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

BENEFIT PLAN YEAR 2019 – 2020

(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 elgible 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 - 2020 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 - 2020 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
Dental
Vision
Disability
Basic Life / AD&D
Supplemental Insurance (Hospital Indemnity Plan)

Enrollment

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

You may also enroll eligible dependents. Elgibile 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 responsbile 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 Adminstrator 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.

aetna : NORTHEAST DISTRICT COUNCIL OF THE OPCMIA WELFARE FUND

Aetna Open Access® Elect Choice® - Low Plan

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

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

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

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

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

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

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

Excluded Services & Other Covered Services:

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

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

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

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

Your Rights to Continue Coverage:

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

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

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

Your Grievance and Appeals Rights:

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

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

Does this plan provide Minimum Essential Coverage? Yes.

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

Does this plan meet Minimum Value Standards? Yes.

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

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

About these Coverage Examples:

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

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

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

This EXAMPLE event includes services like:

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

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

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

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

This EXAMPLE event includes services like:

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

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

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

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

This EXAMPLE event includes services like:

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

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

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

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

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Assistive Technology

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

Smartphone or Tablet

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

Non-Discrimination

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

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

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

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

Civil Rights Coordinator

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

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

Email: CRCoordinator@aetna.com

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

TTY: 711

Language Assistance:

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

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

Hawaiian -	No ke kōkua ma ka ʻōlelo Hawaiʻi, e kahea aku i ka helu kelepona 1-888-982-3862. Kāki ʻole ʻia 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 -	လၢတၢ်မၤစၢၤတၢ်ကတိၤဟ့ၣ်အဂီၢ် ကိ့ၣ် ကိး 1-888-982-3862 လၢတအိၣ်ဒီးတၢ်လၢာ်ဘ့ၣ်လၢာ်စ့ၤဘၢ
Korean -	한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-888-982-3862 번으로 전화해 주십시오.
Kru-Bassa -	Ɓɛ́ m̀ ké gbo-kpá-kpá dyé pidyi ɖé Ɓǎsɔ́ɔ̀-wuɖuǔn wɛ́ɛ, ɖá 1-888-982-3862
Kurdish -	برای راهنمایی به زبان فارسی با شماره 1-888-982-3862 به خورایی پەیوەندی بکەن.
Laotian -	ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ, ກະລຸນາໂທຫາ 1-888-982-3862 ໂດຍບໍ່ເສຍຄ່າໂທ.
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 nínízingo Diné k'ehjí koji' t'áá jíík'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 Thuɔŋjäŋ cɔl 1-888-982-3862 kecin aɣöc.
Norwegian -	For språkassistanse på norsk, ring 1-888-982-3862 kostnadsfritt.
Panjabi -	ਪੰਜਾਬੀ ਵਿੱਚ ਭਾਸ਼ਾਈ ਸਹਾਇਤਾ ਲਈ, 1-888-982-3862 'ਤੇ ਮੁਫ਼ਤ ਕਾਲ ਕਰੋ।
Pennsylvania Dutch -	Fer Helfe in Deitsch, ruf: 1-888-982-3862 aa. Es Aaruf koschtet nix.

Persian - برای راهنمایی به زبان فارسی با شماره 1-888-982-3862 بدون هیچ هزینه ای تماس بگیرید. انگلیسی

Polish - Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-888-982-3862.

Portuguese - Para obter assistência linguística em português ligue para o 1-888-982-3862 gratuitamente.

Romanian - Pentru asistență lingvistică în românește telefonați la numărul gratuit 1-888-982-3862

Russian - Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-888-982-3862.

Samoan - Mo fesoasoani tau gagana I le Gagana Samoa vala'au le 1-888-982-3862 e aunoa ma se totogi.

Serbo-Croatian - Za jezičnu pomoć na hrvatskom jeziku pozovite besplatan broj 1-888-982-3862.

Spanish - Para obtener asistencia lingüística en español, llame sin cargo al 1-888-982-3862.

Sudanic-Fulfude - Fii yo on heɓu balal e ko yowitii e haala Pular noddee e oo numero ɗoo 1-888-982-3862 Njodi woo fawaaki on.

Swahili - Ukihitaji usaidizi katika lugha ya Kiswahili piga simu kwa 1-888-982-3862 bila malipo.

Syriac - [illegible] 1-888-982-3862 [illegible].

Tagalog - Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-888-982-3862 nang walang bayad.

Telugu - భాషతో సహాయం కొరకు ఎలాంటి ఖర్చు లేకుండా **1-888-982-3862** కు కాల్ చేయండి. (తెలుగు)

Thai - สำหรับความช่วยเหลือทางด้านภาษาเป็น ภาษาไทย โทร 1-888-982-3862 ฟรีไม่มีค่าใช้จ่าย

Tongan - Kapau 'oku fiema'u hā tokoni 'i he lea faka-Tonga telefoni 1-888-982-3862 'o 'ikai hā tōtōngi.

Trukese - Ren áninnisin chiakú ren (Kapasen Chuuk) kopwe kékkééri 1-888-982-3862 nge esapw kamé ngonuk.

Turkish - (Dil) çağrısı dil yardım için. Hiçbir ücret ödemeden 1-888-982-3862.

Ukrainian - Щоб отримати допомогу перекладача української мови, зателефонуйте за безкоштовним номером 1-888-982-3862.

Urdu - [illegible] 1-888-982-3862 [illegible]

Vietnamese - Để được hỗ trợ ngôn ngữ bằng (ngôn ngữ), hãy gọi miễn phí đến số 1-888-982-3862.

Yiddish - פאר שפראך הילף אין אידיש רופט 1-888-982-3862 פריי פון אפצאל.

Yoruba - Fún ìrànlọwọ nípa èdè (Yorùbá) pe 1-888-982-3862 lái san owó kankan rárá.

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- **Know your plan.** Check who is covered by your plan and what it covers.
- **Get valuable information.** See which doctors and hospitals have met extra standards for quality and efficiency.
- **Know costs *before* you go.** See cost estimates before you make an appointment for an office visit, test or procedure.
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*Health savings accounts are currently not available to health maintenance organization (HMO) members in Illinois and California.

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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 POS RIDER 08/07, GR-23 and/or GR-29/GR-29N.

