EMERITI NATIONAL RETIREE HEALTH BENEFITS

2019 HEALTH INSURANCE PLANS

Emeriti®
Retirement Health

Emeriti offers 3 Medicare Advantage Plans, 3 Medicare Part D prescription drug plans, and 1 dental plan, all underwritten by Aetna Life Insurance Company.

AETNA'S 4-STAR RATED MEDICARE ADVANTAGE PLANS

Aetna leads national competitors with 87% of members in 4+ out of five (5) star plans.

Emeriti offers 3 Medicare Advantage Plans, underwritten by Aetna. The Aetna Medicare Advantage Premium Plan has no network requirements. You may see any provider who accepts Medicare and Aetna Medicare Advantage plans.

The Aetna Medicare Advantage Plus and Standard plans have in-network and out-of-network features (depending on where you live). You may choose providers within the network or select out-of-network providers as long as they are able to receive Medicare payment and agree to accept the plan.

If you live outside of an Aetna network county, your option will be a Medicare Advantage PPO Extended Service Area (ESA) plan. The ESA option provides you with the same benefits as in the in-network PPO option, and you will pay the in-network level of cost sharing for all services, even when you are accessing care from out-of-network providers.

Aetna's Medicare Advantage PPO Plans replace Original Medicare

The Aetna Medicare Advantage Plans provide all benefits and services covered under Original Medicare Parts A and B. In these Plans, your costs are simplified - you have no Medicare Part A and Part B deductibles and no plan deductible to pay. You do still enroll in Medicare Parts A and B, and pay your Part B premium.

Easy to use

- One ID card
- More benefits than Original Medicare Parts A and B
- Care advocacy programs
- Wellness benefits
- One monthly Explanation of Benefits

2019 RETIREE MEDICAL PLANS

WHAT YOU PAY

BENEFITS	Medicare Advantage PPO PREMIUM Plan (no networks)	Medicare Advantage PPO PLUS Plan (in-network)	Medicare Advantage PPO PLUS Plan (out-of-network)	Medicare Advantage PPO STANDARD Plan (in-network)	Medicare Advantage PPO STANDARD Plan (out-of-network)
Annual plan deductible	$0	$0	$0	$0	$0
Maximum out-of-pocket responsibility	$2,000 annually	$2,750 annually	$5,500 annually	$6,700 annually	$10,000 annually
Preventive care	$0	$0	25%	$0	30%
Primary care	$15	15%	25%	$15	30%
Specialist visit	$15	15%	25%	$40	30%
Hospitalization	$0 No day limit.	$500 per admission. No day limit.	25% per admission. No day limit.	$200 per day (days 1-7) Plan pays 100% thereafter. No day limit.	30% per admission. No day limit.
Emergency room	$50 Waived if admitted.	$50 Waived if admitted.	$50 Waived if admitted.	$75 Waived if admitted.	$75 Waived if admitted.
X-ray	$15	15%	25%	$35 basic x-ray. $200 complex imaging.	30%
Lab	$15	15%	25%	$35	30%
Outpatient surgery	$0	15%	25%	$185	30%
Skilled nursing					
Days 1-20	$0	0%	25%	$0	30%
Days 21-100	$75/day	15%	25%	$125/day	30%
Days 100+	Limited to 100 days per benefit period[1]	Limited to 100 days per benefit period[1]	Limited to 100 days per benefit period[1]	Limited to 100 days per benefit period[1]	Limited to 100 days per benefit period[1]
Home health care	0%	0%	25%	0%	30%
Rehabilitation services	$15	15%	25%	$40	30%
Chiropractic care	$15	15%	25%	$20	30%
Outpatient mental health & substance abuse treatment	$15	15%	25%	$40	30%
Hospice care	Covered by Original Medicare. 0% except for $5 copay[2]	Covered by Original Medicare. 0% except for $5 copay[2]	Covered by Original Medicare. 0% except for $5 copay[2]	Covered by Original Medicare. 0% except for $5 copay[2]	Covered by Original Medicare. 0% except for $5 copay[2]
Durable medical equipment	15%	15%	25%	20%	30%
Foreign travel emergency	$0 except for $50 emergency room	$0 except for $50 emergency room	$0 except for $50 emergency room	$0 except for $75 emergency room	$0 except for $75 emergency room

[1]A benefit period lasts from admittance to a hospital or Skilled Nursing Facility (SNF) until 60 days after re- lease. Re-admission within that 60 day period is part of the same bene t period for purposes of the deductible and day limits. Hospital or SNF admissions after the 60 days start a new bene t period, with a new deductible and new day limits. There is no limit to the number of bene t periods in a plan year. You must meet certain requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.

