



NORTHEAST DISTRICT COUNCIL OF THE OPCMIA WELFARE FUND PLAN YEAR BENEFIT BOOKLET

BENEFIT PLAN YEAR 2019

(Residential)

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Overview

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

In this booklet you will be able to review important benefit plan summary information that is being offered to members.

There are five different sections of benefits that breakdown the cost and reimbursements you and your eligible dependents will pay or receive for the 2019 benefit plan year.

These sections include current Medical, Vision, Short Term Disability/ PFL, Group Life, and Supplemental benefits coverage. Please review this booklet for the 2019 plan year.

We suggest that you keep this benefit booklet in a safe place for your records to reference throughout the benefit plan year. If you require assistance understanding your benefits there is important contact information within. We want to thank you for being a part of the brotherhood of the Northeast District Council of the OPCMIA Welfare Fund.

Core Benefits

Major Medical

Vision

Disability

Basic Life / AD&D

Supplemental Insurance (Hospital Indemnity Plan)



Enrollment

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

You may also enroll eligible dependents. Eligible dependents are:

- Your Legal Spouse
- Your Children under age 26
- Court ordered eligible dependents

Please note – Dependent children may be covered up to age 26 on the medical, dental and vision plans regardless of student status.

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 would be:

- 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 HIPAA
- 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 dependent is claimed on tax documents and proof of incapacity





Major Medical – Aetna Low Plan

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

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

Note: When enrolling in the Aetna Low Medical Plan, you will receive an ID card in the mail. Please keep this on you and present it to your provider, or any facility / hospital when receiving services.



The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, <https://www.aetna.com/sbcsearch/getpolicydocs?u=071700-020020-071758> or by calling 1-888-982-3862. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at <https://www.healthcare.gov/sbc-glossary/> or call 1-888-982-3862 to request a copy.

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





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

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



Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Physician/surgeon fees	No charge	Not covered	None
If you need immediate medical attention	<u>Emergency room care</u>	\$200 <u>copay/visit</u> , <u>deductible</u> doesn't apply	\$200 <u>copay/visit</u> , <u>deductible</u> doesn't apply	No coverage for non-emergency use.
	<u>Emergency medical transportation</u>	0% <u>coinsurance</u>	0% <u>coinsurance</u>	None
	<u>Urgent care</u>	\$40 <u>copay/visit</u> , <u>deductible</u> doesn't apply	Not covered	No coverage for non-urgent use.
If you have a hospital stay	Facility fee (e.g., hospital room)	\$500 <u>copay/stay</u>	Not covered	None
	Physician/surgeon fees	0% <u>coinsurance</u>	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office & other outpatient services: \$40 <u>copay/visit</u> , <u>deductible</u> doesn't apply	Not covered	None
	Inpatient services	\$500 <u>copay/stay</u>	Not covered	None
If you are pregnant	Office visits	No charge	Not covered	Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	0% <u>coinsurance</u>	Not covered	
	Childbirth/delivery facility services	\$500 <u>copay/stay</u>	Not covered	
If you need help recovering or have other special health needs	<u>Home health care</u>	No charge	Not covered	200 visits/calendar year.
	<u>Rehabilitation services</u>	\$40 <u>copay/visit</u> , <u>deductible</u> doesn't apply	Not covered	60 visits/calendar year for Physical, Occupational & Speech Therapy combined.
	<u>Habilitation services</u>	\$40 <u>copay/visit</u> , <u>deductible</u> doesn't apply	Not covered	Limited to treatment of Autism.
	<u>Skilled nursing care</u>	\$500 <u>copay/stay</u>	Not covered	60 days/calendar year.
	<u>Durable medical equipment</u>	0% <u>coinsurance</u>	Not covered	Excludes vehicle modifications, home modifications & exercise equipment.
	<u>Hospice services</u>	\$500 <u>copay/stay</u> for inpatient; not covered for outpatient	Not covered	210 days/lifetime for inpatient.
If your child needs dental or eye care	Children's eye exam	No charge	Not covered	1 routine eye exam/24 months.
	Children's glasses	Not covered	Not covered	Not covered.



Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Children's dental check-up	Not covered	Not covered	Not covered.

Excluded Services & Other Covered Services:

Services Your <u>Plan</u> Generally Does NOT Cover (Check your policy or <u>plan</u> document for more information and a list of any other <u>excluded services</u> .)		
<ul style="list-style-type: none"> • Acupuncture • Cosmetic surgery • Dental care (Adult & Child) • Glasses (Child) 	<ul style="list-style-type: none"> • Hearing aids • Long-term care • Non-emergency care when traveling outside the U.S. • Routine foot care 	<ul style="list-style-type: none"> • Weight loss programs - Except for required preventive services.

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.)		
<ul style="list-style-type: none"> • Bariatric surgery • Chiropractic care 	<ul style="list-style-type: none"> • Infertility treatment - Limited to the diagnosis & treatment of underlying medical condition, artificial insemination, ovulation induction & oral & injectable infertility drugs. 	<ul style="list-style-type: none"> • Private-duty nursing - 20 - 8 hour shifts per calendar year. • Routine eye care (Adult) - 1 routine eye exam/24 months.

Your Rights to Continue Coverage:

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

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

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

Your Grievance and Appeals Rights:

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



- Aetna directly by calling the toll free number on your Medical ID Card, or by calling our general toll free number at 1-888-982-3862.
- Department of Financial Services, (800) 342-3736, <http://www.dfs.ny.gov/consumer/chealth.htm>.
- If your group health coverage is subject to ERISA, you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.
- For non-federal governmental group health plans, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.
- Additionally, a consumer assistance program can help you file your appeal. Contact Department of Financial Services, One State Street, New York, NY 10004-1511, (800) 342-3736, <http://www.dfs.ny.gov/consumer/chealth.htm>.

