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

BENEFIT PLAN YEAR 2020

(Local 780 Retirees)

Table of Contents

Overview

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

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

There are five different sections of benefits that breakdown the cost and reimbursements you will pay or receive for the 2020 benefit plan year.

These sections include current Medical, Dental, Vision, Group Life, and Supplemental (Hospital Admission) benefits coverage. Please review this booklet for the 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
Basic Life / AD&D
Supplemental Insurance (Hospital Admission Plan)

Enrollment

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

Changing Benefit Options

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

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

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

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

Major Medical – Aetna Medicare PPO Plan

The Northeast District Council of the OPCMIA offers a PPO Plan for members that are eligible to enroll. Members who enroll on the Aetna Medicare PPO Plan may see a doctor of their choice. Please be aware that if you choose to see an out-of-network provider, your out-of-pocket costs will be higher than seeing a provider in the Aetna Medicare PPO network. The Aetna Medicare PPO Plan has a number of services that are covered, if there is a service you do not see, contact your Benefit Adminstrator for clarification.

Please refer to the following pages to see a detailed list of your Summary of Benefits and Coverage (SBC) and information on the Aetna Silver Sneakers benefit.

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

Benefits and Premiums are effective January 1, 2020 through December 31, 2020

PLAN DESIGN AND BENEFITS
PROVIDED BY AETNA LIFE INSURANCE COMPANY

PLAN FEATURES	This is what you pay for Network Providers	This is what you pay for Out-of-Network Providers
Annual Deductible	$0	$0
This is the amount you have to pay out of pocket before the plan will pay its share for your covered Medicare Part A and B services.		
Annual Maximum Out-of-Pocket Amount	**Network Services:**	**Network and out-of-network services:**
	$3,400	$3,400 for in and out-of-network services combined
Annual maximum out-of-pocket limit amount includes any deductible, copayment or coinsurance that you pay. It will apply to all medical expenses except Hearing Aid Reimbursement, Vision Reimbursement and Medicare prescription drug coverage that may be available on your plan.		
Primary Care Physician Selection	Optional	Not Applicable
There is no requirement for member pre-certification. Your provider will do this on your behalf.		
Referral Requirement	None	
PREVENTIVE CARE	**This is what you pay for Network Providers**	**This is what you pay for Out-of-Network Providers**
Annual Wellness Exams	$0	25%
One exam every 12 months.		
Routine Physical Exams	$0	15%
Medicare Covered Immunizations	$0	$0
Pneumococcal, Flu, Hepatitis B		

Routine GYN Care (Cervical and Vaginal Cancer Screenings)	$0	15%
One routine GYN visit and pap smear every 24 months.		
Routine Mammograms (Breast Cancer Screening)	$0	15%
One baseline mammogram for members age 35-39; and one annual mammogram for members age 40 & over.		
Routine Prostate Cancer Screening Exam	$0	15%
For covered males age 50 & over, every 12 months.		
Routine Colorectal Cancer Screening	$0	15%
For all members age 50 & over.		
Routine Bone Mass Measurement	$0	15%
Medicare Diabetes Prevention Program (MDPP)	$0	15%
12 months of core session for program eligible members with an indication of pre-diabetes.		
Routine Eye Exams	$0	15%
One annual exam every 12 months.		
Routine Hearing Screening	$0	15%
One exam every 12 months.		
Additional Medicare Preventive Services	$0	25%

- Ultrasound screening for abdominal aortic aneurysm (AAA)
- Cardiovascular disease screening
- Diabetes screening tests and diabetes self-management training (DSMT)
- Medical nutrition therapy
- Glaucoma screening
- Screening and behavioral counseling to quit smoking and tobacco use
- Screening and behavioral counseling for alcohol misuse
- Adult depression screening

- Behavioral counseling for and screening to prevent sexually transmitted infections
- Behavioral therapy for obesity
- Behavioral therapy for cardiovascular disease
- Behavioral therapy for HIV screening
- Hepatitis C screening
- Lung cancer screening

PHYSICIAN SERVICES	This is what you pay for Network Providers	This is what you pay for Out-of-Network Providers
Primary Care Physician Visits	$10	25%
Includes services of an internist, general physician, family practitioner for routine care as well as diagnosis and treatment of an illness or injury and in-office surgery.		
Physician Specialist Visits	$10	25%
DIAGNOSTIC PROCEDURES	**This is what you pay for Network Providers**	**This is what you pay for Out-of-Network Providers**
Outpatient Diagnostic Laboratory	$0	25%
Outpatient Diagnostic X-ray	$0	25%
Outpatient Diagnostic Testing	$0	25%
Outpatient Complex Imaging	$0	25%
EMERGENCY MEDICAL CARE	**This is what you pay for Network Providers**	**This is what you pay for Out-of-Network Providers**
Urgently Needed Care; Worldwide	$15	$15
Emergency Care; Worldwide (waived if admitted)	$65	$65
Ambulance Services	$0	$0
Observation Care		
Your cost share for Observation Care is based upon the services you receive.		

