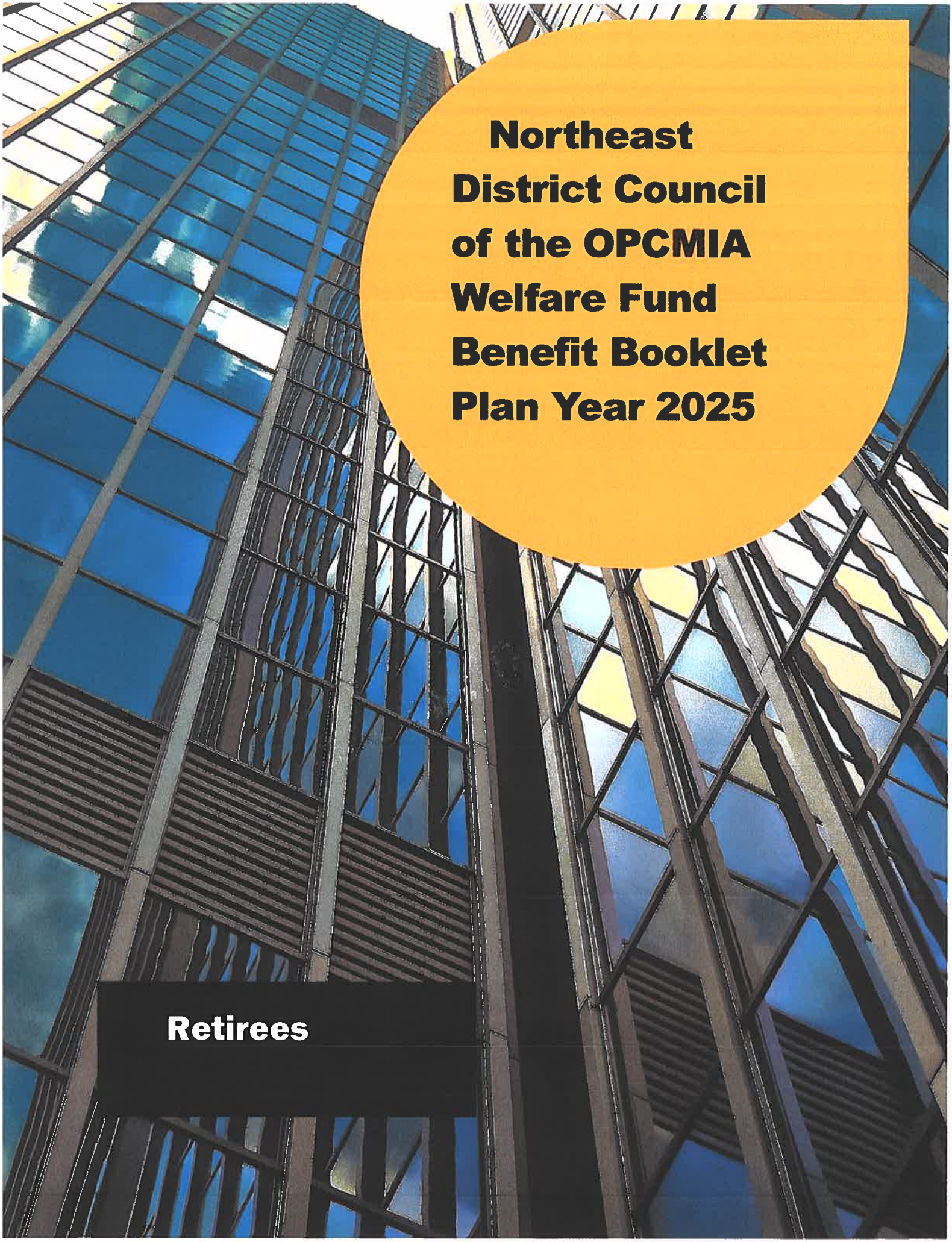

Northeast District Council of the OPCMIA Welfare Fund Benefit Booklet Plan Year 2025

Retirees

Table of Contents

Overview

The Northeast District Council of the OPCMIA, hereinafter, (NEDC) Welfare Fund has put together this booklet of information for all eligible active and retiree members and their eligible dependents.

This booklet will enable you to review important benefit plan information that is offered to eligible members and their dependents.

There are five sections of benefits that breakdown the cost and reimbursements you will pay or receive for the 2025 benefit plan year.

These sections include the Medicare Advantage Program, Dental, Vision, Group Life and the Hospital Admission Reimbursement Plan.

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

Core Benefits

Aetna Medicare Advantage Program PPO & ESA

Aetna Dental DMO and PPO

Aetna Preferred Vision

Retiree Life

Supplemental Hospital Admission Reimbursement

Enrollment

The NEDC 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 current eligibility status is.

If eligible you may also enroll eligible dependents. Eligible dependents are as follows:

- Your Legal Spouse
- Your Dependent Children age 26 and under
- Court ordered eligible dependents
- Disabled children over the age of 26 with required documentation

Changing Benefit Options

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

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

Please note: To change benefits or terminate/add dependents throughout the plan year, you must contact your Fund Office and provide documentation to support these changes. Acceptable forms of documentation are as follows:

- Copy of Marriage Certificate
- Copy of Birth Certificate
- Copy of papers showing placement of child in your home
- Copy of Court Order showing legal guardianship
- Copy of prior year Federal Tax Return showing dependent is claimed on tax documents and proof of incapacity

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Aetna Medicare Advantage Program – PPO & ESA

The NEDC offers PPO and ESA Medicare Plans for eligible Retiree Members. Members who enroll in the Aetna Medicare PPO or ESA Plan may see medical providers 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 if you see a provider in the Aetna Medicare PPO network. If there is a service that you do not see listed, contact your Benefit Administrator for clarification, prior to accessing the service in question.

Please refer to the following pages to see a detailed list of your Summary of Benefits and Coverage (SBC) and information on Aetna Silver Sneakers, Access2Care Transportation and Meals at Home Benefits.

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

Aetna Medicare Advantage Program – PPO

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Aetna Medicare[SM] Plan (PPO)
Medicare (P01) PPO Plan
Custom Rx $10/$20/$50/$50

Benefits and Premiums are effective January 1, 2025 through December 31, 2025

SUMMARY OF BENEFITS
PROVIDED BY AETNA LIFE INSURANCE COMPANY

Primary Care Physician (PCP): You have the option to choose a PCP. When we know who your provider is, we can better support your care.

Referrals: Your plan doesn't require a referral from a PCP to see a specialist. Keep in mind, some providers may require a recommendation or treatment plan from your doctor in order to see you.

Prior Authorizations: Your doctor will work with us to get approval before you receive certain services or drugs. Benefits that may require a prior authorization are listed with an asterisk (*) in the benefits grid.

PLAN FEATURES	This is what you pay for network providers.	This is what you pay for out-of-network providers.
Monthly Premium	Please contact your former employer/union/trust for more information on your plan premium.	
Plan Follows the Federal Medicare Part B Deductible Plan deductible is equal to the Federal Medicare Part B deductible	No	
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:**
Annual maximum out-of-pocket limit amount includes any deductible, copayment or coinsurance that you pay.	$3,400	$3,400 for in and out-of-network services combined
It will apply to all medical expenses except Hearing Aid Reimbursement and Medicare prescription drug coverage that may be available on your plan.		