Does this plan provide Minimum Essential Coverage? Yes.

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

Does this plan Meet Minimum Value Standard? Yes.

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

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



About these Coverage Examples:



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

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

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

This EXAMPLE event includes services like:

Specialist office visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
 Diagnostic tests (*ultrasounds and blood work*)
 Specialist visit (*anesthesia*)

Total Example Cost	\$12,800
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles*	\$1,500
Copayments	\$800
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$2,360

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

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

This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)
 Diagnostic tests (*blood work*)
 Prescription drugs
 Durable medical equipment (*glucose meter*)

Total Example Cost	\$7,400
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles*	\$100
Copayments	\$1,700
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$1,820

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

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

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)
 Diagnostic test (*x-ray*)
 Durable medical equipment (*crutches*)
 Rehabilitation services (*physical therapy*)

Total Example Cost	\$1,900
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles*	\$600
Copayments	\$400
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,000

Note: If your **plan** has a wellness program and you choose to participate, you may be able to reduce your costs.

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

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



Assistive Technology

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

Smartphone or Tablet

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

Non-Discrimination

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

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

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

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

Civil Rights Coordinator

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

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

Email: CRCoordinator@aetna.com

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

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



- Hawaiian - No ke kōkua ma ka ‘ōlelo Hawai‘i, e kahea aku i ka helu kelepona 1-888-982-3862. Kāki ‘ole ‘ia kēia kōkua nei.
- Hindi - हिन्दी में भाषा सहायता के लिए, 1-888-982-3862 पर मुफ्त कॉल करें।
- Hmong - Yog xav tau kev pab txhais lus Hmoob hu dawb tau rau 1-888-982-3862.
- Ibo - **Maka enyemaka asụsụ na Igbo kpọọ 1-888-982-3862 na akwụghị ụgwọ ọ bụla**
- Ilocano - Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-888-982-3862 nga awan ti bayadanyo.
- Italian - Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 1-888-982-3862.
- Japanese - 日本語で援助をご希望の方は、1-888-982-3862 まで無料でお電話ください。
- Karen - v>w>frRp>Rw>fuwdRusd.ft*D>f usd.f ud; 1-888-982-3862 v>wtd.fD;w>fv>mfbl.fv>mfphRb.f
- Korean - 한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-888-982-3862번으로 전화해 주십시오.
- Kru-Bassa - **Bé m ké gbo-kpá-kpá dyé pídyi qé Bāsóò-wùqùün wēε, qá 1-888-982-3862**
- Kurdish - برای راهنمایی به زبان فارسی با شماره 1-888-982-3862 به خورایی پیوندی بکسن.
- Laotian - ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ, ກະລຸນາໃບທາ 1-888-982-3862 ໂດຍບໍ່ເສຍຄ່າໃບ.
- Marathi - तीलभाषा (मराठी) सहाय्यासाठी 1-888-982-3862 क्रमांकावरकोणत्याहीखर्चाशिवायकॉलकरा.
- Marshallese - Ñan bōk jipañ ilo Kajin Majol, kallok 1-888-982-3862 ilo ejjelok wōnān.
- Micronesian-Pohnpeyan - Ohng palien sawas en soun kawewe ni omw lokaia Ponape koahl 1-888-982-3862 ni sohte isais.
- Mon-Khmer, Cambodian - សម្រាប់ជំនួយភាសាជា ភាសាខ្មែរ សូមទូរស័ព្ទទៅកាន់លេខ 1-888-982-3862 ដោយឥតគិតថ្លៃ។
- Navajo - T'áá shi shizaad k'ehjí bee shíká a'doowol nínizingo Diné k'ehjí koji' t'áá jíik'e hólne' 1-888-982-3862
- Nepali - (नेपाली) मा निःशुल्क भाषा सहायता पाउनका लागि 1-888-982-3862 मा फोन गर्नुहोस् ।
- Nilotic-Dinka - Tën kuɔɔny ë thok ë Thuɔɔnjän cɔl 1-888-982-3862 kec'in ayöc.
- Norwegian - For språkassistanse på norsk, ring 1-888-982-3862 kostnadsfritt.
- Panjabi - ਪੰਜਾਬੀ ਵਿੱਚ ਭਾਸ਼ਾਈ ਸਹਾਇਤਾ ਲਈ, 1-888-982-3862 'ਤੇ ਮੁਫਤ ਕਾਲ ਕਰੋ।
- Pennsylvania Dutch - Fer Helfe in Deutsch, ruf: 1-888-982-3862 aa. Es Aaruf koschtet nix.
- Persian - برای راهنمایی به زبان فارسی با شماره 1-888-982-3862 بدون هیچ هزینه ای تماس بگیرید. انگلیسی
- Polish - Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-888-982-3862.



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



Aetna Navigator® Member Website

The edge you need to make the most of your plan

www.aetna.com



When you're an Aetna member, you get tools and resources to help you easily manage your health and your benefits. All of your health benefits and health insurance plan information and cost-savings tools are in one place — your Aetna Navigator member website.

When you sign up and use it, you're not just a member, you're **a navigator**.

