New York State Nurses Association Benefits Fund
Summary Plan Description

This booklet is a summary of the health benefits plan offered by the New York State Nurses Association Benefits Fund as a result of collective bargaining agreements between NYSNA and its members' participating employers, and is effective as of July 2008. Your medical benefits, which are included only in the Summary of Benefits beginning on Page 14, are detailed in a separate Evidence of Coverage provided to you by Health Net.

In this booklet, you will find summaries of the vision, dental, prescription drug, short-term disability, long-term disability, life insurance, and accidental death and dismemberment benefits you receive under the plan. Use it as a reference tool and the first place to check when you have questions about your health benefits.

This Summary Plan Description replaces all previous Summary Plan Descriptions and Summary Material Modifications issued by the New York State Nurses Association Benefits Fund. All changes to this plan after July 2008 will appear as Summary Material Modifications printed in the bimonthly *For Your Benefit* newsletter or in separate publications.

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Chapter 1: Participating Employers

Facility	Plan	Eligibility date*
Albert Einstein College of Medicine of Yeshiva University	96 1A	If hired within first 15 days of month: first day of the following month; if hired within last 15 days of month: first day of the month following one full month employment
Beth Abraham Health Services	96 1A	First day of the month following date of hire
Bronx-Lebanon Hospital Center	97 2B	First day of the month following date of hire
Bronx-Lebanon Special Care Center	97 2B	First day of the month following date of hire
The Brooklyn Hospital Center	97 1A	90 days after date of hire
County of Sullivan	97 1B	First day of the month following date of hire
Flushing Hospital Medical Center	97 1B	If hired within the first 15 days of the month: first day of the month following date of hire; if hired within last 15 days of the month: first day of the month following one full month of employment (eligible for coverage if work at least 1,000 hours per year)
Gracie Square Hospital	96 1A	First of the month following 60 days after date of hire
Interfaith Medical Center	97 1A	First day of the month following date of hire
Kingsbrook Jewish Medical Center	96 1A	Full-time: 60 days; part-time: after four months
Maimonides Medical Center	97 1A	First day of the second month following date of hire
Mary Immaculate Hospital	97 1A	60th day following date of hire
The Monsignor James H. Fitzpatrick Pavilion Skilled Nursing Facility	97 1A	60th day following date of hire
The Mount Sinai Hospital	96 1A	First day of the month following date of hire for medical and weekly disability; full benefit coverage after three months
Nephro Care, Inc.	97 1A	First day of the month following date of hire

* As determined by the collective bargaining agreement between NYSNA and the participating employer.

Facility	Plan	Eligibility date*
New Island Hospital	96 1A	30th day after date of hire
New York Dialysis Management, Inc.	97 2B	First day of the month following date of hire
New York Dialysis Services, Inc.	97 2B	First day of the month following date of hire
New York Dialysis Services, Inc./ ABC	97 1A	First day of the month following date of hire
New York Methodist Hospital	96 1B	90 days after date of hire
New York Presbyterian Hospital	96 1A	First day of the month following date of hire
New York Westchester Square Medical Center	97 1B	First day of the first month following date of hire
NYC Health & Hospitals Corp. - Correctional Health Services/PHS	96 1B	First day of the month following date of hire
Parker Jewish Institute for Health Care and Rehabilitation	97 1A	First day of the month following date of hire (employees are eligible if they work at least 975 hours per year)
Pax Christi Hospice	97 2A	First day of the month following date of hire
Peninsula Hospital Center	97 1A	First day of the month following date of hire
Richmond University Medical Center	97 1A	First day of the month following three months' employment
Southside Hospital	97 1A	60th day following date of hire
St. Cabrini Nursing Home	97 2A	First day of the month following date of hire
St. Elizabeth Ann's Health Care and Rehabilitation Center	97 1A	First day of the month following three months' employment
St. John's Riverside Hospital	97 1B	First day of the month following date of hire
St. Luke's - Roosevelt Hospital Center	96 1A	First day of the month following date of hire
St. Vincent Catholic Medical Center/ Home Health Agency	97 1A	60th day following date of hire

* As determined by the collective bargaining agreement between NYSNA and the participating employer.

Facility	Plan	Eligibility date*
St. Vincent's Hospital Manhattan (Saint Vincent Catholic Medical Centers)	97 1A	First day of the month following date of hire
Staten Island University Hospital - North	97 2A	60th day following date of hire
Syosset Hospital	97 2B	First day of the month following three months' employment
Terence Cardinal Cooke Health Care Center	97 1B	First day of the month following date of hire
Union Community Health Center, Inc.	96 1A	First day of the month following four months from date of hire
US Family Health Center at Mitchell Field/Ft. Wadsworth	97 1A	First day of the month following three months' employment
Vassar Brothers Hospital	97 1B	First day of the month following date of hire
Visiting Nurse Association Health Care Services, Inc.	97 2A	First day of the month following date of hire
Woodbury Center for Health Care	97 1A	30th day of the month following date of hire
Wyckoff Heights Medical Center	97 1A	First day of the month following date of hire

* As determined by the collective bargaining agreement between NYSNA and the participating employer.

Chapter 2: Administration

This Summary Plan Description explains the plan of benefits provided through the New York State Nurses Association Benefits Fund (an IRC 501(c)(9) Taft-Hartley trust fund), which also is referred to in this book as the "Benefits Fund," "Fund" or "plan." It is your responsibility to read this book carefully so you can understand, use, and comply with all provisions in this Summary Plan Description.

The Benefits Fund was established to protect you, your spouse, and eligible dependents from the high cost of catastrophic health care needs. Subject to the Health Insurance Portability and Accountability Act of 1996, the NYSNA Benefits Fund pays premiums and/or fees to provide eight types of benefit plans for participants:

- Medical (administered through Health Net),
- Vision (administered through Davis Vision),
- Dental (administered through Aetna),
- Prescription and maintenance drug (administered through CVS Caremark),
- Short-term disability (administered through The Hartford),
- Long-term disability (administered by the Benefits Fund through a self-funded program),
- Life insurance (administered through The Hartford), and
- Accidental death and dismemberment (administered through The Hartford).

The NYSNA Benefits Fund pays premiums and/or fees to provide four types of group health plans for your spouse and eligible dependents:

- Medical,
- Vision,
- Dental, and
- Prescription and maintenance drug.

This plan is based on collective bargaining agreements between the New York State Nurses Association and participating employers. Participants and beneficiaries may obtain a copy of any such collective bargaining agreement upon written request to the plan administrator, and is available for examination by participants and beneficiaries at the Fund office and at each participating employer's worksite (in locations that have at least 50 covered participants). Copies also may be obtained from NYSNA.

The plan is administered by the Trustees of the New York State Nurses Association Benefits Fund, PO Box 12430, Albany, NY 12212-2430, (518) 869-9501. The Board of Trustees is composed of an equal number of representatives from the New York State Nurses Association and the management of participating employers. A list of Board of Trustees members appears in Chapter 3.

The Trustees meet to review the financial and administrative status of the Fund, and amend the plan as necessary to reflect the economic, social, and technical changes affecting the health care industry.

Participating employers who have negotiated Benefits Fund coverage for Registered Nurses and other eligible employees ("participants") at their facilities make monthly contributions to the plan on your behalf. Contribution rates are determined semiannually by the Fund's actuary. The rates are promulgated by the Trustees for up to three years, based on the plan selected, past experience, and emerging trends. Full-time participants make no direct contributions to the plan. Part-time participants who are required to contribute toward their Benefits Fund coverage do so through payroll deduction.

Chapter 1 of this SPD includes a list of participating employers as of July 2008. In addition, an up-to-date list of the employers and employee organizations (and their addresses)

Benefits Fund participants and their covered dependents have:
• Medical
• Vision
• Dental
• Rx.

Participants also have:
• Short-term disability
• Long-term disability
• Life insurance
• Accidental death & dismemberment.

sponsoring the plan may be obtained free of charge upon written request to the Fund office.

If you have any questions, call our participant service representatives toll-free at (877) RN BENEFITS [762-3633].

Fund administration

The Fund is administered by:

Chief Executive Officer
Michael E. Behan, CEBS
New York State Nurses Association Benefits Fund
PO Box 12430
Albany, NY 12212-2430
(877) RN BENEFITS [762-3633]
(518) 869-9501

Plan Counsel
Albert Kalter, PC
225 Broadway, Suite 1806
New York, NY 10007-3751
(212) 964-5485

Portions of the Fund's benefits coverage are administered by:

Aetna Life Insurance Company
151 Farmington Ave.
Hartford, CT 06156-0001
(860) 273-0123

Aetna administers the plan's self-funded dental benefit.

Davis Vision, Inc.
159 Express St.
Plainview, NY 11803-2404
(516) 932-9500

Davis Vision provides an insured plan for the Fund's vision coverage.

The Hartford Life Insurance Company
2 Park Ave.
New York, NY 10016-5602
(212) 553-8000

The Hartford administers the Fund's self-funded short-term disability benefit and provides an insured plan for the Fund's life insurance and accidental death and dismemberment insurance coverage.

Health Net
One Far Mill Crossing
PO Box 904
Shelton, CT 06484-0944
(203) 402-4200

The Fund provides medical coverage to participants under an insured plan with Health Net of New York Inc. and Health Net of New York Insurance Inc.

Full-time participants make no direct contributions to the plan. Part-time participants who are required to contribute toward their Benefits Fund coverage do so through payroll deduction.

CVS Caremark
2211 Sanders Rd. NBT-7
Northbrook, IL 60062-6150
(847) 559-4700

CVS Caremark administers the plan's self-funded prescription drug benefit.

Amending or eliminating benefits or terminating the plan

The Trustees have the authority to determine the amount and duration of benefits to be provided under the plan, based on prudent estimates of how much the plan can provide.

The plan may be terminated at any time by written agreement of the participating employers and the New York State Nurses Association, or by the Trustees in the event there no longer is a collective bargaining agreement in effect requiring any employers to contribute to the Fund.

Upon termination of the plan, the Trustees will use any assets in the Benefits Fund to pay the Fund's obligations and distribute any remaining surplus in a manner they determine best effectuates the Fund's purposes. However, the Benefits Fund's assets may be used only for the exclusive benefit of the participants, their families, beneficiaries, or dependents, or the administrative expenses of the Fund or for other payments in accordance with the provisions of the Fund. Participants do not have any vested rights or interest in the Fund or its assets.

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

Use and disclosure of health information

The NYSNA Benefits Fund may use your health information (information that constitutes protected health information as defined in the Privacy Rule of the Administrative Simplification provision of the Health Insurance Portability and Accountability Act of 1996) for purposes of making or obtaining payment for your care and conducting health care operations.