[2]$5 copay per prescription for pain management and 5% for inpatient respite care.

2019 PART D PRESCRIPTION DRUG PLANS

You have a choice of three Medicare Part D drug plans in 2019. You choose an Rx Plan when you choose your medical plan.

Alternatively, you may enroll in Aetna's Rx Standard Plan as a stand-alone option, and add medical coverage later.

Aetna Part D plans are based on the Medicare Part D benefit each year. In order to better understand how the plans work, it's helpful to review Medicare's Part D foundational design (see diagram below), which reflects the minimum amount of coverage that Medicare allows. Aetna's plans are richer than the Medicare allowance.

2019 MEDICARE PART D DESIGN (non low-income subsidy eligibles)

PHASE 1	PHASE 2	PHASE 3	PHASE 4
DEDUCTIBLE	INITIAL COVERAGE	COVERAGE GAP*	CATASTROPHIC COVERAGE
YOU PAY FIRST $415 AS A DEDUCTIBLE. You stay in this phase until you have paid your yearly deductible amount.	YOU PAY PART OF THE COST OF YOUR DRUGS. Your plan pays the rest of the cost until the combined amount (plus deductible) reaches $3,820.	After your total yearly drug cost reaches $3,820: YOU PAY 25% OF THE PLAN'S COST FOR BRAND AND 37% FOR GENERIC DRUGS.	After your total covered out-of-pocket costs reach $5,100: YOU PAY $3.40 FOR GENERICS AND $8.50 FOR BRAND DRUGS, OR 5% OF THE TOTAL COST (whichever is greater)

The Medicare Coverage Gap Discount Program will continue to provide manufacturer discounts on brand name drugs to Part D beneficiaries who reach the Coverage Gap and are not already receiving "Extra Help." A 70% discount on the negotiated price of preferred and non-preferred brand drugs (excluding the dispensing fee) will be available from manufacturers that have agreed to provide the discount.

2019 Rx PLANS

BENEFITS	PREMIUM PLAN	PLUS PLAN	STANDARD PLAN
Formulary	Open 2 Plus	Open 2 Plus	GRP B2
Your annual deductible	$100	$200	$415
Initial Coverage Phase Up to $3,820 in total drug costs			
Initial coverage phase:[2] what you pay	15% generic 25% preferred brand 40% non-preferred	15% generic 25% preferred brand 50% non-preferred	15% Tier 1 generic 25% higher cost generic & covered brand
Coverage Gap[2] After $3,820 in total drug costs, and before reaching $5,100 out-of-pocket (TrOOP)			
Coverage gap[1]: what you pay	15% generic 25% preferred brand[3] 25% non-preferred	15% Tier 1 generic 25% brand[3]	37% generic 25% brand[3]
Catastrophic Coverage After reaching $5,100 out-of-pocket (TrOOP)			
Catastrophic coverage: what you pay	$0	You pay greater of 5% or $3.40 generic and $8.50 brand	You pay greater of 5% or $3.40 generic and $8.50 brand
Step therapy[3]	Not required	Required for some drugs	Required for some drugs
Prior authorization[5]	Required for some drugs	Required for some drugs	Required for some drugs

[1]Coinsurance is the amount a member pays as a percentage of the negotiated cost for the drug. Coinsurance is applied against the overall cost of the drug, before any discounts or benefits are applied.

[2] The Medicare Coverage Gap Discount Program will continue to provide manufacturer discounts on brand name drugs to Part D beneficiaries who reach the Coverage Gap and are not already receiving "Extra Help." A 70% discount on the negotiated price of preferred and non-preferred brand drugs (excluding the dispensing fee) will be available from manufacturers that have agreed to provide the discount.

[3]Step Therapy is a process where in certain cases one or more clinically equivalent drugs must be tried before the prescribed drug can be covered. If the step therapy drug does not work, Aetna can then cover the requested drug.

Aetna requires you or your physician to get prior authorization for certain drugs. This means that you will need to get approval from Aetna before you fill your prescriptions. If you don't get approval, Aetna may not cover the drug.

UNDERSTANDING DRUG FORMULARIES

A formulary is a list of Part D prescription drugs covered by the Aetna plan. The drugs on Aetna's Medicare Formularies are selected with the help of a team of doctors and pharmacists. The list must meet requirements set by Medicare.