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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.		
Observation Stay	Your cost share for Observation Care is based upon the services you receive	Your cost share for Observation Care is based upon the services you receive
Frequency:	per stay	per stay
Outpatient Services & Surgery	$0	25%
Ambulatory Surgery Center	$0	25%
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%
PREVENTIVE CARE	**This is what you pay for network providers.**	**This is what you pay for out-of-network providers.**
Medicare-covered Preventive Services	$0	25%

- Abdominal aortic aneurysm screenings
- Alcohol misuse screenings and counseling
- Annual Well Visit - One exam every 12 months.
- Breast exams
- Breast cancer screening: mammogram - one baseline mammogram for members age 35-39; and one annual mammogram for members age 40 & over.
- Cardiovascular behavior therapy
- Cardiovascular disease screenings

- Cervical and vaginal cancer screenings (Pap) - one routine GYN visit and pap smear every 24 months.
- Depression screenings
- Diabetes screenings
- HBV infection screening
- Hepatitis C screening tests
- HIV screenings
- Lung cancer screenings and counseling
- Nutrition therapy services
- Obesity behavior therapy
- Pelvic Exams and pap test (screening) - one routine GYN visit and pap smear every 24 months.
- Prolonged Preventive Services - prolonged preventive service(s) (beyond the typical service time of the primary procedure), in the office or other outpatient setting requiring direct patient contact beyond the usual service
- Prostate cancer screenings (PSA) - for all male patients aged 50 and older (coverage begins the day after 50th birthday)
- Sexually transmitted infections screenings and counseling
- Tobacco use cessation counseling
- Welcome to Medicare preventive visit

Medicare-covered Preventive Services (continued)		
• Bone mass measurements	$0	15%
• Colorectal cancer screenings (colonoscopy, fecal occult blood test, flexible sigmoidoscopy)	$0	15%
• Medicare Diabetes Prevention Program - 12 months of core session for program eligible members with an indication of pre-diabetes.	$0	15%
Immunizations • Flu • Hepatitis B • Pneumococcal	$0	$0
Additional Medicare Preventive Services • Barium enema - one exam every 12 months.	$0	25%

- Diabetes self-management training (DSMT)
- Digital rectal exam (DRE)
- EKG following welcome exam
- Glaucoma screening

EMERGENCY AND URGENT MEDICAL CARE	This is what you pay for network providers.	This is what you pay for out-of-network providers.
Emergency Care; Worldwide (waived if admitted)	$65	$65
Urgently Needed Care; Worldwide	$15	$15
DIAGNOSTIC PROCEDURES*	**This is what you pay for network providers.**	**This is what you pay for out-of-network providers.**
Diagnostic Radiology CT scans	$0	25%
Diagnostic Radiology Other than CT scans	$0	25%
Lab Services	$0	25%
Diagnostic testing & procedures	$0	25%
Outpatient X-rays	$0	25%
HEARING SERVICES	**This is what you pay for network providers.**	**This is what you pay for out-of-network providers.**
Routine Hearing Screening We cover one exam every twelve months	$0	15%
Medicare Covered Hearing Examination	$10	25%
Hearing Aid Reimbursement	$500 once every 36 months	
DENTAL SERVICES	**This is what you pay for network providers.**	**This is what you pay for out-of-network providers.**
Medicare Covered Dental*	$10	25%

Non-routine care covered by Medicare.

VISION SERVICES	This is what you pay for network providers.	This is what you pay for out-of-network providers.
Routine Eye Exams One annual exam every 12 months.	$0	15%
Diabetic Eye Exams	$0	15%
Medicare Covered Eye Exam	$10	25%
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 Individual visit	$10	25%
Partial Hospitalization and Intensive Outpatient Services	$10	25%
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 Individual visit	$10	25%

SKILLED NURSING 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 per day, days 1-20; $20 per day, days 21-100	25% per day, days 1-100

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.

PHYSICAL THERAPY SERVICES*	This is what you pay for network providers.	This is what you pay for out-of-network providers.
Outpatient Rehabilitation Services (Speech, physical, and occupational therapy)	$0	25%

AMBULANCE SERVICES	This is what you pay for network providers.	This is what you pay for out-of-network providers.
Ambulance Services	$0	$0

Prior authorization rules may apply for non-emergency transportation services received in-network. Your network provider is responsible for requesting prior authorization. Our plan recommends pre-authorization of non-emergency transportation services when provided by an out-of-network provider.

TRANSPORTATION SERVICES	This is what you pay for network providers.	This is what you pay for out-of-network providers.
Transportation (non-emergency)	24 one-way trips with 60 miles allowed per trip	

MEDICARE PART B PRESCRIPTION DRUGS*	This is what you pay for network providers.	This is what you pay for out-of-network providers.
Medicare Part B Prescription Drugs	$0	25%
Medicare Part B Prescription Drugs - Insulin	$0	$0
MEDICARE PART D PRESCRIPTION DRUGS	**This is what you pay for network providers.**	**This is what you pay for out-of-network providers.**

Part D drugs are covered. See PHARMACY - PRESCRIPTION DRUG BENEFITS section below for your plan benefits at each part D stage, including cost share and other important pharmacy benefit information.

ADDITIONAL PROGRAMS AND SERVICES	This is what you pay for network providers.	This is what you pay for out-of-network providers.
Allergy Shots	$0	25%
Allergy Testing	$10	25%
Blood	$0	15%
All components of blood are covered beginning with the first pint.		
Cardiac Rehabilitation Services	$0	25%
Intensive Cardiac Rehabilitation Services	$0	25%
Chiropractic Services*	$15	25%
Medicare covered benefits only.		
Diabetic Supplies*	$0	25%
Includes supplies to monitor your blood glucose from LifeScan.		
Durable Medical Equipment/ Prosthetic Devices*	$0	25%
Home Health Agency Care*	$0	25%
Hospice Care	Covered by Original Medicare at a Medicare certified hospice.	
Medical Supplies*	Your cost share is based upon the provider of services	Your cost share is based upon the provider of services
Medicare Covered Acupuncture	$10	25%
Outpatient Dialysis Treatments*	$0	$0
Podiatry Services	$10	25%
Medicare covered benefits only.		
Pulmonary Rehabilitation Services	$15	25%
Supervised Exercise Therapy (SET) for PAD Services	$15	25%
Radiation Therapy*	$0	25%
ADDITIONAL PROGRAMS (NOT COVERED BY ORIGINAL MEDICARE)	**This is what you pay for network providers.**	**This is what you pay for out-of-network providers.**

Fitness Benefit	SilverSneakers®	
Meals	$0	
Covered up to 14 meals following an inpatient stay.		
Resources For Living®	Covered	
For help locating resources for every day needs.		
Smoking and Tobacco Use Cessation Supplies	$0	25%
Frequency	unlimited visits every year	unlimited visits every year
Teladoc™	$0	
Telemedicine services with a Teladoc™ provider. State mandates may apply.		
Telehealth	Covered	
Telemedicine Services. Member cost share will apply based on services rendered.		
Telehealth PCP	$10	25%
Telehealth Specialist	$10	25%
Telehealth Occupational Therapy Services	$0	25%
Telehealth PT and SP Services	$0	25%
Telehealth Other Health care Providers	$10	25%
Telehealth Individual Mental Health	$10	25%
Telehealth Group Mental Health	$10	25%
Telehealth Individual Psychiatric Services	$10	25%
Telehealth Group Psychiatric Services	$10	25%
Telehealth Individual Substance Abuse Services	$10	25%
Telehealth Group Substance Abuse Services	$10	25%
Telehealth Kidney Disease Education Services	$0	25%
Telehealth Diabetes Self-Management Training	$0	25%
Telehealth Opioid Treatment Program Services	$10	25%
Telehealth Urgent care	$15	$15
Wigs*	$0	$0

Maximum	$400
Frequency	every year

ADDITIONAL SERVICES (NOT COVERED BY ORIGINAL MEDICARE)	This is what you pay for network providers.	This is what you pay for out-of-network providers.
Routine Physical Exams One exam per calendar year	$0	15%

Benefits that may require a prior authorization are listed with an asterisk (*) in the benefits grid.