HOSPITAL CARE	This is what you pay for Network Providers	This is what you pay for Out-of-Network Providers
Inpatient Hospital Care	$250 per stay	25% per stay
The member cost sharing applies to covered benefits incurred during a member's inpatient stay.		
Outpatient Surgery	$0	25%
Blood	All components of blood are covered beginning with the first pint.	
MENTAL HEALTH SERVICES	**This is what you pay for Network Providers**	**This is what you pay for Out-of-Network Providers**
Inpatient Mental Health Care	$250 per stay	25% per stay
The member cost sharing applies to covered benefits incurred during a member's inpatient stay.		
Outpatient Mental Health Care	$10	25%
ALCOHOL/DRUG ABUSE SERVICES	**This is what you pay for Network Providers**	**This is what you pay for Out-of-Network Providers**
Inpatient Substance Abuse	$250 per stay	25% per stay
The member cost sharing applies to covered benefits incurred during a member's inpatient stay.		
Outpatient Substance Abuse	$10	25%
OTHER SERVICES	**This is what you pay for Network Providers**	**This is what you pay for Out-of-Network Providers**
Skilled Nursing Facility (SNF) Care	$0 copay per day, day(s) 1-20; $20 copay per day, day(s) 21-100	25%
Limited to 100 days per Medicare Benefit Period*.		
The member cost sharing applies to covered benefits incurred during a member's inpatient stay.		

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

Home Health Agency Care	$0	25%
Hospice Care	Covered by Original Medicare at a Medicare certified hospice.	
Outpatient Rehabilitation Services (Speech, Physical, and Occupational therapy)	$0	25%
Cardiac Rehabilitation Services	$0	25%
Pulmonary Rehabilitation Services	$15	25%
Radiation Therapy	$0	25%
Chiropractic Services	$15	25%
Limited to Original Medicare - covered services for manipulation of the spine.		
Durable Medical Equipment/ Prosthetic Devices	$0	25%
Podiatry Services	$10	25%
Limited to Original Medicare covered benefits only.		
Diabetic Supplies Includes supplies to monitor your blood glucose from LifeScan.	$0	25%
Diabetic Eye Exams	$0	15%
Outpatient Dialysis Treatments	$0	$0
Medicare Part B Prescription Drugs	$0	25%
Medicare Covered Dental Non-routine care covered by Medicare.	$10	25%
ADDITIONAL NON-MEDICARE COVERED SERVICES		
Fitness Benefit	Silver Sneakers	
Resources for Living For help locating resources for every day needs.	Covered	

See next page for Pharmacy-Prescription Drug Benefits.

PHARMACY - PRESCRIPTION DRUG BENEFITS	
Calendar-year deductible for prescription drugs	$0
Prescription drug calendar year deductible must be satisfied before any Medicare Prescription Drug benefits are paid. Covered Medicare Prescription Drug expenses will accumulate toward the pharmacy deductible.	
Pharmacy Network	S2
Your Medicare Part D plan is associated with pharmacies in the above network. To find a network pharmacy, you can visit our website (http://www.aetnaretireeplans.com).	
Formulary (Drug List)	GRP B2
Your cost for generic drugs is usually lower than your cost for brand drugs. However, Aetna in some instances combines higher cost generic drugs on brand tiers.	
Initial Coverage Limit (ICL)	$4,020

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

4 Tier Plan	Retail cost-sharing up to a 30 -day supply	Retail cost-sharing up to a 90 -day supply	Preferred mail order cost-sharing up to a 90 -day supply
Tier 1 - Generic Generic Drugs	$10	$20	$20
Tier 2 - Preferred Brand Includes some high-cost generic and preferred brand drugs	$20	$40	$40

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

Coverage Gap

The Coverage Gap starts once covered Medicare prescription drug expenses have reached the Initial Coverage Limit. Here's your cost-sharing for covered Part D drugs after the Initial Coverage Limit and until you reach $6,350 in prescription drug expenses:

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

Catastrophic Coverage:	Greater of 5% of the cost of the drug - or - $3.60 for a generic drug or a drug that is treated like a generic and $8.95 for all other drugs.

Catastrophic Coverage benefits start once $6,350 in true out-of-pocket costs is incurred.

Requirements:	
Precertification	Applies
Step-Therapy	Does Not Apply

Non-Part D Drug Rider

- Not Covered

For more information about Aetna plans, go to www.aetna.com or call Member Services at toll-free at 1-888-267-2637 (TTY: 711) for additional information. Hours are 8 a.m. to 6 p.m. local time, Monday through Friday.

