



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

## BENEFIT PLAN YEAR 2019

(Retirees)

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## Overview

The Northeast District Council of the OPCMIA Welfare Fund has put together this packet of information for all retired members.

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

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

These sections include current Medical, Vision, 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

Basic Life / AD&D

Supplemental Insurance (Hospital Admission 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.

### **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

***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 Medicare PPO Plan

The Northeast District Council of the OPCMIA offers a PPO Plan for members that are eligible to enroll. Members who enroll on the Aetna Medicare PPO Plan may see a doctor of their choice. Please be aware that if you choose to see an out-of-network provider, your out-of-pocket costs will be higher than seeing a provider in the Aetna Medicare PPO network. The Aetna Medicare PPO Plan has a number of services that are covered, 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 and Coverage (SBC) and information on the Aetna Silver Sneakers benefit.

*Note:* When enrolling in the Aetna Medicare PPO 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.





NORTHEAST DISTRICT COUNCIL OF THE OPCMIA WELFARE FUND

Aetna Medicare<sup>SM</sup> Plan (PPO)

Medicare (P01) PPO Plan

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

Benefits and Premiums are effective January 01, 2019 through December 31, 2019

PLAN DESIGN AND BENEFITS

PROVIDED BY AETNA LIFE INSURANCE COMPANY

PLAN FEATURES	Network Providers	Out-of-Network Providers
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<b>Annual Deductible</b>	\$0	\$0
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This is the amount you have to pay out of pocket before the plan will pay its share for your covered Medicare Part A and B services.

<b>Annual Maximum Out-of-Pocket Amount</b>	<b>Network services:</b>	<b>Network and out-of-network services:</b>
	\$3,400	\$3,400 for in and out-of-network services combined

Annual maximum out-of-pocket limit amount includes any deductible, copayment or coinsurance that you pay. It will apply to all medical expenses except Hearing Aid Reimbursement, Vision Reimbursement and Medicare prescription drug coverage that may be available on your plan.

<b>Primary Care Physician Selection</b>	Optional	Not Applicable
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There is no requirement for member pre-certification. Your provider will do this on your behalf.

<b>Referral Requirement</b>	There is no requirement for member pre-certification. Your provider will do this on your behalf.	
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PREVENTIVE CARE	This is what you pay for Network Providers	This is what you pay for Out-of-Network Providers
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<b>Annual Wellness Exams</b> One exam every 12 months.	\$0	25%
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<b>Routine Physical Exams</b>	\$0	15%
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<b>Medicare Covered Immunizations</b> Pneumococcal, Flu, Hepatitis B	\$0	\$0
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<b>Routine GYN Care (Cervical and Vaginal Cancer Screenings)</b>	\$0	15%
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Aetna Medicare<sup>SM</sup> Plan (PPO)  
 Medicare (P01) PPO Plan  
 Custom Rx \$10/\$20/\$50/\$50

One routine GYN visit and pap smear every 24 months.

<b>Routine Mammograms (Breast Cancer Screening)</b>	\$0	15%
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One baseline mammogram for members age 35-39; and one annual mammogram for members age 40 & over.

<b>Routine Prostate Cancer Screening Exam</b>	\$0	15%
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For covered males age 50 & over, every 12 months.

<b>Routine Colorectal Cancer Screening</b>	\$0	15%
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For all members age 50 & over.

<b>Routine Bone Mass Measurement</b>	\$0	15%
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<b>Additional Medicare Preventive Services*</b>	\$0	25%
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<b>Medicare Diabetes Prevention Program (MDPP)</b>	\$0	15%
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12 months of core session for program eligible members with an indication of pre-diabetes.

<b>Routine Eye Exams</b>	\$0	15%
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One annual exam every 12 months.

<b>Routine Hearing Screening</b>	\$0	15%
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One exam every 12 months.

<b>PHYSICIAN SERVICES</b>	<b>This is what you pay for Network Providers</b>	<b>This is what you pay for Out-of-Network Providers</b>
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<b>Primary Care Physician Visits</b>	\$10	25%
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Includes services of an internist, general physician, family practitioner for routine care as well as diagnosis and treatment of an illness or injury and in-office surgery.