See next page for Pharmacy-Prescription Drug Benefits.

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PHARMACY - PRESCRIPTION DRUG BENEFITS

Pharmacy Network S2

Your Medicare Part D plan uses the network above. To find a network pharmacy, you can visit our website (http://www.aetnaretireeplans.com.)

Formulary (Drug List) Classic

Your cost for generic drugs is usually lower than your cost for brand drugs. However, some higher cost generic drugs are combined on brand tiers.

Beginning 1/1/25, the Centers for Medicare Services (CMS) made the following changes to the standard Part D plan design:

- Reduction to three phases - Deductible, Initial Coverage, and Catastrophic
- Elimination of the Initial Coverage Limit and the Coverage Gap Phase
- Introduction of a $2,000 annual out-of-pocket threshold
- Replacement of the Coverage Gap Discount Program with the Manufacturer Discount Program which will provide a 10% manufacturer discount for brand drugs in the Initial Coverage phase and 20% manufacturer discount for brand drugs in the Catastrophic phase

See below for your specific benefits and cost sharing.

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. The deductible does not apply to covered insulins and most Part D vaccines.

Initial Coverage Phase - The table below represents cost sharing after the deductible, if applicable, has been reached.

4 Tier Plan	30-day Supply through Retail	90-day Supply through Retail or Mail	
	Standard	**Preferred Mail**	**Standard Retail or Mail**
Tier 1 - Generic Generic Drugs	$10	$20	$20

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4 Tier Plan	30-day Supply through Retail	90-day Supply through Retail or Mail	
	Standard	**Preferred Mail**	**Standard Retail or Mail**
Tier 2 - Preferred Brand Includes some high-cost generic and preferred brand drugs	$20	$40	$40
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

If you reside in a long-term care facility, your cost share is the same as a 30 day supply at a retail pharmacy and you may receive up to a 31 day supply.

You won't pay more than $35 for a one-month supply or $105 for up to a three-month supply of each covered insulin product regardless of the cost-sharing tier.

Catastrophic Coverage: You pay $0 for covered Part D prescription drugs.

Catastrophic Coverage benefits start once the CMS-determined annual out-of-pocket threshold of $2,000 for covered Part D prescription drugs is reached.

Requirements:	
Precertification	Applies
Step-Therapy	Does Not Apply

Medical Disclaimers

For more information about Aetna plans, go to www.AetnaRetireePlans.com or call Member Services toll-free at 1-888-267-2637 (TTY: 711). Hours are 8 a.m. to 9 p.m. EST, Monday through Friday.

Not all PPO Plans are available in all areas

The provider network may change at any time. You will receive notice when necessary.

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

The complete list of services can be found in the Evidence of Coverage (EOC). You can request a copy of the EOC by contacting Member Services at 1-888-267-2637 (TTY: 711). Hours are 8 a.m. to 9 p.m. EST, Monday through Friday.

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 Original 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).

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

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.

Pharmacy clinical programs such as precertification, step therapy and quantity limits may apply to your prescription drug coverage.

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.

The typical number of business days after the mail order pharmacy receives an order to receive your shipment is up to 10 days. Enrollees have the option to sign up for automated mail order delivery. If your mail order drugs do not arrive within the estimated time frame, please contact us toll-free at 1-866-241-0357, 24 hours a day, 7 days a week. TTY users call 711.

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 HMO and PPO plan with a Medicare contract. Enrollment in our plans depends on contract renewal.

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

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.

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

Resources For Living is the brand name used for products and services offered through the Aetna group of subsidiary companies.

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 2025* 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 http://www.aetnaretireeplans.com. As a reminder, our website has the most up-to-date information about our provider network (Provider Directory) and our list of covered drugs (Formulary/Drug List).

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-800-307-4830. Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-800-307-4830. Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑 问。如果您需要此翻译服务，请致电 1-800-307-4830。我们的中文工作人员很乐意帮助您。 这是一项免费服务。

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Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯 服務。如需翻譯服務，請致電 1-800-307-4830。我們講中文的人員將樂意為您提供幫助。這 是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-800-307-4830. Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-800-307-4830. Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1-800-307-4830 sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí .

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-800-307-4830. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-800-307-4830번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-800-307-4830. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic:
إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 1-800-307-4830. سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-800-307-4830 पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-800-307-4830. Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Português: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-800-307-4830. Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-800-307-4830. Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-800-307-4830. Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするため に、無料の通訳サービスがありますございます。通訳をご用命になるには、1-800-307-4830にお電話ください。日本語を話す人 者 が支援いたします。これは無料のサービスです。

Hawaiian: He kōkua māhele ʻōlelo kā mākou i mea e pane ʻia ai kāu mau nīnau e pili ana i kā mākou papahana olakino a lāʻau lapaʻau paha. I mea e loaʻa ai ke kōkua māhele ʻōlelo, e kelepona mai iā mākou ma 1-800-307-4830. E hiki ana i kekahi mea ʻōlelo Pelekānia/ʻŌlelo ke kōkua iā ʻoe. He pōmaikaʻi manuahi kēia.

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

Aetna Medicare Advantage Program – ESA PPO

NORTHEAST DISTRICT COUNCIL OF THE OPCMIA WELFARE FUND
Aetna Medicare[SM] Plan (PPO)
Medicare (P01) ESA PPO Plan
Custom Rx $10/$20/$50/$50

Benefits and Premiums are effective January 1, 2025 through December 31, 2025

SUMMARY OF BENEFITS
PROVIDED BY AETNA LIFE INSURANCE COMPANY

Primary Care Physician (PCP): You have the option to choose a PCP. When we know who your provider is, we can better support your care.

Referrals: Your plan doesn't require a referral from a PCP to see a specialist. Keep in mind, some providers may require a recommendation or treatment plan from your doctor in order to see you.

Prior Authorizations: Your doctor will work with us to get approval before you receive certain services or drugs. Benefits that may require a prior authorization are listed with an asterisk (*) in the benefits grid.