Medical Disclaimers

Not all PPO Plans are available in all areas

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

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

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

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

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

Out-of-network/non-contracted providers are under no obligation to treat Aetna members, except in emergency situations. Please call our Customer Service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.

Aetna will pay any non contracted provider (that is eligible for Medicare payment and is willing to accept the Aetna Medicare Plan) the same as they would receive under Origional Medicare for Medicare covered services under the plan.

Pharmacy Disclaimers

Aetna's retiree pharmacy coverage is an enhanced Part D Employer Group Waiver Plan that is offered as a single integrated product. The enhanced Part D plan consists of two components: basic Medicare Part D benefits and supplemental benefits. Basic Medicare Part D benefits are offered by Aetna based on our contract with CMS. We receive monthly payments from CMS to pay for basic Part D benefits. Supplemental benefits are non-Medicare benefits that provide enhanced coverage beyond basic Part D. Supplemental benefits are paid for by plan sponsors or

members and may include benefits for non-Part D drugs. Aetna reports claim information to CMS according to the source of applicable payment (Medicare Part D, plan sponsor or member).

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

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

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

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

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

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

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

- Cover a drug that would be covered under Medicare Part A or Part B.
- Cover a drug purchased outside the United States and its territories.

- Generally cover drugs prescribed for "off label" use, (any use of the drug other than indicated on a drug's label as approved by the Food and Drug Administration) unless supported by criteria included in certain reference books like the American Hospital Formulary Service Drug Information, the DRUGDEX Information System and the USPDI or its successor.

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

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

Plan Disclaimers

Aetna Medicare is a PDP, HMO, PPO plan with a Medicare contract. Enrollment in our plans depends on contract renewal.
This information is not a complete description of benefits. Call 1-888-267-2637 (TTY: 711) for more information.

Plans are offered by Aetna Health Inc., Aetna Health of California Inc., and/or Aetna Life

Insurance Company (Aetna).

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

You must be entitled to Medicare Part A and continue to pay your Part B premium and Part A, if applicable.

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

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

You can read the *Medicare & You 2020* Handbook. Every year in the fall, this booklet is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. If you don't have a copy of this booklet, you can get it at the Medicare website (http://www.medicare.gov) or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

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

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

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

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

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

This is the end of this plan benefit summary

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August 2019 20173_2_20175_1

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

The Northeast District Council of the OPCMIA offers an ESA Plan for members that are eligible to enroll and live outside of the Aetna PPO service area. Members who enroll on the Aetna Medicare ESA Plan may see a doctor of their choice. Please be aware that if you choose to see an out-of-network provider, your out-of-pocket costs will be higher than seeing a provider in the Aetna Medicare ESA network. The Aetna Medicare ESA Plan has a number of services that are covered, if there is a service you do not see, contact your Benefit Adminstrator for clarification.

Please refer to the following pages to see a detailed list of your Summary of Benefits and Coverage (SBC) and information on the Aetna Silver Sneakers benefit.

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

Benefits and Premiums are effective January 1, 2020 through December 31, 2020

PLAN DESIGN AND BENEFITS
PROVIDED BY AETNA LIFE INSURANCE COMPANY

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

One baseline mammogram for members age 35-39; and one annual mammogram for members age 40 & over.	
Routine Prostate Cancer Screening Exam For covered males age 50 & over, every 12 months.	$0
Routine Colorectal Cancer Screening For all members age 50 & over.	$0
Routine Bone Mass Measurement	$0
Medicare Diabetes Prevention Program (MDPP) 12 months of core session for program eligible members with an indication of pre-diabetes.	$0
Routine Eye Exams One annual exam every 12 months.	$0
Routine Hearing Screening One exam every 12 months.	$0
Additional Medicare Preventive Services	$0

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

- Hepatitis C screening
- Lung cancer screening

PHYSICIAN SERVICES	This is what you pay for Network & Out-of-Network Providers
Primary Care Physician Visits	$10
Includes services of an internist, general physician, family practitioner for routine care as well as diagnosis and treatment of an illness or injury and in-office surgery.	
Physician Specialist Visits	$10
DIAGNOSTIC PROCEDURES	**This is what you pay for Network & Out-of-Network Providers**
Outpatient Diagnostic Laboratory	$0
Outpatient Diagnostic X-ray	$0
Outpatient Diagnostic Testing	$0
Outpatient Complex Imaging	$0
EMERGENCY MEDICAL CARE	**This is what you pay for Network & Out-of-Network Providers**
Urgently Needed Care; Worldwide	$15
Emergency Care; Worldwide (waived if admitted)	$65
Ambulance Services	$0
Observation Care	
Your cost share for Observation Care is based upon the services you receive.	
HOSPITAL CARE	**This is what you pay for Network & Out-of-Network Providers**
Inpatient Hospital Care	$250 per stay
The member cost sharing applies to covered benefits incurred during a member's inpatient stay.	
Outpatient Surgery	$0