The Fund has established a policy to guard against unnecessary disclosure of your health information. The following is a summary of the circumstances under which and purposes for which your health information may be used and disclosed:

- To make or obtain payment. The Fund may use or disclose your health information to make payment to or collect payment from third parties, such as other health plans or providers, for the care you receive. For example, the Fund may provide information regarding your coverage or health care treatment to other health plans to coordinate payment of benefits.
- To conduct health care operations. The Fund office may use or disclose health information for its own operations to facilitate the administration of the Fund and as necessary to provide coverage and services to all participants. Health care operations include such activities as:
  - Quality assessment and improvement activities.
  - Activities designed to improve health or reduce health care costs.
  - Clinical guideline and protocol development, case management, and care coordination.
  - Contacting health care providers and participants with information about treatment alternatives and other related functions.
  - Health care professional competence or qualifications review and performance evaluation.
  - Accreditation, certification, licensing, or credentialing activities.
  - Underwriting, premium rating, or related functions to create, renew, or replace health insurance or health benefits.

The Fund has established a policy to guard against unnecessary disclosure of your health information.

– Review and auditing, including compliance reviews, medical reviews, legal services, and compliance programs.
– Business planning and development, including cost management and planning-related analyses and formulary development.
– Business management and general administrative activities of the Fund, including customer service and resolution of internal grievances.

For example, the Benefits Fund may use your health information to provide customer service and resolve grievances.

- For treatment alternatives. The Fund may use and disclose your health information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.
- When legally required. The Fund will disclose your health information when it is required to do so by any federal, state, or local law.
- To conduct health oversight activities. The Fund may disclose your health information to a health oversight agency for authorized activities including audits, civil administrative, or criminal investigations, inspections, licensure, or disciplinary action. The Fund, however, may not disclose your health information if you are the subject of an investigation and the investigation does not arise out of or is not directly related to your receipt of health care or public benefits.
- In connection with judicial and administrative proceedings. As permitted or required by law, the Fund may disclose your health information in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal as expressly authorized by such order or in response to a subpoena, discovery request, or other lawful process.
- For law enforcement purposes. As permitted or required by law, the Fund may disclose your health information to a law enforcement official for certain law enforcement purposes, including, but not limited to, if the Fund has a suspicion that your death was the result of criminal conduct or in an emergency to report a crime.
- In the event of a serious threat to health or safety. The Fund may, consistent with applicable law and ethical standards of conduct, disclose your health information if the Fund, in good faith, believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to your health or safety or to the health and safety of the public.
- For specified government functions. In certain circumstances, federal regulations require the Fund to use or disclose your health information to facilitate specified government functions related to the military and veterans, national security and intelligence activities, protective services for the president and others, and correctional institutions and inmates.
- For workers' compensation. The Fund may release your health information to the extent necessary to comply with laws related to workers' compensation or similar programs.

The Fund may use your health information to provide customer service and resolve grievances.

Authorization to use or disclose health information

Other than as stated above, the Fund will not disclose your health information other than with your written authorization. If you authorize the Fund to use or disclose your health information, you may revoke that authorization in writing at any time.

Your rights with respect to your health information

You have the following rights regarding the health information that the Fund maintains:

- Right to request restrictions. You may request restrictions on certain uses and disclosures of your health information. You have the right to request a limit on the Fund's disclosure of your health information to someone involved in the payment of your care. However, the Fund is not required to agree to your request. If you wish to make a request for restrictions, please contact our privacy official at (877) RN BENEFITS [762-3633].
- Right to receive confidential communications. You have the right to request that the Fund

communicate with you in a certain reasonable way if you feel the disclosure of your health information could endanger you. For example, you may ask that the Fund only communicate with you at a certain telephone number or by e-mail. If you wish to receive confidential communications, please make your request in writing and fax it to our privacy official at (518) 869-2317, or send it to the NYSNA Benefits Fund, PO Box 12430, Albany, NY 12212-2430. The Fund will attempt to honor your reasonable requests for confidential communications.

- Right to inspect and copy your health information. You have the right to inspect and copy your health information. A request to inspect and copy records containing your health information must be made in writing and faxed to our privacy official at (518) 869-2317, or sent to the NYSNA Benefits Fund, PO Box 12430, Albany, NY 12212-2430. If you request a copy of your health information, the Fund may charge a reasonable fee for copying, assembling costs, and postage, if applicable, associated with your request.
- Right to amend your health information. If you believe that your health information records are inaccurate or incomplete, you may request that the Fund amend the records. That request may be made as long as the information is maintained by the Fund. A request for an amendment of records must be made in writing and faxed to our privacy official at (518) 869-2317 or sent to the NYSNA Benefits Fund, PO Box 12430, Albany, NY 12212-2430. The Fund may deny the request if it does not include a reason to support the amendment. The request also may be denied if your health information records were not created by the Fund, if the health information you are requesting to amend is not part of the Fund's records, if the health information you wish to amend falls within an exception to the health information you are permitted to inspect and copy, or if the Fund determines that the records containing your health information are accurate and complete.
- Right to an accounting. You have the right to request a list of certain disclosures of your health information that the Fund is required to keep a copy of under the Privacy Rule, such as disclosures for public purposes authorized by law or disclosures that are not in accordance with the Fund's privacy policies and applicable law. The request must be made in writing and faxed to our privacy official at (518) 869-2317 or sent to the NYSNA Benefits Fund, PO Box 12430, Albany, NY 12212-2430. The request should specify the time period for which you are requesting the information, but may not start earlier than April 14, 2003. Accounting requests may not be made for periods of time going back more than six years. The Fund will provide the first accounting you request during any 12-month period without charge. Subsequent accounting requests may be subject to a reasonable cost-based fee. The Fund will inform you in advance of the fee, if applicable.
- Right to a paper copy of this notice. You have a right to request and receive a paper copy of this notice at any time, even if you have received this notice previously or agreed to receive the notice electronically. To obtain a paper copy, please contact the Fund office at (877) RN BENEFITS [762-3633]. You also may obtain a copy of the current version of the Fund's notice from its Web site at www.rnbenefits.org.

You have rights regarding the health information the Fund maintains.

Duties of the Benefits Fund

The Benefits Fund is required by law to maintain the privacy of your health information as set forth in this notice and to provide you this notice of its duties and privacy practices. The Fund is required to abide by the terms of this notice, which may be amended from time to time. The Fund reserves the right to change the terms of this notice and to make the new notice provisions effective for all health information that it maintains. If the Fund changes its policies and procedures, the Fund will revise the notice and provide a copy of the revised notice to you within 60 days of the change. You have the right to express complaints to the Fund and to the Secretary of the Department of Health and Human Services if you believe that your pri-

vacy rights have been violated. All complaints to the Fund should be made in writing and sent to the privacy official at the NYSNA Benefits Fund, PO Box 12430, Albany, NY 12212-2430. The Fund encourages you to express any concerns you may have regarding the privacy of your information. You will not be retaliated against in any way for filing a complaint.

Contact person

The Fund has designated Linda M. Whelton, Benefits Department manager, as its contact person for all issues regarding participant privacy and your privacy rights. You may contact Ms. Whelton by letter at PO Box 12430, Albany, NY 12212-2430, or calling her toll-free at (877) RN BENEFITS [762-3633].

You may contact the Fund's privacy official by letter at PO Box 12430, Albany, NY 12212-2430, or by phone at (877) RN BENEFITS.

Chapter 3: Board of Trustees

As of July 2008, the NYSNA Benefits Fund Board of Trustees members are:

Association Trustees

John Barrett
Chief Financial Officer
New York State Nurses Association
Latham, NY

Joanne Billott, RN
Saint Vincent Catholic Medical Center
of New York
New York, NY

Isabel Cheren, RN
Bronx-Lebanon Hospital Center
Bronx, NY

Barbara Conklin
Senior Associate Director
NYSNA Economic and General Welfare
Program
New York, NY

Carol Lynn Esposito
Associate Director
NYSNA Economic and General Welfare
Program
New York, NY

Betty B. Long, RN
New York Presbyterian Hospital
New York, NY

Glenda Newman, RN
Peninsula Hospital Center
Far Rockaway, NY

Bernadette Bellantoni, RN
(Alternate Trustee)
Staten Island University Hospital - North
Staten Island, NY

Nancy Kaleda
(Alternate Trustee)
Senior Associate Director
NYSNA Economic and General Welfare
Program
New York, NY

Employer Trustees

Dennis Buchanan
Vice President, Human Resources
New York Methodist Hospital
Brooklyn, NY

G. Thomas Ferguson
Senior Vice President and Chief Human
Resources Officer
New York Presbyterian Hospital
New York, NY

Rebecca Gordon
Assistant Vice President, Employee/Labor
Relations
North Shore University Hospital
Great Neck, NY

Howard Green
Green Consulting
Mt. Kisco, NY

Kenneth Kruger
President and Chief Executive Officer
Healthcare Human Resources Consulting
Consortium
New York, NY

Marc Leff
Vice President, Human Resources
Maimonides Medical Center
Brooklyn, NY

Bart Metzger
Senior Vice President, Human Resources
St. Vincent Catholic Medical Centers
New York, NY

Carmen Suardy
Director of Labor Relations
St. Luke's-Roosevelt Hospital Center
New York, NY

The Board of Trustees is composed of an equal number of representatives from the New York State Nurses Association and the management of participating employers.

Chapter 4: Summary of Benefits

	Benefit	In-Network		Out-of-Network Plans			
Financial (Medical)		**96 and 97 Plans**	**98 Plan**	**96 1A 96 1B**	**97 1A 97 1B**	**97 2A 97 2B**	**98**
	Deductible	None		$50 Single; $150 Family		$100 Single; $200 Family	$250 Single; $500 Family
	Maximum out-of-pocket cost (does not include charges in excess of allowed amount or noncovered benefits)	$1,000 Single; $2,000 Family copayment maximum		None		$1,000/ individual/ calendar year	None
	Maximum lifetime benefit per participant or dependent	Unlimited		$1,000,000			

SUMMARIES

- Medical: *Pages 14-19*
- Vision: *Page 20*
- Dental: *Page 20*
- Rx: *Page 21*
- Disability: *Page 22*
- Other: *Page 22*

	Benefit	In-Network		Out-of-Network Plans			
Preventive Care		**96 and 97 Plans**	**98 Plan**	**96 1A[2] 96 1B[3]**	**97 1A[2] 97 1B[3]**	**97 2A[2] 97 2B[3]**	**98[3]**
	Routine physical exams for children through age 18	No cost		Paid at 80% of UCR*			Paid at 70% of UCR*
	Routine gynecological care for children through age 18	No cost		Paid at 80% of UCR*			Paid at 70% of UCR*
	Routine physical exams for adults age 19 and older	$10 copay per visit	$20 copay per visit	Paid at 80% of UCR*			Paid at 70% of UCR*
	Routine gynecological care for adults age 19 and older	$10 copay per visit	$20 copay per visit	Paid at 80% of UCR*			Paid at 70% of UCR*
	Immunizations	No cost		Paid at 80% of UCR*			Paid at 70% of UCR*

*After participant or dependent meets deductible

[2]Reimbursed at 90th percentile of HIAA

[3]Reimbursed at 70th percentile of HIAA

For complete information about your medical benefits, refer to your Health Net Evidence of Coverage.