<b>Physician Specialist Visits</b>	\$10	25%
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<b>DIAGNOSTIC PROCEDURES</b>	<b>This is what you pay for Network Providers</b>	<b>This is what you pay for Out-of-Network Providers</b>
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<b>Outpatient Diagnostic Laboratory</b>	\$0	25%
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<b>Outpatient Diagnostic X-ray</b>	\$0	25%
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<b>Outpatient Diagnostic Testing</b>	\$0	25%
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<b>Outpatient Complex Imaging</b>	\$0	25%
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<b>EMERGENCY MEDICAL CARE</b>	<b>This is what you pay for Network Providers</b>	<b>This is what you pay for Out-of-Network Providers</b>
<b>Urgently Needed Care; Worldwide</b>	\$15	\$15
<b>Emergency Care; Worldwide (waived if admitted)</b>	\$65	\$65
<b>Ambulance Services</b>	\$0	\$0

**Observation Care**

Your cost share for Observation Care is based upon the services you receive.

<b>HOSPITAL CARE</b>	<b>This is what you pay for Network Providers</b>	<b>This is what you pay for Out-of-Network Providers</b>
<b>Inpatient Hospital Care</b>	\$250 per stay	25% per stay

The member cost sharing applies to covered benefits incurred during a member's inpatient stay.

<b>Outpatient Surgery</b>	\$0	25%
<b>Blood</b>	All components of blood are covered beginning with the first pint.	

<b>MENTAL HEALTH SERVICES</b>	<b>This is what you pay for Network Providers</b>	<b>This is what you pay for Out-of-Network Providers</b>
<b>Inpatient Mental Health Care</b>	\$250 per stay	25% per stay

The member cost sharing applies to covered benefits incurred during a member's inpatient stay.

<b>Outpatient Mental Health Care</b>	\$10	25%
<b>ALCOHOL/DRUG ABUSE SERVICES</b>	<b>This is what you pay for Network Providers</b>	<b>This is what you pay for Out-of-Network Providers</b>
<b>Inpatient Substance Abuse (Detox and Rehab)</b>	\$250 per stay	25% per stay

The member cost sharing applies to covered benefits incurred during a member's inpatient stay.

<b>Outpatient Substance Abuse (Detox and Rehab)</b>	\$10	25%
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<b>OTHER SERVICES</b>	<b>This is what you pay for Network Providers</b>	<b>This is what you pay for Out-of-Network Providers</b>
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**Skilled Nursing Facility (SNF) Care** \$0 copay per day, day(s) 1-20; \$20 copay per day, day(s) 21-100

25%

Limited to 100 days per Medicare Benefit Period\*\*.

The member cost sharing applies to covered benefits incurred during a member's inpatient stay.

**Home Health Agency Care** \$0 25%

**Hospice Care** Covered by Original Medicare at a Medicare certified hospice.

**Outpatient Rehabilitation Services** \$0 25%  
(Speech, Physical, and Occupational therapy)

**Cardiac Rehabilitation Services** \$0 25%

**Pulmonary Rehabilitation Services** \$15 25%

**Radiation Therapy** \$0 25%

**Chiropractic Services** \$15 25%

Limited to Original Medicare - covered services for manipulation of the spine.

**Durable Medical Equipment/ Prosthetic Devices** \$0 25%

**Podiatry Services** \$10 25%

Limited to Original Medicare covered benefits only.

**Diabetic Supplies** \$0 25%  
Includes supplies to monitor your blood glucose from LifeScan.

**Diabetic Eye Exams** \$0 15%

**Outpatient Dialysis Treatments** \$0 \$0

**Medicare Part B Prescription Drugs** \$0 25%

**Medicare Covered Dental** \$10 25%  
Non-routine care covered by Medicare.

**ADDITIONAL NON-MEDICARE COVERED SERVICES**

**Fitness Benefit** Silver Sneakers

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**Resources for Living** Covered

For help locating resources for every day needs.