Blood	All components of blood are covered beginning with the first pint.
MENTAL HEALTH SERVICES	**This is what you pay for Network & Out-of-Network Providers**
Inpatient Mental Health Care	$250 per stay
The member cost sharing applies to covered benefits incurred during a member's inpatient stay.	
Outpatient Mental Health Care	$10
ALCOHOL/DRUG ABUSE SERVICES	**This is what you pay for Network & Out-of-Network Providers**
Inpatient Substance Abuse	$250 per stay
The member cost sharing applies to covered benefits incurred during a member's inpatient stay.	
Outpatient Substance Abuse	$10
OTHER SERVICES	**This is what you pay for Network & Out-of-Network Providers**
Skilled Nursing Facility (SNF) Care	$0 copay per day, day(s) 1-20; $20 copay per day, day(s) 21-100
Limited to 100 days per Medicare Benefit Period*.	
The member cost sharing applies to covered benefits incurred during a member's inpatient stay.	
*A benefit period begins the day you go into a hospital or skilled nursing facility. The benefit period ends when you haven't received any inpatient hospital care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a skilled nursing facility after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods.	
Home Health Agency Care	$0
Hospice Care	Covered by Original Medicare at a Medicare certified hospice.
Outpatient Rehabilitation Services (Speech, Physical, and Occupational therapy)	$0
Cardiac Rehabilitation Services	$0
Pulmonary Rehabilitation Services	$15

Radiation Therapy	$0
Chiropractic Services Limited to Original Medicare - covered services for manipulation of the spine.	$15
Durable Medical Equipment/ Prosthetic Devices	$0
Podiatry Services Limited to Original Medicare covered benefits only.	$10
Diabetic Supplies Includes supplies to monitor your blood glucose from LifeScan.	$0
Diabetic Eye Exams	$0
Outpatient Dialysis Treatments	$0
Medicare Part B Prescription Drugs	$0
Medicare Covered Dental Non-routine care covered by Medicare.	$10
ADDITIONAL NON-MEDICARE COVERED SERVICES	
Fitness Benefit	Silver Sneakers
Resources for Living For help locating resources for every day needs.	Covered

See next page for Pharmacy-Prescription Drug Benefits.

PHARMACY - PRESCRIPTION DRUG BENEFITS	
Calendar-year deductible for prescription drugs	$0
Prescription drug calendar year deductible must be satisfied before any Medicare Prescription Drug benefits are paid. Covered Medicare Prescription Drug expenses will accumulate toward the pharmacy deductible.	
Pharmacy Network	S2
Your Medicare Part D plan is associated with pharmacies in the above network. To find a network pharmacy, you can visit our website (http://www.aetnaretireeplans.com).	
Formulary (Drug List)	GRP B2
Your cost for generic drugs is usually lower than your cost for brand drugs. However, Aetna in some instances combines higher cost generic drugs on brand tiers.	
Initial Coverage Limit (ICL)	$4,020

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

4 Tier Plan	Retail cost-sharing up to a 30 -day supply	Retail cost-sharing up to a 90 -day supply	Preferred mail order cost-sharing up to a 90 -day supply
Tier 1 - Generic Generic Drugs	$10	$20	$20
Tier 2 - Preferred Brand Includes some high-cost generic and preferred brand drugs	$20	$40	$40

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

Coverage Gap

The Coverage Gap starts once covered Medicare prescription drug expenses have reached the Initial Coverage Limit. Here's your cost-sharing for covered Part D drugs after the Initial Coverage Limit and until you reach $6,350 in prescription drug expenses:

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

Catastrophic Coverage:	Greater of 5% of the cost of the drug - or - $3.60 for a generic drug or a drug that is treated like a generic and $8.95 for all other drugs.

Catastrophic Coverage benefits start once $6,350 in true out-of-pocket costs is incurred.

Requirements:	
Precertification	Applies
Step-Therapy	Does Not Apply

Non-Part D Drug Rider

- Not Covered

For more information about Aetna plans, go to www.aetna.com or call Member Services at toll-free at 1-888-267-2637 (TTY: 711) for additional information. Hours are 8 a.m. to 6 p.m. local time, Monday through Friday.

Medical Disclaimers

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

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

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

- Services that are not medically necessary unless the service is covered by Original

Medicare or otherwise noted in your Evidence of Coverage

- Plastic or cosmetic surgery unless it is covered by Original Medicare
- Custodial care
- Experimental procedures or treatments that Original Medicare doesn't cover
- Outpatient prescription drugs unless covered under Original Medicare Part B

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

Out-of-network/non-contracted providers are under no obligation to treat Aetna members, except in emergency situations. Please call our Customer Service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.