	Benefit	In-Network		Out-of-Network Plans			
		96 and 97 Plans	98 Plan	96 1A[2] 96 1B[3]	97 1A[2] 97 1B[3]	97 2A[2] 97 2B[3]	98[3]
Maternity Care	Obstectrical, prenatal care, delivery, and postnatal care for mother	$10 copay initial visit only[1]	$20 copay initial visit only[1]	Paid at 100% of UCR[1]	Paid at 83% of UCR*[1]		Paid at 80% of UCR*[1]
Inpatient Care	Room and board (including maternity)	No cost[1]	$300 copay per admis-sion	Generally paid so there are no out-of-pocket facility charges (private room charge allowance paid at 100% for all A plans and at 50% up to $75 per day for B plans)[1]			Paid at 80% for semiprivate room only*[1]
Inpatient Care	Physician's services (including maternity, mental health, and substance abuse)	No cost		Paid at 100% of UCR	Paid at 80% of UCR*		Paid at 80% of UCR*
Inpatient Care	Surgery	No cost[1]		Paid at 100% of UCR[1]	Paid at 83% of UCR*[1]		Paid at 80% of UCR*[1]
Inpatient Care	Restorative physical and occupational therapy	No cost[1]	$300 copay per admis-sion[1]	Paid at 100% of facility charges to a maximum of 30 days[1]; then paid at 80% of facility charges*[1]			Paid at 80% of facility charges to a maximum of 30 days*[1]; then paid at 70% of facility charges*[1]

*After participant or dependent meets deductible

[1]Prior Authorization may be required

[2]Reimbursed at 90th percentile of HIAA

[3]Reimbursed at 70th percentile of HIAA

	Benefit	In-Network		Out-of-Network Plans			
		96 and 97 Plans	98 Plan	96 1A[2] 96 1B[3]	97 1A[2] 97 1B[3]	97 2A[2] 97 2B[3]	98[3]
Outpatient Care	Office visits	$10 copay per visit	$20 copay/ PCP visit; $30/ specialist visit	Paid at 80% of UCR*			Paid at 70% of UCR*
	Chiropractic care	$10 copay per visit[1]	$30 copay per visit[1]	Paid at 80% of UCR*[1]			Paid at 70% of UCR*[1]
	Acupuncture	$20 copay per visit[1]	$30 copay per visit[1]	Paid at 80% of UCR*[1]			Paid at 70% of UCR*[1]
	Allergy treatment	$10 copay per visit	$30 copay per visit	Paid at 80% of UCR*			Paid at 70% of UCR*
	Restorative PT and OT	$10 copay per visit[1]	$30 copay per visit[1]	Paid at 80% of UCR*[1]			Paid at 70% of UCR*[1]
	Cardiac re-habilitation	$10 copay per visit[1]	$30 copay per visit[1]	Paid at 80% of UCR*[1]			Paid at 70% of UCR*[1]
	Radiology	No cost[1]		Paid at 80% of UCR*[1]			Paid at 70% of UCR*[1]
	Laboratory tests	No cost		Paid at 80% of UCR*			Paid at 70% of UCR*
	Restorative speech therapy for up to 60 consecutive days	$10 copay per visit[1]	$30 copay per visit[1]	Paid at 80% of UCR*[1]			Paid at 70% of UCR*[1]
	Surgery (physician's services)	No cost[1]		Paid at 100% of UCR[1]	Paid at 83% of UCR*[1]		Paid at 80% of UCR*[1]
	Surgery (facility charges)	No cost[1]	$75 copay	Generally paid so there are no out-of-pocket facility charges to patient[1]			Paid at 80%*[1]

*After participant or dependent meets deductible

[1]Prior Authorization may be required

[2]Reimbursed at 90th percentile of HIAA

[3]Reimbursed at 70th percentile of HIAA

	Benefit	In-Network		Out-of-Network Plans			
		96 and 97 Plans	98 Plan	96 1A[2] 96 1B[3]	97 1A[2] 97 1B[3]	97 2A[2] 97 2B[3]	98[3]
Emergency Care	At physician's office or urgent care center	$10 copay per visit	$20 copay/ PCP visit; $30/ special-ist visit	$10 copay per visit			$20 copay/ PCP visit; $30 copay/special-ist visit
	At hospital ER (waived if admitted)	$25 copay per visit	$75 copay per visit	$25 copay per visit			$75 copay per visit
Other Services	Physician house calls	No cost		Paid at 80% of UCR*			Paid at 70% of UCR*
	Skilled home health care services	No cost[1]		Paid at 100% of UCR for first 100 visits; additional 40 visits paid at 80%*[1]			Paid at 80% of UCR*[1]
	Hospice care (up to 210 days)	No cost[1]		Paid at 100% of charges[1]			Paid at 80% of charges*[1]
	Durable medical equipment	Paid at 80% of cost of covered items to an un-limited maximum per participant or dependent per calendar year[1]		Paid at 80% of cost of covered items to an unlimited maximum per participant or dependent per calendar year[1]			Paid at 70% of cost of cov-ered items to an unlimited maximum per participant or dependent per calendar year[1]
	In vitro fertiliza-tion services (up to a $5,000 life-time maximum benefit combined with covered fer-tility drugs avail-able through the prescription drug benefit)	No cost[1]		Paid at 100% of UCR[1]	Paid at 80% of UCR*[1]		Paid at 80% of UCR*[1]

*After participant or dependent meets deductible

[1]Prior Authorization may be required

[2]Reimbursed at 90th percentile of HIAA

[3]Reimbursed at 70th percentile of HIAA

<table>
<tr><th></th><th>Benefit</th><th colspan="2">In-Network</th><th colspan="4">Out-of-Network Plans</th></tr>
<tr><th></th><th></th><th>96 and 97 Plans</th><th>98 Plan</th><th>96 1A[2]
96 1B[3]</th><th>97 1A[2]
97 1B[3]</th><th>97 2A[2]
97 2B[3]</th><th>98[3]</th></tr>
<tr><td rowspan="2">Mental Health</td><td>Outpatient mental health (combined maximum for in- and out-of-network benefits)</td><td>$10 copay/ visit up to 20 visits/cal. year[1]; more visits if nec. for certain biologically based conditions or severe emotional disorders in children[1]</td><td>$30 copay/ visit up to 20 visits/cal. year[1]; more visits if nec. for certain biologically based conditions or severe emotional disorders in children[1]</td><td colspan="3">Paid at 80% of UCR up to 20 visits per calendar year*[1]; more visits if necessary for certain biologically based conditions or severe emotional disorders in children*[1]</td><td>Paid at 70% of UCR up to 20 visits/cal. year*[1]; more visits if necessary for certain biologically based conditions or severe emotional disorders in children*[1]</td></tr>
<tr><td>Inpatient mental health care (combined maximum for in- and out-of-network benefits)</td><td>No cost[1]</td><td>$300 copay per admission[1]</td><td colspan="3">Generally paid at 100% of facility charges to a maximum of 30 days[1]; more days if necessary for certain biologically based conditions or severe emotional disorders in children*[1]</td><td>Generally paid at 80% of facility charges to a max. of 30 days[1]; more days if nec. for certain biologically based conditions or severe emotional disorders in children*[1]</td></tr>
<tr><td rowspan="2">Substance Abuse</td><td>Outpatient medical rehabilitative care for substance abuse/alcohol addiction (combined maximum for in- and out-of-network benefits)</td><td>$10 copay per visit up to 60 visits per year[1]</td><td>$30 copay per visit up to 60 visits per year[1]</td><td colspan="3">Paid at 80% of UCR to a maximum of 60 visits per calendar year*[1]</td><td>Paid at 70% of UCR to a maximum of 60 visits per calendar year*[1]</td></tr>
<tr><td>Inpatient medical rehabilitative care for substance abuse/alcohol addiction (combined maximum for in- and out-of-network benefits)</td><td>No cost[1]</td><td>$300 copay per admission[1]</td><td colspan="3">Paid at 100% of facility charges in a general hospital to a maximum of 30 days[1]; subsequent days paid at 80% of facility charges*[1]; paid at 80% of specialty drug/alcohol facility charges*[1]</td><td>Paid at 80% of facility charges*[1]</td></tr>
</table>

*After participant or dependent meets deductible

[1]Prior Authorization may be required

[2]Reimbursed at 90th percentile of HIAA

[3]Reimbursed at 70th percentile of HIAA

	Benefit	In-Network		Out-of-Network Plans			
		96 and 97 Plans	**98 Plan**	**96 1A 96 1B**	**97 1A 97 1B**	**97 2A 97 2B**	**98**
Vision Care	Routine eye exam every two years (every year for children up to age 18)	$10 copayment per visit		Paid at up to $75 for exam and glasses or contact lenses (every two years)			
Vision Care	Eyeglasses or contact lenses every two years (through Davis Vision)	$30 copayment for lenses, and/or Designer selection frames within Tower Collection, *or* $150 credit toward non-plan frames, *or* $25 copayment for standard, soft, daily wear contact lenses, *or* $45 copayment for disposable/planned replacement lenses					
Dental Care	Yearly deductible	None		$25/person; $75/family		$50/person; $150/family	$25/person; $75/family
Dental Care	Maximum yearly benefit	$1,200		$1,200			
Dental Care	Orthodontia maximum	$1,000 per course of treatment separated by two years		$1,000 per course of treatment separated by two years*			
Dental Care	Diagnostic and preventive services	No cost		Paid at 80% of usual and prevailing fee*			
Dental Care	Basic restorative services, endodontics, periodontics, maintenance of prosthodontics, and oral surgery	Paid at 80% of fee schedule		Paid at 80% of usual and prevailing fee*			
Dental Care	Major restorative services, installation of prosthodontics, and orthodontics	Paid at 50% of fee schedule		Paid at 50% of usual and prevailing fee*			

*After participant or dependent meets deductible

Prescription Drug Care	Benefit	In-Network		Out-of-Network Plans			
		96 and 97 Plans	**98 Plan**	**96 1A 96 1B**	**97 1A 97 1B**	**97 2A 97 2B**	**98**
	Prescription drugs at retail pharmacy (up to a 34-day supply)	96 1A, 97 1A No cost 96 1B, 97 1B, 97 2B $3 or $5 copay 97 2A $1 copay	$5 copay for generic; 10% coinsurance for brand-name up to $100 maximum per prescription	Reimbursed at average wholesale cost minus applicable in-network copay			Reimbursed at average wholesale cost minus $5 copay for generic and 10% coinsurance for brand-name up to $100 maximum per prescription
	Mail-order Rx drug program (mandatory for all maintenance prescription medications for up to a 90-day supply)	No cost	$10 copay for generic; 10% coinsurance for brand-name up to $100 maximum per prescription	Not applicable			

	Benefit	All Plans			
		96 1A 96 1B	97 1A 97 1B	97 2A 97 2B	98
Disability	Short-term, nonoccupational disability (through The Hartford)	Paid at 66⅔% of regular, weekly compensation, up to $215 per week for a maximum period of 26 weeks in a 52-week period			
Disability	Long-term disability that extends beyond the qualifying period of six consecutive months (through the NYSNA Benefits Fund)	Paid at 50% of monthly base compensation, up to $350 per month, less other disability payments, to age 65 (age 70 if disabled after age 60)			
Other Insurance	Life	Paid at a minimum of $20,000 and a maximum of $50,000, computed by taking 150% of current base compensation, to the maximum allowable. Benefit is reduced 35% at age 65, and 50% at age 70.			
Other Insurance	Accidental death and dismemberment and loss of sight	Paid at 100% or 50% of maximum benefit, according to specific loss			

Chapter 5: Enrollment

When you enter covered employment within a collective bargaining unit represented by the New York State Nurses Association, your employer will give you a Benefits Fund enrollment card. This card must be completed and returned to the Benefits Fund so you can participate in the Fund and become eligible for benefits coverage.