**PHARMACY - PRESCRIPTION DRUG BENEFITS**

**Calendar-year deductible for prescription drugs** \$0

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

**Pharmacy Network** S2

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

**Formulary (Drug List)** GRP B2

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

**Initial Coverage Limit (ICL)** \$3,820

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

4 Tier Plan	Retail cost-sharing up to a 30-day supply	Retail cost-sharing up to a 90-day supply	Preferred mail order cost-sharing up to a 90-day supply
Tier 1 - Generic Generic Drugs	\$10	\$20	\$20





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4 Tier Plan	Retail cost-sharing up to a 30-day supply	Retail cost-sharing up to a 90-day supply	Preferred mail order cost-sharing up to a 90-day supply
<b>Tier 2 - Preferred Brand</b> Includes some high-cost generic and preferred brand drugs	\$20	\$40	\$40
<b>Tier 3 - Non-Preferred Drug</b> Includes some high-cost generic and non-preferred brand drugs	\$50	\$100	\$100
<b>Tier 4 - Specialty</b> Includes high-cost/unique generic and brand drugs	\$50	Limited to one-month supply	Limited to one-month supply

**Coverage Gap†**

The Coverage Gap starts once covered Medicare prescription drug expenses have reached the Initial Coverage limit. Here’s your cost-sharing for covered Part D drugs between the Initial Coverage limit until you reach \$5,100 in prescription drug expenses:

Your former employer/union/trust provides additional coverage during the Coverage Gap stage for covered drugs. This means that you will generally continue to pay the same amount for covered drugs throughout the Coverage Gap stage of the plan as you paid in the Initial Coverage stage.

Coinsurance-based cost-sharing is applied against the overall cost of the drug, prior to the application of any discounts or benefits.

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**Catastrophic Coverage** Greater of 5% of the cost of the drug - or - \$3.40 for a generic drug or a drug that is treated like a generic and \$8.50 for all other drugs.

Catastrophic Coverage benefits start once \$5,100 in true out-of-pocket costs is incurred.

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**Requirements:**

**Precertification** Applies  
**Step-Therapy** Does Not Apply

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**Non-Part D Drug Rider**

- Not Covered
- 

\* Additional Medicare preventive services include:

- Ultrasound screening for abdominal aortic aneurysm (AAA)
- Cardiovascular disease screening
- Diabetes screening tests and diabetes self-management training (DSMT)
- Medical nutrition therapy
- Glaucoma screening
- Screening and behavioral counseling to quit smoking and tobacco use
- Screening and behavioral counseling for alcohol misuse
- Adult depression screening
- Behavioral counseling for and screening to prevent sexually transmitted infections
- Behavioral therapy for obesity
- Behavioral therapy for cardiovascular disease
- Behavioral therapy for HIV screening
- Hepatitis C screening
- Lung cancer screening





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

**Not all PPO Plans are available in all areas**

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

**The formulary, pharmacy network and/or provider network may change at any time. You will receive notice when necessary.**

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

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

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

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

You must continue to pay your Part B premium.

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





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

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

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

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

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

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

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





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

Coinsurance is applied against the overall cost of the drug, before any discounts or benefits are applied.

Aetna’s retiree pharmacy coverage is an enhanced Part D Employer Group Waiver Plan that is offered as a single integrated product. The enhanced Part D plan consists of two components: basic Medicare Part D benefits and supplemental benefits. Basic Medicare Part D benefits are offered by Aetna based on our contract with CMS. We receive monthly payments from CMS to pay for basic Part D benefits. Supplemental benefits are non-Medicare benefits that provide enhanced coverage beyond basic Part D. Supplemental benefits are paid for by plan sponsors or members and may include benefits for non-Part D drugs. Aetna reports claim information to CMS according to the source of applicable payment (Medicare Part D, plan sponsor or member).

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

- Cover a drug that would be covered under Medicare Part A or Part B.
- Cover a drug purchased outside the United States and its territories.
- Generally cover drugs prescribed for “off label” use, (any use of the drug other than indicated on a drug's label as approved by the Food and Drug Administration) unless supported by criteria included in certain reference books like the American Hospital Formulary Service Drug Information, the DRUGDEX Information System and the USPDI or its successor.

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





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

Aetna Medicare is a PDP, HMO, PPO plan with a Medicare contract. Our SNPs also have contracts with State Medicaid programs. Enrollment in our plans depends on contract renewal.

You can read the *Medicare & You 2019 Handbook*. Every year in the fall, this booklet is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. If you don't have a copy of this booklet, you can get it at the Medicare website (<http://www.medicare.gov>) or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

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

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

This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments, and restrictions may apply. Benefits, premium and/or co-payments/co-insurance may change on January 1 of each year.