PLAN FEATURES	Network & out-of-network providers.
Monthly Premium	Please contact your former employer/union/trust for more information on your plan premium.
Plan Follows the Federal Medicare Part B Deductible Plan deductible is equal to the Federal Medicare Part B deductible	No
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	
Annual maximum out-of-pocket limit amount includes any deductible, copayment or coinsurance that you pay.	$3,400
It will apply to all medical expenses except Hearing Aid Reimbursement and Medicare prescription drug coverage that may be available on your plan.	

aetna™

NORTHEAST DISTRICT COUNCIL OF THE OPCMIA WELFARE FUND
Aetna Medicare[SM] Plan (PPO)
Medicare (P01) ESA PPO Plan
Custom Rx $10/$20/$50/$50

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.	
Observation Stay	Your cost share for Observation Care is based upon the services you receive
Frequency:	per stay
Outpatient Services & Surgery	$0
Ambulatory Surgery Center	$0
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
PREVENTIVE CARE	**This is what you pay for network & out-of-network providers.**
Medicare-covered Preventive Services	$0

- Abdominal aortic aneurysm screenings
- Alcohol misuse screenings and counseling
- Annual Well Visit - One exam every 12 months.
- Bone mass measurements
- Breast exams
- Breast cancer screening: mammogram - one baseline mammogram for members age 35-39; and one annual mammogram for members age 40 & over.
- Cardiovascular behavior therapy
- Cardiovascular disease screenings
- Cervical and vaginal cancer screenings (Pap) - one routine GYN visit and pap smear every 24 months.
- Colorectal cancer screenings (colonoscopy, fecal occult blood test, flexible sigmoidoscopy)
- Depression screenings
- Diabetes screenings

- HBV infection screening
- Hepatitis C screening tests
- HIV screenings
- Lung cancer screenings and counseling
- Medicare Diabetes Prevention Program - 12 months of core session for program eligible members with an indication of pre-diabetes.
- Nutrition therapy services
- Obesity behavior therapy
- Pelvic Exams and pap test (screening) - one routine GYN visit and pap smear every 24 months.
- Prolonged Preventive Services - prolonged preventive service(s) (beyond the typical service time of the primary procedure), in the office or other outpatient setting requiring direct patient contact beyond the usual service
- Prostate cancer screenings (PSA) - for all male patients aged 50 and older (coverage begins the day after 50th birthday)
- Sexually transmitted infections screenings and counseling
- Tobacco use cessation counseling
- Welcome to Medicare preventive visit

Immunizations • Flu • Hepatitis B • Pneumococcal	$0
Additional Medicare Preventive Services • Barium enema - one exam every 12 months. • Diabetes self-management training (DSMT) • Digital rectal exam (DRE) • EKG following welcome exam • Glaucoma screening	$0
EMERGENCY AND URGENT MEDICAL CARE	**This is what you pay for network & out-of-network providers.**
Emergency Care; Worldwide (waived if admitted)	$65
Urgently Needed Care; Worldwide	$15

DIAGNOSTIC PROCEDURES*	This is what you pay for network & out-of-network providers.
Diagnostic Radiology CT scans	$0
Diagnostic Radiology Other than CT scans	$0
Lab Services	$0
Diagnostic testing & procedures	$0
Outpatient X-rays	$0
HEARING SERVICES	**This is what you pay for network & out-of-network providers.**
Routine Hearing Screening We cover one exam every twelve months	$0
Medicare Covered Hearing Examination	$10
Hearing Aid Reimbursement	$500 once every 36 months
DENTAL SERVICES	**This is what you pay for network & out-of-network providers.**
Medicare Covered Dental* Non-routine care covered by Medicare.	$10
VISION SERVICES	**This is what you pay for network & out-of-network providers.**
Routine Eye Exams One annual exam every 12 months.	$0
Diabetic Eye Exams	$0
Medicare Covered Eye Exam	$10

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
Individual visit	
Partial Hospitalization and Intensive Outpatient Services	$10
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
Individual visit	

SKILLED NURSING SERVICES*	This is what you pay for network & out-of-network providers.
Skilled Nursing Facility (SNF) Care	$0 per day, days 1-20; $20 per day, days 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.	

PHYSICAL THERAPY SERVICES*	This is what you pay for network & out-of-network providers.
Outpatient Rehabilitation Services	$0
(Speech, physical, and occupational therapy)	

AMBULANCE SERVICES	This is what you pay for network & out-of-network providers.
Ambulance Services	$0
Prior authorization rules may apply for non-emergency transportation services received in-network. Your network provider is responsible for requesting prior authorization. Our plan recommends pre-authorization of non-emergency transportation services when provided by an out-of-network provider.	

TRANSPORTATION SERVICES	This is what you pay for network & out-of-network providers.
Transportation (non-emergency)	24 one-way trips with 60 miles allowed per trip
MEDICARE PART B PRESCRIPTION DRUGS*	**This is what you pay for network & out-of-network providers.**
Medicare Part B Prescription Drugs	$0
Medicare Part B Prescription Drugs - Insulin	$0
MEDICARE PART D PRESCRIPTION DRUGS	**This is what you pay for network & out-of-network providers.**

Part D drugs are covered. See PHARMACY - PRESCRIPTION DRUG BENEFITS section below for your plan benefits at each part D stage, including cost share and other important pharmacy benefit information.

ADDITIONAL PROGRAMS AND SERVICES	This is what you pay for network & out-of-network providers.
Allergy Shots	$0
Allergy Testing	$10
Blood	$0
All components of blood are covered beginning with the first pint.	
Cardiac Rehabilitation Services	$0
Intensive Cardiac Rehabilitation Services	$0
Chiropractic Services*	$15
Medicare covered benefits only.	
Diabetic Supplies*	$0
Includes supplies to monitor your blood glucose from LifeScan.	
Durable Medical Equipment/ Prosthetic Devices*	$0
Home Health Agency Care*	$0
Hospice Care	Covered by Original Medicare at a Medicare certified hospice.
Medical Supplies*	Your cost share is based upon the provider of services
Medicare Covered Acupuncture	$10
Outpatient Dialysis Treatments*	$0
Podiatry Services	$10
Medicare covered benefits only.	
Pulmonary Rehabilitation Services	$15
Supervised Exercise Therapy (SET) for PAD Services	$15
Radiation Therapy*	$0
ADDITIONAL PROGRAMS (NOT COVERED BY ORIGINAL MEDICARE)	**This is what you pay for network & out-of-network providers.**
Fitness Benefit	SilverSneakers®
Meals	$0

Covered up to 14 meals following an inpatient stay.

Resources For Living®	Covered
For help locating resources for every day needs.	
Smoking and Tobacco Use Cessation Supplies	$0
Frequency	unlimited visits every year
Teladoc™	$0
Telemedicine services with a Teladoc™ provider. State mandates may apply.	
Telehealth	Covered
Telemedicine Services. Member cost share will apply based on services rendered.	
Telehealth PCP	$10
Telehealth Specialist	$10
Telehealth Occupational Therapy Services	$0
Telehealth PT and SP Services	$0
Telehealth Other Health care Providers	$10
Telehealth Individual Mental Health	$10
Telehealth Group Mental Health	$10
Telehealth Individual Psychiatric Services	$10
Telehealth Group Psychiatric Services	$10
Telehealth Individual Substance Abuse Services	$10
Telehealth Group Substance Abuse Services	$10
Telehealth Kidney Disease Education Services	$0
Telehealth Diabetes Self-Management Training	$0
Telehealth Opioid Treatment Program Services	$10
Telehealth Urgent care	$15
Wigs*	$0
Maximum	$400
Frequency	every year

ADDITIONAL SERVICES (NOT COVERED BY ORIGINAL MEDICARE)	This is what you pay for network & out-of-network providers.
Routine Physical Exams One exam per calendar year	$0

Benefits that may require a prior authorization are listed with an asterisk (*) in the benefits grid.

See next page for Pharmacy-Prescription Drug Benefits.

PHARMACY - PRESCRIPTION DRUG BENEFITS

Pharmacy Network S2

Your Medicare Part D plan uses the network above. To find a network pharmacy, you can visit our website (http://www.aetnaretireeplans.com.)

Formulary (Drug List) Classic

Your cost for generic drugs is usually lower than your cost for brand drugs. However, some higher cost generic drugs are combined on brand tiers.