Navigators have know-how

Navigators are smart about their health care. Once you're a navigator, you can easily:

- **Find the right doctor — and save money.** Locate in-network doctors who accept your plan.
- **See what you owe.** Look up claims to see how much the plan paid and what you may have to pay.
- **Know your plan.** Check who is covered by your plan and what it covers.
- **Get valuable information.** See which doctors and hospitals have met extra standards for quality and efficiency.
- **Know costs before you go.** See cost estimates before you make an appointment for an office visit, test or procedure.
- **Get healthier.** Take a health assessment to learn about your health and how to lower your risks.
- **Check your health accounts.** Easily look up your health savings account* or health fund balances.

Easy-to-use tools help you make smart choices about your health.

Peace of mind is a password away

It's easy to be a navigator. (You don't need any special technical skills, we promise.) Just sign up at www.aetna.com once you are an Aetna member. Then you can start using Aetna Navigator's valuable features and tools.

Meet Ann, your virtual assistant

She can help you sign up for Aetna Navigator. She can even help you find a doctor, estimate the cost of services, answer questions about claims, ID cards and more. Ann never sleeps, so chat with her anytime.

Go to www.aetnatools.com to see a preview of what Aetna Navigator has to offer once you are an Aetna member.

Find what you need — wherever, whenever



The Aetna Mobile app puts our most popular online features at your fingertips. It's available for iPhone® and Android™ mobile devices.

Scan this code now to download.
Or visit www.aetna.com/mobile.



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

Health benefits and health insurance plans are offered, administered and/or underwritten by Aetna Health Inc., Aetna Health of California Inc., Aetna Health Insurance Company of New York, Aetna Health Insurance Company and/or Aetna Life Insurance Company (Aetna). In Florida, by Aetna Health Inc. and/or Aetna Life Insurance Company. In Maryland, by Aetna Health Inc., 151 Farmington Avenue, Hartford, CT 06156. Each insurer has sole financial responsibility for its own products.

This material is for information only and is not an offer or invitation to contract. An application must be completed to obtain coverage. Rates and benefits vary by location. The availability of Aetna Navigator's key features may vary by plan. 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. Health information programs provide general health information and are not a substitute for diagnosis or treatment by a physician or other health care professional. Providers are independent contractors and are not agents of Aetna. Provider participation may change without notice. Aetna does not provide care or guarantee access to health services. The health assessment is used in a variety of ways to support Aetna products and services that help you manage your health. Aetna will use your health assessment information in compliance with all applicable state and federal laws, including the Health Insurance Portability and Accountability Act (HIPAA) privacy and security rules. For more information, view Aetna's Notice of Privacy Practices, located at the bottom of Aetna's website, or call the number on the back of your ID card. 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.

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

www.aetna.com

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Vision Insurance – NVA Vision Plan

The Northeast District Council of the OPCMIA also offers a Vision Plan through National Vision Administrators (NVA) 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.

Members who enroll in the NVA Vision Plan can see a doctor of their choice, however out of network benefits are subject to a maximum reimbursed amount. The most liberal benefits are paid when you use a network provider. 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 NVA Vision Plan and to view information to their easy online access tool.

Note: Printed ID cards are available through the easy online access tool only.



Vision Insurance - Gold Plan Summary

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

Benefit Amounts		<i>This is a partial listing only. Please refer to the policy for details.</i>	
		In-network benefits	Out-of-network reimbursements
Examination	Once every 12 months¹	Covered 100%	Up to \$70
Lenses	Once every 12 months¹		
	Single vision	Covered 100%	Up to \$45
	Bifocal vision	Covered 100%	Up to \$115
	Intermediate vision	Covered 100%	Up to \$115
	Trifocal	Covered 100%	Up to \$190
	Lenticular	Covered 100%	Up to \$190
Lens Options	Once every 12 months¹		
	Scratch resistant coating	Covered 100%	N/A
	Fashion/gradient tint	Covered 100%	
	Solid tint	Covered 100%	
	Glass photogrey single vision lens	Covered 100%	
	Glass photogrey bifocal and trifocal lens	Covered 100%	
	Ultraviolet (UV) coating	Covered 100%	
	Standard anti-reflective (AR) coating	Covered 100% after \$35 copay	
	Polarized lenses	Discounted to \$75²	
	Polycarbonate lenses	Covered 100%	
	Standard progressive lenses	Covered 100%	
	Premium progressive lenses	Covered 100% after \$40 copay	
Frames	Once every 12 months¹		
	Frame allowance	\$175 retail allowance⁵ (20% overage discount)	Up to \$100
Contacts	Once every 12 months¹		
<i>(In lieu of eyeglasses)</i>	Maximum allowance for conventional lenses	\$175 retail allowance³ (10% overage discount)	Up to \$290⁶
	Maximum allowance for disposable lenses	\$175 retail allowance³ (10% overage discount)	
	Medically necessary contact lenses ⁴	Covered 100%	
	Evaluation, fitting, and follow-up care - standard lens	Covered 100%	N/A
	Evaluation, fitting, and follow-up care - specialty lens	Covered 100%	

¹Benefit year is based on an enrollee's last date of service.

²Actual discounted amounts may vary.

³Does not apply at Contact Fill or Cole corporate locations (if applicable) and where prohibited by law. Prohibited by some manufacturers.

⁴Prior authorization required.

⁵Does not apply for certain proprietary frame brands and where prohibited by law.

⁶Only covered if member chooses contact lenses.