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New! Dental Insurance – Aetna Dental DMO Plan

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

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

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DMO® Dental Benefits Summary

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

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

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DMO® Dental Benefits Summary

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

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D6073	Abutment Supported Retainer for Cast Metal FPD (Predominantly Base Metal)	$362	D6794	Crown - Titanium	$362
D6074	Abutment Supported Retainer for Cast Metal FPD (Noble Metal)	$362	D6930	Recement Fixed Partial Denture	$25
D6075	Implant Supported Retainer for Ceramic FPD	$362	Additional Charge per Unit for Full Mouth Rehabilitation.		$125
Full mouth rehabilitation is defined as 6 or more units of covered crowns and/or pontics under one treatment plan.					
Charges for crowns and bridgework are per unit. There will be additional charges for the actual cost for gold/high noble metal.					
ENDODONTICS					
D3110	Pulp Cap - Direct (excluding final restoration)	No Charge	D3333	Internal Root Repair of Perforation Defects	$110
D3120	Pulp Cap - Indirect (excluding final restoration)	No Charge	D3346	Retreatment of Previous Root Canal Therapy - Anterior	$242
D3220	Therapeutic Pulpotomy (excluding final restoration)	$77	D3347	Retreatment of Previous Root Canal Therapy - Bicuspid	$308
D3221	Pulpal Debridement, Primary and Permanent Teeth	$14	D3348	Retreatment of Previous Root Canal Therapy - Molar	$433
D3222	Partial Pulpotomy	$70	D3410 (1)	Apicoectomy/Periradicular Surgery - Anterior	$179
D3230	Pulpal Therapy (Resorbable Filling) - Anterior, Primary Tooth	$77	D3421 (1)	Apicoectomy/Periradicular Surgery - Bicuspid (First Root)	$179
D3240	Pulpal Therapy (Resorbable Filling) - Posterior, Primary Tooth	$77	D3425 (1)	Apicoectomy/Periradicular Surgery - Molar (First Root)	$179
D3310	Root Canal Therapy - Anterior (excluding final restoration)	$135	D3426 (1)	Apicoectomy/Periradicular Surgery- Each Additional Root	$110
D3320	Root Canal Therapy - Bicuspid (excluding final restoration)	$216	D3427 (1)	Periradicular surgery without apicoectomy	$134
D3330	Root Canal Therapy - Molar (excluding final restoration)	$331	D3430 (1)	Retrograde Filling - Per Root	$80
D3331	Treatment of Root Canal Obstruction, Nonsurgical Access	$135	D3450 (1)	Root Amputation - Per Root	$88
D3332	Incomplete Endodontic Therapy; Inoperable, Unrestorable or Fractured Tooth	$99			
(1) Certain services may be covered under the Medical Plan. Contact Member Services for more details.					
PERIODONTICS					
D4210 (1)	Gingivectomy or Gingivoplasty - 4 or More Teeth - Per Quadrant	$105	D4275 (1)	Soft Tissue Allograft	$342
D4211 (1)	Gingivectomy or Gingivoplasty - 1-3 Teeth - Per Quadrant	$39	D4276 (1)	Connective Tissue/Pedicle Graft, Per Tooth	$200
D4212 (1)	Gingivectomy to allow access, per tooth	$13	D4277 (1)	Free soft tissue graft - first tooth	$86
D4240 (1)	Gingival Flap Procedure, Including Root Planing - 4 or More Teeth - Per Quadrant	$116	D4278 (1)	Free soft tissue graft - each additional tooth	$43
D4241 (1)	Gingival Flap Procedure, Including Root Planing - 1-3 Teeth - Per Quadrant	$69	D4283 (1)	Autogenous connective tissue graft	$67
D4245 (1)	Apically Positioned Flap	$95	D4285 (1)	Non-autogenous connective tissue graft	$188
D4249	Clinical Crown Lengthening, Hard Tissue	$158	D4341	Periodontal Scaling and Root Planing - 4 or More Teeth - Per Quadrant	$53
D4260 (1)	Osseous Surgery (Including Flap Entry and Closure) - 4 or More Teeth - Per Quadrant	$263	D4342	Periodontal Scaling and Root Planing - 1-3 Teeth - Per Quadrant	$32
D4261 (1)	Osseous Surgery (Including Flap Entry and Closure) - 1-3 Teeth - Per Quadrant	$158	D4355	Debridement	$70
D4268 (1)	Surgical Revision Procedure, Per Tooth	$105	D4910	Periodontal Maintenance	$33
D4270 (1)	Pedicle Soft Tissue Graft Procedure	$200	D4920	Unscheduled Dressing Change (By Someone Other Than Treating Dentist)	$11
D4273 (1)	Subepithelial Connective Tissue Graft, Per Tooth	$121			
(1) Certain services may be covered under the Medical Plan. Contact Member Services for more details.					
PROSTHODONTICS-REMOVABLE (2)					
D5110	Complete Denture - Maxillary	$318	D5223-D5224	Immediate max/mand partial denture - cast base framework w/resin denture base (including any conventional clasps, rests and teeth)	$393