Aetna will pay any non contracted provider (that is eligible for Medicare payment and is willing to accept the Aetna Medicare Plan) the same as they would receive under Origional Medicare for Medicare covered services under the plan.

Pharmacy Disclaimers

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

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

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

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

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

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

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

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

- Cover a drug that would be covered under Medicare Part A or Part B.
- Cover a drug purchased outside the United States and its territories.
- Generally cover drugs prescribed for "off label" use, (any use of the drug other than indicated on a drug's label as approved by the Food and Drug Administration) unless

supported by criteria included in certain reference books like the American Hospital Formulary Service Drug Information, the DRUGDEX Information System and the USPDI or its successor.

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

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

Plan Disclaimers

Aetna Medicare is a PDP, HMO, PPO plan with a Medicare contract. Enrollment in our plans depends on contract renewal.
This information is not a complete description of benefits. Call 1-888-267-2637 (TTY: 711) for more information.

Plans are offered by Aetna Health Inc., Aetna Health of California Inc., and/or Aetna Life Insurance Company (Aetna).

Your coverage is provided through a contract with your former employer/union/trust. The plan

benefits administrator will provide you with information about your plan premium (if applicable).

You must be entitled to Medicare Part A and continue to pay your Part B premium and Part A, if applicable.

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

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

You can read the *Medicare & You 2020* Handbook. Every year in the fall, this booklet is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. If you don't have a copy of this booklet, you can get it at the Medicare website (http://www.medicare.gov) or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

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

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

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

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

August 2019 20174_2_20175_1

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

This is the end of this plan benefit summary

GRP_0009_659

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

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

Work out indoors

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

Experience SilverSneakers FLEX® classes

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

Connect online

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

Start using SilverSneakers today!

made available through aetna®

SilverSneakers®

*At-home kits are offered for members who want to start working out at home or for those who can't get to a fitness location due to injury, illness or being homebound.

Aetna Medicare is a PDP, HMO, PPO plan with a Medicare contract. Our SNPs also have contracts with State Medicaid programs. Enrollment in our plans depends on contract renewal. Our dual-eligible Special Needs Plan is available to anyone who has both Medical Assistance from the state and Medicare. This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments, and restrictions may apply. Benefits may change on January 1 of each year. See Evidence of Coverage for a complete description of benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by service area.

Dental Insurance – Aetna Dental DMO Plan

The Northeast District Council of the OPCMIA now offers a Dental DMO Plan for retired members. The plan offers various benefits for different dental services and procedures. When receiving services, you may present your dental ID card.

Retired 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, you will be responsible for 100% of the charges. Most expenses are subject to a copay or fee amount and there is no annual maximum. 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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Northeast District Council of the OPCMIA Welfare Fund
Plan 75
Effective Date: 07-01-2019

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

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

DMO® Dental Benefits Summary

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

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

DMO® Dental Benefits Summary

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.

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.

ed.2019

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 ponties 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.

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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Dental Insurance – Aetna Dental PPO Plan

The Northeast District Council of the OPCMIA now offers a Dental PPO Plan for retired members that live outside of the Aetna DMO dental network. The plan offers various benefits for different dental services and procedures. When receiving services, you may present your dental ID card.

Retired 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. 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 is not subject to the annual deductible.

Dental Benefits Summary

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

*The deductible applies to: Basic & Major services only

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

Partial List of Services	Active PPO MAX With PPOII Network	
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.

Vision Insurance – NVA Vision Plan

The Northeast District Council of the OPCMIA also offers a Vision Plan through National Vision Administrators (NVA) for retired members eligible to enroll. The plan offers various benefits for different vision services. Most services are covered 100% or are covered up to an allowable amount.

Members who enroll in the NVA Vision Plan can see a doctor of their choice, however out of network benefits are subject to a maximum reimbursed amount. The most liberal benefits are paid when you use a network provider. If there is a service you do not see, contact your Benefit 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**