Getting the most out of your Vision Plan

Members have the freedom to visit the Vision Care provider of their choice but out-of-pocket expenses may be reduced significantly when choosing a network provider. Our network has more than **40,000+ eye care professionals** including retailers and independent doctors nationwide. **Locate participating providers at: www.e-nva.com.**

Additionally, after the member has exhausted their funded benefit, they're eligible to access significant discounts on materials through participating network providers through the **EYEESENTIAL Plan**.

Register your account online

Once enrolled, members can register their account online at **www.e-nva.com** and use a full menu of helpful tools:

- **View eligibility information** and print copies of **ID cards**
- **Search participating eyecare professionals** in the area, or nominate a preferred eyecare professional (if not participating)
- **Submit, view, and check the status of claims**
- Find answers to our most **frequently asked questions**
- **Use the Member's Guide to Purchasing Eyewear - Vision Benefit Maximizer**
Find an eyecare professional's service level and frame inventory (the number of frames they have available at no additional out-of-pocket cost when using the vision plan)
- **Smart Buyer's Guide to Frames**
Makes it easy to pick out frames according to face shape, skin tone, eye/hair color, etc.
- **Smart Buyer's Guide to Lenses**
Find out which eyeglass lens types, materials, lens coatings, etc. are best for you

Vision Claims Guide

How often can I use my benefits?

Since the benefit year is based on your last date of service, you can use your benefits once every 12 months from the last date of service.

- Preventive eye health examination benefits are available once every 12 months.
- Lenses/frames or contact lenses are covered once every 12 months.

How do I find a participating provider?

Our policy with network option offers you the freedom to visit the Vision Care provider of your choice, but your out-of-pocket expenses may be reduced significantly when choosing an NVA (National Vision Administrators, L.L.C.) network provider.

If you choose to take advantage of the network savings, you can locate NVA Vision network providers on their website: **www.e-nva.com**

How do ShelterPoint and NVA work together?

ShelterPoint is your carrier, providing you with an insured Vision Care plan. NVA is a network enhancement to your underlying vision coverage from ShelterPoint: Participating providers accept a fixed, lower negotiated fee when receiving payment for their services. Your Benefit Plan Administrator can explain your specific benefit levels and fees.

Using the network is easy

No ID cards needed! In-network providers can **easily verify member information and eligibility for services without an ID card**, however for easy identification and reference, members may print them from their member portal.

No claim forms are needed for services from a participating network provider! Simply provide the office with the member ID number and/or name and date of birth of any covered member needing services.

How out-of-network services work

Members have the freedom to choose any Vision Care provider. When choosing an **out-of-network** provider, the member pays the fees for services and materials first to the provider **at point of service and is then reimbursed** according to their plan's schedule.

Out-of-network claims:

For services from an out-of-network provider, members need to submit a claim for reimbursement either online or by mail.

Vision Claim Administrator:

NVA

Attn: ShelterPoint

P.O. Box 2187

Clifton, NJ 07015

Claim forms are available for download at either:

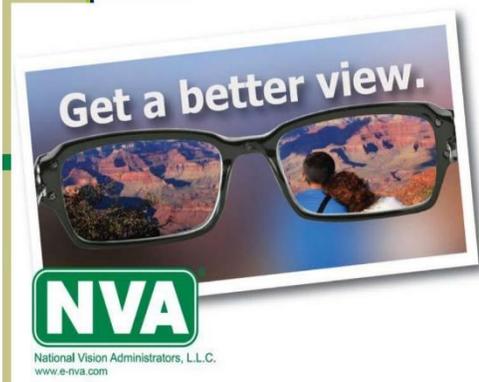
www.shelterpoint.com or **www.e-nva.com**

How can I check the status of my claim?

- Visit the member portal at: **www.e-nva.com**
- Call the dedicated toll-free member services telephone number: **877-241-7124**



MEMBER WEB REGISTRATION



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Already Registered? Login

User Name:
Password:

Note: User Name and Password are case sensitive

Not Registered? Register Now

- [Provider Registration](#)
- [Subscriber Registration](#)
- [Forgot Password?](#)

[Subscribers](#) [Plan Sponsors](#) [Brokers/Consultants](#) [Eyecare Professionals](#) [Find Provider](#) [LASIK](#)



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www.e-nva.com

- To begin the subscriber registration process, visit www.e-nva.com to securely register to view your specific benefit information via the NVA website.
- Simply click on the 'Subscriber Registration' link located in the upper right hand corner of our Home Page.



Subscriber Registration

[Home](#) > [Subscribers](#) > Subscriber Registration

Subscriber Registration

Four Easy Steps	 Begin Registration Process	Receive Email Confirmation	Verify Personal Information	Enter User Information
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Please fill in all the details below and click 'Submit' to begin the Registration process.

A message will be sent to the email address you provide below. This message will allow you to continue the Register link included in the message.

You are presently logged in. If you click 'Submit' you will be logged out.

All fields are required.

Required Fields

Subscriber ID: (may be your SSN)
Last Name:
First Initial:
Date of Birth: (mm/dd/yyyy)
ZIP Code: (#####)
Email Address: (ab@xyz.com)
Confirm Email Address:

- Next, you will be directed to the **Subscriber Registration screen** (shown at right).

- **Fill out all registration fields and click on the 'Submit' button.**

- **After clicking 'Submit', you will be sent an e-mail to your registered e-mail address** (shown on the next slide).



www.e-nva.com



E-Mail Confirmation

To reply, forward or delete this message, please close this window and use the corresponding email client.

From: www@e-nva.com
To: bob.jones@brownsoffice.com
Date: 10/24/2012 02:10:53 EDT
Subject: Registration at www.e-nva.com

Subscriber Registration

Dear Subscriber,

Thank you for submitting your registration at www.e-nva.com.

