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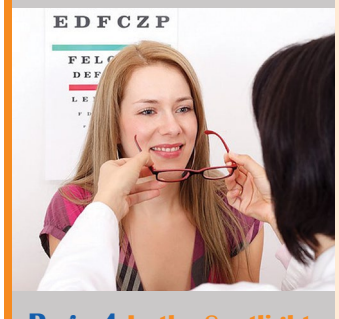

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Deciphering insurance benefits lingo

Benefits Fund participants work in the healthcare field taking care of patients day in and day out. As Registered Nurses, and like others in the medical field, you use a wide variety of medical terminology on a daily basis most likely learned back in college, nursing school, or later, on the job. These terms, or lingo, have become second nature for you – you hear them and immediately know what your fellow nurse, administrator, or the physician is referring to.

What may not come as naturally to you, is understanding all the terminology surrounding your benefits from the NYSNA Benefits Fund. Deductible, coinsurance, copay, EOB, COB, CPT codes. Many of these acronyms even sound the same! It can certainly be tricky keeping everything straight in your mind when reading one of our newsletters, correspondence from a service provider such as Oxford or OptumRx, or paperwork from one of your medical providers. In addition, our Benefits Fund participant service representatives also use these terms when answering your questions on the phone.

While you should never hesitate to ask for an explanation if you don't understand something you read or hear, we know how frustrating it can be getting a clear grasp on all the lingo. Therefore, we've compiled the following guide to explain some of these insurance terms in language that we can all understand:

What is a deductible?

A deductible is the amount a participant must pay for covered services within a calendar year before the Benefits Fund will begin paying **out-of-network** benefits within that calendar year. Benefits Fund participants covered by Benefit Coverage Plan A have a $250/individual or $500/family deductible, while Benefit Coverage Plan B participants have a $300/individual or $600/family deductible.

What is a copayment (copay)?

A copayment is the set dollar amount you're required to pay for certain covered **in-network** services. It's typically paid at the time of service or when billed by the provider. For example, if you have a $10 in-network primary care provider office visit copayment, you'll pay $10 when you visit your doctor's office.

A full list of copayments is listed in your NYSNA Benefits Fund *Summary Plan Description* or in the Summary of Benefits posted on our Web site at **www.rnbenefits.org**. Copayments also may refer to the amount you pay for a prescription drug at a retail pharmacy or through OptumRx's mail order pharmacy.

What is coinsurance?

Coinsurance is the percentage of medical costs that you may be required to pay for certain **out-of-network** services covered under the plan. All Benefits Fund participants currently have a 70 percent/30 percent coinsurance split. This means participants are responsible for paying 30 percent of the allowed amount for covered services.

For example, let's say the maximum amount that Oxford will pay for a particular covered service is $100. Benefits Fund participants have a 30 percent coinsurance. Therefore, in this example, the participant will pay $30 and Oxford would pay the remaining $70. You also must first meet your deductible and are responsible for paying anything above the allowed amount.

What is Coordination of Benefits (COB)?

If an insured individual has two or more insurance sources available that would cover payment for certain medical services, such as being under a spouse's insurance plan along with your own, COB determines which plan is the primary (first to pay) plan and which plan is secondary (pays second). The secondary plan may determine its benefits based on the benefits paid by the primary plan.

The Benefits Fund follows New York State Department of Financial Services rules for determining primary and secondary carriers. You are primary under the Benefits Fund and secondary under your spouse's health plan, if he has one provided by his employer. Your spouse is primary under his health plan and secondary under the Benefits Fund.

For children, the plan of the parent whose birthday falls earlier in the calendar year is primary. The child is then secondary under the other parent's plan.

For more information on COB, please refer to the cover story in our April 2013 issue of For Your Benefit *(to find it online, go to* ***www.rnbenefits.org*** *and click on "Newsletters" in the drop-down menu under the Benefit Fund tab).*

What is an Explanation of Benefits (EOB)?

An EOB is a statement provided to you after a medical or dental claim has been processed that explains:

- the Benefits provided (if any);
- the allowable reimbursement amounts;
- deductibles;
- coinsurance;
- the amount paid by the Plan;
- and, if the claim was denied in whole or in part, the reason for the denial or partial payment.

Oxford EOBs are automatically mailed to Benefits Fund participants or they can be viewed online at **www.Oxfordhealth.com**. Aetna EOBs for dental services also are mailed to participants but if you prefer not to receive paper copies, you may go online to **www.aetna.com** and choose to eliminate paper copies and only receive online notification of your EOBs.