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D5120	Complete Denture - Mandibular	$318	D5225	Maxillary Partial Denture - Flexible Base (including any clasps, rests and teeth)	$363
D5130	Immediate Denture - Maxillary	$342	D5226	Mandibular Partial Denture - Flexible Base (including any clasps, rests and teeth)	$363
D5140	Immediate Denture - Mandibular	$342	D5282-83	Removable Unilateral Partial Denture - One Piece Cast Metal (including clasps and teeth)	$318
D5211	Maxillary Partial Denture - Resin Base (including any conventional clasps, rests and	$318	D5410	Adjust Complete Denture - Maxillary	$11
D5212	Mandibular Partial Denture - Resin Base (including any conventional clasps, rests and teeth)	$318	D5411	Adjust Complete Denture - Mandibular	$11
D5213	Maxillary Partial Denture - Cast Metal Framework with Resin Denture Bases (including any conventional clasps, rests and teeth)	$342	D5421	Adjust Partial Denture - Maxillary	$11
D5214	Mandibular Partial Denture - Cast Metal Framework with Resin Denture Bases (including any conventional clasps, rests and teeth)	$342	D5422	Adjust Partial Denture - Mandibular	$11
D5221-D5222	Immediate max/mand partial dental - resin base (including any conventional clasps, rests and teeth)	$366			
(2) Includes relines, adjustments, rebases within the 1st six months. Adjustments to dentures that are done within six months of placement of the denture, are limited to no more than four adjustments.					
REPAIRS TO PROSTHETICS					
D5511-D5512	Repair Broken Complete Denture Base	$45	D5730	Reline Complete Maxillary Denture (Chairside)	$66
D5520	Replace Missing or Broken Teeth - Complete Denture (each tooth)	$45	D5731	Reline Complete Mandibular Denture (Chairside)	$66
D5611-D5612	Repair Resin Partial Denture Base	$45	D5740	Reline Maxillary Partial Denture (Chairside)	$66
D5621-D5622	Repair Cast Partial Framework	$45	D5741	Reline Mandibular Partial Denture (Chairside)	$66
D5630	Repair or Replace Broken Clasp	$45	D5750	Reline Complete Maxillary Denture (Lab)	$110
D5640	Replace Broken Teeth - Per Tooth	$50	D5751	Reline Complete Mandibular Denture (Lab)	$110
D5650	Add Tooth to Existing Partial Denture	$45	D5760	Reline Maxillary Partial Denture (Lab)	$110
D5660	Add Clasp to Existing Partial Denture	$50	D5761	Reline Mandibular Partial Denture (Lab)	$110
D5670	Replace All Teeth and Acrylic on Cast Metal Framework (Maxillary)	$110	D5820	Interim Partial Denture (Maxillary) (3)	$132
D5671	Replace All Teeth and Acrylic on Cast Metal Framework (Mandibular)	$110	D5821	Interim Partial Denture (Mandibular) (3)	$132
D5710	Rebase Complete Maxillary Denture	$110	D5850	Tissue Conditioning, Maxillary	$61
D5711	Rebase Complete Mandibular Denture	$110	D5851	Tissue Conditioning, Mandibular	$61
D5720	Rebase Maxillary Partial Denture	$110	D5876	Add metal substructure to acrylic full denture (per arch)	$40
D5721	Rebase Mandibular Partial Denture	$110			
(3) Eligible on Anterior Teeth only.					
ORAL SURGERY					
D7111	Extraction, Coronal Remnants - Deciduous Tooth	No Charge	D7285 (1)	Biopsy of Oral Tissue - Hard (Bone, Tooth)	$88
D7140	Extraction, Erupted Tooth or Exposed Root (Elevation and/or Forceps Removal)	No Charge	D7286 (1)	Biopsy of Oral Tissue - Soft	$88
D7210 (1)	Surgical Removal of Erupted Tooth	$57	D7287 (1)	Cytological Sample Collection	$44
D7220 (1)	Removal of Impacted Tooth - Soft Tissue	$65	D7310 (1)	Alveoloplasty in Conjunction With Extractions - 4 or More Teeth or Tooth Spaces - Per Quadrant	$66
D7230 (1)	Removal of Impacted Tooth - Partially Bony	$94	D7311 (1)	Alveoloplasty in Conjunction With Extractions - 1 to 3 Teeth or Tooth Spaces - Per Quadrant	$33
D7240 (1)	Removal of Impacted Tooth - Completely Bony	$145	D7320 (1)	Alveoloplasty Not in Conjunction With Extractions - 4 or More Teeth or Tooth Spaces - Per Quadrant	$83
D7241 (1)	Removal of Impacted Tooth - Completely Bony, With Unusual Surgical Complications	$145	D7321 (1)	Alveoloplasty Not in Conjunction With Extractions - 1-3 Teeth or Tooth Spaces - Per Quadrant	$42
D7250 (1)	Surgical Removal of Residual Tooth Roots	$59	D7510 (1)	Incision and Drainage of Abcess - Intraoral Soft Tissue	$33

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

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DMO® Dental Benefits Summary

D7251	Coronectomy - intentional partial tooth removal	$66	D7511 (1)	Incision and Drainage of Abcess - Intraoral Soft Tissue - Complicated	$36
D7280 (1)	Surgical Access of Unerupted Tooth	$62	D7960 (1)	Frenulectomy (Frenectomy, Frenotomy) Separate Procedure	$99
D7282 (1)	Mobilization of Erupted or Malpositioned Tooth to Aid Eruption	$77	D7963 (1)	Frenuloplasty	$105
D7283	Placement of Device to Facilitate Eruption of Impacted Tooth	$15			
(1) Certain services may be covered under the Medical Plan. Contact Member Services for more details.					
OTHER (ADJUNCTIVE) SERVICES					
D9110	Palliative (Emergency) Treatment of Dental Pain - minor procedure	$11	D9942	Repair and/or Reline of Occlusal Guard	$22
D9222	Deep sedation/general anesthesia - 1st 15 min	$109	D9943	Occlusal guard adjustment	$19
D9223	Deep sedation/general anesthesia - each 15 minute increment	$87	D9944	Occlusal guard – hard appliance, full arch	$173
D9239	Intravenous conscious sedation/analgesia - 1st 15 min	$109	D9945	Occlusal guard – soft appliance, full arch	$150
D9243	Intravenous conscious sedation/analgesia - each 15 minute increment	$87	D9946	Occlusal guard – hard appliance, partial arch	$90
D9310	Consultation - Diagnostic Service Provided by Dentist or Physician Other Than Requesting Dentist or Physician	No Charge	D9951	Occlusal Adjustment - limited	$35
D9311	Consultation with a medical health care professional	No Charge	D9952	Occlusal Adjustment - complete	$96
D9932-D9935	Denture cleaning and inspection	$25			
ORTHODONTICS					
	Orthodontic Screening Exam	$30			
	Diagnostic Records	$150			
	Comprehensive Orthodontic Treatment				
	Adolescent (appliance must be placed prior to age 20)	$1,545			
	Adult	N/A			
	Orthodontic Retention	$275			

Other Important Information

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

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

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

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

PLAN EXCLUSIONS AND LIMITATIONS*

Some Services Not Covered Under the Plan Are:

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

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

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

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

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DMO® Dental Benefits Summary