To proceed with the registration process, please click the link below.*

[Continue Registration Process...](#)

You will then be asked to verify information about yourself, and you will choose a user name and password.

Please note that you must complete the registration process within 14 days, otherwise the link will be disabled.

If you have any questions about the registration process or if you have received this message in error, please contact us at www.e-nva.com.

Thanks!

National Vision Administrators

*If you cannot click on the above link, copy and paste the following address into your browser window: www.e-nva.com/registration/confirm.asp

• Click on the 'Continue Registration Process...' link provided in your e-mail message to continue on to the verification portion of the registration process.



Get a better view.

www.e-nva.com



Verify Registration Information

- After clicking on the 'Continue Registration Process...' link, you will be directed back to the Subscriber Registration page to verify your registration information and accept the Internet User Agreement (shown at right).
- Once you have agreed to the User Agreement and completed the registration process, you will then be allowed specific access to your account.



Welcome back to the Registration process at www.e-nva.com! To continue, please review the personal information below.

Personal Information

Name: BOB JONES
Subscriber ID: 111111111
Date of Birth: 01/01/1955
Street Address: 22 SOUTH STREET
City: TOWNSHIP
State: WI
ZIP Code: 53225
Email Address: bob.jones@brownsoffice.com
Groups: THE BROWN'S OFFICE

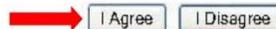
Internet User Agreement

By using this web site, subscribers may be able to view up to 48 months of vision experience claims history for themselves and for all covered household members.

By accepting this User Agreement, you acknowledge that the claims history for yourself and all covered family members may be displayed in this web site. In addition you confirm the statement below:

"I have financial responsibility for the minor and adult dependents covered by this vision benefits plan. I have obtained the consent of any adult dependents to view their claims history for the purpose of vision benefit management. I understand that this information cannot be used for any other purposes without the written consent of the dependents"

To accept the User Agreement and verify that the above information refers to you, click the 'I Agree' button. You will then be asked to select a User Name and Password, the final step in the Registration process.



Get a better view.

www.e-nva.com



Registered Subscriber Home

You are now registered and logged-in, allowing you access to navigate through the NVA website via the navigation toolbar or via the NVA Smart Buyer® subscriber home page (shown at right).

Beginning with the 'View Eligibility' option on the navigation toolbar, you can review each toolbar option's capabilities and the information available to you.

- > Subscriber Home
- > View Eligibility
- > Print ID Cards
- > Find Eyecare Professional
- > Nominate Eyecare Professional
- > Subscriber Materials
- Helpful Info
 - > Frequently Asked Questions
 - > Wellness
- Claims
 - > View Claims
 - > Submit Claim
- NVA Smart Buyer's Guides
 - > Eyeglass Frames
 - > Eyeglass Lenses
 - Eyeglass Lens Type
 - Eyeglass Lens Material
 - Coatings,

Subscriber Home

Welcome testsubbj1. Your last login was on 10/23/2012.

i The Current Group View is for THE BROWN'S OFFICE.

NVA SMART BUYER®

In addition to viewing your eligibility and vision plan coverage, printing ID cards (if available through your vision plan), asking Eyecare Professional Questions (FAQ) and saving on LASIK surgery, NVA now offers a program that provides you with the vision care services and eyewear. The NVA Smart Buyer® will help you use your vision benefit to its full extent and reduce your out-of-pocket expenses to a minimum.

Vision Benefit Maximizer™
ECP Search Tool

Frames

Eyeglass Lenses

Vision Benefit Maximizer® Eyecare Professional Search

Now find Eyecare Professionals based on their specific frame

While searching for participating Eyecare Professionals (ECPs) you will now receive information on their services and locations available at certain locations at no cost to you. This important information makes it easier for you to select the ECP best suited for you. Try it now.

Find your perfect provider



Get a better view.