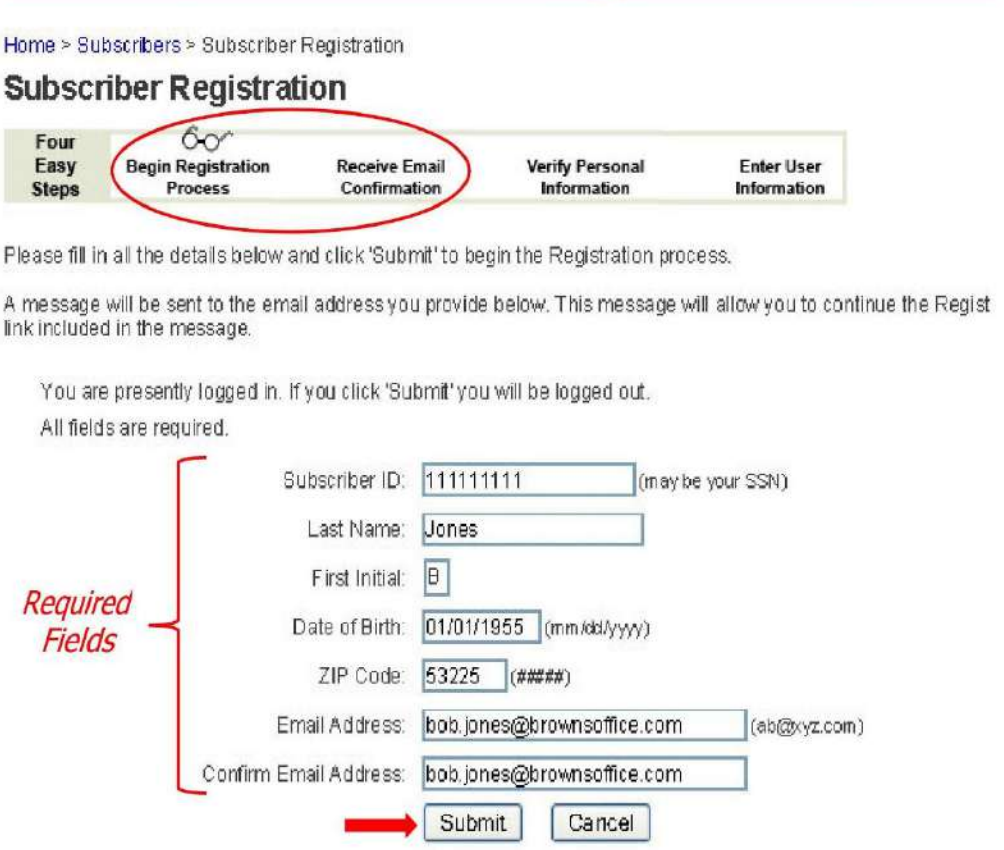
MEMBER WEB REGISTRATION

- 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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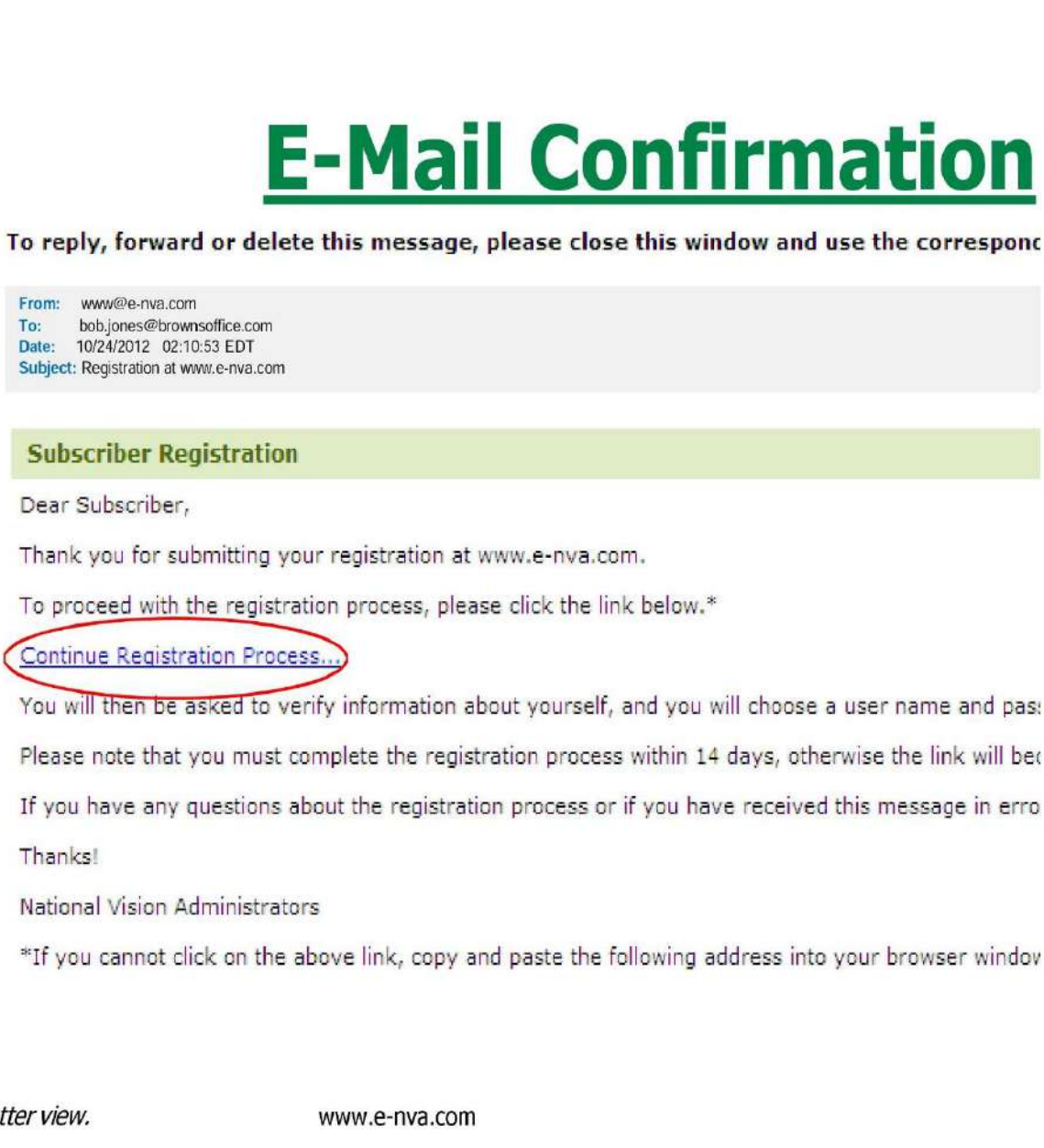
E-Mail Confirmation