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Medicare (P01) PPO Plan

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Plans are offered by Aetna Health Inc., Aetna Health of California Inc., and/or Aetna Life Insurance Company (Aetna). Not all health services are covered. See Evidence of Coverage for a complete description of benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by location.

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

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

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

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

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

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## **Major Medical – Aetna Medicare Extended Service Area Plan (ESA)**

The Northeast District Council of the OPCMIA offers an ESA Plan for members that are eligible to enroll and live outside of the Aetna PPO service area. Members who enroll on the Aetna Medicare ESA Plan may see a doctor of their choice. Please be aware that if you choose to see an out-of-network provider, your out-of-pocket costs will be higher than seeing a provider in the Aetna Medicare ESA network. The Aetna Medicare ESA Plan has a number of services that are covered, 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 and Coverage (SBC) and information on the Aetna Silver Sneakers benefit.

*Note:* When enrolling in the Aetna Medicare ESA 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.





NORTHEAST DISTRICT COUNCIL OF THE OPCMIA WELFARE FUND

Aetna Medicare<sup>SM</sup> Plan (PPO)

Medicare (P01) ESA PPO Plan

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

Benefits and Premiums are effective January 01, 2019 through December 31, 2019

PLAN DESIGN AND BENEFITS

PROVIDED BY AETNA LIFE INSURANCE COMPANY

PLAN FEATURES	Network & Out-of-Network Providers
<b>Annual Deductible</b>	\$0
This is the amount you have to pay out of pocket before the plan will pay its share for your covered Medicare Part A and B services.	
<b>Annual Maximum Out-of-Pocket Amount</b>	\$3,400
Annual maximum out-of-pocket limit amount includes any deductible, copayment or coinsurance that you pay. It will apply to all medical expenses except Hearing Aid Reimbursement, Vision Reimbursement and Medicare prescription drug coverage that may be available on your plan.	
<b>Primary Care Physician Selection</b>	Optional
There is no requirement for member pre-certification. Your provider will do this on your behalf.	
<b>Referral Requirement</b>	None
PREVENTIVE CARE	This is what you pay for Network & Out-of-Network Providers
<b>Annual Wellness Exams</b>	\$0
One exam every 12 months.	
<b>Routine Physical Exams</b>	\$0
<b>Medicare Covered Immunizations</b>	\$0
Pneumococcal, Flu, Hepatitis B	
<b>Routine GYN Care (Cervical and Vaginal Cancer Screenings)</b>	\$0
One routine GYN visit and pap smear every 24 months.	
<b>Routine Mammograms (Breast Cancer Screening)</b>	\$0
One baseline mammogram for members age 35-39; and one annual mammogram for members age 40 & over.	

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Medicare (P01) ESA PPO Plan

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

<b>Routine Prostate Cancer Screening Exam</b>	\$0
For covered males age 50 & over, every 12 months.	
<b>Routine Colorectal Cancer Screening</b>	\$0
For all members age 50 & over.	
<b>Routine Bone Mass Measurement</b>	\$0
<b>Additional Medicare Preventive Services*</b>	\$0
<b>Medicare Diabetes Prevention Program (MDPP)</b>	\$0
12 months of core session for program eligible members with an indication of pre-diabetes.	
<b>Routine Eye Exams</b>	\$0
One annual exam every 12 months.	
<b>Routine Hearing Screening</b>	\$0
One exam every 12 months.	
<b>PHYSICIAN SERVICES</b>	<b>This is what you pay for Network &amp; Out-of-Network Providers</b>
<b>Primary Care Physician Visits</b>	\$10
Includes services of an internist, general physician, family practitioner for routine care as well as diagnosis and treatment of an illness or injury and in-office surgery.	
<b>Physician Specialist Visits</b>	\$10
<b>DIAGNOSTIC PROCEDURES</b>	<b>This is what you pay for Network &amp; Out-of-Network Providers</b>
<b>Outpatient Diagnostic Laboratory</b>	\$0
<b>Outpatient Diagnostic X-ray</b>	\$0
<b>Outpatient Diagnostic Testing</b>	\$0
<b>Outpatient Complex Imaging</b>	\$0
<b>EMERGENCY MEDICAL CARE</b>	<b>This is what you pay for Network &amp; Out-of-Network Providers</b>
<b>Urgently Needed Care; Worldwide</b>	\$15
<b>Emergency Care; Worldwide (waived if admitted)</b>	\$65

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**Ambulance Services** \$0

**Observation Care**

Your cost share for Observation Care is based upon the services you receive.