What is a Summary Plan Description (SPD)?

The Plan's SPD is a document provided to all Benefits Fund participants that describes your rights, benefits, and responsibilities under the plan in understandable language. The SPD provides an overview of relevant plan information including:

- the name and type of plan;
- the Plan's requirements regarding eligibility;
- a comprehensive description of your benefits; and
- procedures regarding claims for benefits and the process for disputing denied claims.

If you have questions about your health benefits and it's after-hours at the Benefits Fund office, the SPD is a good place to find answers. Benefits Fund participants should have received an SPD when they first enrolled in the plan. These booklets also are mailed to your home each time we publish an updated version. You also may find the latest SPD online at our Web site, **www.rnbenefits.org**. *(Fund RNs should keep an eye on your mailbox for the 2013 Summary Plan Description, which will be mailed to all participants later this year.)*

What is usual, customary, and reasonable (UCR)?

The usual, customary, and reasonable rate is the amount paid for a medical service in a limited geographic area based on what providers in that area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the allowed amount when insurance companies calculate out-of-network claims. Oxford sets the UCR using data from Ingenix and other recognized industry sources.

Continued on Page 2

More women understand risks of heart disease

Heart disease is the number one killer of women in the United States, and, thankfully, more women are realizing the danger than ever before, though not at levels acceptable to health care professionals.

The American Heart Association-sponsored study, conducted in 2012, found that 56 percent of the 2,400 women surveyed knew about the risk of heart disease, nearly double the 30 percent who recognized the risk in 1997.

Awareness increased from 15 percent to 36 percent among black women and 20 percent to 34 percent with Hispanic women over the 15 year time span. Younger women (those between age 25 and 34) had the least awareness of heart disease out of all age groups, at just 44 percent.

In the 1997 study, women were more likely to cite cancer than heart disease as the leading killer (35 percent versus 30 percent). In 2012, only 24 percent cited cancer as the top killer of women.

Risk factors for heart disease include:

- High blood pressure;
- High blood cholesterol;
- Diabetes;
- Smoking;
- Being overweight;
- Being physically inactive;
- Family history of early heart disease; and
- Age (55 or older for women).

While certain risk factors cannot be changed (such as age and family history), it's important to understand that you do have control over many of the others. Regardless of age, background, or health status, heart disease risks can be minimized. If you have any of the risk factors listed above and are concerned about your heart health, speak with your primary care physician about taking preventative steps to better health.

Be careful wearing headphones

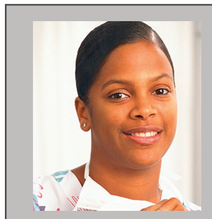
Go ahead and listen to your favorite music, just be careful! Wearing headphones or ear buds can be dangerous – even deadly – for your health if you're not aware of your surroundings while wearing them.

Researchers from the University of Maryland, Baltimore, found that over a seven and a half year period from January 2004 through June 2011, 116 pedestrians were injured or killed while wearing headphones.

The study, published in the journal *Injury Prevention*, found that in 34 of these cases, the victims didn't hear the warning sounds of horns or sirens before they were hit.

Approximately two thirds of the pedestrians struck were between the ages of 18 and 34. The majority, 68 percent, were male. Fifty-five percent of the accidents involved trains.

Oxford tool helps participants make informed decisions on health care



Oxford Health Plan understands that many factors are typically taken into consideration when choosing a health care provider. Therefore, Oxford's UnitedHealth Premium® designation program was designed to provide additional information to participants looking to make the most informed choices about where they receive medical care.

The program evaluates and recognizes doctors who meet national industry standards for quality and local market benchmarks for cost efficiency and provides this list to those who inquire.

Participants can find a UnitedHealth Premium doctor either over the phone by calling a Benefits Fund participant service representative at (877) RN BENEFITS [762-3633] or online at **www.oxfordhealth.com**.

To find a UnitedHealth Premium doctor via a search on **www.oxfordhealth.com**, first click "Search for an Oxford doctor" in the lower left hand corner of the home page. Then, under "Optional," choose "Yes" for United Healthcare Premium Providers.

What types of providers are included?

Many of the doctors in the UnitedHealth Premium program are a part of the Oxford network and UnitedHealthcare's Choice Plus Network. The UnitedHealth Premium designation program covers primary care providers as well as providers in a vast array of specialty areas.

