2]	$55 Copay	$120 Reimbursement
Premium Progressive Lens Tier 4[2]	$0 Copay; 80% of Charge less $120 allowance	$120 Reimbursement

Lens Options		
UV Treatment	$0 Copay	$12 Reimbursement
Tint (Solid And Gradient)	$0 Copay	$12 Reimbursement
Standard Plastic Scratch Coating	$0 Copay	$12 Reimbursement
Polycarbonate Lenses - Adult	$0 Copay	$32 Reimbursement
Polycarbonate Lenses - Children to age 19	$0 Copay	$32 Reimbursement
Standard Anti-Reflective Coating	Member pays discounted fee of $45	Not Covered
Premium Anti-Reflective Coating Tier 1[2]	$57 Copay	Not Covered
Premium Anti-Reflective Coating Tier 2[2]	$68 Copay	Not Covered
Premium Anti-Reflective Coating Tier 3[2]	20% off Retail	Not Covered
Photochromic/Transitions Plastic - Adult	$0 Copay	$60 Reimbursement
Photochromic/Transitions Plastic - Child to age 19	$0 Copay	$60 Reimbursement
Other Add-Ons	20% off Retail Price	Not Covered
Contact Lenses		
Use your Contact Lens Coverage once every Calendar Year to purchase 1 pair of eyeglass lenses OR 1 order of contact lenses		
Conventional	$0 Copay; $175 Allowance**, 15% off balance over allowance	$175 Reimbursement
Disposable	$0 Copay; $175 Allowance	$175 Reimbursement
Medically Necessary	Covered in Full	$290 Reimbursement
In Network Discounts		
Discounts cannot be combined with any other discounts or promotional offers and may not be available on all brands		
Additional pairs of eyeglasses or prescription sunglasses[3]	**Up to a 40% discount**	
Non-covered Items[4]	**20% discount**	
Lasik Laser vision correction or PRK from **U.S. Laser Network**[5] only. Call 1-800-422-6600	**15% discount off retail or 5% discount off promotional price**	
Hearing Discounts[6] - two ways to save: **Hearing Care Solutions** 1-866-344-7756 **Amplifon Hearing Health Care** 1-877-301-0840	**Save on hearing aids, exams, batteries, repairs and more**	

Partial list of exclusions and limitations

Enrolled members can access our secure member website once their plan becomes effective. Enrolled subscribers will receive a welcome packet with ID card mailed to their home within 15 business days after enrollment is processed.

*Out of network coverage is available. To receive reimbursement up to the amounts listed above, a claim form with itemized receipt is required. Reimbursement will not exceed the providers actual charge. Claims forms can be found at aetnavision.com or by calling customer service Monday through Sunday at 1-877-973-3238. Completed claim forms can be submitted electronically or mailed to Aetna, PO Box 8504 Mason, OH 45040-7111. You also have access to Allied Providers, such as Costco Vision, who will apply your out-of-network benefits at the point of service and handle the claim submission process for you.

**Allowances are one-time use benefits. No remaining balances may be used. The plan does not provide a declining balance benefit.

[1]Contact lens fit and two follow-up visits are allowed once a comprehensive eye exam has been completed.

[2]Premium progressives and premium anti-reflective Brand designations are subject to annual review and change based on market conditions. Ask your eye care provider for more information. Premium Progressive Lens cost includes bifocal cost.

[3]Additional pair discount applies to purchases made after the plan allowances have been exhausted. Discounts are not insurance.

[4]Non covered discounts may not be available in all states.

[5]Lasik or PRK from the US Laser Network, owned and operated by LCA Vision.

[6]Aetna does not endorse any vendor, product or service associated with these discount offers. Vendors are independent of Aetna, not agents or employees. Programs, products and services may not be available at all times. Certain offers may not be available in some states. Products and services are provided by Hearing Care Solutions and Amplifon Hearing Health Care (formerly HearPO).

Policies and plans are insured and/or administered by Aetna Life Insurance Company (Aetna). Certain claims administration services are provided by First American Administrators, Inc. and certain network administration services are provided through EyeMed Vision Care ("EyeMed"), LLC.

Not all services are covered. See plan documents for a complete description of benefits, exclusions and limitations of coverage. Plan features and availability may vary by location and are subject to change. These are the plan's main exclusions and limitations. See the booklet-certificate for a complete description. The plan does not cover: special vision procedures, such as orthoptics, vision therapy or vision training; vision services or supplies that do not meet professionally accepted standards; plano (nonprescription) lenses; nonprescription sunglasses; two pair of glasses in lieu of bifocals; medical and/or surgical treatment of the eyes; cosmetic services; lost or broken lenses, frames, glasses or contact lenses.

Providers in the Aetna Vision network are contracted and credentialed through EyeMed Vision Care, LLC according to EyeMed's requirements. EyeMed and Aetna are independent contractors and not agents of each other. Provider participation may change without notice.

Refer to Aetna.com for more information about Aetna® plans.

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 877-973-3238. 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 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). Help for those who speak another language and for the hearing impaired.

For language assistance in your language call 877-973-3238. Para obtener asistencia lingüística en español, llame sin cargo al número que figura en su tarjeta de identificación.

INDEPENDENT PROVIDER NETWORK + LENSCRAFTERS PEARLE VISION TARGET OPTICAL

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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.

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.

The Aetna Hospital Indemnity Plan can help
The plan pays you a lump-sum cash benefit for a covered hospital admission and daily stays—even when you deliver a baby. You can use the money to help pay out-of-pocket medical costs or personal expenses. The choice is yours.