**HOSPITAL CARE This is what you pay for Network & Out-of-Network Providers**

**Inpatient Hospital Care** \$250 per stay

The member cost sharing applies to covered benefits incurred during a member's inpatient stay.

**Outpatient Surgery** \$0

**Blood** All components of blood are covered beginning with the first pint.

**MENTAL HEALTH SERVICES This is what you pay for Network & Out-of-Network Providers**

**Inpatient Mental Health Care** \$250 per stay

The member cost sharing applies to covered benefits incurred during a member's inpatient stay.

**Outpatient Mental Health Care** \$10

**ALCOHOL/DRUG ABUSE SERVICES This is what you pay for Network & Out-of-Network Providers**

**Inpatient Substance Abuse (Detox and Rehab)** \$250 per stay

The member cost sharing applies to covered benefits incurred during a member's inpatient stay.

**Outpatient Substance Abuse (Detox and Rehab)** \$10

**OTHER SERVICES This is what you pay for Network & Out-of-Network Providers**

**Skilled Nursing Facility (SNF) Care** \$0 copay per day, day(s) 1-20; \$20 copay per day, day(s) 21-100

Limited to 100 days per Medicare Benefit Period\*\*.

The member cost sharing applies to covered benefits incurred during a member's inpatient stay.

**Home Health Agency Care** \$0





NORTHEAST DISTRICT COUNCIL OF THE OPCMIA WELFARE FUND

Aetna Medicare<sup>SM</sup> Plan (PPO)

Medicare (P01) ESA PPO Plan

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

**Hospice Care**

Covered by Original Medicare at a Medicare certified hospice.

---

**Outpatient Rehabilitation Services** \$0  
(Speech, Physical, and Occupational therapy)

---

**Cardiac Rehabilitation Services** \$0

---

**Pulmonary Rehabilitation Services** \$15

---

**Radiation Therapy** \$0

---

**Chiropractic Services** \$15  
Limited to Original Medicare - covered services for manipulation of the spine.

---

**Durable Medical Equipment/ Prosthetic Devices** \$0

---

**Podiatry Services** \$10  
Limited to Original Medicare covered benefits only.

---

**Diabetic Supplies** \$0  
Includes supplies to monitor your blood glucose from LifeScan.

---

**Diabetic Eye Exams** \$0

---

**Outpatient Dialysis Treatments** \$0

---

**Medicare Part B Prescription Drugs** \$0

---

**Medicare Covered Dental** \$10  
Non-routine care covered by Medicare.

---

**ADDITIONAL NON-MEDICARE COVERED SERVICES**

**Fitness Benefit** Silver Sneakers

---

**Resources for Living** Covered

---

For help locating resources for every day needs.

---

**PHARMACY - PRESCRIPTION DRUG BENEFITS**

**Calendar-year deductible for prescription drugs** \$0

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

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**Pharmacy Network** S2

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

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**Formulary (Drug List)** GRP B2

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

---

**Initial Coverage Limit (ICL)** \$3,820

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

<b>4 Tier Plan</b>	<b>Retail cost-sharing up to a 30-day supply</b>	<b>Retail cost-sharing up to a 90-day supply</b>	<b>Preferred mail order cost-sharing up to a 90-day supply</b>
<b>Tier 1 - Generic</b> Generic Drugs	\$10	\$20	\$20
<b>Tier 2 - Preferred Brand</b> Includes some high-cost generic and preferred brand drugs	\$20	\$40	\$40
<b>Tier 3 - Non-Preferred Drug</b> Includes some high-cost generic and non-preferred brand drugs	\$50	\$100	\$100





4 Tier Plan	Retail cost-sharing up to a 30-day supply	Retail cost-sharing up to a 90-day supply	Preferred mail order cost-sharing up to a 90-day supply
<b>Tier 4 - Specialty</b> Includes high-cost/unique generic and brand drugs	\$50	Limited to one-month supply	Limited to one-month supply

**Coverage Gap†**

The Coverage Gap starts once covered Medicare prescription drug expenses have reached the Initial Coverage limit. Here’s your cost-sharing for covered Part D drugs between the Initial Coverage limit until you reach \$5,100 in prescription drug expenses:

Your former employer/union/trust provides additional coverage during the Coverage Gap stage for covered drugs. This means that you will generally continue to pay the same amount for covered drugs throughout the Coverage Gap stage of the plan as you paid in the Initial Coverage stage.