Primary Care

- Family medicine
- Internal medicine
- Obstetrics and gynecology
- Pediatrics

Other specialty areas

- Allergy
- Cardiology (including electrophysiology or interventional)
- Endocrinology
- Nephrology
- Neurology
- Neurosurgery – Spine
- Orthopedics (including general, hand, foot/ankle, hip/knee, shoulder/elbow, and spine)
- Pulmonology
- Rheumatology

Designations – One or two stars

Physicians may receive a designation of one or two stars depending upon if they meet Oxford's guidelines for providing quality and cost-effective care. To receive the quality designation, providers must meet national, evidence-based medical society and national industry standards for quality care. Cost-efficiency criteria are based on the physician's cost-effective use of resources when delivering care in a specific geographic area.

Please note, because a provider doesn't show a Premium Designation doesn't mean he or she offers a lower standard of care. Some physicians request that their designation not be listed, while in other situations, Oxford may have not had sufficient data available to include the doctor in the program. For more information on Oxford's Premium Designation program, please go online to ***www.oxfordhealth.com*** *and click on "Search for an Oxford doctor" on the bottom of the page or ask a NYSNA Benefits Fund participant service representative.* FYB

Benefits lingo cont. from Page 1

What are CPT (Current Procedural Terminology) codes?

Current Procedural Terminology codes are a listing of numbers assigned to every standardized task and service a medical practitioner may provide to a patient, including medical, surgical, and diagnostic services. The codes are used by health insurers to determine the amount of reimbursement that a provider will receive from the insurer. The broad purpose of CPT is to provide a uniform language accurately describing medical, surgical, and diagnostic services and serves as a means for reliable nationwide communication within the health care industry.

CPT codes are developed, maintained, and copyrighted by the American Medical Association. As the practice of health care changes, new codes are developed for new services, current codes may be revised, and old, unused codes may be eliminated. Thousands of codes are in use, and they're updated annually by the AMA. You may see these codes listed on your EOBs from Oxford. There are similar codes, called Code on Dental Procedures and Nomenclature (CDT), used for processing dental care claims maintained by the Council on Dental Benefit Programs, that you'll likely come across on your Aetna EOBs. FYB

Ask the Fund: How can I find out if my claim has been paid?

Question

I'd like to know the status of a claim after a recent procedure I had. Where can I find this information?

Participant Service Representative Pat Vrablic, who is celebrating 35 years with us at the NYSNA Benefits Fund this year, answers this question below:

Answer

There's several easy ways to find out the status of a claim, whether it's a medical or dental claim.

For medical claims with Oxford and dental claims with Aetna, you can:

Call the Benefits Fund – Between 8:30 a.m. and 4:30 p.m., Monday through Friday, the Benefits Fund's participant service representatives are available to answer all your dental and medical claims questions. Call us at (877) RN BENEFITS [762-3633].

To find the status of a medical claim with Oxford:

Go online – Fund participants can go online anytime to **www.oxfordhealth.com** to find out if a medical claim has been processed. After signing in to your personal member site, simply click on the "View My Claims" button or the "Claims & Accounts" tab on the menu at the top of the Home page.

To determine the status of an Aetna dental claim:

Go online – Aetna's Web site, **www.aetna.com**, allows Fund participants the opportunity to check the status of dental claims 24 hours a day, seven days a week. Begin by signing in to your secure member Web site from the Aetna home page. Once you are logged in, click on the "Claims" tab in the menu bar at the top of the main page or fill out the information in the box labeled "Your Claims" located in the middle of this page.

2013 Notice of Creditable Coverage

This document of creditable coverage applies only to those who have health benefits coverage through the New York State Nurses Association Benefits Fund and also are eligible for Medicare.

Please read this notice carefully and keep it where you can find it. It has information about your current prescription drug coverage through the NYSNA Benefits Fund and your options under Medicare's prescription drug coverage (Medicare Plan D). This information can help you decide whether you want to join a Medicare drug plan. Sources to help you make a decision about your prescription drug coverage are at the end of this notice.

Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans also may offer more coverage for a higher monthly premium.

The NYSNA Benefits Fund has determined that the prescription drug coverage you have through the Benefits Fund is, on average for all plan participants, expected to pay as much as standard Medicare prescription drug coverage pays, and is considered creditable coverage.