- **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 corresponc

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 bec

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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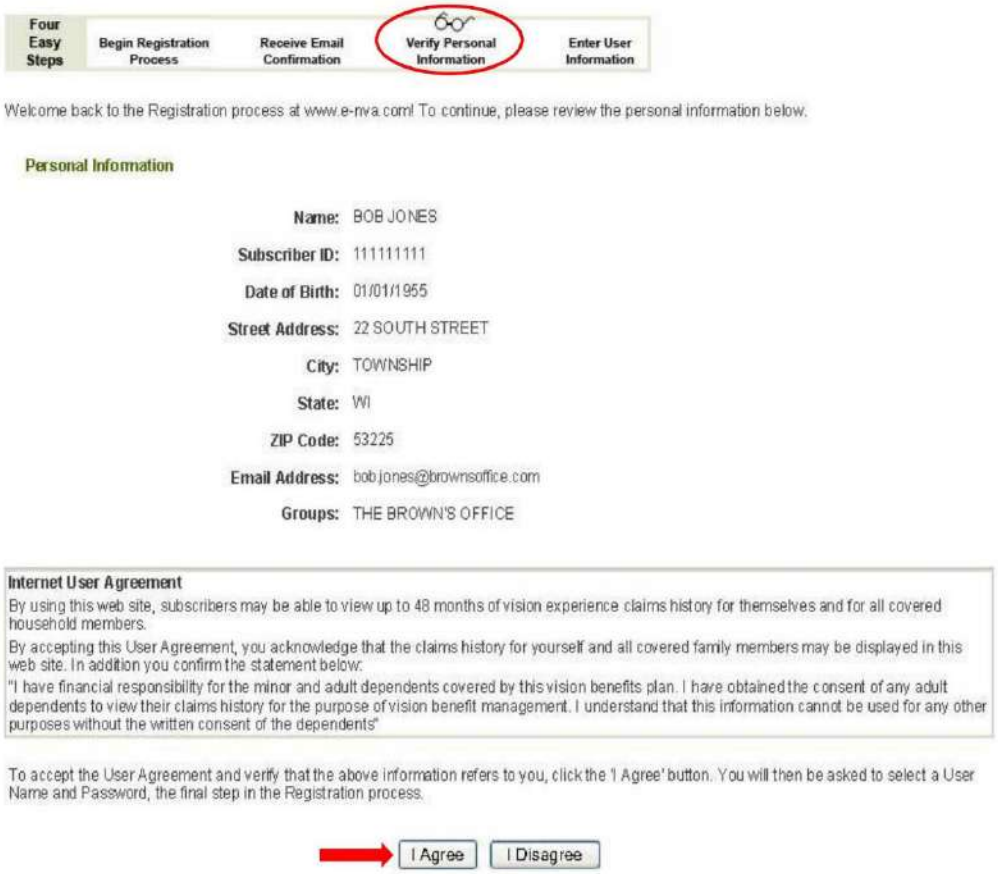
Verify Registration Information