Coinsurance-based cost-sharing is applied against the overall cost of the drug, prior to the application of any discounts or benefits.

---

**Catastrophic Coverage** Greater of 5% of the cost of the drug - or - \$3.40 for a generic drug or a drug that is treated like a generic and \$8.50 for all other drugs.

Catastrophic Coverage benefits start once \$5,100 in true out-of-pocket costs is incurred.

**Requirements:**

**Precertification** Applies

**Step-Therapy** Does Not Apply







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**Non-Part D Drug Rider**

- Not Covered
- 

\* Additional Medicare preventive services include:

- Ultrasound screening for abdominal aortic aneurysm (AAA)
- Cardiovascular disease screening
- Diabetes screening tests and diabetes self-management training (DSMT)
- Medical nutrition therapy
- Glaucoma screening
- Screening and behavioral counseling to quit smoking and tobacco use
- Screening and behavioral counseling for alcohol misuse
- Adult depression screening
- Behavioral counseling for and screening to prevent sexually transmitted infections
- Behavioral therapy for obesity
- Behavioral therapy for cardiovascular disease
- Behavioral therapy for HIV screening
- Hepatitis C screening
- Lung cancer screening

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

**Not all PPO Plans are available in all areas**

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





Aetna Medicare<sup>SM</sup> Plan (PPO)

Medicare (P01) ESA PPO Plan

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

**The formulary, pharmacy network and/or provider network may change at any time. You will receive notice when necessary.**

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

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

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

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

You must continue to pay your Part B premium.

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

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

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

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





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

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

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

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

Coinsurance is applied against the overall cost of the drug, before any discounts or benefits are applied.

Aetna's retiree pharmacy coverage is an enhanced Part D Employer Group Waiver Plan that is offered as a single integrated product. The enhanced Part D plan consists of two components: basic Medicare Part D benefits and supplemental benefits. Basic Medicare Part D benefits are offered by Aetna based on our contract with CMS. We receive monthly payments from CMS to pay for basic Part D benefits. Supplemental benefits are non-Medicare benefits that provide enhanced coverage beyond basic Part D. Supplemental benefits are paid for by plan sponsors or members and may include benefits for non-Part D drugs. Aetna reports claim information to CMS according to the source of applicable payment (Medicare Part D, plan sponsor or member).

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





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- Cover a drug that would be covered under Medicare Part A or Part B.
- Cover a drug purchased outside the United States and its territories.
- Generally cover drugs prescribed for “off label” use, (any use of the drug other than indicated on a drug's label as approved by the Food and Drug Administration) unless supported by criteria included in certain reference books like the American Hospital Formulary Service Drug Information, the DRUGDEX Information System and the USPDI or its successor.

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

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

Aetna Medicare is a PDP, HMO, PPO plan with a Medicare contract. Our SNPs also have contracts with State Medicaid programs. Enrollment in our plans depends on contract renewal.

You can read the *Medicare & You 2019 Handbook*. Every year in the fall, this booklet is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. If you don't have a copy of this booklet, you can get it at the Medicare website (<http://www.medicare.gov>) or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

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Medicare (P01) ESA PPO Plan

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

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

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

This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments, and restrictions may apply. Benefits, premium and/or co-payments/co-insurance may change on January 1 of each year.

Plans are offered by Aetna Health Inc., Aetna Health of California Inc., and/or Aetna Life Insurance Company (Aetna). Not all health services are covered. See Evidence of Coverage for a complete description of benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by location.

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

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

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

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

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

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## Get active with SilverSneakers®

Check out all the ways to use your fitness membership. It's provided for you at **no extra cost** by **Aetna Medicare**.