If your drug is not included on Aetna's formularies, you can speak to your doctor about switching to a drug that is on the list. Or your doctor may request a medical exception for the drug to be covered. If you decide to continue taking medications not covered on the formulary without obtaining a medical exception, you will pay the full cost; and these expenses do not count toward the plan's deductible or out-of-pocket limits.

Visit emeritihealth.org to view the Aetna formularies, and estimate the cost of your prescriptions

HEALTH CARE REFORM (ACA) UPDATES

Part D enrollees will receive a 75% Donut Hole discount on the total cost of their brand-name drugs purchased while in the Donut Hole. The discount includes, a 70% discount paid by the brand-name drug manufacturer and a 5% discount paid by your Medicare Part D plan. The 70% paid by the drug manufacturer combined with the 25% you pay, count toward your TrOOP or Donut Hole exit point.

For example: If you reach the Donut Hole and purchase a brand-name medication with a retail cost of $100, you will pay $25 for the medication, and receive $95 credit toward meeting your 2019 total out-of-pocket spending limit. This amount may vary, based on your plan.

SOURCE: Medicare.gov

PLAN FEATURES	HOW PLAN WORKS
Annual deductible*	You pay $100
Preventive services	Plan pays 100%
Basic services	Plan pays 50%
Major services	Plan pays 50%
Annual benefit maximum paid by plan	$1,500
Office visit copay	$0
Orhodontic services	Not covered
PARTIAL LIST OF PLAN PROVISIONS	**WHAT PLAN PAYS**
Preventive	
Oral exams**	100%
Cleanings, scalings, polishing**	100%
Flouride**	100%
Sealants (permanent molars only)**	100%
Bitewing X-rays**	100%
Full mouth series X-rays**	100%
Space maintainers	100%
Basic	
Amalgam (silver) fillings	50%
Composit fillings (anterior teeth only)	50%
Stainless steel crowns	50%
Scaling and root planning**	50%
Gingivectomy	50%
Incision and drainage of abscess	50%
Uncomplicated extractions	50%
Surgical removal of erupted tooth	50%
Surgical removal of impacted tooth (soft tissue)	50%
Major* **	
Root canal therapy, anterior/bicuspid teeth, with X-rays and cultures	50%
Root canal therapy, molar teeth, with X-rays and cultures	50%
Osseous surgery**	50%
Surgical removal of impacted tooth (partial bony/ full bony)	50%
General anesthesia/intravenous sedation	50%
Inlays / Onlays	50%
Crowns	50%
Full and partial dentures and denture repairs	50%
Pontics	50%

** The deductible applies to basic & major services only*
*** Frequency and/or age limitations may apply to these services. These limits are described in the booklet/certificate or evidence of coverage.*
**** Twelve month waiting period applies, but may be waived with evidence of continuing coverage.*

Note: One-time only opt-in opportunity. Dental plan is community rated. Dental is only available when you enroll in a combination Medical/Rx coverage, or elect the stand-alone Rx Standard Plan. ***DENTAL PLAN IS NOT AVAILABLE IN MARYLAND.***

NEED HELP DECIDING WHICH PLAN TO CHOOSE?

Help is a phone call away! Aetna specialists will provide personalized counseling for you and your dependents.

Call 1-855-212-5666 to speak to an Aetna specialist

TWO CONVENIENT WAYS TO ENROLL

1. **Enroll by calling the Emeriti Service Center at 1-866-EMERITI (1-866-363-7484), and pressing option #1.**

2. **Enroll online at myemeritibenefits.org**

Please have the following information available:

- Your Social Security number
- Your spouse's (or domestic partner's*1*) Social Security number, if you choose to enroll him/her
- Your Medicare number and effective dates of coverage (on your Medicare card) and the Medicare information for your post-65 spouse*1*

Coverage will begin January 1, 2019.

1Dependent domestic partners are also eligible, if elected by your institution. Non-dependent domestic partners may also be eligible, if elected by your institution. Please note that there are tax implications for non-dependent domestic partners.

You may have or will soon be receiving an Aetna mailing called "Annual Notice of Change" for the Prescription Drug plan and the Medicare Advantage PPO (or PPO ESA) plan, in which you are currently enrolled. These required documents outline your current plan benefits that will change in 2019.

While this material is believed to be accurate as of the print date, it is subject to change. In the event of a conflict or inconsistency between this material and plan documents, the terms of the plan documents shall govern.