- **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.**



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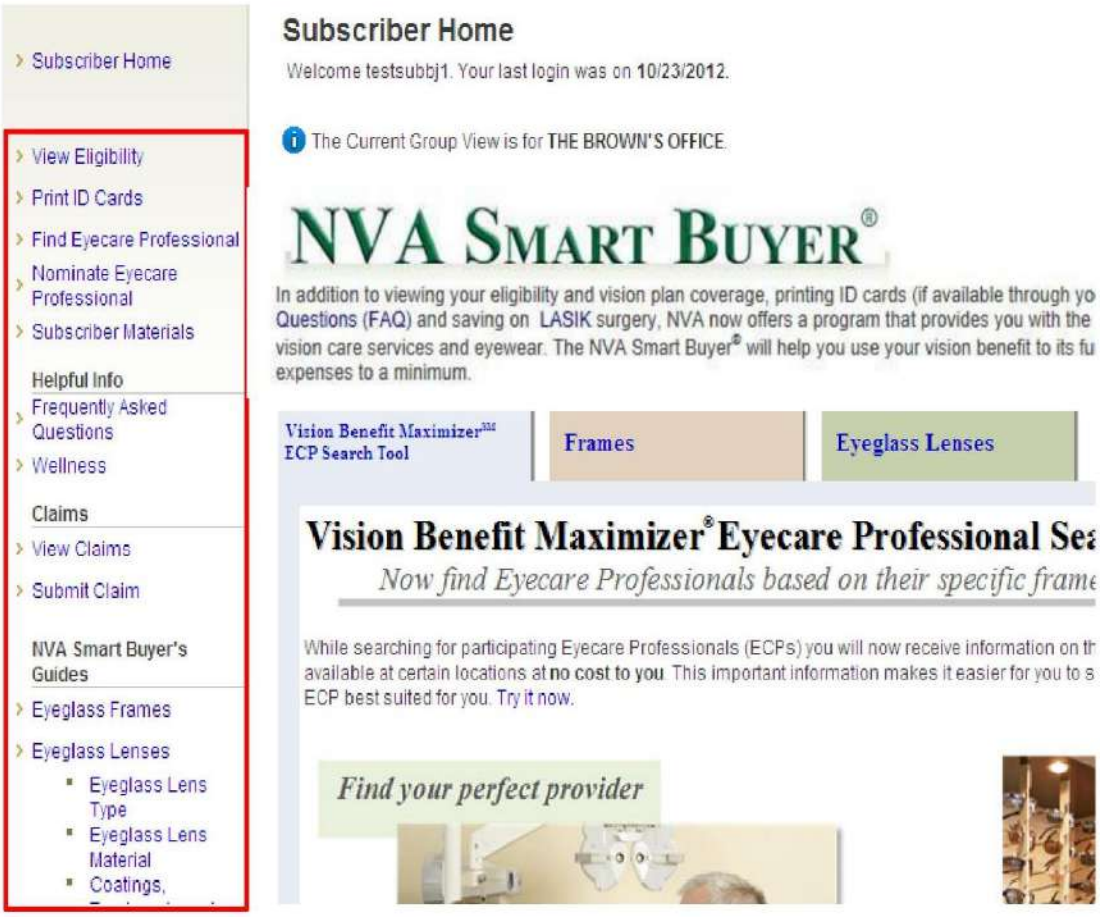
Registered Subscriber Home

- **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.**



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

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

The following Group Life / AD&D plan is for those retired members who are pension eligible.

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

Group Name: Northeast District Council of the OPCMIA Welfare Fund

Plan Design

Basic Group Term Life

Class 3: Retirees

Benefit Schedule

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

Supplemental Insurance (Hospital Admission Plan)

SUMMARY OF MATERIAL MODIFICATIONS TO

THE NORTHEAST DISTRICT COUNCIL OF THE OPCMIA WELFARE FUND

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

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

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

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

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

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

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

In order to make a claim for the hospital admission reimbursement offered by the Fund, your Explanation of Benefits showing the hospital admission should be sent to Praetorian Guard Group, LLC using the contact information provided below:

By mail:

Praetorian Guard Group, LLC

140 Adams Ave., Suite B11

Hauppauge, NY 11788

By e-mail:

nicoledpgg@optonline.net

emilylpgg@optonline.net

By fax:

1-631-656-5514

1-980-444-0711

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

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

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

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

CONTACT INFORMATION

CARRIER CONTACT	PHONE NUMBER	WEB ADDRESS
Medical (Aetna Medicare)	1-800-282-5366	www.aetnamedicare.com
Dental (Aetna)	1-800-872-3862	www.aetna.com
Vision (NVA)	1-877-241-7124	www.e-nva.com

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

BENEFIT CONSULTANTS	PHONE	EMAIL
Praetorian Guard Group, LLC	1-631-656-3070 ext. 2000 1-631-656-3070 ext. 2001 1-631-656-3070 ext. 2002	tdimattinapgg@optonline.net emilylpgg@optonline.net nicoledpgg@optonline.net