Your enrollment card marks your official registration in the Benefits Fund. The card:

- Establishes your personal data record,
- Identifies your covered dependents,
- Records your proper beneficiary, and
- Provides a verification of your signature.

Accurate enrollment data on you and your covered dependents allow us to properly issue two separate identification cards for your various coverages, and to quickly and efficiently process your claims. One of your identification cards will come from Health Net and is for your medical coverage, while the other card will come from CVS Caremark and is for your prescription drug coverage.

If you change your name, address, marital status, acquire a new dependent, or wish to make any change in your enrollment record information, call or write the Benefits Fund and indicate the change to be made.

If you change your name, address, marital status, acquire a new dependent, or wish to make any change in your enrollment record information, call or write the Fund and indicate the change to be made.

Chapter 6: Eligibility

If you choose to opt out of health coverage at the time of eligibility, you must wait until June of any plan year to re-enroll in the Benefits Fund and have coverage reinstated July 1 of that year, unless you involuntarily lose coverage due to a qualifying event.

You, your spouse, and your eligible dependents are covered for the benefits in this book as long as you are an eligible member of a collective bargaining unit represented by the New York State Nurses Association under a collective bargaining agreement which requires that a contribution be made to the NYSNA Benefits Fund in the amount determined by the Trustees, or are on COBRA continuation benefits and timely maintain your premium payments.

Benefits under this plan will be paid only if the plan administrator decides in his discretion that the applicant is entitled to them. Newly hired members are eligible for coverage as indicated in Chapter 1 of this book and your NYSNA contract.

Full-time employees effective date

Your coverage will become effective on your eligibility date. To check your eligibility date, find your facility listed in Chapter 1 of this book. The criteria used to determine your eligibility date appear beside it.

Your employer makes full contributions to the Benefits Fund for your coverage unless otherwise stipulated in the collective bargaining agreement.

Full-time employees who opt out

You may be employed at a participating employer under a collective bargaining agreement that allows an otherwise eligible participant to opt out of Benefits Fund health coverage if she is covered under another group health plan. This information is available in your NYSNA contract.

You will be required to provide proof of other coverage and complete an opt-out application available at your place of employment. You will continue to be covered by the Fund for disability, life, and accidental death and dismemberment benefits.

If you choose to opt out of health coverage at the time of eligibility, you must wait until June of any plan year to re-enroll in the Benefits Fund and have coverage reinstated July 1 of that year.

If you decline enrollment for yourself and your dependents (including your spouse) because you have other health insurance coverage (medical, dental, vision, and prescription drug), you may in the future be able to enroll yourself and your dependents in this plan, provided you request enrollment within 30 days after your other coverage ends due to the following:

1. Death of the covered individual (death certificate and COBRA notification or letter from the covered individual's employer must be provided within 30 days of the event).
2. Termination of employment or reduction of hours that would cause loss of coverage for the covered individual (COBRA notification or letter from the covered individual's employer must be provided within 30 days of the event).
3. Divorce or legal separation from the covered individual, causing a loss of coverage (a copy of the divorce or legal separation decree must be provided within 30 days of the event).
4. Covered individual's employer discontinues group health insurance coverage (a letter or notification from the covered individual's employer must be provided within 30 days of the event).

All other reasons for losing coverage (including the covered individual voluntarily discontinuing coverage or failing to make required payments) will not be considered.

Part-time employees effective date

Your coverage as a part-time employee will become effective on the day you become eligible for benefits, provided you authorize payroll deductions by your employer. You have the right to discontinue coverage at any time. You will be required to make payroll deduction contributions

toward the cost of your coverage as defined in the current collective bargaining agreement.

If you choose not to enroll at the time of eligibility or to discontinue coverage, you must wait until October of any plan year to re-enroll in the Benefits Fund and have coverage reinstated November 1 of that year.

If you decline enrollment for yourself and your dependents (including your spouse) because you have other health insurance coverage, you may in the future be able to enroll yourself and your dependents in this plan, provided you request enrollment within 30 days after your other coverage ends for the reasons previously cited.

Eligible dependents

Your spouse, your same-sex domestic partner, and your unmarried children from birth through December 31 of the year they reach their 19th birthday are eligible for medical, dental, vision, and prescription drug benefits. Dependent children living with you while awaiting your legal adoption also are eligible for these benefits. Legal wards, stepchildren, and the children of your same-sex domestic partner also are eligible for these benefits, provided certain conditions are met as detailed in this section.

If you don't have a dependent now, you will become eligible for dependent coverage on the day you acquire a new dependent as a result of marriage, birth, adoption, or placement for adoption, provided you request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption, otherwise that dependent's coverage will become effective on the date we receive notification.

Notify the Fund office of your new dependent by sending a letter to the Fund office, along with a copy of the marriage certificate (for spouse) or birth certificate (for dependent). If you have submitted a signed, short-term disability claim stating that you are pregnant or have delivered, there's no need to send a copy of your child's birth certificate.

Stepchildren

Stepchildren are eligible for medical, dental, vision, and prescription drug coverage until December 31 of the year they reach age 19, provided they have the same principal residence as the Benefits Fund participant. Proof of custody and/or residence is required.

Legal wards

Other children under your custody or guardianship are not covered unless the unmarried child, who would otherwise be an eligible dependent, resides with you and you have been issued a Guardian of the Person order by a judge. Coverage continues through December 31 of the year in which the ward turns age 19. To effect coverage, the participant must submit a copy of the ward's birth certificate; proof of residency, such as student ID, driver's license, tax return, or letter from the ward's school; and a certified copy of guardianship appointment.

Same-sex domestic partner

The same-sex domestic partner who resides with a participant is eligible for Benefits Fund coverage provided the following conditions are met. The participant's same-sex domestic partner must:

- Be age 18 or older;
- Not be married;
- Not be related by blood to the participant in a manner that would bar marriage in New York state;
- Have a close and committed personal relationship with the participant;
- Have been living with the participant on a continuous basis for at least six months;
- Be financially interdependent with the participant and submit evidence of at least two of the following:
  - –Joint bank account,
  - –Joint credit card,

Eligible dependents include your spouse, same-sex domestic partner, and unmarried children. You'll be eligible for dependent coverage on the day you acquire a new dependent, provided you request enrollment within 31 days. Otherwise, the Fund will begin coverage on the date we receive notification.

–Joint loan obligation,
–Joint mortgage or lease,
–Joint ownership of a residence,
–Joint household expenses such as utility and telephone bills,
–Joint ownership of a motor vehicle,
–Wills naming each other as executor and/or beneficiary,
–Granting each other powers of attorney,
–Designation of one or the other as beneficiary under a retirement benefits account,
–Proof of other joint responsibility.

In addition, the participant must provide an affidavit of domestic partnership. Affidavits are available from the Benefits Fund. Call (877) RN BENEFITS [762-3633] or logon to www.rnbenefits.org and go to the Forms page.

Should a domestic partner's coverage be terminated voluntarily, a one-year waiting period must be met before re-enrollment in the Benefits Fund can occur. The waiting period may be waived upon written request if coverage through another source is lost.

The value of coverage for same-sex domestic partners may be subject to federal income taxes and state income taxes in most states.

Dependent children of the participant's same-sex domestic partner also are extended Benefits Fund coverage, provided the children meet all eligibility requirements for covered dependents as described in this chapter.

Full-time college students

If your child is an unmarried, full-time student and primarily dependent on you for support, your child will remain eligible for benefits through December 31 of the year she reaches her 23rd birthday.

To ensure continuity of coverage for your full-time student, ask the school registrar to send a letter to the Fund office verifying her full-time student status. Separate letters are required for the autumn and spring semesters. The fall letter is due by September 1 and covers your child from September 1 through December 31. The spring letter is due to the Fund office by January 1 and covers your child from January 1 through May 31. Students are covered through the summer only if they are full-time students for both the spring and fall semesters.

The verification letter must be an original and must be mailed. The Fund cannot accept copies sent by fax. The letter should include your and your dependent's full name and Social Security number and verify that she is a full-time college student for the semester. Failure to have the school registrar send a letter confirming the student's full-time status will cause your child's coverage to be terminated.

A certificate from the National Student Clearinghouse® also is acceptable as proof of full-time enrollment. The same due dates and criteria for student letters apply to certificates.

If your dependent child's student status changes (she no longer is an unmarried, full-time student), benefits will be terminated as of the date the change of status occurred.

Full-time college student letters must be sent by the school registrar for each semester: Sept. 1 for coverage through Dec. 31 and Jan. 1 for coverage through May 31. A certificate from the National Student Clearinghouse® also is acceptable.

Disabled dependents

Coverage for any of your unmarried children who are disabled and incapable of earning their own living will be extended beyond the 19-year age limit. In this case, you must notify the Benefits Fund and submit proof of your child's disability within 60 days after the coverage would otherwise cease. For information, contact the Benefits Fund. Proof of the disability must be updated as applicable.

Qualified Medical Child Support Order

The Fund will comply with the terms of any Qualified Medical Child Support Order, as the term is defined in the amended Employee Retirement Income Security Act of 1974.

In general, a QMCSO is a state order or administrative directive requiring a parent to

provide medical support to a child in case of separation or divorce and under certain statutory conditions.

A QMCSO may require the Fund to offer coverage to your child even though the child is not, for income tax purposes or Fund purposes, your legal dependent due to separation or divorce.

A Qualified Medical Child Support Order must:

- Be issued by a court or an administrative agency (under certain circumstances),
- Clearly specify the alternate recipient,
- Reasonably describe the type of coverage to be provided to such alternate recipient, and
- Clearly state the period to which such order applies.

Upon receipt of a medical child support order, the Benefits Fund will notify you and the affected child that it is reviewing the order to determine if it is qualified and will explain the procedures used to determine whether the order is qualified.

The plan administrator will determine the qualified status of a medical child support order in accordance with the Fund's written procedures.

Participants and beneficiaries can obtain, without charge, a copy of these procedures from the plan administrator.