To find fitness locations and SilverSneakers FLEX classes, request your SilverSneakers ID number or get additional details, visit [silversneakers.com](http://silversneakers.com) or call SilverSneakers Customer Service at 1-888-423-4632 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. ET.



### Work out indoors

- 13,000+ fitness locations\*
- all basic amenities and SilverSneakers group exercise classes
- easy enrollment with your SilverSneakers ID number



### Experience SilverSneakers FLEX® classes

- tai chi, yoga, walking groups and more
- at local parks, recreation centers and adult-living communities (in select states)



### Connect online

- fitness location and SilverSneakers FLEX class lookup tool
- meal plans and healthy recipes
- resources and inspiration

Start using SilverSneakers today!

made available through  
**aetna**®

**SilverSneakers**  
by Tivity Health

\*At-home kits are offered for members who want to start working out at home or for those who can't get to a fitness location due to injury, illness or being homebound. Aetna Medicare is a PDP, HMO, PPO plan with a Medicare contract. Our SNPs also have contracts with State Medicaid programs. Enrollment in our plans depends on contract renewal. Our dual-eligible Special Needs Plan is available to anyone who has both Medical Assistance from the state and Medicare. This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments, and restrictions may apply. Benefits may change on January 1 of each year. See Evidence of Coverage for a complete description of benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by service area. © 2017 Aetna Inc.

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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 retired members 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.

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

<sup>1</sup>Benefit year is based on an enrollee's last date of service.

<sup>2</sup>Actual discounted amounts may vary.

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

<sup>4</sup>Prior authorization required.

<sup>5</sup>Does not apply for certain proprietary frame brands and where prohibited by law.

<sup>6</sup>Only covered if member chooses contact lenses.



## Getting the most out of your Vision Plan

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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](http://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 **EYEESSENTIAL Plan**.

### *Register your account online*

Once enrolled, members can register their account online at **[www.e-nva.com](http://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

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## *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](http://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](http://www.shelterpoint.com)** or **[www.e-nva.com](http://www.e-nva.com)**

## *How can I check the status of my claim?*

- Visit the member portal at: **[www.e-nva.com](http://www.e-nva.com)**
- Call the dedicated toll-free member services telephone number: **877-241-7124**



# MEMBER WEB REGISTRATION



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# Home

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Already Registered? Login

User Name:

Password:

Note: User Name and Password are case sensitive

Not Registered? Register Now

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*Get a better view.*

[www.e-nva.com](http://www.e-nva.com)

- To begin the subscriber registration process, visit [www.e-nva.com](http://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
-----------------	--	----------------------------	-----------------------------	------------------------

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.

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](http://www.e-nva.com/registration)

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

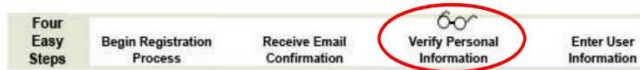


*Get a better view.*

[www.e-nva.com](http://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](http://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.





[www.e-nva.com](http://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 testsubj1. 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 vision care 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