Beginning 1/1/25, the Centers for Medicare Services (CMS) made the following changes to the standard Part D plan design:

- Reduction to three phases - Deductible, Initial Coverage, and Catastrophic
- Elimination of the Initial Coverage Limit and the Coverage Gap Phase
- Introduction of a $2,000 annual out-of-pocket threshold
- Replacement of the Coverage Gap Discount Program with the Manufacturer Discount Program which will provide a 10% manufacturer discount for brand drugs in the Initial Coverage phase and 20% manufacturer discount for brand drugs in the Catastrophic phase

See below for your specific benefits and cost sharing.

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. The deductible does not apply to covered insulins and most Part D vaccines.

Initial Coverage Phase - The table below represents cost sharing after the deductible, if applicable, has been reached.

4 Tier Plan	30-day Supply through Retail	90-day Supply through Retail or Mail	
	Standard	**Preferred Mail**	**Standard Retail or Mail**
Tier 1 - Generic Generic Drugs	$10	$20	$20

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4 Tier Plan	30-day Supply through Retail	90-day Supply through Retail or Mail	
	Standard	**Preferred Mail**	**Standard Retail or Mail**
Tier 2 - Preferred Brand Includes some high-cost generic and preferred brand drugs	$20	$40	$40
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

If you reside in a long-term care facility, your cost share is the same as a 30 day supply at a retail pharmacy and you may receive up to a 31 day supply.

You won't pay more than $35 for a one-month supply or $105 for up to a three-month supply of each covered insulin product regardless of the cost-sharing tier.

Catastrophic Coverage: You pay $0 for covered Part D prescription drugs.

Catastrophic Coverage benefits start once the CMS-determined annual out-of-pocket threshold of $2,000 for covered Part D prescription drugs is reached.

Requirements:	
Precertification	Applies
Step-Therapy	Does Not Apply

Medical Disclaimers

For more information about Aetna plans, go to www.AetnaRetireePlans.com or call Member Services toll-free at 1-888-267-2637 (TTY: 711). Hours are 8 a.m. to 9 p.m. EST, Monday through Friday.

The provider network may change at any time. You will receive notice when necessary.

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

The complete list of services can be found in the Evidence of Coverage (EOC). You can request a copy of the EOC by contacting Member Services at 1-888-267-2637 (TTY: 711). Hours are 8 a.m. to 9 p.m. EST, Monday through Friday.

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 Original 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).

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

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.

Pharmacy clinical programs such as precertification, step therapy and quantity limits may apply to your prescription drug coverage.

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.

The typical number of business days after the mail order pharmacy receives an order to receive your shipment is up to 10 days. Enrollees have the option to sign up for automated mail order delivery. If your mail order drugs do not arrive within the estimated time frame, please contact us toll-free at 1-866-241-0357, 24 hours a day, 7 days a week. TTY users call 711.

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 HMO and PPO plan with a Medicare contract. Enrollment in our plans depends on contract renewal.

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

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.

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

Resources For Living is the brand name used for products and services offered through the Aetna group of subsidiary companies.

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 2025* 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 http://www.aetnaretireeplans.com. As a reminder, our website has the most up-to-date information about our provider network (Provider Directory) and our list of covered drugs (Formulary/Drug List).

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-800-307-4830. Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-800-307-4830. Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑 问。如果您需要此翻译服务，请致电 1-800-307-4830。我们的中文工作人员很乐意帮助您。 这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯 服務。如需翻譯服務，請致電 1-800-307-4830。我們講中文的人員將樂意為您提供幫助。這 是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-800-307-4830. Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-800-307-4830. Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1-800-307-4830 sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí .

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-800-307-4830. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-800-307-4830번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-800-307-4830. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

:Arabic
إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 1-800-307-4830. سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-800-307-4830 पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-800-307-4830. Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Português: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-800-307-4830. Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-800-307-4830. Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-800-307-4830. Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするため に、無料の通訳サービスがありますございます。通訳をご用命になるには、1-800-307-4830にお電話ください。日本語を話す人 者 が支援いたします。これは無料のサービスです。

Hawaiian: He kōkua māhele ʻōlelo kā mākou i mea e pane ʻia ai kāu mau nīnau e pili ana i kā mākou papahana olakino a lāʻau lapaʻau paha. I mea e loaʻa ai ke kōkua māhele ʻōlelo, e kelepona mai iā mākou ma 1-800-307-4830. E hiki ana i kekahi mea ʻōlelo Pelekānia/ʻŌlelo ke kōkua iā ʻoe. He pōmaikaʻi manuahi kēia.

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

Access2Care℠ Transportation Benefit

Safe, comfortable transportation to your medical appointments

AetnaRetireePlans.com

72.30.319.1 B-Flyer (5/20)

aetna™

Safe, comfortable transportation to your medical appointments

We don't want you to worry about how you'll get to your medical appointments. Instead, we want you to focus on what matters, like your health and treatment plans. That's why Aetna offers optional, non-emergency transportation that gets you there and back.

These rides are included with your plan at **no extra cost**.

You can check your Evidence of Coverage or call the number below for information on trip and mileage allowances. Rides are provided through Access2Care℠. If you need a ride to and from the doctor, you'll use two trips.

Here are some examples* of how members may use the benefit

- Diane's son can take her to an appointment with her cardiologist, but he has to pick up his kids later and can't make the return trip. Diane uses one trip of her transportation benefit to get home from the doctor.
- John's neighbor Mary usually takes him to check-ups with his primary care doctor, but she's busy on one appointment day. John needs a ride both to and from the doctor, so he uses two trips.

* These are illustrative examples only, not actual member experiences.

If you need to reserve a ride, call **1-855-814-1699 (TTY: 711)**, Monday–Friday, 8 AM–8 PM all time zones. Visit **Access2Care.net** to reserve a ride and get more details.

Aetna Medicare is a HMO, PPO plan with a Medicare contract. Enrollment in our plans depends on contract renewal. This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments, and restrictions may apply. Benefits, premium and/or co-payments/co-insurance may change on January 1 of each year. See Evidence of Coverage for a complete description of plan benefits, exclusions, limitations and conditions of coverage.

GRP_4001_1541 06/2018

72.30.319.1 B-Flyer (5/20)

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AetnaRetireePlans.com

Get home-delivered meals after leaving the hospital

With your Aetna Medicare Advantage plan, you can get healthy, precooked meals delivered to your home after an inpatient hospital stay — **at no extra cost.** This new meal benefit lets you stay focused on recuperating, while getting good nutrition.

Aetna partners with a vendor called GA Foods® to coordinate this benefit. They deliver high-quality, nutritious meals to members during this important recovery period.

AetnaRetireePlans.com

1A.03.509.1 (6/20)

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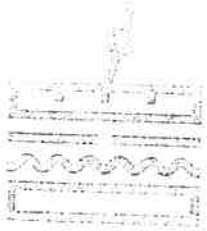
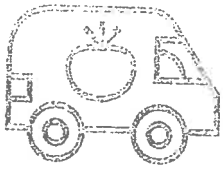
How many meals can you receive?

You'll get 14 — 2 meals a day, for 7 days.



What are the meal options?

Each meal includes a chef-inspired entrée, such as pasta, stews and salads. They also feature fruit, vegetables and desserts. The menu is developed by registered dietitians so all meals are low in sodium, fat, cholesterol and sugar, and are high in vitamins and minerals. All meals come frozen, or are shelf-stable, and are easy to prepare.



It's easy to get your meals.