Termination, denial, and reduction of coverage

Your coverage will terminate on the earliest of the following events, including but not limited to whenever:

- You no longer are a member of an eligible class of employees within the NYSNA bargaining unit;
- You or your employer fail to make the contribution, if required;
- The collective bargaining agreement terminates;
- You are no longer working for the employer; or
- The collective bargaining agreement no longer requires a contribution to the Fund in the amount determined by the Trustees.

The coverage for a dependent terminates on the earliest of the following events, including but not limited to whenever:

- Your coverage terminates;
- You or your employer fail to make the contribution, if required; or
- The dependent no longer is eligible, as indicated under the eligible dependents section in this chapter.

You and/or your dependents may be eligible for other coverage in some circumstances. See Chapter 8 for more details.

Your coverage (and that of your dependents) may be denied or reduced, including but not limited to whenever:

- A utilization review determines that the proposed service, the service currently being provided, or the service that was provided is not medically necessary, deemed to be appropriate, or wasn't properly authorized (please refer to Chapters 9 through 11 of this Summary Plan Description for detailed information on medical necessity and prior authorization requirements for vision, dental, and prescription drug care);
- The plan's claims reimbursement procedures weren't followed (please see Chapters 9 through 15 for information on claims reimbursement procedures for vision, dental, prescription drug, short- and long-term disability, life insurance, and accidental death and dismemberment benefits);
- The coordination of benefits guidelines used when a claimant is covered by more than one plan reduces or excludes benefits (please refer to Chapter 7);
- Subrogation activity reduces or excludes benefits (please refer to Chapters 9 through 15 for detailed information);

- You exceed the maximum lifetime benefit of $1,000,000 per participant or dependent for out-of-network medical benefits (please see your Health Net Evidence of Coverage for details);
- You exceed the $1,200 maximum amount payable per individual per calendar year for covered dental expenses (please see Chapter 10 for details);
- You exceed the $1,000 maximum amount payable per individual per course of orthodontic treatment separated by two years (please see Chapter 10 for details);
- You exceed the $5,000 lifetime maximum combined benefit for in vitro fertilization and/or covered fertility drugs (please see Chapter 11 for details);
- Your prescription is for off-label use, refilled too soon, filled above dispensing limits or beyond FDA recommendations or approval, a maintenance prescription filled more than two times at retail, or has an over-the-counter equivalent available (please see Chapter 11 for details);
- The service is excluded from Benefits Fund coverage (please see Chapters 9 through 13 and Chapter 15 for a list of exclusions);
- A dental or orthodontic course of treatment was started prior to your entry in the plan.

In addition, dental services given after the covered person's coverage terminates are not covered. However, ordered inlays, onlays, crowns, removable bridges, cast or processed restorations, dentures, fixed bridgework, and root canals will be covered when ordered if the item is installed or delivered no later than 30 days after coverage terminates.

"Ordered" means that prior to the date coverage ends:

- Impressions have been taken from which a denture will be prepared;
- The pulp chamber was opened in preparation for a root canal; and
- The teeth that will serve as retainers or support or are being restored have been fully prepared to receive the item, and impressions have been taken from which the item will be prepared for any other item listed above.

Chapter 7: Coordination of Benefits

Coordination of benefits determines the amount payable by each insurance plan when a claimant is covered by more than one plan, which occurs when a participant, spouse, or dependent are covered by two different plans.

COB guidelines determine which plan provides primary coverage for the individual for whom charges are incurred so that duplicate insurance payments and out-of-pocket expenses are avoided.

Once the primary plan has paid a claim, the claim should immediately be submitted to the secondary plan with a copy of the Explanation of Benefits from the primary carrier.

COB guidelines

Which plan is primary (pays first) and which plan is secondary (pays second) is determined by using the first of the following rules that apply:

- You, the employee, are primary under this plan and secondary under any plan that covers you as a dependent.
- Your spouse is primary under his own plan, if he has one, and is secondary under the Benefits Fund.
- If both you and your spouse cover your child as a dependent, the plan of the parent whose birthday falls earlier in the calendar year is primary.
- If you and your spouse have the same birth date, the plan that has covered you or your spouse for the longer period of time is primary to the plan that covered the other parent for a shorter period of time.
- When two or more plans cover your dependent child and you and your spouse are separated or divorced, or you and your dependent child's other parent never have married, the order of priority for the plans will be determined as follows:
  - 1st – The plan of the parent who has physical custody of the dependent child;
  - 2nd – The plan of the spouse of the parent who has physical custody of the child;
  - 3rd – The plan of the parent without physical custody.

  However, if the terms of your court decree state that one of the parents is more responsible for the health care expenses of the dependent child, that parent's plan will pay as the primary plan if it has knowledge of the court decree terms.

COB determines the amount payable by each insurance plan when a claimant is covered by more than one plan.

Chapter 8: Benefits Following Termination

Your Benefits Fund coverage terminates when you voluntarily or involuntarily teminate employment, transfer out of the bargaining unit, take an uncovered leave of absence, or become a part-time, noncontributing employee. You and your eligible dependents may qualify for COBRA continuation of benefits or one of several conversion options offered by Health Net.

Medical, dental, vision, and prescription drug coverage are available under COBRA at 102% of the total cost of coverage. You can choose COBRA after the Fund receives notice of a qualifying event.

COBRA continuation coverage

The Consolidated Omnibus Budget Reconciliation Act (Public Law 99-272, Title X), also known as COBRA, was enacted April 7, 1986. This law requires that in addition to offering conversion opportunities, the Benefits Fund must offer participants, their spouses, and eligible dependents the opportunity for a temporary extension of group health coverage (called continuation coverage) at 102% of the total cost of the coverage in certain instances where coverage under the plan would otherwise end.

What's available under COBRA?

The Benefits Fund's medical, dental, vision, and prescription drug benefits are available under COBRA continuation coverage. Life insurance and disability coverages are not available under COBRA continuation coverage.

Who's eligible for COBRA?

If you are a Benefits Fund participant, you have the right to continue your health coverage under the health insurance plan at your own expense if you lose coverage due to:

- A reduction in your hours of employment, or
- The voluntary or involuntary termination of your employment (for reasons other than gross misconduct on your part).

If you are the spouse of an eligible participant, you are a "qualified beneficiary" and have the right to choose continuation coverage for yourself under the health insurance plan at your own expense if you lose health insurance coverage due to any of the following qualifying events:

- Your spouse dies,
- Your spouse's employment is terminated (for reasons other than gross misconduct) or he/she experiences a reduction in hours of employment,
- You and your spouse get a divorce or legal separation,
- Your spouse enrolls in Medicare.

An eligible dependent child (including any children born to or placed for adoption with a covered participant while the participant is on continuation coverage) of a participant has the right to continue coverage under the group health plan at his own expense if coverage is lost due to any of the following qualifying events:

- His/her covered parent dies,
- His/her covered parent experiences a termination of employment (for reasons other than gross misconduct) or a reduction in hours of employment,
- His/her parents get a divorce or legal separation,
- His/her covered parent enrolls in Medicare, or
- He/she ceases to be a dependent child under the terms of the employee benefits program.

What notification is required?

In general, employers are required to notify the Fund when you experience a qualifying event. However, if the qualifying event is a divorce or legal separation, or your child is losing dependent status under the terms of the employee benefits program, you (or your spouse or child) must notify the Fund within 60 days. You also should notify the Fund of an address

change or any change in your marital status.

When the Fund receives notice of a qualifying event, it will notify qualified beneficiaries of their continuation rights within 14 days. When the Benefits Fund has notified a spouse of continuation rights, it will assume that all dependent children who live with the spouse have been notified by the spouse.

Under the law, qualified beneficiaries have 60 days from the date of notification to elect continuation coverage. Each qualified beneficiary is entitled to make a separate COBRA election. Any qualified beneficiaries who fail to elect continuation coverage in a timely fashion will lose their COBRA rights, but still may be eligible for a conversion option. Qualified beneficiaries who fail to notify the plan within 60 days of a qualifying event also will lose their COBRA rights.

In some cases, trade-displaced qualified beneficiaries may be eligible for a second 60-day COBRA continuation coverage election period. This second 60-day election period is available only to trade-displaced qualified beneficiaries who do not initially elect continuation coverage, but are later determined to be eligible for federal trade adjustment assistance. (Pursuant to the Trade Act of 1974, trade adjustment assistance generally is available only to workers whose employment is adversely affected by international trade.) If you have questions about trade adjustment assistance eligibility, contact your state Employment Security Administration or the Department of Labor's Employment and Training Administration (Division of Trade Adjustment Assistance).

If you choose COBRA continuation coverage, the Benefits Fund is required to offer you the same coverage as that provided to similarly situated participants or family members.

How long can COBRA coverage be maintained?

If group health coverage is lost because of a termination of employment or reduction in hours of employment, the law requires that qualified beneficiaries be afforded the opportunity to maintain continuation coverage for up to 18 months, beginning on the date of the qualifying event. If group health coverage is lost due to any other qualifying event, the law requires that qualified beneficiaries be given the opportunity to maintain continuation coverage for up to 36 months.

Additional qualifying events can occur while continuation coverage is in effect. Such events may extend an 18-month period of continuation coverage to a period of up to 36 months, but in no event will coverage extend beyond 36 months after the initial qualifying event. Notify the Fund office immediately if a second qualifying event occurs during your continuation coverage period.

Disability extension

An 18-month period of continuation coverage may be extended an additional 11 months (for a total of up to 29 months of continuation coverage) if the qualified beneficiary has been determined to be disabled (under Title II or XVI of the Social Security Act). The qualified beneficiary must have been disabled as of the date of the participant's termination or reduction in hours (or any time within the first 60 days of the 18-month continuation coverage period). The Fund office also must be notified within 60 days of such determination (and within the initial 18-month continuation coverage period). The 11-month extension also applies to all nondisabled qualified beneficiaries entitled to COBRA coverage as a result of the same qualifying event. Qualified beneficiaries must notify the plan administrator within 30 days if they no longer are deemed disabled.

Can COBRA continuation coverage be cut short for any reason?

The law provides that your continuation coverage may be cut short prior to the expiration of the 18-, 29- or 36-month period for any of the following reasons:

- The Benefits Fund no longer provides group health coverage to its participants,

Qualifying events for you are termination of your employment or a reduction in hours. Qualifying events for your dependents include your death, a divorce or legal separation, your eligibility for Medicare, termination of your employment, a reduction in your hours, or loss of "dependent child" status.

- The premium for continuation coverage is not paid in a timely fashion (please see "How much will COBRA coverage cost?" section below for more information),
- The continuation enrollee becomes covered as an employee or dependent under another group health plan, unless the plan contains pre-existing condition exclusions or limitations,
- The continuation enrollee becomes enrolled in Medicare,
- Coverage has been extended for up to 29 months due to disability and there has been a final determination that the individual no longer is disabled.

How much will COBRA coverage cost?

Under the law, you may be required to pay up to 102% of the total cost of coverage during the 18- or 36-month continuation coverage period. If you are eligible for the 11-month disability extension, you may be required to pay up to 150% of the total cost of coverage during that period.