4. Those for replacement of a lost, missing or stolen appliance, and those for replacement of appliances that have been damaged due to abuse, misuse or neglect.
5. Those for plastic, reconstructive or cosmetic surgery, or other dental services or supplies, that are primarily intended to improve, alter or enhance appearance. This applies whether or not the services and supplies are for psychological or emotional reasons. Facings on molar crowns and pontics will always be considered cosmetic.
6. Those for or in connection with services, procedures, drugs or other supplies that are determined by Aetna to be experimental or still under clinical investigation by health professionals.
7. Those for dentures, crowns, inlays, onlays, bridgework, or other appliances or services used for the purpose of splinting, to alter vertical dimension, to restore occlusion, or to correct attrition, abrasion or erosion. Does not apply to CA contracts.
8. Those for any of the following services (Does not apply to TX contracts): (a) An appliance or modification of one if an impression for it was made before the person became a covered person; (b) A crown, bridge, or cast or processed restoration if a tooth was prepared for it before the person became a covered person; (c) Root canal therapy if the pulp chamber for it was opened before the person became a covered person.
9. Services that Aetna defines as not necessary for the diagnosis, care or treatment of the condition involved. This applies even if they are prescribed, recommended or approved by the attending physician or dentist.
10. Those for services intended for treatment of any jaw joint disorder, unless otherwise specified in the Booklet-Certificate.
11. Those for space maintainers, except when needed to preserve space resulting from the premature loss of deciduous teeth.
12. Those for orthodontic treatment, unless otherwise specified in the Booklet-Certificate.
13. Those for general anesthesia and intravenous sedation, unless specifically covered. For plans that cover these services, they will not be eligible for benefits unless done in conjunction with another necessary covered service.
14. Those for treatment by other than a dentist, except that scaling or cleaning of teeth and topical application of fluoride may be done by a licensed dental hygienist. In this case, the treatment must be given under the supervision and guidance of a dentist.
15. Those in connection with a service given to a dependent age 5 or older if that dependent becomes a covered dependent other than: (a) during the first 31 days the dependent is eligible for this coverage, or (b) as prescribed for any period of open enrollment agreed to by the employer and Aetna. This does not apply to charges incurred: (i) after the end of the 12-month period starting on the date the dependent became a covered dependent; or (ii) as a result of accidental injuries sustained while the dependent was a covered dependent; or (iii) for a primary care service in the Dental Care Schedule that applies as shown under the headings Visits and Exams, and X-rays and Pathology.
16. Services given by a nonparticipating dental provider to the extent that the charges exceed the amount payable for the services shown in the Dental Care Schedule that applies.
17. Those for a crown, cast or processed restoration unless: (a) It is treatment for decay or traumatic injury and teeth cannot be restored with a filling material; or (b) The tooth is an abutment to a covered partial denture or fixed bridge.
18. Those for pontics, crowns, cast or processed restorations made with high-noble metals, unless otherwise specified in the Booklet-Certificate.
19. Those for surgical removal of impacted wisdom teeth only for orthodontic reasons, unless otherwise specified in the Booklet-Certificate.
20. Services needed solely in connection with non-covered services.
21. Services done where there is no evidence of pathology, dysfunction or disease other than covered preventive services. Does not apply to CA contracts.
Any exclusion above will not apply to the extent that coverage of the charge is required under any law that applies to the coverage.
*This is a partial list of exclusions and limitations, others may apply. Please check your plan booklet for details.

A partial list of what your plan doesn't cover* – some eligible dental service exceptions and exclusions
1. Charges for services or supplies • Provided by a network provider in excess of the negotiated charge. • Provided by an out-of-network provider in excess of the recognized charge. • Provided for your personal comfort or convenience, or the convenience of any other person, including a dental provider • Provided in connection with treatment or care that is not covered under the plan • Cancelled or missed appointment charges or charges to complete claim forms • Charges for which you have no legal obligation to pay • Charges that would not be made if you did not have coverage, including: - Care in charitable institutions - Care for conditions related to current or previous military service
2. Any charge in excess of any benefit, dollar, visit, or frequency limit stated in the schedule of benefits.

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

DMO® Dental Benefits Summary

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

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

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

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DMO® Dental Benefits Summary

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

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

Emergency Dental Care

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

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

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

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

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

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

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

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

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

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

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

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

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

- If a charge is made for a non-eligible dental service or supply and an eligible dental service that would provide an acceptable result, then your plan will pay a benefit for the eligible dental service or supply.
- If a charge is made for an eligible dental service but another eligible dental service that would provide an acceptable result is less expensive, the benefit will be for the least expensive eligible dental service.
- You should review the differences in the cost of alternate treatment with your dental provider. Of course, you and your dental provider can still choose the more costly treatment method. You are responsible for any charges in excess of what your plan will cover.

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

- Crowns

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

DMO® Dental Benefits Summary

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

These eligible dental services are covered only when you give us proof that:

• While you were covered by the plan:
– You had a tooth (or teeth) extracted after the existing denture or bridge was installed.
– As a result, you need to replace or add teeth to your denture or bridge.

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

• While you were covered by the plan:
– You had a tooth (or teeth) extracted.
– Your present denture is an immediate temporary one that replaces that tooth (or teeth).
– A permanent denture is needed, and the temporary denture cannot be used as a permanent denture. Replacement must occur within 12 months from the date that the temporary denture was installed.

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

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

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

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

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

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

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

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

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

Finding Participating Providers

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

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

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

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

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

DMO® Dental Benefits Summary

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

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

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

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

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

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

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

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

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

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New! Dental Insurance – Aetna Dental PPO Plan

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

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

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

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Dental Benefits Summary

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

*The deductible applies to: Basic & Major services only

**Orthodontia is covered only for children (appliance must be placed prior to age 20).

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

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

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

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Good news to smile about Aetna Dental® plans

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

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

How will my dentist know I'm an Aetna Dental member?
When you visit your dentist, simply tell the office your name, date of birth and member ID number (or your Social Security number).

But what if I want a card?

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

Here's what else you can do online:

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

Aetna Mobile — find what you need, wherever, whenever

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

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

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

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

**Standard text messaging rates may apply.

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

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

Here is a reminder card. Just cut it out and keep it close by.

aetna®

Aetna Dental® plans

Log in to your secure member website at **www.aetna.com** to explore the resources available to you. Call **1-877-238-6200** if you have any questions — 24 hours a day, 365 days a year.