How is this different from a major medical plan?
Medical plans help pay providers for services and treatment. But, they don't cover the 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. It can help pay:

- Deductibles or copays
- Mortgage or rent
- Groceries or utility bills

...or for anything else you choose.

Easy to use
Online tools make it easy to manage your plan on our app or member portal. You can file a claim in about 90 seconds or less if you or a family member experience a covered hospital stay. And, benefits get paid directly to you by check or direct deposit.

The Aetna Hospital Indemnity Plan is underwritten by Aetna Life Insurance Company (Aetna).

Aetna.com
57.03.503.1 (02/21)

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Because it happens

$1.24 trillion was spent on hospital services in 2020. **60%-65%** of all bankruptcies are related to medical expenses.[1]

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 online and, as an Aetna Medical member, didn't need to upload his medical bills.

Carter's benefits were deposited right into his bank account. That money helped make up for the time he missed work while recovering and paid some of his deductible. Now, he can focus more on his health.

A Simplified Claims Experience™

Just register on the **My Aetna Supplemental** app or on the member portal at **MyAetnaSupplemental.com** to view plan documents, submit and track claims, and sign up for direct deposit. Aetna Medical members can also visit **Aetna.com** to access the member portal.

Filing a claim is easy! Click "Report New Claim" and answer a few quick questions. Filing claims is even easier for Aetna Medical Plan members. **Aetna Easy File™** uses information from your medical claim to process your hospital indemnity plan claim. That's less paperwork for you. Don't have Aetna Medical? No problem- just upload or take a picture of your medical bill.

You can also print and mail a paper claim form to Aetna Voluntary Plans.

[1]Debt.org. Hospital and Surgery Costs. October 2021. Available at: https://www.debt.org/medical/hospital-surgery-costs/. Accessed June 3, 2022.

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

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.

The Aetna Hospital Indemnity Plan is a hospital confinement indemnity plan. This insurance 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 Oklahoma include: AL VOL HPOL-Hosp 01 and AL VOL HCOC-Hosp 01, GR-96173-HI 01.
Policy forms issued in Missouri include: AL VOL HPOL-Hosp 01, GR-96172-01.

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BENEFIT SUMMARY

Northeast District Council of the OPCMIA Welfare Fund

802405

Aetna Hospital Indemnity

Insurance plans are underwritten by Aetna Life Insurance Company.

Here's how the plan works:

You have an unexpected event and have to go to the hospital.

You are admitted into the hospital and spend two days there.

You submit your hospital claim to Aetna.

Aetna pays benefits directly to you.

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. 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.

Inpatient Stays

Covered Benefit	Low	High
Hospital stay - Admission Provides a lump sum benefit for the initial day of your stay in a hospital. *Maximum 1 stay per plan year*	$2,500	$3,000
Hospital stay - Daily Pays a daily benefit, beginning on day two of your stay in a non-ICU room of a hospital. *Maximum 30 days per plan year*	$100	$100
Hospital stay - (ICU) Daily Pays a daily benefit, beginning on day two of your stay in an ICU room of a hospital. *Maximum 30 days per plan year*	$150	$150
Nursery admission (non-NICU) Provides a lump-sum benefit after the birth of your newborn. This will not pay for an outpatient birth.	$100	$100
Substance abuse stay - Daily Pays a daily benefit for each day you have a stay in a hospital or substance abuse treatment facility for the treatment of substance abuse. *Maximum 30 days per plan year*	$100	$100
Mental disorder stay - Daily Pays a daily benefit for each day you have a stay in a hospital or mental disorder treatment facility for the treatment of mental disorders. *Maximum 30 days per plan year*	$100	$100
Rehabilitation unit stay - Daily Pays a benefit each day of your stay in a rehabilitation unit immediately after your hospital stay due to an illness or accidental injury. *Maximum 30 days per plan year*	$50	$50

Important Note:
All daily inpatient stay benefits begin on day two and count toward the plan year maximum including nursing and hospice care.

Inpatient Benefits

Covered Benefit	Low	High
Skilled nursing facility stay - Daily Pays a daily benefit for each day you have a stay in a skilled nursing facility due to an illness or accidental injury. *Maximum 30 days per plan year*	$50	$50

Important Note:
Plan year maximums for inpatient stay daily benefits, including skilled nursing facility 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, 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.

If I lose my employment, can I take the Hospital Indemnity Plan with me?

Yes, you are able to continue coverage under the Portability provision. You will need to pay premiums directly to Aetna.

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

How do I file a claim?

Go to **myaetnasupplemental.com** and either "Log In" or "Register", depending on if you've set up your account. Click the "Create a new claim" button and answer a few quick questions. You can even save your claim to finish later. 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 you 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（フリーダイアル）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)

Anthem Life

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.

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
SpecialOffers	Included
Rate guarantee	**Rates in this Proposal are guaranteed for 24 months**

Anthem Life

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.

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
SpecialOffers	Included
Rate guarantee	Rates in this Proposal are guaranteed for 24 months

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	=	$2,500.00
Parent/Child	=	$2,500.00
Couple	=	$2,500.00
Single	=	$2,000.00

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

By fax:

1-980-444-0711

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.

CONTACT INFORMATION

CARRIER CONTACT	PHONE	WEB ADDRESS
Aetna Medical, Dental & Vision	1-855-281-8858	www.aetna.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.parisi@nedcfunds.org
Diane Ferchland	1-516-775-2280	diane@nedcfunds.org
1406 Blondell Avenue, 2nd floor, Bronx, NY 10461		

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