Payment of the initial premium must be received within 45 days after you notify the Benefits Fund that you have elected such coverage. Payment shall be made on a regular, monthly basis thereafter (a 30-day grace period for subsequent late payments applies).

Further information

This notice is a summary of the law and therefore is general in nature. The law itself and the actual plan provisions must be consulted with regard to the application of these provisions in any particular circumstance. Further information about COBRA continuation coverage is available from the Benefits Fund.

You can be covered by COBRA for up to 18 months. Dependents may be covered for up to 36 months.

Conversion options

If you do not choose COBRA continuation coverage, your Benefits Fund group coverage will end. You will be offered the opportunity to convert your Benefits Fund medical benefits to one of several individual pay programs offered by Health Net. A letter extending this conversion offer will be sent to participants or their dependents when Health Net is notified of the termination. The participant or dependent will have a specific time period in which to accept the offer and continue coverage. The participant or dependent will be responsible for making monthly payments to Health Net's third-party administrator for the conversion plan.

Further information about the direct pay conversion options is available from the Benefits Fund.

You also can convert life insurance to an individual policy.

Chapter 9: Vision Benefits

Routine vision care for you, your spouse, and eligible dependents is provided through Davis Vision.

You are entitled to the following every 24 months:

- A complete eye examination including 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 so, the required prescription (every 12 months for dependent children up to age 18), and
- A complete pair of eyeglasses (frames and lenses) or contact lenses in lieu of eyeglasses.

You have the option of choosing an in-network Davis Vision provider for this benefit, or any other provider who is not in the Davis Vision network.

To verify your eligibility for this benefit, call the Benefits Fund, or check the Davis Vision Web site at www.davisvision.com.

You're entitled to a complete eye exam and a complete pair of glasses or contacts every 24 months. Children up to age 18 are entitled to a complete eye exam every 12 months and a complete pair of glasses or contacts every 24 months.

In-network benefits

The in-network providers are licensed optometrists and ophthalmologists who are extensively reviewed and credentialed to ensure that the strictest standards for quality service are maintained. A complete list of network providers will be furnished to each participant, without charge, as a separate document. To obtain a list, call the Fund office toll-free at (877) RN BENEFITS [762-3633]. A list of in-network providers also is available from Davis Vision at (800) 999-5431 or www.davisvision.com.

To receive services from an in-network doctor:

- Call to schedule an appointment, and
- Identify yourself as a NYSNA Benefits Fund participant covered through Davis Vision.

The doctor's office will verify your eligibility for services and schedule an appointment for an eye examination. You'll have no claim forms to fill out.

After the eye exam, you may select one of the following types of eyewear under the in-network benefit:

- Any frames from the special Designer selection within the Tower Collection (available in most in-network doctors' offices), and any lens type (most are included at no additional cost), or
- Standard, soft, daily wear contact lenses, or an initial supply of disposable/planned replacement contact lenses, which are available for most prescriptions. New wearers will receive a comprehensive fitting and two standard lenses or two boxes of either disposable lenses or planned replacement lenses. Existing wearers will receive a reassessment fitting and two standard lenses or two boxes of planned replacement lenses or four boxes of disposable lenses. Medically necessary contact lenses are covered in full with prior approval. Special contact lenses such as hard, gas permeable, and toric lenses are not covered. Once the contact lens option is selected and the lenses are fitted, they cannot be exchanged for eyeglasses.

The costs for these in-network services include a:

- $10 copayment for your eye examination, and
- $30 copayment for the eyeglass lenses and/or frames from a special selection, or
- $25 copayment for standard, soft, daily wear contact lenses (guaranteed lowest price mail-order replacement lenses are available by calling [800] LENS 123), or
- $45 copayment for an initial supply of disposable/planned replacement contact lenses (guaranteed lowest price mail-order replacement lenses are available by calling [800] LENS 123).

The lenses and coatings included in the coverage are:

- Single vision, bifocal, or trifocal lenses;
- Glass grey prescription lenses;
- Blended segment lenses; and
- Oversized lenses.

All ranges of prescriptions are covered, including:

- Overdiopter (higher power) lenses;
- Post-cataract (lenticular) lenses;
- Fashion, sun, and gradient-tinted plastic lenses; and
- Polycarbonate lenses for dependent children.

A one-year unconditional warranty for breakage covers all eyeglasses supplied from the special Davis collection (excludes lost eyeglasses).

If you choose a frame from the doctor's private selection, a $150 retail credit will be applied toward the cost of those frames.

The following items are not covered by the routine vision care program:

- Medical treatment of eye disease or injury, which is covered under your medical benefit;
- Visual therapy;
- Special lens designs or coatings (other than those previously noted);
- Replacement of lost eyewear;
- Nonprescription (plano) lenses; and
- Two pairs of eyeglasses, in lieu of a bifocal.

In addition to the basic eyeglass lens copayment, you also can pay the following charges and receive these optional items:

- $20 for a Premier frame from the Tower Collection;
- $50 for standard progressive addition lenses or $90 for premium progressive addition lenses (while these can be worn by most people, you can switch to conventional bifocals at no additional cost if you are unable to adapt to progressive addition lenses, but the copayment for the progressive addition multifocals won't be refunded);
- $12 for ultraviolet coating;
- $20 for blended invisible bifocals;
- $30 for polycarbonate lenses;
- $35 for standard antireflective coating or $48 for premium antireflective coating;
- $20 for scratch-resistant coating;
- $75 for polarized lenses;
- $55 for high-index lenses;
- $20 for Photogrey Extra® photosensitive plastic lenses;
- $65 for plastic photosensitive lenses;
- $30 for intermediate vision lenses.

You, your spouse, and your eligible dependents also can receive the lesser of:

- Up to a 25% discount or
- A 5% discount on an advertised special on laser vision correction at an in-network Davis Vision provider. Additional information is available by calling the Fund office or accessing the Davis Vision Web site.

Check for eligibility or in-network providers online at davisvision.com or by calling (877) RN BENEFITS.

Out-of-network benefits

For out-of-network provider benefits, services will be reimbursed up to a $75 maximum allowance every two years for the eye exam and the eyeglasses (frame and lenses) or contact lenses. If you do not use the entire $75 in a single visit, the balance will be available to you during the two-year period.

If you choose an out-of-network provider, you must:

- Pay the provider directly for all charges, and
- Submit your claim for reimbursement to: Vision Care Processing Unit, PO Box 1525, Latham, NY 12110-8025. Claims for services performed outside the United States must be submitted for payment in English, with charges indicated in U.S. dollars.

Routine vision care claims

You do not have to file claims for routine vision care services provided by an in-network Davis Vision provider. If you see an out-of-network provider for routine vision care services and are eligible for services, you will be reimbursed up to $75 for the routine vision exam and the glasses or contact lenses if you submit a claim form.

To receive an out-of-network claim reimbursement, complete a vision care claim form and send it with an itemized bill for the out-of-network services to Vision Care Processing Unit, PO Box 1525, Latham, NY 12110-8025.

Out-of-network vision care claims must be submitted within two years after the date of service for which the claim is made.

Appealing or grieving a coverage decision

Coverage decisions are based on your NYSNA Benefits Fund vision care benefits and the information submitted with your claims. Benefits Fund participant service representatives can provide more information about how your coverage was applied and answer any questions you may have about your benefits. To reach a participant service representative, call (877) RN BENEFITS [762-3633].

If all or part of a claim was not covered, you have a right to see, upon request and at no charge, any rule, guideline, protocol, or criterion that Davis Vision relied upon in making the coverage decision. If a coverage decision was based on medical necessity or the experimental nature of the care, you are entitled to receive, upon request and at no charge, the explanation of the scientific or clinical basis for the decision as it relates to your medical condition. If after speaking with a participant service representative you feel that Davis Vision's coverage decision was not correct, you or your authorized representative (any person you authorize in writing to act on your behalf) may appeal the decision by following the steps below.

To appeal or grieve a coverage decision, please send to the address below a written explanation of why you feel the coverage was incorrect. This information also may be provided to a Davis Vision member service representative by calling (800) 999-5431. Please include with the explanation:

- Your or your dependent's name, relationship to you (if appealing or grieving a dependent's coverage decision), address, and telephone number;
- Your Davis Vision identification number;
- The name of the health care professional or facility that provided the service, including the date and description of the service(s) provided and the charge(s), if applicable.

Send written appeals to: Quality Assurance/Patient Advocate Department, Davis Vision, Inc., 159 Express Street, Plainview, NY 11803-2404.

You must file an appeal within 180 days of the date you received a notification of coverage decision. Davis Vision will respond in writing to appeals within 60 calendar days.

If you are not satisfied with the appeals outcome, contact the Benefits Fund.

As a member of an Employee Retirement Income Security Act of 1974 (ERISA)-regulated group health care plan who has completed the appeals process without satisfaction, you have the right to bring civil action under 502 (a) of ERISA. See Chapter 16 for more information.

Send out-of-network vision care claims to: Vision Care Processing Unit, PO Box 1525, Latham, NY 12110-8025 within two years after date of service.

Chapter 10: Dental Benefits

The Benefits Fund contracts with Aetna to provide dental coverage for you, your spouse, and your eligible dependents. For questions or service regarding your dental benefits, contact the Benefits Fund at (877) RN BENEFITS [762-3633].

You and your eligible dependents have dental benefits as described in this section.

Two different benefits options are available. The in-network option allows you to see a provider in the Aetna Preferred Provider Organization network. The out-of network option allows you to see any nonparticipating dentist. You may choose either benefit option each time you or your dependents receive services.

Family members are not required to select the same benefit option.

Covered dental services must be performed by or under the direction of a dentist, be essential for the necessary care of the teeth, and begin while you are covered for dental expense benefits. If the dental service is performed on a date other than the date the service was recommended or considered necessary, the Benefits Fund will consider the service to begin on the date when the actual service starts.

The maximum amount payable for each individual for all covered dental expenses incurred during a calendar year is $1,200. The orthodontia maximum is $1,000 per course of treatment separated by two years. See Page 40 for more information about orthodonitics.

When charges for a proposed dental service or series of dental services are expected to be $350 or more, your dentist should submit a claim form for a predetermination of benefits to Aetna showing the treatment plan and fees. Aetna will then use this form to determine the benefits payable for each dental service according to the terms of this dental plan, and will notify your dentist of the estimated benefits. Predetermination is recommended whether you go to a PPO dentist or a nonparticipating dentist.

Certain dental expenses are covered. These are the dentists' charges for the services and supplies listed below which, for the condition being treated, are necessary, customarily used nationwide, and deemed by the profession to be appropriate. They must meet broadly accepted national standards of dental practice.

You have in- and out-of-network dental care benefits. You may choose either option each time you or your dependents receive services.

Covered services

Covered dental services include only the following services.