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 Adminstrator 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.

SHELTERPOINT Life Insurance Company

Vision Insurance - Gold Plan Summary

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

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

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

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

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 ***EYEESSENTIAL 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

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**

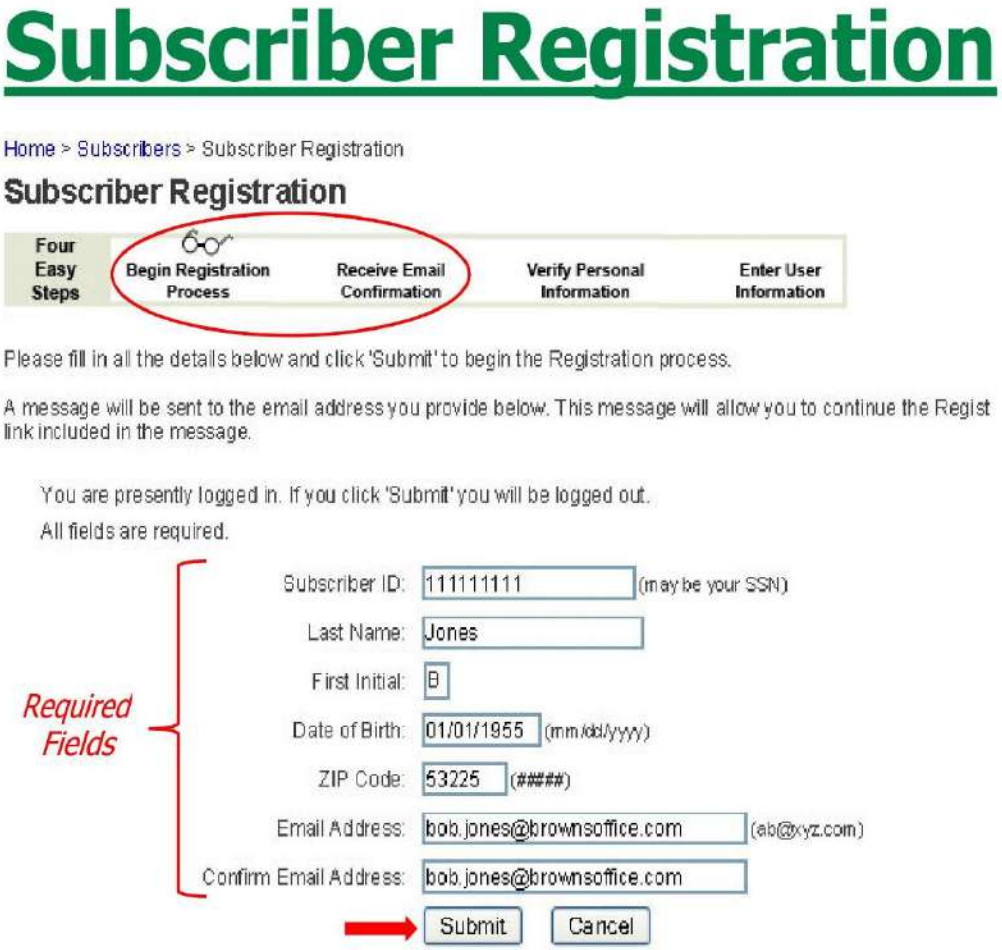
MEMBER WEB REGISTRATION

- **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.**

NVA® *Get a better view.* www.e-nva.com

Subscriber Registration

- **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).



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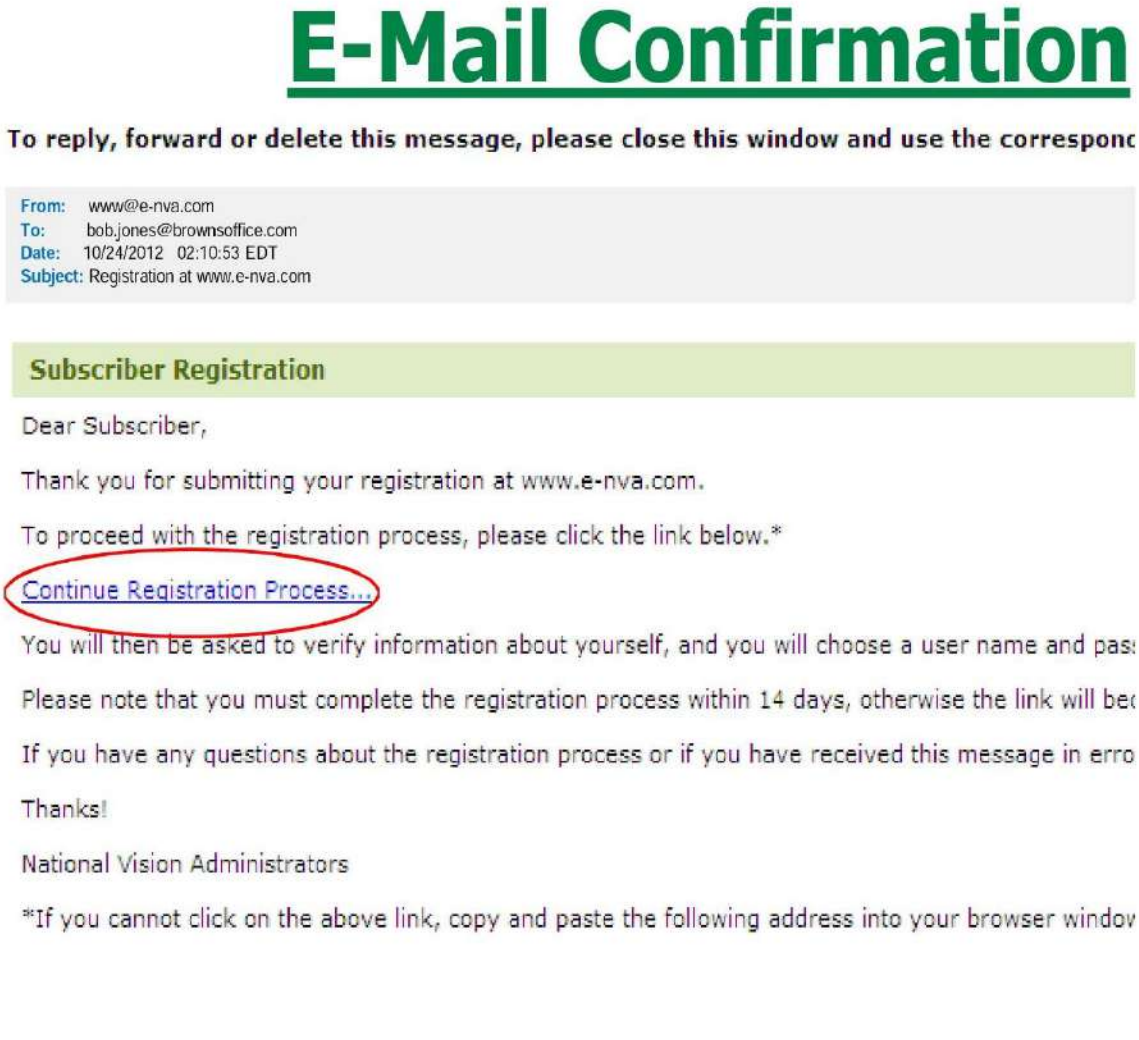
www.e-nva.com