Because your existing coverage is, on average, at least as good as standard Medicare prescription coverage (creditable coverage), you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

You can join a Medicare drug plan when you first become eligible for Medicare and each year thereafter from October 15 through December 7. This may mean that you'll have to wait to join a Medicare plan and pay a higher premium if you join later, and pay that higher premium as long as you have Medicare prescription drug coverage.

However, if you lose creditable prescription drug coverage through no fault of your own, you will be eligible for a two-month Special Enrollment Period to join a Part D plan. In addition, if you lose coverage through or decide to leave the NYSNA Benefits Fund, you'll be eligible to join a Part D plan at that time using an Employer Group Special Enrollment Period. You should compare your current coverage, and which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area.

If you decide to join a Medicare drug plan, your Benefits Fund coverage will not be affected. Your Medicare Part D coverage will supplement your Benefits Fund coverage.

If you decide to join a Medicare drug plan and drop your Benefits Fund coverage, you and your dependents will not be able to re-enroll in the Benefits Fund.

You also should know that if you drop or lose your Benefits Fund coverage and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium to later join a Medicare drug plan.

If you go 63 continuous days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly premium may increase by at least 1 percent of the base beneficiary premium per month for every month you did not have coverage.

For example, if you go 19 months without coverage, your premium may be consistently at least 19 percent higher than the base beneficiary premium. You may have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For more information about this notice or the prescription drug coverage you have through the NYSNA Benefits Fund, contact the Fund office at (877) RN BENEFITS [762-3633].

Note: You will receive this notice every year, and at other times in the future, such as before the next period when you can join a Medicare drug plan, and if the coverage through the Benefits Fund changes. You also may request additional copies of this notice by calling the Fund office.

For more information about your options under the Medicare prescription drug program:

- Read the Medicare & You handbook sent to you by Medicare every year,
- Visit **www.medicare.gov**,
- Call your State Health Insurance Assistance Program (see the inside back cover of your Medicare & You handbook for the telephone number) for personalized help, or
- Call (800) MEDICARE [633-4227]. TTY users should call (877) 486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information, visit the Social Security Web site at **www.socialsecurity.gov** or call (800) 772-1213. [TTY users should call (800) 325-0778.]

Remember to keep this creditable coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice to show whether you have maintained creditable coverage, and may be required to pay a higher premium.

Adult vaccination rates need improvement

As health professionals, NYSNA Benefits Fund RNs understand the importance of vaccinations and their role in protecting children, as well as adults, from serious diseases. However, across the United States, not enough adults are receiving their recommended vaccines, according to health officials.

As reported by Harvard Medical School, some adults:

- Don't know they need vaccines;
- Don't believe vaccines work;
- Don't find time in their busy schedules to get their vaccinations.

The U.S. Centers for Disease Control and Prevention released its latest statistics earlier this year, based on a 2011 national survey, and found that vaccinations were low for the most routinely recommended vaccines and well below federal government targets. Other than the human papilloma virus and Tdap vaccines, which saw slight rate increases, there was little or no improvement in vaccination rates among adults in 2011, according to the CDC.

For instance, the pneumococcal vaccine, recommended for people over age 65, was received by only 62 percent of adults in this age group. The CDC would ideally like 90 percent of those older than 65 to be vaccinated against pneumonia, according to a CDC official. Furthermore, only 13 percent of adults reported getting the Tdap vaccine, protecting against tetanus, diphtheria, and pertussis.

The survey also found that just 36 percent of adults at high risk for hepatitis B have been vaccinated. The rate for hepatitis A sits at 13 percent, CDC reported. The shingles vaccine, highly recommended for those over age 60, was received by only 16 percent of the adults surveyed.

The CDC also found that, compared to 2010, more women received the HPV vaccine in 2011. About 30 percent of women ages 19 to 26 received this vaccine in 2011, representing a nine percentage point increase in the number of young women vaccinated against the virus.

The NYSNA Benefits Fund office will be closed Monday, Sept. 2 in observance of Labor Day.

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CHANGE SERVICE REQUESTED

Create a member profile at OxfordHealth.com

Here at the Fund office, we encourage our participants to sign up as members on Oxford's Web site, **www.oxfordhealth.com,** in order to better track your health care coverage and for access to resources that may help you with important health care decisions for you and your family. The process is simple – the hardest part may be coming up with a password you'll remember. You'll need your identification number (found on your Oxford ID card) the first time you sign in but after that, all you'll need to access your personal information is your username and password. The site contains a wide variety of useful resources, such as a doctor search feature, a health and wellness center that gives participants access to a health care library, live events, and discussion groups, and a health risk assessment tool.