Type A expenses (diagnostic and preventive)

Visits and X-rays

- Office visit for oral examination (limited to two visits per year)
- Prophylaxis (cleaning, limited to two treatments per year; limit is combined with the periodontal maintenance frequency)
- Topical application of fluoride (limited to one course of treatment per year and to children through age 18)
- Bitewing X-rays (limited to two sets per year)
- Complete X-ray series, including bitewings if necessary, or panoramic film (limited to one set every three years)
- Vertical bitewing X-rays (limited to one set every three years)
- Periapical X-rays (single films up to 13)
- Intra-oral, occlusal view, maxillary, or mandibular X-rays
- Upper or lower jaw, extra-oral X-rays
- Sealants, per tooth (limited to one application every three years for permanent molars only

for children to age 18)
- Periodontal maintenance procedures (limited to two per year; limit is combined with the prophylaxis frequency).

Type B expenses (basic)

Visits and exams
- Professional visit after hours (payment will be made on the basis of services rendered or visit, whichever is greater)
- Emergency palliative treatment, per visit.

X-ray and pathology
- Biopsy and histopathologic examination of oral tissue
- Diagnostic casts.

Oral surgery (Includes local anesthetics and routine post-operative care)
- Extractions
  - Exposed root or erupted tooth
  - Coronal remnants
  - Surgical removal of erupted tooth
  - Postoperative visit (sutures and complications) after multiple extractions and impaction
- Impacted teeth
  - Removal of tooth
- Alveolar or gingival reconstructions
  - Alveolectomy (edentulous) per quadrant
  - Alveolectomy (in addition to removal of teeth) per quadrant
  - Alveoplasty with ridge extension, per arch
  - Removal of exostosis
  - Excision of hyperplastic tissue per arch
  - Excision of pericoronal gingiva
- Odontogenic cysts and neoplasms
  - Incision and drainage of abscess
  - Removal of odontogenic cyst or tumor
- Other surgical procedures
  - Sialolithotomy: removal of salivary calculus
  - Closure of salivary fistula
  - Dilation of salivary duct
  - Transplantation of tooth or tooth bud
  - Removal of foreign body from bone (independent procedure)
  - Maxillary sinusotomy for removal of tooth fragment or foreign body
  - Closure of oral fistula of maxillary sinus
  - Sequestrectomy for osteomyelitis or bone abcess, superficial
  - Condylectomy of temporomandibular joint
  - Meniscectomy of temporomandibular joint
  - Radical resection of mandible with bone graft
  - Crown exposure to aid eruption
  - Removal of foreign body from soft tissue
  - Frenectomy
  - Suture of soft tissue injury
  - Injection of sclerosing agent into temporomandibular joint
  - Treatment of trigeminal neuraglia by injection into second and third divisions.

The maximum amount payable per calendar year for each individual for all covered dental expenses is $1,200. The orthodontia maximum is $1,000 per course of treatment separated by two years.

General anesthesia and intravenous sedation **(Only when provided in conjunction with a covered surgical procedure.)**

Periodontics

- Occlusal adjustment (other than with an appliance or by restoration)
- Root planing and scaling, per quadrant (limited to four separate quadrants per year)
- Root planing and scaling, one to three teeth per quadrant
- Gingivectomy per quadrant
- Gingivectomy, one to three teeth per quadrant
- Gingival flap procedure, including root planing, per quadrant
- Gingival flap procedure, including root planing, one to three teeth per quadrant
- Osseous surgery, including flap entry and closure, per quadrant
- Osseous surgery, including flap entry and closure, one to three teeth per quadrant
- Soft tissue graft procedures
- Clinical crown lengthening, hard tissue
- Bone replacement graft.

Endodontics

- Pulp capping
- Pulpotomy
- Apexification/recalcification
- Apicoectomy
- Root canal therapy, including necessary X-rays
  - Anterior
  - Bicuspid
  - Molar.

Restorative dentistry **(Excludes inlays, crowns [other than prefabricated stainless steel or resin] and bridges; multiple restorations in one surface will be considered as a single restoration.)**

- Amalgam restorations
- Resin restorations
- Sedative fillings
- Pins
  - Pin retention, per tooth, in addition to amalgam or resin restoration
- Crowns (when tooth cannot be restored with a filling material)
  - Prefabricated stainless steel
  - Prefabricated resin crown (excluding temporary crowns)
- Recementation
  - Inlay
  - Crown
  - Bridge
- Repairs
  - Crowns
  - Bridges
- Full and partial denture repairs
  - Broken dentures, no teeth involved
  - Repair cast framework
  - Replacing missing or broken teeth, each tooth.

Space maintainers **(Includes all adjustments within six months after installation.)**

- Fixed (unilateral or bilateral)
- Removable (unilateral or bilateral)

- Removable inhibiting appliance to correct thumbsucking
- Fixed or cemented inhibiting appliance to correct thumbsucking.

Prosthodontics

- Occlusal guard (for bruxism only).

Type C expenses (major)

Restorative **(Cast or processed restorations and crowns are covered only as treatment for decay or acute traumatic injury and only when teeth cannot be restored with a filling material or when the tooth is an abutment to a fixed bridge.)**

- Inlays/onlays, metallic or porcelain/ceramic
  - Inlay, one or more surfaces
  - Onlay, two or more surfaces
- Inlays/onlays, resin
  - Inlay, one or more surfaces
  - Onlay, two or more surfaces
- Labial veneers
  - Laminate, chairside
  - Resin laminate, laboratory
  - Porcelain laminate, laboratory
- Crowns
  - Resin
  - Resin with noble metal
  - Resin with base metal
  - Porcelain
  - Porcelain with noble metal
  - Porcelain with base metal
  - Base metal (full cast)
  - Noble metal (full cast)
  - Metallic (3/4 cast)
- Post and core
- Core buildup, including pins.

Prosthodontics

- Bridge abutments (see Inlays and Crowns)
- Pontics
  - Base metal (full cast)
  - Noble metal (full cast)
  - Porcelain with noble metal
  - Porcelain with base metal
  - Resin with noble metal
  - Resin with base metal
- Removable bridge (unilateral)
  - One piece casting, chrome cobalt alloy clasp attachment (all types) per unit, including pontics
- Dentures and partials (Fees for dentures and partial dentures include relines, rebases, and adjustments within six months after installation; fees for relines and rebases include adjustments within six months after installation; specialized techniques and characterizations are not eligible)
  - Complete upper denture
  - Complete lower denture

Find an in-network Aetna PPO dental care provider by using DocFind® on aetna.com or by calling (877) RN BENEFITS.

- Partial upper or lower, resin base (including any conventional clasps, rests, and teeth)
  - Partial upper or lower, cast metal base with resin saddles (including any conventional clasps, rests, and teeth)
  - Stress breakers
  - Interim partial denture (stayplate), anterior only
  - Office reline
  - Laboratory reline
  - Special tissue conditioning, per denture
  - Rebase, per denture
  - Adjustment to denture more than six months after installation
- Adding teeth to existing partial denture
  - Each tooth
  - Each clasp.

Orthodontics

- Comprehensive orthodontic treatment
- Post treatment stabilization
- Interceptive orthodontic treatment
- Limited orthodontic treatment.

The maximum amount payable for each individual for orthodontic treatment is $1,000 per course of treatment separated by two years. The orthodontic treatment maximum is separate from the yearly maximum. A course of treatment is a plan of care prepared by a physician or dentist with a specific goal to be accomplished over a particular period of time. A course of orthodontia refers to the period of time that begins with the placement of the first orthodontic appliance, and ends when the last one is removed, in accordance with the plan prepared by the provider of service. A course of treatment that begins more than two years after the preceding course ended will be considered a new course of treatment. Covered expenses for a course of orthodontic treatment will be prorated in quarterly installments for the number of quarters it takes to complete the course of treatment. Consideration will be given for the additional expenses during the first quarter for preliminary charges for diagnosis and evaluation. Quarterly payments will be made for claims filed for orthodontic services performed during each quarter while you are insured. If you started an orthodontic course of treatment prior to your entry in the plan, your benefit may be reduced.

(The above list of covered services, which begins on Page 36, is subject to change.)

Alternate treatment

If your dental care provider charges for an unlisted service for care of a specific condition, or 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 the service selected is deemed by the dental profession to be an appropriate method of treatment and meets broadly accepted national standards of dental practice.

Dental emergency

If treatment is received for the speedy relief of a dental emergency, coverage will be provided for charges incurred during the initial dental visit. Services in connection with a dental emergency will be covered as in-network even if care is not provided by an in-network provider. The maximum amount payable is $75. Additional dental services to treat the dental emergency will be covered at the appropriate payment percentage level.

In-network benefits

The Aetna Preferred Provider Organization includes licensed dentists. A complete list of network providers will be furnished to each participant, without charge, as a separate document. To obtain

a list, call the Fund office toll-free at (877) RN BENEFITS [762-3633]. A list of in-network providers also is available through the DocFind® feature on Aetna's Web site at www.aetna.com. When making an appointment, always verify that the dentist is an Aetna PPO provider.

There is no deductible to meet for dental services provided by a dentist who is a participating PPO provider.

If you receive services from a PPO provider, benefits are paid in accordance with the schedule of dental services at:

- 100% for covered diagnostic and preventive services;
- 80% of the fee schedule for covered basic restorative, endodontic, periodontic, prosthodontic maintenance, and oral surgery services;
- 50% of the fee schedule for covered major restorative, prosthodontic installation, and orthodontic services.

Out-of-network benefits

The out-of-network benefits allow you to use any licensed provider of your choice.

There is a yearly deductible for dental services provided by a dentist who is not a participating provider in the PPO. Your yearly deductible for dental expenses is as follows:

Plan	Per Individual	Per Family
96 1A	$25	$75
96 1B	$25	$75
97 1A	$25	$75
97 1B	$25	$75
97 2A	$50	$150
97 2B	$50	$150
98	$25	$75

If two or more individuals are injured in the same accident, only one deductible will apply to all individuals in the accident. There will still be a separate maximum for each individual.

Once your yearly deductible has been met, your covered expenses for that calendar year will be paid in accordance with the schedule of dental services at:

- 80% of the usual and prevailing fee for covered diagnostic, preventive, basic restorative, endodontic, periodontic, prosthodontic maintenance, and oral surgery services; and
- 50% of the usual and prevailing fee for covered major restorative, prosthodontic installation, and orthodontic services.

Payments are made on a usual and prevailing basis. In determining what the U&P fee will be, the dental program will take into consideration:

- The usual fee charged by the provider for similar services or procedures when there is no coverage (except in the case of participating dentists);
- The prevailing range of fees charged by most providers with similar training in the same locality; and
- Unusual circumstances or complications requiring additional time, skills and experience, and the complexity of the service performed.

Charges in excess of the U&P charge will not be covered.

Obtain claim forms by calling (877) RN BENEFITS or printing them from rnbenefits.org. Send them to: Aetna, PO Box 14094, Lexington, KY 40512-4094.