www.e-nva.com

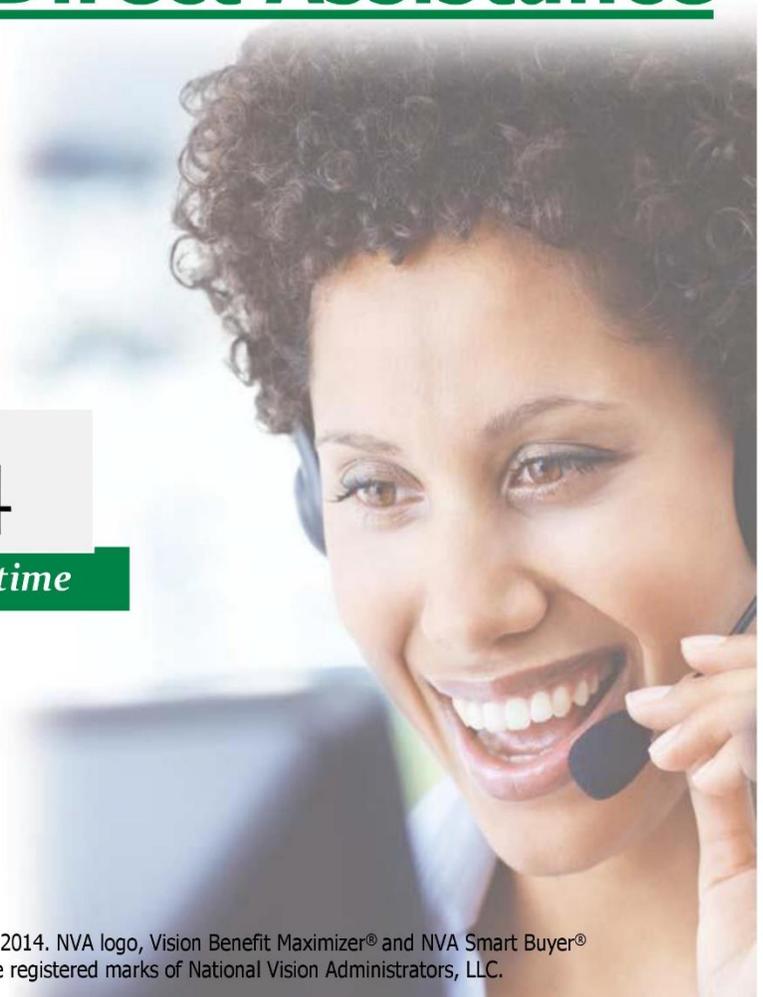
Direct Assistance

Congratulations!
Your memberweb registration and website tutorial is complete.

- If you cannot locate the information you require via the website, for whatever reason, you may contact a service representative directly at:

1.877.241.7124

24/7/365 – any question, any time



® National Vision Administrators, L.L.C.
1200 Route 46 West
Clinton, NJ 07013
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Disability Insurance – Shelterpoint NY DBL and PFL Plans

The Northeast District Council of the OPCMIA offers a NY Disability Plan through Shelterpoint for their members. The plan pays out a weekly benefit amount of 50% up to a maximum of \$410 for a total of 26 weeks.

New to NY State effective January 1, 2018 is Paid Family Leave coverage (PFL) that works in conjunction with your NY DBL to provide continuous income replacement in times of need. Please refer to the following pages to view the benefits you may receive with PFL.

NY STATE SHORT TERM DIABILITY

Important Information	You have 30 days from the date of disability to file a claim
Weekly Benefit	50%
Maximum Weekly Amount for 2019	\$410
Total Weeks Paid	26 Weeks
PAID FAMILY LEAVE (PFL)	
Weekly Benefit	55% of Pay
Maximum Weekly Amount for 2019	\$718.00
Total Weeks Paid	10 Weeks



Paid Family Leave Basics

Here's what you need to know

What is Paid Family Leave (PFL):

Starting in January 2018, Paid Family Leave (PFL) becomes a mandatory benefit in New York providing paid time off to employees to bond with a new child, care for a seriously sick family member, or address family matters due to a qualifying military exigency while their job is protected. PFL is a rider to your statutory short-term disability (DBL) policy – unless you self-fund or your business is exempt. Here's the top things to know about this new mandate:

- PFL provides more than just a monetary benefit – it provides **job security** for employees out on paid leave, similar to unpaid leave under FMLA, but regardless of the size of the employer.
- PFL benefits phase in over 4 years with gradually increasing benefit amounts and durations
- Paid leave can be taken in daily increments and – unlike DBL – in **intermittent** intervals, such as every other Monday.
- There is **no “waiting period”**
- **30 days advanced employernotice** is required **for foreseeable leave**. If this is not possible due to the circumstances (such as an accident or heart attack), then the notification needs to be given as soon as practicable (possible).
- If a qualifying event stretches over more than 52 consecutive weeks, a new request must be submitted before the next 52-week period begins.
- The benefit amount that is in effect at the time the leave began applies to the full duration of the paid leave for that event, even if a new calendar year with increased benefit levels falls within that period
- An employee **can't take DBL and PFL at the same time**, i.e., receive benefits for both concurrently. They have to be taken in sequence, and if the employee qualifies for both, the combined duration may not exceed 26 weeks in a consecutive 52-week period.
- An employer cannot require employees to exhaust their accumulated PTO before letting them go out on paid family leave (unless it's an approved FMLA leave).

What PFL Can be Used for

While DBL is for your employee's own no occupational injury or illness, **Paid Family Leave is taken to care for/bond with someone else**. There are 3 main categories of qualifying events for which employees may take paid leave:



To provide care for a family member with a qualifying health condition



To bond with a child after birth, adoption, or to welcome a child into foster care



To cope with a military exigency leave event

PFL Benefits

How they're calculated & other requirements

How the PFL Benefit Works

Employees may take paid leave in weekly increments or in daily increments (intermittent leave).

- The maximum length for all PFL-qualifying events from the first day of paid leave and regardless of re-qualifying at a new employer during that period is: 8 weeks (capped at 56 days for intermittent leave) beginning in 2018, and increasing to a maximum of 12 weeks (capped at 60 days for intermittent leave) in 2021, in a consecutive 52-week period.
 - It is based on the calendar year, **not** your policy year.
 - The 52-week period starts with the first day of either DBL taken or paid leave.
- Maximum length for DBL and PFL benefits can't exceed 26 weeks in any consecutive 52-week period.
- Employees may take paid leave for multiple Paid Family Leave events in a consecutive 52-week period as long as the overall leave doesn't exceed the maximum length they may take. For example: bonding and caring. Caring for mom and then for dad. Taking rest and recuperation leave (under military exigency) and then bonding, etc.
- The benefit amount that is in effect at the time the leave begins applies to the full duration of the paid leave event – even if a new calendar year with increased benefit levels falls within that period.
- Benefits are paid from the insurance carrier to the employee within 18 days of filing a completed claim.
- Benefits paid may be offset by child support deductions
- Benefits paid to employees are considered taxable non-wage income that must be included in federal gross income for tax reporting purposes.