E-Mail Confirmation

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



To reply, forward or delete this message, please close this window and use the correspond

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 pas

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

If you have any questions about the registration process or if you have received this message in erro

Thanks!

National Vision Administrators

*If you cannot click on the above link, copy and paste the following address into your browser windov

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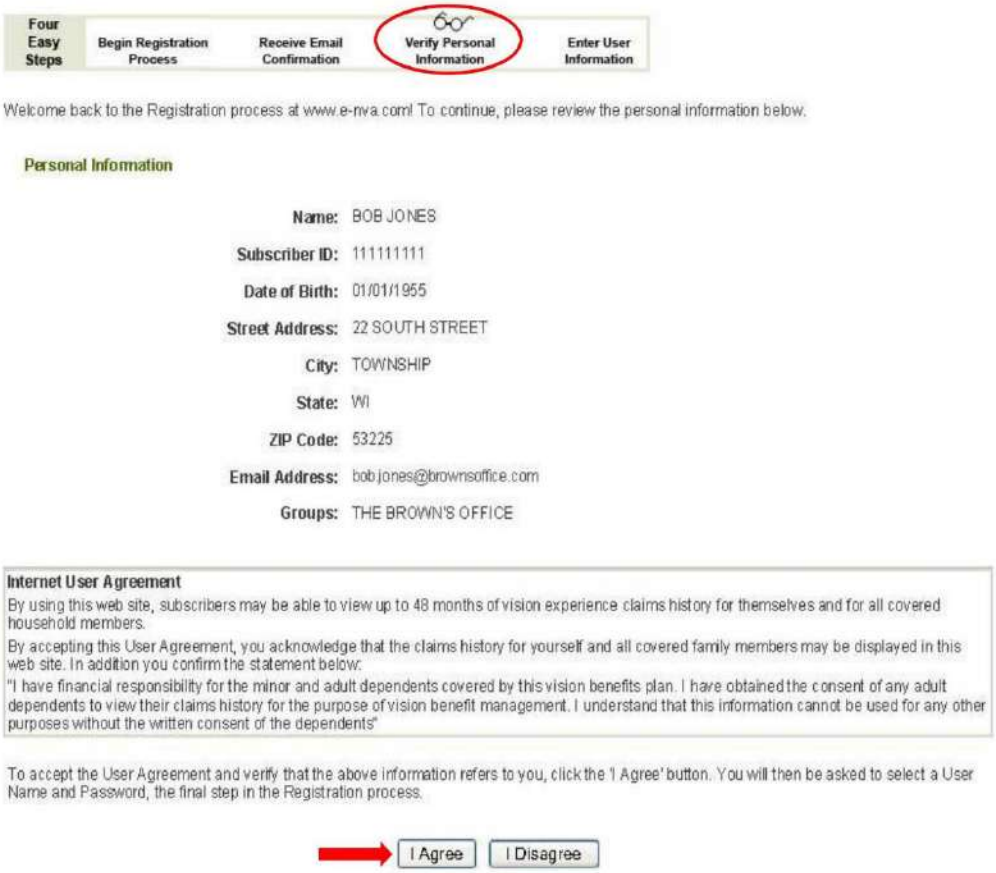
Verify Registration Information

- **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.**



Four Easy Steps | Begin Registration Process | Receive Email Confirmation | Verify Personal Information | Enter User Information

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:	bobjones@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.