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

You must continue to pay your Medicare Part B premium.

Discount offers provide access to discounted services and are not part of an insured plan or policy. Discount offers are rate-access offers and may be in addition to any plan benefits. The member is responsible for the full cost of discounted services. Aetna may receive a percentage of the fee paid to a discount vendor.

The provider network may change at any time. You will receive notice when necessary. Out-of-network/non-contracted providers are under no obligation to treat Aetna Medicare members, except in emergency situations. For a decision about whether we will cover an out-of-network service, we encourage you or your provider to ask us for a pre-service organization determination before you receive the service. 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. Providers are independent contractors and are not agents of Aetna.

Provider participation may change without notice. Aetna is not a provider of health care services and, therefore, cannot guarantee any results or outcomes. The availability of any particular provider cannot be guaranteed and is subject to change.

Emeriti, TIAA, CBIZ RPS, Aetna Life Insurance Company, and HealthPartners are independent corporations and are not legally affiliated. The full name of Emeriti Retirement Health Solutions is The Emeriti Consortium for Retirement Health Solutions, an Illinois Nonprofit Corporation. Emeriti Retirement Health Solutions is not an insurance company, insurance broker or insurance provider.

Please refer to the insurance plan documents (Evidence of Coverage) for a complete listing of benefits, exclusions and limitations.

The following is a partial listing of exclusions and limitations under the Aetna MedicareSM Plan (PPO):

- *Services that are not medically necessary or not covered under the Original Medicare Program unless otherwise noted*
- *Plastic or cosmetic surgery unless medically necessary*
- *Custodial care*
- *Experimental procedures or treatments beyond Original Medicare limits*
- *Routine foot care that is not medically necessary*
- *Outpatient Prescription Drugs except those covered under Medicare Part B*

The benefit information provided herein is a brief summary, not a comprehensive description of bene ts. For more information contact the plan. A Medicare Advantage organization with a Medicare contract. A Medicare approved Part D sponsor. Bene ts, formulary, pharmacy network, premium and/or components/co-insurance may change on January 1, 2018. Plans are offered by Aetna Health Inc., Aetna Health of California Inc., and/or Aetna Life Insurance Company (Aetna). Not all health services are covered. See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by location and are subject to change each year. Discount Programs provide access to discounted prices and are not insured benefits. While this material is believed to be accurate as of the print date, it is subject to change. Participating physicians, hospitals and other health care providers are independent contractors and are neither agents nor employees of Aetna. The availability of any particular provider cannot be guaranteed, and provider network composition is subject to change.

You must be entitled to Medicare Part A and continue to pay your Part B premium and Part A, if applicable. Higher costs may apply for out-of- network services. Precertification, or prior approval of coverage, is requested for certain services. Providers must be licensed and eligible to receive payment under the federal Medicare program, and agree to accept the PPO plan.

Affordable Care Act (ACA) Information About Insurance and Reimbursement Benefit Eligibility

NOTE: In order for the Emeriti Program to comply with the ACA Legislation, active employees and any eligible dependents cannot be enrolled in the Emeriti insurance or use the Emeriti Reimbursement Benefit while employed at your institution in any capacity; either full time benefits eligible or part time non-benefits eligible. This includes retirees who are rehired on a part-time or by appointment basis. Only when you are not employed by your institution, can you and your eligible dependents be enrolled in the Emeriti health insurance plans and use the Emeriti Reimbursement Benefit.

The ACA mandate only applies if you are rehired by your institution. You may work anywhere else and still maintain retiree status in the Emeriti Program and therefore, still utilize all of the Emeriti benefits. Further, if you are rehired by your institution, you will not lose any of your Emeriti benefits, they will simply be suspended until you move back into "retired" status.

Exclusions and limitations for the Prescription Drug Plans (PDP):

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

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

The formulary and pharmacy network may change at any time. You will receive notice when necessary. Members who get "extra help" are not required to ll prescriptions at preferred network pharmacies in order to get Low Income Subsidy (LIS) copays. You must be entitled to Medicare Part A and continue to pay your Part B premium and Part A, if applicable. See Evidence of Coverage for a complete description of bene ts, exclusions, limitations and conditions of coverage. Plan features and availability may vary by location.