More on PFL Benefits

Are there circumstances where an employee who's eligible for PFL coverage may not be eligible to receive PFL benefits?

Yes, if the employee is:

- on administrative leave
- receiving side pay or PTO
- working part of a day: they can't claim that day for PFL to take paid leave (i.e., PFL must be taken in daily increments)
- receiving total disability benefits from a Workers' Compensation claim, voluntary fire fighters or voluntary ambulance worker's benefits that meet/exceed the benefit amount the employee would be entitled to under PFL. If those benefits are less than the PFL benefits they can still file, but the PFL claim will be offset by the other benefits they're receiving.

Weekly Leave

Benefit chart for employees taking paid leave in weekly increments (regardless of full-time or part-time).

Benefit Stage Effective Date*	Maximum Length of Paid Leave*	Maximum Benefit Amount		
		Payable % of Employee's Average Weekly Wage (AWW)**	To the Maximum % of NY Average Weekly Wage (NYSAWW)**	\$ Max based on 2016 NYSAWW of \$1,305.92**
01/01/2018	8 weeks	50%	50%	\$653
01/01/2019	10 weeks	55%	55%	\$718
01/01/2020	10 weeks	60%	60%	\$784
01/01/2021	12 weeks	67%	67%	\$875

* While this is the anticipated phase-in schedule, New York State may delay increases at its discretion.

** NY Department of Labor releases the updated NYSAWW every March 31.



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 members only, dependents are not eligible to enroll. The plan offers a benefit if you were to pass away. The benefit is paid out to your 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 beneficiaries to make sure your benefit is paid to the correct person.



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





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 members only, dependents are not eligible to enroll. The plan offers a benefit if you were to pass away. The benefit is paid out to your 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 – 1,399 hours in the prior calendar year.

Note: Please update any beneficiaries to make sure your benefit is paid to the correct person



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

Supplemental Plan (Hospital Indemnity)



SUMMARY OF MATERIAL MODIFICATIONS TO



THE NORTHEAST DISTRICT COUNCIL OF THE OPCMIA WELFARE FUND

To: Participants in the Northeast District council of the OPCMIA Welfare Fund

From: Board of Trustees of the Northeast District council of the OPCMIA Welfare Fund

Re: Changes to the Northeast District council of the OPCMIA Welfare Fund

The following summary describes changes to the Northeast District council of the OPCMIA Welfare Fund (the “Plan” or the “Fund”). This summary is intended to satisfy the requirements for issuance of a Summary of Material Modification (“SMM”) under the Employee Retirement Income Security Act of 1974, as amended (“ERISA”). You should take time to read this material carefully and keep it with the copy of the Summary Plan Description (“SPD”) that was previously provided to you. If you need another copy of the SPD, or if you have any questions regarding these changes to the Plan, please contact the Fund Office, either in writing at 100 Merrick Road, Suite 500 West, Rockville Centre, NY 11570 or by telephone at 516-775-2280.

As a participant in the Plan, the Fund provides you and your eligible dependents with a range of hospital and medical benefits. This SMM is intended to notify you of important changes with respect to your out-of-pocket deductible costs for certain hospital and other ancillary medical benefits, which become effective November 1, 2018.

Effective November 1, 2018, the Colonial/Paul Revere Supplemental Plan will be cancelled and replaced with the Aetna Hospital Indemnity Plan.

Please note that **these changes do not become effective until November 1, 2018.** Accordingly, any claims incurred prior to November 1, 2018 will be processed by Colonial/Paul Revere.

Enclosed is a summary of the Aetna Hospital Indemnity Plan benefits. You will notice that many of the reimbursements for your out-of-pocket deductible costs that were formerly covered by the Colonial/Paul Revere Supplemental Plan will, after November 1, 2018, be covered by the Aetna Hospital Indemnity Plan. Because the Aetna Hospital Indemnity Plan is offered in conjunction with your major medical insurance provider (also Aetna), all claims for reimbursement under the Aetna Hospital Indemnity Plan should be made in accordance with the Fund’s Summary Plan Description.



Additionally, for those reimbursements that were formerly covered by the Colonial/Paul Revere Supplemental Plan that are NOT to be covered by the Aetna Hospital Indemnity Plan, **the Fund will provide deductible reimbursements** at the rates specified below:

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

Effective November 1, 2018, examples of deductibles that may be reimbursed by the Fund (at the rates above) are those incurred in connection with the use of allergy injections, emergency ambulances, convalescent facilities, hospice care and durable medical equipment.

In order for the Fund to provide you with this 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 mail:

Praetorian Guard Group, LLC
140 Adams Ave., Suite B11
Hauppauge, NY 11788

By e-mail:

nicoledpgg@optonline.net
emilylpgg@optonline.net

By fax:

1-631-656-5514
1-980-444-0711

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



The Board of Trustees

Northeast District council of the OPCMIA Welfare Fund

This SMM is intended to provide you with an easy-to-understand description of certain changes to the Plan. While every effort has been made to make this description as complete and as accurate as possible, this SMM, of course, cannot contain a full restatement of the terms and provisions of the Plan. If any conflict should arise between this summary and the Plan, or if any point is not discussed in this SMM or is only partially discussed, the terms of the Plan will govern in all cases.

The Board of Trustees (or its duly authorized designee) reserves the right, in its sole and absolute discretion, to amend, modify or terminate the Plan, or any benefits provided under the Plan, in whole or in part, at any time and for any reason, in accordance with the applicable amendment procedures established under the Plan and the Agreement and Declaration of Trust establishing the Plan (the "Trust Agreement"). The Trust Agreement and the full Plan document are at the Fund Office and may be inspected by you free of charge during normal business hours.