After you're discharged to your home from an inpatient hospital stay:

- You'll get a phone call from GA Foods. On the call, you'll learn about the meal benefit and discuss delivery time frames.
- If you decide to receive meals, they will be delivered by FedEx or GA Foods within 48 to 72 hours.

Questions?

For more information, call the number on the back of your medical ID card.

Get active with SilverSneakers®

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

To find fitness locations and SilverSneakers FLEX classes, request your SilverSneakers ID number or get additional details, visit silversneakers.com 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!

Insurance products offered through aetna®

SilverSneakers

*At-home kits are offered to members who want to start working out at home or for those who are ineligible 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 Plans are 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.

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Dental Insurance – Aetna Dental DMO Plan

The Northeast District Council of the OPCMIA offers a Dental DMO Plan for retired members. The plan offers various benefits for different dental services and procedures.

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 Administrator for clarification. Please refer to the following pages to see a detailed list of your Summary of Benefits for the Aetna DMO Dental Plan.

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

DMO® Dental Benefits Summary

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

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

DMO® Dental Benefits Summary

D2710	Crown - Resin-Based Composite, Indirect	$362	D6242	Pontic - Porcelain Fused to Noble Metal	$362
D2712	Crown - 3/4 Resin-Based Composite, Indirect	$265	D6245	Pontic - Porcelain/Ceramic	$362
D2720	Crown - Resin With High Noble Metal	$362	D6250	Pontic - Resin With High Noble Metal	$362
D2721	Crown - Resin With Predominantly Base Metal	$362	D6251	Pontic - Resin With Predominantly Base Metal	$362
D2722	Crown - Resin With Noble Metal	$362	D6252	Pontic - Resin With Noble Metal	$362
D2740	Crown - Porcelain/Ceramic Substrate	$362	D6545	Retainer - Cast Metal for Resin-Bonded Fixed	$236
D2750	Crown - Porcelain Fused to High Noble Metal	$362	D6548	Retainer - Porcelain/Ceramic for Resin-Bonded Fixed Prosthesis	$236
D2751	Crown - Porcelain Fused to Predominantly Base Metal	$362	D6549	Resin Retainer - Resin Bonded Prosthesis	$130
D2752	Crown - Porcelain Fused to Noble Metal	$362	D6600	Inlay - Porcelain/Ceramic, 2 Surf	$236
D2780	Crown - 3/4 Cast High Noble Metal	$362	D6601	Inlay - Porcelain/Ceramic, 3+ Surf	$236
D2781	Crown - 3/4 Cast Predominantly Based Metal	$362	D6602	Inlay - Cast High Noble Metal, 2 Surf	$269
D2782	Crown - 3/4 Cast Noble Metal	$362	D6603	Inlay - Cast High Noble Metal, 3+ Surf	$269
D2783	Crown - 3/4 Porcelain/Ceramic	$362	D6604	Inlay - Cast Predominantly Base Metal, 2 Surf	$236
D2790	Crown - Full Cast High Noble Metal	$362	D6605	Inlay - Cast Predominantly Base Metal, 3+ Surf	$236
D2791	Crown - Full Cast Predominantly Base Metal	$362	D6606	Inlay - Cast Noble Metal, 2 Surf	$257
D2792	Crown - Full Cast Noble Metal	$362	D6607	Inlay - Cast Noble Metal, 3+ Surf	$257
D2794	Crown - Titanium	$362	D6608	Onlay - Porcelain/Ceramic, 2 Surf	$253
D2910	Recement Inlay, Onlay or Partial Coverage Restoration	$15	D6609	Onlay - Porcelain/Ceramic, 3+ Surf	$253
D2915	Recement Cast or Prefab Post and Core	$8	D6610	Onlay - Cast High Noble Metal, 2 Surf	$285
D2920	Recement Crown	$15	D6611	Onlay - Cast High Noble Metal, 3+ Surf	$285
D2929	Prefab Porcelain/Ceramic Crown - Primary Tooth	$76	D6612	Onlay - Cast Predominantly Base Metal, 2 Surf	$253
D2930	Prefab, Stainless Steel Crown - Primary Tooth	$54	D6613	Onlay - Cast Predominantly Base Metal, 3+ Surf	$253
D2931	Prefab, Stainless Steel Crown - Permanent Tooth	$65	D6614	Onlay - Cast Noble Metal, 2 Surf	$274
D2934	Prefabricated Esthetic Coated Stainless Steel Crown - Primary Tooth	$54	D6615	Onlay - Cast Noble Metal, 3+ Surf	$274
D2950	Core Buildup, Including Any Pins	$141	D6624	Inlay - Titanium	$269
D2952	Post & Core in Addition to Crown	$140	D6634	Onlay - Titanium	$285
D6058	Abutment Supported Porcelain/Ceramic Crown	$362	D6710	Crown - Indirect Resin Based Composite	$362
D6059	Abutment Supported Porcelain Fused to Metal Crown (High Noble Metal)	$362	D6720	Crown - Resin With High Noble Metal	$362
D6060	Abutment Supported Porcelain Fused to Metal Crown (Predominantly Base Metal)	$362	D6721	Crown - Resin With Predominantly Base Metal	$362
D6061	Abutment Supported Porcelain Fused to Metal Crown (Noble Metal)	$362	D6722	Crown - Resin With Noble Metal	$362
D6062	Abutment Supported Cast Metal Crown (High Noble Metal)	$362	D6740	Crown - Porcelain/Ceramic	$362
D6063	Abutment Supported Cast Metal Crown (Predominantly Base Metal)	$362	D6750	Crown - Porcelain Fused to High Noble Metal	$362
D6064	Abutment Supported Cast Metal Crown (Noble Metal)	$362	D6751	Crown - Porcelain Fused to Predominantly Base Metal	$362
D6065	Implant Supported Porcelain/Ceramic Crown	$362	D6752	Crown - Porcelain Fused to Noble Metal	$362
D6066	Implant Supported Porcelain Fused to Metal Crown (Titanium, Titanium Alloy or High Noble Metal)	$362	D6780	Crown - 3/4 Cast High Noble Metal	$362
D6067	Implant Supported Metal Crown (Titanium, Titanium Alloy or High Noble Metal)	$362	D6781	Crown - 3/4 Cast Predominantly Base Metal	$362
D6068	Abutment Supported Retainer for Porcelain/Ceramic FPD	$362	D6782	Crown - 3/4 Cast Noble Metal	$362
D6069	Abutment Supported Retainer for Porcelain Fused to Metal FPD (High Noble Metal)	$362	D6783	Crown - 3/4 Porcelain/Ceramic	$362
D6070	Abutment Supported Retainer for Porcelain Fused to Metal FPD (Predominantly Base Metal)	$362	D6790	Crown - Full Cast High Noble Metal	$362
D6071	Abutment Supported Retainer for Porcelain Fused to Metal FPD (Noble Metal)	$362	D6791	Crown - Full Cast Predominantly Base Metal	$362
D6072	Abutment Supported Retainer for Cast Metal FPD (High Noble Metal)	$362	D6792	Crown - Full Cast Noble Metal	$362