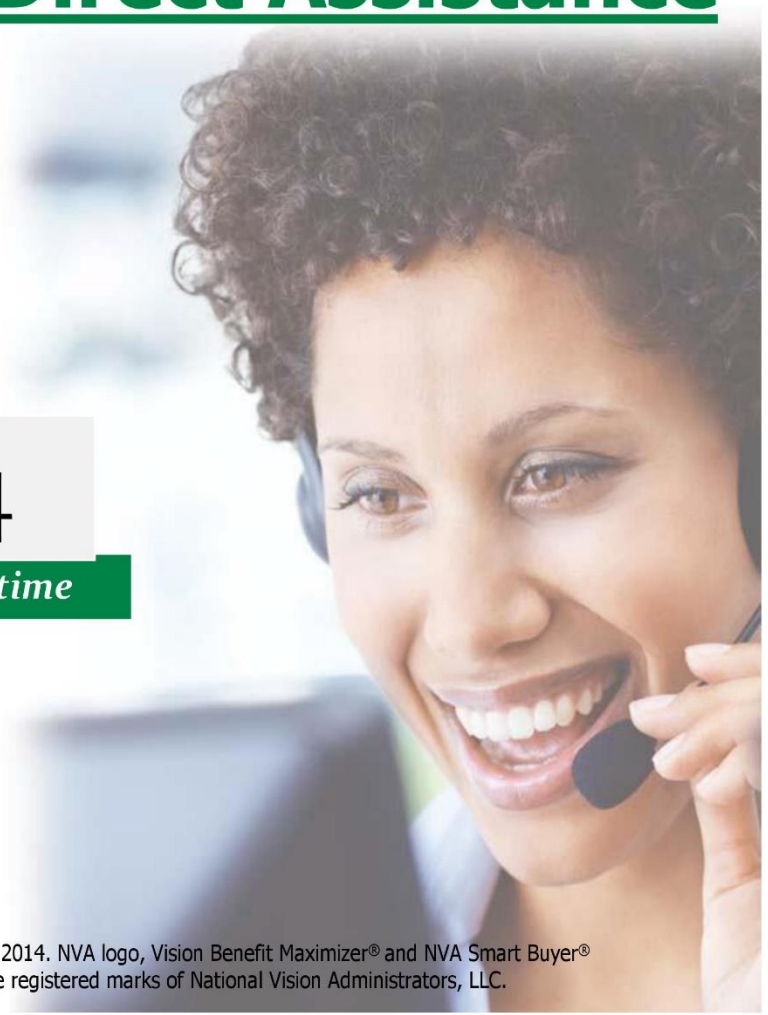
# Direct Assistance

**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  
*Get a better view.*

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

The Northeast District Council of the OPCMIA also offers a Group Life / AD&D plan for retired members. 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 retired members who are pension eligible.

*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

Class 3: Retirees

#### Benefit Schedule

Feature	Description
<b>Basic Life benefits</b>	
Basic life benefit	\$15,000
Guaranteed issue limit	\$15,000
Living benefit (accelerated death benefit)	Not Available
Waiver of premium	Not Available
Conversion	Included
Portability	Not Available
Age reductions	Benefits do not reduce due to age.
Employee contribution	Non-contributory
Participation requirement	100% of eligible employees must be enrolled for coverage
<b>General Provisions</b>	
Resource Advisor	Not Available
Travel Assistance	Not Available
SpecialOffers	Included
Rate guarantee	Rates in this Proposal are guaranteed for 24 months





# Supplemental Insurance (Hospital Admission Plan)

## 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 receiving benefits, 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 certain hospital benefits, which become effective November 1, 2018.

Effective November 1, 2018, the Colonial/Paul Revere Supplemental Plan will be cancelled. In its place, the Fund will offer a \$250.00 reimbursement of your out-of-pocket deductible per hospital admission.

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.

In order to make a claim for the hospital admission reimbursement offered by the Fund, your Explanation of Benefits showing the hospital admission should be sent to 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.

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.



## CONTACT INFORMATION

CARRIER CONTACT	PHONE NUMBER	WEB ADDRESS
Medical (Aetna Medicare)	1-800-282-5366	<a href="http://www.aetnamedicare.com">www.aetnamedicare.com</a>
Vision (NVA)	1-877-241-7124	<a href="http://www.e-nva.com">www.e-nva.com</a>

<b>NORTHEAST DISTRICT COUNCIL OF THE OPCMIA WELFARE FUND OFFICE</b>		
CONTACT	PHONE	EMAIL
Lisa Parisi (Fund Manager)	1-516-775-2280	<a href="mailto:lisa.parisi@nedcfunds.org">lisa.parisi@nedcfunds.org</a>
Laura Brennan	1-516-775-2280	<a href="mailto:laura@nedcfunds.org">laura@nedcfunds.org</a>
Diane Ferchland	1-516-775-2280	<a href="mailto:diane@nedcfunds.org">diane@nedcfunds.org</a>
<b>100 Merrick Road, Suite 500 West ● Rockville Centre, NY 11570</b>		

BENEFIT CONSULTANTS	PHONE	EMAIL
Praetorian Guard Group, LLC	1-631-656-3070	<a href="mailto:tdimattinapgg@optonline.net">tdimattinapgg@optonline.net</a> <a href="mailto:emilylpgg@optonline.net">emilylpgg@optonline.net</a> <a href="mailto:nicoledpgg@optonline.net">nicoledpgg@optonline.net</a>