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

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

The Medicare Coverage Gap Discount Program provides a manufacturer discount on brand name drugs to members in a Medicare prescription drug plan. You must have reached the coverage gap and not be receiving Extra Help. Your plan sponsor or former employer provides some additional coverage, during the coverage gap phase, for certain tiers of brand name drugs (depending upon your plan of bene ts). For these drugs, you will generally continue to pay the same amount during the coverage gap as you paid in the initial coverage phase. When you obtain other covered brand name drugs that do not qualify for the additional bene t, the pharmacy automatically applies the applicable manufacturer discount when you are billedf or your prescription. A 50 percent discount on the negotiated price (excluding a dispensing fee) is available for brand name drugs from manufacturers that have agreed to pay the discount. Coinsurance is applied against the overall cost of the drug, before any discounts or benefits are applied. Aetna's retiree pharmacy coverage is an enhanced Part D Employer Group Waiver Plan that is o ered as a single integrated product. The enhanced Part D plan consists of two components: basic Medicare Part D benefits and supplemental bene ts. 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 bene ts. Supplemental benefits are non-Medicare benefits that provide enhanced coverage beyond basic Part D. Supplemental benefits are paid for by plan sponsors or members and may include benefits for non-Part D drugs. Aetna reports claim information to CMS according to the source of applicable payment (Medicare Part D, plan sponsor or member).

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

- *Cover a drug that would be covered under Medicare Part A or Part B.*
- *Cover a drug purchased outside the United States and its territories.*
- *Generally cover drugs prescribed for "o 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 anduoride preparations*
- *Outpatient drugs that the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer as a condition of sale*
- *Drugs used to promote fertility*
- *Drugs used to relieve the symptoms of cough and colds*
- *Non-prescription drugs, also called over-the-counter (OTC) drugs*
- *Drugs when used for the treatment of sexual or erectile dysfunction*

Aetna receives rebates from drug manufacturers that may be considered when determining our preferred drug list. Rebates do not reduce the amount you pay the pharmacy for covered prescriptions. Pharmacy participation is subject to change.

You must use network pharmacies to receive plan bene ts except in limited, non- routine circumstances when a network pharmacy is not available. If you become ill while traveling in the United States, but are outside of your plan's service area, you may need to use an out-of-network pharmacy. An additional cost may be charged for drugs received at an out-of-network pharmacy. Quantity limits and restrictions may apply. If you reside in a long-term care facility, your cost share is the same as at a retail pharmacy and you may receive up to a 31-day supply. You may get drugs from an out-of-network pharmacy in certain situations, but are limited to a 30-day supply. You may be able to get Extra Help to pay for your prescription drug premiums and costs.

To see if you qualify for Extra Help, call:

- *1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24/7*
- *The Social Security Office at 1-800-772-1213 between 7 a.m. and 7 p.m., Monday through Friday. TTY users should call 1-800-325-0778*
- *Your state Medicaid to determine if you qualify, Medicare could pay for up to 75 percent or more of your drug costs including monthly prescription drug premiums, annual deductibles and coinsurance. Additionally, those who qualify will not be subject to the coverage gap or a late enrollment penalty. Many people are eligible for these savings and don't even know it. If there is a difference between this document and the Evidence of Coverage (EOC), the EOC is considered correct.*

Important Dental PPO Information

Under the Dental® Preferred Provider Organization (PPO) plan, you may choose at the time of service either a PPO participating dentist or any non-participating dentist. With the PPO plan, savings are possible because the PPO participating dentists have agreed to provide care at negoti- ated rates. Nonparticipating dentists will only be paid based on the standard negotiated rate provided to participating general dentists in the same geographical area.

Emergency Dental Care
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. Covered emergency services may vary, based on state law.

Some Services Not Covered Under the Plan Are:

1. *Services or supplies that are covered in whole or in part: (a) under any other part of this Dental Care Plan; or b) under any other plan of group benefits provided by or through your employer.*
2. *Services and supplies to diagnose or treat a disease or injury that is not: (a) a non-occupational disease; or (b) a non-occupational injury.*
3. *Services not listed in the Dental Care Schedule that applies, unless otherwise specified in the Booklet-Certificate.*
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: 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 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.*

Any exclusion above will not apply to the extent that coverage of the charges is required under any law that applies to the coverage.

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 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 Indemnity Dental plans are provided or 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 avail- ability 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.

2019 AETNA INSURANCE PLANS

Inside you will find details about the 2019 medical benefits available to you and your dependents through your institution's Emeriti retirement health plan.

Emeriti Service Center: 1-866-EMERITI (1-866-363-7484)

Visit emeritihealth.org for information.

Emeriti®
Retirement Health

2019 NATIONAL COMP