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

DMO® Dental Benefits Summary

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

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

DMO® Dental Benefits Summary

D5110	Complete Denture - Maxillary	$318	D5223-D5224	Immediate max/mand partial denture - cast base framework w/resin denture base (including any conventional clasps, rests and teeth)	$393
D5120	Complete Denture - Mandibular	$318	D5225	Maxillary Partial Denture - Flexible Base (including any clasps, rests and teeth)	$363
D5130	Immediate Denture - Maxillary	$342	D5226	Mandibular Partial Denture - Flexible Base (including any clasps, rests and teeth)	$363
D5140	Immediate Denture - Mandibular	$342	D5282-83	Removable Unilateral Partial Denture - One Piece Cast Metal (including clasps and teeth)	$318
D5211	Maxillary Partial Denture - Resin Base (including any conventional clasps, rests and teeth)	$318	D5410	Adjust Complete Denture - Maxillary	$11
D5212	Mandibular Partial Denture - Resin Base (including any conventional clasps, rests and teeth)	$318	D5411	Adjust Complete Denture - Mandibular	$11
D5213	Maxillary Partial Denture - Cast Metal Framework with Resin Denture Bases (including any conventional clasps, rests and teeth)	$342	D5421	Adjust Partial Denture - Maxillary	$11
D5214	Mandibular Partial Denture - Cast Metal Framework with Resin Denture Bases (including any conventional clasps, rests and teeth)	$342	D5422	Adjust Partial Denture - Mandibular	$11
D5221-D5222	Immediate max/mand partial dental - resin base (including any conventional clasps, rests and teeth)	$366			

(2) Includes relines, adjustments, rebases within the 1st six months. Adjustments to dentures that are done within six months of placement of the denture, are limited to no more than four adjustments.

REPAIRS TO PROSTHETICS

D5511-D5512	Repair Broken Complete Denture Base	$45	D5730	Reline Complete Maxillary Denture (Chairside)	$66
D5520	Replace Missing or Broken Teeth - Complete Denture (each tooth)	$45	D5731	Reline Complete Mandibular Denture (Chairside)	$66
D5611-D5612	Repair Resin Partial Denture Base	$45	D5740	Reline Maxillary Partial Denture (Chairside)	$66
D5621-D5622	Repair Cast Partial Framework	$45	D5741	Reline Mandibular Partial Denture (Chairside)	$66
D5630	Repair or Replace Broken Clasp	$45	D5750	Reline Complete Maxillary Denture (Lab)	$110
D5640	Replace Broken Teeth - Per Tooth	$50	D5751	Reline Complete Mandibular Denture (Lab)	$110
D5650	Add Tooth to Existing Partial Denture	$45	D5760	Reline Maxillary Partial Denture (Lab)	$110
D5660	Add Clasp to Existing Partial Denture	$50	D5761	Reline Mandibular Partial Denture (Lab)	$110
D5670	Replace All Teeth and Acrylic on Cast Metal Framework (Maxillary)	$110	D5820	Interim Partial Denture (Maxillary) (3)	$132
D5671	Replace All Teeth and Acrylic on Cast Metal Framework (Mandibular)	$110	D5821	Interim Partial Denture (Mandibular) (3)	$132
D5710	Rebase Complete Maxillary Denture	$110	D5850	Tissue Conditioning, Maxillary	$61
D5711	Rebase Complete Mandibular Denture	$110	D5851	Tissue Conditioning, Mandibular	$61
D5720	Rebase Maxillary Partial Denture	$110	D5876	Add metal substructure to acrylic full denture (per arch)	$40
D5721	Rebase Mandibular Partial Denture	$110			

(3) Eligible on Anterior Teeth only.

ORAL SURGERY

D7111	Extraction, Coronal Remnants - Deciduous Tooth	No Charge	D7285 (1)	Biopsy of Oral Tissue - Hard (Bone, Tooth)	$88
D7140	Extraction, Erupted Tooth or Exposed Root (Elevation and/or Forceps Removal)	No Charge	D7286 (1)	Biopsy of Oral Tissue - Soft	$88
D7210 (1)	Surgical Removal of Erupted Tooth	$57	D7287 (1)	Cytological Sample Collection	$44
D7220 (1)	Removal of Impacted Tooth - Soft Tissue	$65	D7310 (1)	Alveoloplasty in Conjunction With Extractions - 4 or More Teeth or Tooth Spaces - Per Quadrant	$66
D7230 (1)	Removal of Impacted Tooth - Partially Bony	$94	D7311 (1)	Alveoloplasty in Conjunction With Extractions - 1 to 3 Teeth or Tooth Spaces - Per Quadrant	$33
D7240 (1)	Removal of Impacted Tooth - Completely Bony	$145	D7320 (1)	Alveoloplasty Not in Conjunction With Extractions - 4 or More Teeth or Tooth Spaces - Per Quadrant	$83

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

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D7241 (1)	Removal of Impacted Tooth - Completely Bony, With Unusual Surgical Complications	$145	D7321 (1)	Alveoloplasty Not in Conjunction With Extractions - 1-3 Teeth or Tooth Spaces - Per Quadrant	$42
D7250 (1)	Surgical Removal of Residual Tooth Roots	$59	D7510 (1)	Incision and Drainage of Abcess - Intraoral Soft Tissue	$33
D7251	Coronectomy - intentional partial tooth removal	$66	D7511 (1)	Incision and Drainage of Abcess - Intraoral Soft Tissue - Complicated	$36
D7280 (1)	Surgical Access of Unerupted Tooth	$62	D7960 (1)	Frenulectomy (Frenectomy, Frenotomy) Separate Procedure	$99
D7282 (1)	Mobilization of Erupted or Malpositioned Tooth to Aid Eruption	$77	D7963 (1)	Frenuloplasty	$105
D7283	Placement of Device to Facilitate Eruption of Impacted Tooth	$15			
(1) Certain services may be covered under the Medical Plan. Contact Member Services for more details.					
OTHER (ADJUNCTIVE) SERVICES					
D9110	Palliative (Emergency) Treatment of Dental Pain - minor procedure	$11	D9942	Repair and/or Reline of Occlusal Guard	$22
D9222	Deep sedation/general anesthesia - 1st 15 min	$109	D9943	Occlusal guard adjustment	$19
D9223	Deep sedation/general anesthesia - each 15 minute increment	$87	D9944	Occlusal guard – hard appliance, full arch	$173
D9239	Intravenous conscious sedation/analgesia - 1st 15 min	$109	D9945	Occlusal guard – soft appliance, full arch	$150
D9243	Intravenous conscious sedation/analgesia - each 15 minute increment	$87	D9946	Occlusal guard – hard appliance, partial arch	$90
D9310	Consultation - Diagnostic Service Provided by Dentist or Physician Other Than Requesting Dentist or Physician	No Charge	D9951	Occlusal Adjustment - limited	$35
D9311	Consultation with a medical health care professional	No Charge	D9952	Occlusal Adjustment - complete	$96
D9932-D9935	Denture cleaning and inspection	$25			
ORTHODONTICS					
	Orthodontic Screening Exam	$30			
	Diagnostic Records	$150			
	Comprehensive Orthodontic Treatment				
	Adolescent (appliance must be placed prior to age 20)	$1,545			
	Adult	N/A			
	Orthodontic Retention	$275			

Other Important Information

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

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

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

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

PLAN EXCLUSIONS AND LIMITATIONS*

Some Services Not Covered Under the Plan Are:

1. Services or supplies that are covered in whole or in part:
(a) under any other part of this Dental Care Plan; or

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

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

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

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DMO® Dental Benefits Summary

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

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DMO® Dental Benefits Summary

*This is a partial list of exclusions and limitations, others may apply. Please check your plan booklet for details.