I Agree | I Disagree

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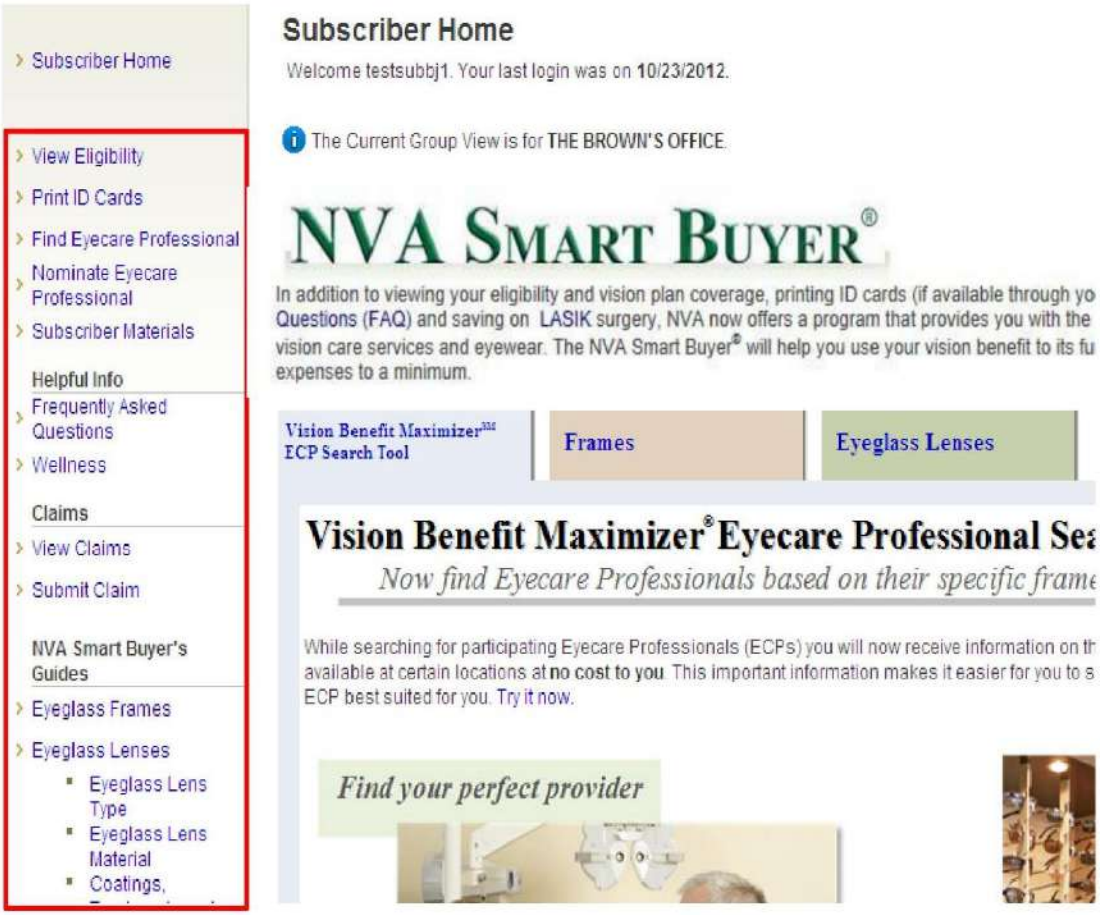
www.e-nva.com

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.**



NVA® *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

NVA® National Vision Administrators, L.L.C.
1200 Route 46 West
Clifton, NJ 07013
Get a better view.

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 2020	$410
Total Weeks Paid	26 Weeks
PAID FAMILY LEAVE (PFL) 2020	
Weekly Benefit	60% of Pay
Maximum Weekly Amount for 2020	$840.70 (Based off average weekly wage of $1,401.17)
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 employer notice** 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 qualifiying 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.

BENEFIT SUMMARY

Northeast District Council of the OPCMIA Welfare Fund

802405

Aetna Hospital Indemnity

Insurance plans are underwritten by Aetna Life Insurance Company.

Here's how the plan works:

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

THIS PLAN DOES NOT COUNT AS MINIMUM ESSENTIAL COVERAGE UNDER THE AFFORDABLE CARE ACT. THIS IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMUM ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES.

THIS IS NOT A MEDICARE SUPPLEMENT (MEDIGAP) PLAN. If you are or will become eligible for Medicare, review the free Guide to Health Insurance for People with Medicare available at **www.medicare.gov.**

This policy, alone, does not meet Massachusetts Minimum Creditable Coverage standards.

The insurance evidenced by this certificate provides limited benefits health insurance only. It does NOT provide basic hospital, basic medical, major medical, Medicare supplement, long term care insurance, nursing home insurance only, home care insurance only, or nursing home and home care insurance as defined by the New York State Department of Financial Services.

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

Important Note:
All inpatient stays begin on day two and count toward the plan year maximum.

Inpatient Benefits	Plan 2
Skilled nursing facility stay - Daily Pays a daily benefit for each day you have a stay in a skilled nursing facility due to an illness or accidental injury. *Maximum 30 days per plan year*	$50

Important Note:
Plan year maximums for inpatient stay daily benefits, including skilled nursing facility and hospice care, start counting on day two of the inpatient stay.

Waiver of premium

If you are in a hospital for more than 30 days in a row, we will waive the premium beginning on the first premium due date that occurs after the 30th day of your stay, through the next 6 months of coverage. During your stay, you must remain employed with the policyholder.

Exclusions and Limitations

This plan has exclusions and limitations. Refer to the actual policy and certificate to determine which benefits are not payable. The following is a partial list of services and supplies that are generally not covered. However, the plan may contain exceptions to this list based on state mandates or the plan design purchased.

Benefits will not be paid for any stay or other service for an illness or accidental injury related to the following:

1. Engaging in extra-hazardous activities meaning aviation and related activities
2. Participating as a professional in athletics or sports
3. Act of war, riot, war
4. Operating, learning to operate or serving as a pilot or crew member of any aircraft, whether motorized or not
5. Assault, felony, illegal occupation, or other criminal act
6. Care provided by a spouse, parent, child, or sibling
7. Cosmetic services and plastic surgery, with certain exceptions
8. Custodial Care
9. Hospice services, except as specifically provided in the Benefits under your plan section of the certificate;
10. Self-harm, suicide, except when resulting from a diagnosed disorder
11. Violating any cellular device use laws of the state in which the accident occurred, while operating a motor vehicle
12. Care or services received outside the United States, its possessions or the countries of Canada and Mexico
13. Accidental injury sustained while under the influence of any narcotic unless administered on the advice of a physician and taken in the prescribed dose
14. Dental and orthodontic care and treatment
15. Any care, prescription drugs, and medicines related to infertility
16. Outpatient cognitive rehabilitation, physical therapy, occupational therapy, or speech therapy for any reason
17. Vision-related care

Questions and Answers

Do I have to be actively at work to enroll in coverage?

Yes, you must be actively at work in order to enroll and for coverage to take effect. You are actively at work if you are working, or are available to work, and meet the criteria set by your employer to be eligible to enroll.

Can I enroll in the Aetna Hospital Indemnity plan even though I have a Health Savings Account (HSA)?

Yes, you can still enroll in the Aetna Hospital Indemnity plan if you have a Health Savings Account.

What is considered a hospital stay?

A stay is a period during which you are admitted as an inpatient; and are confined in a hospital, non-hospital residential facility, skilled nursing facility or rehabilitation facility; and are charged for room, board and general nursing services. A stay does not include time in the hospital because of custodial or personal needs that do not require medical skills or training. A stay specifically excludes time in the hospital for observation or in the emergency room unless this leads to a stay.

How do I file a claim?