No individual other than the Board of Trustees (or its duly authorized designee) has any authority to interpret the plan documents, make any promises to you about benefits under the Plan, or to change any provision of the Plan. Only the Board of Trustees (or its duly authorized designee) has the exclusive right and power, in its sole and absolute discretion, to interpret the terms of the Plan and decide all matters arising under the Plan.



What are some of the highlights of the Aetna Hospital Indemnity Plan?

The Aetna Hospital Indemnity Plan pays benefits related to an inpatient hospital stay. Below are some of the benefits available. Benefits are payable once per member during a plan year unless otherwise specified. Pre-existing condition exclusions do not apply to your plan. For more details, including exclusions and limitations that apply, review your benefit summary.

Aetna Hospital Plan	Benefits
Hospital stay – Admission	\$1,500
Inpatient hospital stay – Daily* (up to 30 days)	\$100
Intensive care unit (ICU) stay – Daily* (up to 30 days)	\$150
Nursery Admission (non-ICU/hospital birth only)	\$100
Rehabilitation unit stay - Daily* (up to 30 days)	\$50
Substance abuse – Daily / Mental disorder– Daily* (up to 30 days)	\$100
Skilled Nursing Facility– Daily* (up to 30 days)	\$50

*Important Note: All daily inpatient stay benefits begin on day two and count towards the plan year maximum. Maximum 30 daily benefits per plan year, combined days for all stays.

We make it simple

If you're eligible to enroll and apply for coverage, your acceptance is guaranteed. We don't ask you any questions about your health. Cash benefits are paid directly to you and are not reduced by other insurance benefits you may have. And there's more:

- You get access to negotiated group rates.
- You'll enjoy the convenience of payroll deduction to pay premiums.
- If you leave your company, you can take your plan with you.

Filing a claim couldn't be easier

After you become a member, you can review your benefits and file claims on our member portal at myaetnasupplemental.com. If you're an Aetna medical plan member, you don't typically need to provide medical paperwork to process a claim. Not an Aetna medical plan member? No problem. Just fill out the online form and upload your medical paperwork.

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Hospital Indemnity Plan 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

THIS IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE.

This plan provides limited benefits. It pays fixed dollar benefits for covered services without regard to the health care provider's actual charges. The benefits payments are not intended to cover the full cost of medical care. You are responsible for making sure the provider's bills get paid. These benefits are paid in addition to any other health coverage you may have.

This material is for information only. Insurance plans contain exclusions and limitations. Not all health services are covered, and coverage is subject to applicable laws and regulations, including economic and trade sanctions. See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Plan features, rates, eligibility and availability may vary by location and are subject to change. Providers are independent contractors and are not agents of Aetna. Aetna does not provide care or guarantee access to health services. Health information programs provide general health information and are not a substitute for diagnosis or treatment by a physician or other health care professional. 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 aetna.com.

Hospital Indemnity Plan Policy form numbers issued in Oklahoma include: GR-96172, GR-96173.

Hospital Indemnity Plan Policy form numbers issued in Idaho include: GR-96172, AL VOL HPOL-Hosp 01.

Hospital Indemnity Plan Policy form numbers issued in Missouri include: GR-96172 01.

NE_Dist_Council_of_OPCMA
10/2018



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)

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

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

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

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

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

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

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)



A range of options to meet your needs

Aetna Hospital Plan

While medical plans typically cover hospitalization, they don't cover everything. This plan can help employees with the out-of-pocket costs associated with a covered inpatient stay.

Fact



Fewer than
1 in 4
Americans ...



have enough money in their **savings account** to cover at least six months of expenses or medical emergency.⁵

Aetna's simplified claims process



Covered medical event



Submit your claim using the online claims form



Our system matches this claim to the medical claim to retrieve the necessary medical information



Your Supplemental Health benefit claim is processed



Payments are sent directly to you

Submitting claims is easy

1. Go to www.aetnavoluntaryforms.com.
2. Use the "Online claims process" link to fill out the form and submit your claim.

Your payment for covered services is on the way.

That's all there is to it!

Claims can be completed online at

www.aetnavoluntaryforms.com or printed and mailed to:
Aetna Voluntary Plans, PO Box 14079,
Lexington, KY 40512-4079.

Don't have internet access? You can request a paper claim form by calling us toll-free at **1-888-772-9682**.

⁵CNNMoney. 76% of Americans are living paycheck-to-paycheck. June 24, 2013. Available at: www.money.cnn.com/2013/06/24/pf/emergency-savings. Accessed February 2015.

This material is for information only. Plans are underwritten by Aetna Life Insurance Company (Aetna). Insurance plans contain exclusions and limitations and are subject to United States economic and trade sanctions. Providers are independent contractors and are not agents of Aetna. Aetna does not provide care or guarantee access to health services. 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.

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CONTACT INFORMATION

CARRIER CONTACT	PHONE NUMBER	WEB ADDRESS
Medical, and Supplemental Plans (Aetna)	1-855-281-8858	www.aetna.com
Vision (NVA)	1-877-241-7124	www.e-nva.com

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

BENEFIT CONSULTANTS	PHONE	EMAIL
Praetorian Guard Group, LLC	1-631-656-3070	tdimattinapgg@optonline.net emilylpgg@optonline.net nicoledpgg@optonline.net