Specialty Referrals

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

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

Emergency Dental Care

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- While you were covered by the plan:
  - You had a tooth (or teeth) extracted after the existing denture or bridge was installed.
  - As a result, you need to replace or add teeth to your denture or bridge.
- The present item cannot be made serviceable, and is:
  - A crown installed at least 5 years before its replacement.
  - An inlay, onlay, veneer, complete denture, removable partial denture, fixed partial denture (bridge), or other prosthetic item installed at least 5 years before its replacement.
- While you were covered by the plan:
  - You had a tooth (or teeth) extracted.
  - Your present denture is an immediate temporary one that replaces that tooth (or teeth).
  - A permanent denture is needed, and the temporary denture cannot be used as a permanent denture. Replacement must occur within 12 months from the date that the temporary denture was installed.

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

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

- The dentures, bridges or other prosthetic items are needed to replace one or more natural teeth. (The extraction of a third molar tooth does not qualify.)
- The tooth that was removed was not an abutment to a removable or fixed partial denture installed during the prior 5 years

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

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

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

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

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

Finding Participating Providers

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.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

▯ ID
(Burmese)

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

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

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

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

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

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Dental Insurance – Aetna Dental PPO Plan

The Northeast District Council of the OPCMIA offers a Dental PPO Plan for retired members that live outside of the Aetna DMO dental network or who simply prefer to go to a provider that is not in the Aetna DMO dental network. The plan offers various benefits for different dental services and procedures.

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 that you do not see, contact your Benefit Administrator for clarification. Please refer to the following pages to see a detailed list of your Summary of Benefits for the Aetna PPO Dental Plan.

Note: Preventive care is not subject to the annual deductible.

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

Dental Benefits Summary

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

*The deductible applies to: Basic & Major services only
**Orthodontia is covered only for children (appliance must be placed prior to age 20).

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

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

Emergency Dental Care

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

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

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

1. Services or supplies that are covered in whole or in part:
   (a) under any other part of this Dental Care Plan; or
   (b) under any other plan of group benefits provided by or through your employer.
2. Services and supplies to diagnose or treat a disease or injury that is not:
   (a) a non-occupational disease; or
   (b) a non-occupational injury.
3. Services not listed in the Dental Care Schedule that applies, unless otherwise specified in the Booklet-Certificate.
4. Those for replacement of a lost, missing or stolen appliance, and those for replacement of appliances that have been damaged due to abuse, misuse or neglect.
5. Those for plastic, reconstructive or cosmetic surgery, or other dental services or supplies, that are primarily intended to improve, alter or enhance appearance. This applies whether or not the services and supplies are for psychological or emotional reasons. Facings on molar crowns and pontics will always be considered cosmetic.
6. Those for or in connection with services, procedures, drugs or other supplies that are determined by Aetna to be experimental or still under clinical investigation by health professionals.
7. Those for dentures, crowns, inlays, onlays, bridgework, or other appliances or services used for the purpose of splinting, to alter vertical dimension, to restore occlusion, or to correct attrition, abrasion or erosion.
8. Those for any of the following services (Does not apply to the DMO plan in TX):
   (a) an appliance or modification of one if an impression for it was made before the person became a covered person;
   (b) a crown, bridge, or cast or processed restoration if a tooth was prepared for it before the person became a covered person; or
   (c) root canal therapy if the pulp chamber for it was opened before the person became a covered person.
9. Services that Aetna defines as not necessary for the diagnosis, care or treatment of the condition involved. This applies even if they are prescribed, recommended or approved by the attending physician or dentist.
10. Those for services intended for treatment of any jaw joint disorder, unless otherwise specified in the Booklet-Certificate.
11. Those for space maintainers, except when needed to preserve space resulting from the premature loss of deciduous teeth.
12. Those for orthodontic treatment, unless otherwise specified in the Booklet-Certificate.
13. Those for general anesthesia and intravenous sedation, unless specifically covered. For plans that cover these services, they will not be eligible for benefits unless done in conjunction with another necessary covered service.
14. Those for treatment by other than a dentist, except that scaling or cleaning of teeth and topical application of fluoride may be done by a licensed dental hygienist. In this case, the treatment must be given under the supervision and guidance of a dentist.
15. Those in connection with a service given to a person age 5 or older if that person becomes a covered person other than:
   (a) during the first 31 days the person is eligible for this coverage, or
   (b) as prescribed for any period of open enrollment agreed to by the employer and Aetna. This does not apply to charges incurred:
      (i) after the end of the 12-month period starting on the date the person became a covered person; or
      (ii) as a result of accidental injuries sustained while the person was a covered person; or
      (iii) for a primary care service in the Dental Care Schedule that applies as shown under the headings Visits and Exams, and X-rays and Pathology.
16. Services given by a nonparticipating dental provider to the extent that the charges exceed the amount payable for the services shown in the Dental Care Schedule that applies.
17. Those for a crown, cast or processed restoration unless:
   (a) it is treatment for decay or traumatic injury, and teeth cannot be restored with a filling material; or
   (b) the tooth is an abutment to a covered partial denture or fixed bridge.
18. Those for pontics, crowns, cast or processed restorations made with high-noble metals, unless otherwise specified in the Booklet-Certificate.

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

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

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

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

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

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

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

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

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

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

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

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

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. 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, national origin, sex, age, or disability.

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

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

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

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

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

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

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

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

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

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Vision Insurance – Aetna Preferred Vision Plan

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

Please see the following pages to see a detailed list of your Vision Summary of Benefits for the Aetna Preferred Vision.

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

Aetna Vision℠ Preferred

www.aetnavision.com

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

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

Partial list of exclusions and limitations

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

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

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

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

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

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

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

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

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

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

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

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

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

Aetna complies with applicable Federal civil rights laws and does not discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, or disability. Aetna provides free aids/services to people with disabilities and to people who need language assistance. If you need a qualified interpreter, written information in other formats, translation or other services, call 877-973-3238. If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with Civil Rights Coordinator by contacting: Civil Rights Coordinator, P.O. Box 14462, Lexington, KY 40512. 1-800-648-7817, TTY: 711, Fax: 859-425-3379, CRCoordinator@aetna.com.

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

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

INDEPENDENT PROVIDER NETWORK + LENSCRAFTERS PEARLE VISION OPTICAL

Anthem Life

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

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 designated 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 beneficiary information to ensure that your benefit is paid to the correct person of your choice.

Group Name: Northeast District Council of the OPCMIA Welfare Fund

Plan Design

Basic Group Term Life

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

Hospital Copay Reimbursement

The NEDC Welfare Fund offers a $250.00 reimbursment of your out of pocket deductible per hospital admission. In order to make a claim for the hospital admission reimbursement, please supply a copy of your Explanation of Benefits ("EOB") or hospital admission bill. This documentation can be sent directly to the Praetorian Guard Group, LLC using the contact information provided below:

By e-mail

tdimattinapgg@optonline.net

By Fax:

1-980-444-0711

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

CONTACT INFORMATION

CARRIER CONTACT	PHONE	WEB ADDRESS
Aetna Medical - Medicare	1-800-282-5366	www.aetnamedicare.com
Aetna Dental & Vision	1-800-872-3862	www.aetna.com

NORTHEAST DISTRICT COUNCIL FO THE OPCMIA WELFARE FUND OFFICE		
CONTACT	PHONE	EMAIL
Lisa Parisi (Fund Manager)	1-516-775-2280	lisa.parisi@nedcfunds.org
Diane Ferchland	1-516-775-2280	diane@nedcfunds.org
1406 Blondell Avenue, 2nd Floor, Bronx, NY 10461		

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