Go to **www.aetnavoluntaryforms.com** to find your benefit claim form. Use the "Online claims process" link to fill out the form and submit your claim. You can also print/mail in form(s) to: Aetna Voluntary Plans, PO Box 14079, Lexington, KY 40512-4079, or you can ask us to mail a printed form.

What should I do in case of an emergency?

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

What if I don't understand something I've read here, or have more questions?

Please call us. We want you to understand these benefits before you decide to enroll. You may reach one of our Customer Service representatives **Monday through Friday, 8 a.m. to 6 p.m.**, by calling **1-800-607-3366**. We're here to answer questions before and after you enroll.

Important information about your benefits

The Aetna Hospital Indemnity Plan is a hospital confinement indemnity plan with other fixed indemnity benefits. This plan provides LIMITED BENEFITS. This plan pays you fixed dollar amounts regardless of the amount that the provider charges. You are responsible for making sure the provider's bills get paid. These benefits are paid in addition to any other health coverage you may have. This disclosure provides a very brief description of the important features of the benefits being considered. It is not an insurance contract and only the actual policy provisions will control.

IN ORDER FOR THE HOSPITAL INDEMNITY BENEFITS TO BE PAYABLE, THE INITIAL DAY OF YOUR STAY AND OTHER SERVICES MUST BE ON OR AFTER YOUR EFFECTIVE DATE OF COVERAGE.

Complaints and appeals

Please tell us if you are not satisfied with a response you received from us or with how we do business. Call Member Services to file a verbal complaint or to ask for the address to mail a written complaint. You can also e-mail Member Services through the secure member website. If you're not satisfied after talking to a Member Services representative, you can ask us to send your issue to the appropriate department.

If you don't agree with a denied claim, you can file an appeal. To file an appeal, follow the directions in the letter or explanation of benefits statement that explains that your claim was denied. The letter also tells you what we need from you and how soon we will respond.

We protect your privacy

We consider personal information to be private. Our policies protect your personal information from unlawful use. By "personal information," we mean information that can identify you as a person, as well as your financial and health information. Personal information does not include what is available to the public. For example, anyone can access information about what the plan covers. It also does not include reports that do not identify you.

When necessary for your care or treatment, the operation of our health plans or other related activities, we use personal information within our company, share it with our affiliates and may disclose it to: your doctors, dentists, pharmacies, hospitals and other caregivers, other insurers, vendors, government departments and third-party administrators (TPAs).

We obtain information from many different sources —particularly you, your employer or benefits plan sponsor if applicable, other insurers, health maintenance organizations or TPAs, and health care providers.

These parties are required to keep your information private as required by law. Some of the ways in which we may use your information include: Paying claims, making decisions about what the plan covers, coordination of payments with other insurers, quality assessment, activities to improve our plans and audits.

We consider these activities key for the operation of our plans. When allowed by law, we use and disclose your personal information in the ways explained above without your permission. Our privacy notice includes a complete explanation of the ways we use and disclose your information. It also explains when we need your permission to use or disclose your information.

We are required to give you access to your information. If you think there is something wrong or missing in your personal information, you can ask that it be changed. We must complete your request within a reasonable amount of time. If we don't agree with the change, you can file an appeal.

If you'd like a copy of our privacy notice, call **1-800-607-3366** or visit us at **www.aetna.com.**

If you require language assistance, please call Member Services at 1-800-607-3366 and an Aetna representative will connect you with an interpreter. If you're deaf or hard of hearing, use your TTY and dial 711 for the Telecommunications Relay Service. Once connected, please enter or provide the Aetna telephone number you're calling.

Si usted necesita asistencia lingüística, por favor llame al Servicios al Miembro a 1-800-607-3366, y un representante de Aetna le conectará con un intérprete. Si usted es sordo o tiene problemas de audición, use su TTY y marcar 711 para el Servicio de Retransmisión de Telecomunicaciones (TRS). Una vez conectado, por favor entrar o proporcionar el número de teléfono de Aetna que está llamando.

ATTENTION MASSACHUSETTS RESIDENTS: As of January 1, 2009, the Massachusetts Health Care Reform Law requires that Massachusetts residents, eighteen (18) years of age and older, must have health coverage that meets the Minimum Creditable Coverage standards set by the Commonwealth Health Insurance Connector, unless waived from the health insurance requirement based on affordability or individual hardship. For more information call the Connector at **1-877-MA-ENROLL (1-877-623-6765)** or visit the Connector website **(www.mahealthconnector.org)**. THIS POLICY, ALONE, DOES NOT MEET MINIMUM CREDITABLE COVERAGE STANDARDS. If you have questions about this notice, you may contact the Division of Insurance by calling **1-617-521-7794** or visiting its website at **www.mass.gov/doi.**

Financial Sanctions Exclusions Clause

If coverage provided by this policy violates or will violate any US economic or trade sanctions, the coverage is immediately considered invalid. For example, Aetna companies cannot make payments or reimburse for health care or other claims or services if it violates a financial sanction regulation. This includes sanctions related to a blocked person or entity, or a country under sanction by the United States, unless permitted under a valid written Office of Foreign Assets Control (OFAC) license. For more information on OFAC, visit **http://www.treasury.gov/resource-center/sanctions/Pages/default.aspx.**

Plans are underwritten by Aetna Life Insurance Company (Aetna).

This material is for information only and is not an offer or invitation to contract. Information is believed to be accurate as of the production date; however, it is subject to change. For more information about Aetna plans, refer to **www.aetna.com**.

Hospital Indemnity Policy forms issued in Idaho, Oklahoma and Missouri include:
AL VOL HPOL-Hosp 01 and AL VOL HCOC-Hosp 01.

CONTACT INFORMATION

CARRIER CONTACT	PHONE NUMBER	WEB ADDRESS
Medical, and Dental (Aetna)	1-855-281-8858	www.aetna.com
Vision (NVA)	1-877-241-7124	www.e-nva.com
Supplemental / Hospital Indemnity (Aetna)	1-800-607-3366	www.aetnavoluntaryforms.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
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	(631) 656-3070 ext. 2000 (631) 656-3070 ext. 2001 (631) 656-3070 ext. 2002	tdimattinapgg@optonline.net emilylpgg@optonline.net nicoledpgg@optonline.net