You'll also have access to your personal information, where you can find the status of claims and verify your benefits. You also can print temporary ID cards or request that additional ID cards for you or a family member be mailed to you. And, by logging on as a member, you'll be automatically directed to the appropriate network to search for in-network providers.

For Your Benefit is published six times each year as a service to participants in the New York State Nurses Association Benefits Fund. The information in this newsletter is not intended to be complete plan information, and is not a substitute for the Summary Plan Description. Please address questions regarding this newsletter to the Communications Department.

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If you'll be changing your address, please notify us so you won't miss the next issue of For Your Benefit.

Vision care

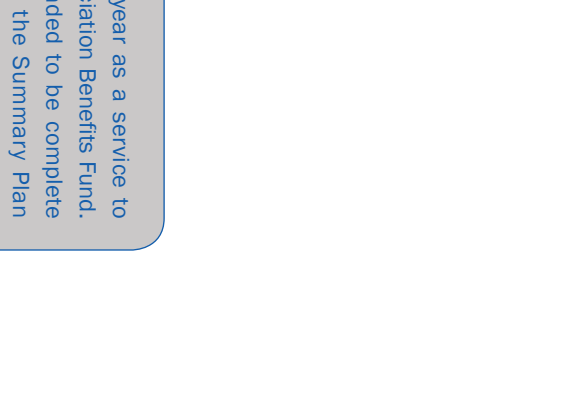
All NYSNA Benefits Fund participants receive a vision care benefit that covers routine vision care for the RN, his or her spouse, and eligible dependents. Available through Davis Vision, this benefit includes a complete eye exam every 24 months for RNs and their covered dependents age 18 and older or every 12 months (in-network only) for dependents up to age 18.

The exam consists of a Dilated Fundus Evaluation for diabetes if indicated, visual acuity test with an eye chart, ophthalmoscopy to magnify the view of the retina, tonometry to measure fluids and test for the presence of glaucoma, and eye refraction to determine whether eyeglasses are needed and, if they are, the appropriate prescription.

The benefit also includes a complete pair of eye glasses (frames and lenses) or contact lenses every 24 months.

Participants also may take advantage of a discount on laser vision correction at participating Davis Vision laser correction providers.

Benefits Fund participants have the choice of seeing in-network Davis Vision providers (find one near you by calling us at [877] RN BENEFITS or searching online at **www.davisvision.com**) or any other provider, even if they're not in the Davis Vision network. Providers may determine eligibility by calling the Fund office or using the Davis Vision Web site.



How do I receive services in-network?

Davis Vision in-network providers are licensed optometrists and ophthalmologists who are extensively reviewed and credentialed. When calling to schedule services with one of these providers, always identify yourself as a New York State Nurses Association Benefits Fund participant. You'll probably need to provide your nine-digit identification number and the year of birth of any dependent child you're seeking service for.

The vision care provider's office will handle verifying your eligibility. You won't be required to submit any claim forms, and the only cost to you at the time of your visit is a $10 copayment for an in-network eye exam.

Eyewear choices

You may choose from the following types of eyewear under your in-network eye care benefits:

• Any frames from the special Designer selection within the Davis Collection (available at most in-network doctor's offices), and any lens type (most are included at no additional cost). A one-year unconditional warranty for breakage covers all frames in the Davis Vision Collection (excludes lost eyeglasses). The cost to participants for in-network eyeglass lenses and/or frames is a $30 copayment.

• An initial supply of disposable/planned replacement contact lenses if available in your prescription. A care kit for proper cleaning and sterilization of your lenses also is supplied. All necessary visits for proper fitting are included. Hard, gas permeable, and replacement lenses aren't covered. Once the contact lens option is selected and the lenses are fitted, they can't be exchanged for eyeglasses. An initial supply of disposable/planned replacement contact lenses is a $45 copayment.

To find a complete list of covered lenses and coatings, items not covered by the routine vision care program, and charges for optional items, refer to Pages 33 and 34 of your Benefits Fund *Summary Plan Description*.

Receiving out-of-network care

Out-of-network provider services will be reimbursed up to a $75 maximum allowance every two years for an eye exam and eyeglasses (frame and lenses) or contact lenses. If you choose to receive routine eye care services out-of-network, you'll need to pay the provider directly for all charges and submit a claim form, along with an itemized receipt, to Vision Care Processing Unit, PO Box 1525, Latham, NY 12110-8025. **FYB**