To receive out-of-network benefits, you must file an Aetna dental claim form. You can obtain claim forms by calling the Benefits Fund or printing them from the Fund's Web site at www.rnbenefits.org. Send the claim form to: Aetna, PO Box 14094, Lexington, KY 40512-4094. Claims for services performed outside the United States must be submitted for payment in English, with charges indicated in U.S. dollars.

Dental care claims

You may file claims for Fund benefits and appeal adverse claim decisions either yourself or through an authorized representative. If your claim is denied in whole or in part, you will receive a written notice of the denial from Aetna Life Insurance Company. The notice will explain the reason for the denial and the review procedures.

An authorized representative is any person you authorize in writing to act on your behalf. The Fund also will recognize a court order giving a person authority to submit claims on your behalf. In addition, a health care professional with knowledge of your condition always may act as your authorized representative regarding an urgent care claim.

Urgent care claims

If the Fund requires advance approval of a service, supply, or procedure before a benefit will be payable, and if Aetna or your dentist determines the claim is an urgent care claim, you will be notified of the decision no later than 72 hours after the claim is received by Aetna.

An urgent care claim is any claim for dental care or treatment that, if delayed due to the application of time periods for making nonurgent determinations, could seriously jeopardize your life, health, or ability to regain maximum function, or in the opinion of a dentist with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment specified in the claim.

If there is not sufficient information to decide the claim, you will be notified of the information necessary to complete the claim as soon as possible, but no later than 24 hours after receipt of the claim. You will be given a reasonable additional amount of time, but not less than 48 hours, to provide the information, and you will be notified of the decision no later than 48 hours after the end of that additional time period (or after receipt of the information, if earlier).

Other claims (pre-service and post-service)

If the Fund requires you to obtain advance approval of a service, supply, or procedure before a benefit will be payable, a request for advance approval is considered a pre-service claim. You will be notified of the decision no later than 15 days after receipt of the pre-service claim.

For other claims (post-service claims), you will be notified of the decision no later than 30 days after receipt of the claim.

For either a pre-service or a post-service claim, these time periods may be extended up to an additional 15 days due to circumstances outside Aetna's control. In that case, you will be notified of the extension before the end of the initial 15- or 30-day period. For example, time periods may be extended because you have not submitted sufficient information. In that case, you will be notified of the specific information necessary and given an additional period of at least 45 days after receiving the notice to provide that information. You will be notified of Aetna's claim decision no later than 15 days after the end of that additional period (or after receipt of the information, if earlier).

For pre-service claims that name a specific participant, dental condition, and service or supply for which approval is requested and submitted to Aetna, but otherwise fail to follow Aetna's procedures for filing pre-service claims, you will be notified of the failure within five days (within 24 hours in the case of an urgent care claim) and of the proper procedures to be followed. The notice may be oral unless you request written notification.

Ongoing course of treatment

If you have received pre-authorization for an ongoing course of treatment, you will be notified in advance if Aetna intends to terminate or reduce benefits for the previously authorized course of treatment so you will have an opportunity to appeal the decision and receive a decision on that appeal before the termination or reduction takes effect. If the course of treatment involves urgent care, and you request an extension of the course of treatment at least 24 hours before its expiration, you will be notified of the decision within 24 hours after receipt of the request.

Filing an appeal of an adverse benefit determination

As a member of an Aetna dental plan, you have the right to file an appeal about coverage for service(s) you have received from your dental care provider or Aetna if you are not satisfied with the outcome of the initial determination and the appeal is regarding a change in the decision for certification of dental care services, claim payment, plan interpretation, benefit determination, or eligibility.

You may file an appeal in writing to: Aetna Appeals, PO Box 14080, Lexington, KY 40512-4080 or, if your appeal is of an urgent nature, you may call Aetna's Member Services Unit toll-free at (877) 238-6200. Your request should include your name, Social Security number or other identifying information shown on the front of the Explanation of Benefits form, and any other comments, documents, records, and other information you would like to have considered, whether or not it was submitted with the initial claim. You also should identify yourself as a NYSNA Benefits Fund participant.

You will have 180 days following receipt of an adverse benefit decision to appeal the decision to Aetna. You will be notified of the decision no later than 15 days (for pre-service claims) or 30 days (for post-service claims) after the appeal is received. You may submit written comments, documents, records, and other information relating to your claim, whether or not the information was submitted with the initial claim. A copy of the specific rule, guideline, or protocol relied upon in the adverse benefit determination will be provided free of charge upon request by you or your authorized representative. You also may request that Aetna provide you, free of charge, copies of all documents, records, and other information relevant to the claim.

If your claim involves urgent care, an expedited appeal may be initiated by a toll-free telephone call to Member Services at (877) 238-6200. You or your authorized representative may appeal urgent care claim denials either orally or in writing. All necessary information, including the appeal decision, will be communicated between you or your authorized representative and Aetna by telephone or other method. You will be notified of the decision no later than 36 hours after the appeal is received.

If you are dissatisfied with the appeal decision on a claim involving urgent care, you may file a second-level appeal with Aetna. You will be notified of the decision no later than 36 hours after the appeal is received.

If you are dissatisfied with a pre-service or post-service appeal decision, you may file a second-level appeal with Aetna within 60 days of receipt of the level-one appeal decision. Aetna will notify you of the decision no later than 15 days (for pre-service claims) or 30 days (for post-service claims) after the appeal is received.

If you do not agree with the final determination on review, you have the right to bring a civil action, if applicable.

Exhaustion of process

You must exhaust the applicable level-one and level-two processes of the appeal procedure before you establish any litigation, arbitration, or administrative proceeding regarding an alleged breach of the policy terms by Aetna Life Insurance Company, or any matter within the scope of the appeals procedure.

You may file an appeal in writing to: Aetna Appeals, PO Box 14080, Lexington, KY 40512-4080 or, if your appeal is of an urgent nature, you may call Aetna's Member Services Unit toll-free at (877) 238-6200.

Exclusions

General exclusions to dental coverage

Coverage is not provided for the following charges:

- Care, treatment, services, or supplies that are not prescribed, recommended, or approved by the person's dentist.
- Services and supplies not necessary for the diagnosis, care, or treatment of the disease or injury involved as determined by Aetna. This applies even if they are prescribed, recommended, or approved by the person's dentist.
- Those for or in connection with services or supplies that are determined by Aetna to be experimental or investigational. A drug, device, procedure, or treatment will be determined to be experimental or investigational if:
  - There are insufficient outcomes data available from controlled clinical trials published in the peer-reviewed literature to substantiate its safety and effectiveness for the disease or injury involved; or
  - Approval has not been granted for marketing if required by the Food and Drug Administration; or
  - A recognized national medical or dental society or regulatory agency has determined in writing that it is experimental, investigational, or for research purposes; or
  - The written protocol or protocols used by the treating facility, or the protocol or protocols of any other facility studying substantially the same drug, device, procedure, or treatment, or the written informed consent used by the treating facility or by another facility studying the same drug, device, procedure, or treatment states that it is experimental, investigational, or for research purposes.
- Services of a resident physician or intern rendered in that capacity.
- Those that are made only because there is health coverage.
- Those that a covered person is not legally obliged to pay.
- To the extent allowed by the law of the jurisdiction where the group contract is delivered, those for services and supplies:
  - Furnished, paid for, or for which benefits are provided or required by reason of the past or present service of any person in the armed forces of a government.
  - Furnished, paid for, or for which benefits are provided or required under any law of a government. (This exclusion will not apply to "no fault" auto insurance if it is required by law and is provided on other than a group basis. In addition, this exclusion will not apply to a plan established by government for its own employees or their dependents, or Medicaid.)
- Routine dental exams or other preventive services and supplies, except to the extent coverage for such exams, services, or supplies is specifically indicated.
- Acupuncture therapy, except when it is performed by a physician as a form of anesthesia in connection with surgery that is covered as indicated.
- Plastic surgery, reconstructive surgery, cosmetic surgery, or other services and supplies that improve, alter, or enhance appearance, whether or not for psychological or emotional reasons, except to the extent needed to repair an injury. Surgery must be performed in the calendar year of the accident that causes the injury or in the next calendar year. Facings on molar crowns and pontics always will be considered cosmetic.
- Those to the extent they are not reasonable charges as determined by Aetna.
- Service or supply furnished by a preferred care provider (a provider in the PPO) in excess of such provider's negotiated charge for that service or supply.

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

These excluded charges will not be used when figuring benefits.

The law of the jurisdiction where a person lives when a claim occurs may prohibit some benefits. If so, they will not be paid.

Exclusions and limitations

Covered dental expenses do not include and no benefits are payable for:

- Any dental services and supplies that are covered in whole or in part or under any other plan of group benefits provided by the Fund, or to the extent that the charges are otherwise payable as fully described under coordination of benefits.
- Services and supplies to diagnose or treat an occupational disease or injury.
- Services not listed in the dental care schedule that applies, except as specifically provided.
- Replacement of a lost, missing, or stolen appliance, and those for replacement of appliances that have been damaged due to abuse, misuse, or neglect.
- Dentures, crowns, inlays, onlays, bridgework, or other appliances or services used for the purpose of splinting; to alter vertical dimension to restore occlusion; or correcting attrition, abrasion, or erosion.
- Any of the following services:
  - An appliance, or modification of one, if an impression for it was made before the person became a covered person;
  - A crown, bridge, or cast or processed restoration, if a tooth was prepared for it before the person became a covered person;
  - Root canal therapy, if the pulp chamber for it was opened before the person became a covered person.
- Services intended for treatment of any jaw joint disorder, except as specifically provided.
- Space maintainers, except when needed to preserve space resulting from the premature loss of deciduous teeth.
- Orthodontic treatment, except as specifically provided.
- General anesthesia and intravenous sedation, unless done in conjunction with another necessary covered service.
- 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.
- Charges in connection with a service given to a person age 5 or more if that person becomes a covered person other than during the first 31 days the person is eligible for this coverage, or as prescribed for any period of open enrollment agreed to by the Benefits Fund and Aetna. This does not apply to charges incurred:
  - As a result of accidental injuries sustained while the person was a covered person, or
  - For a service in the dental care schedule that applies as shown under the headings "Visits and X-rays," "Visits and Exams," and "X-ray and Pathology."
- Services given by a non-preferred provider to the extent that the charges exceed the amount payable for the services shown in the dental care schedule that applies.
- Crown, cast, or processed restoration unless:
  - It is treatment for decay or traumatic injury and teeth cannot be restored with a filling material, or
  - The tooth is an abutment to a covered partial denture or fixed bridge.
- Pontics, crowns, cast, or processed restorations made with high noble metals, except as specifically provided.
- Surgical removal of impacted wisdom teeth only for orthodontic reasons, except as specifically provided.

- Services needed solely in connection with non-covered services.
- Services done where there is no evidence of pathology, dysfunction, or disease other than covered preventive services.

Definitions

- **Dental emergency –** Any traumatic dental condition that occurs unexpectedly, requires immediate diagnosis and treatment, and is characterized by symptoms such as severe pain and bleeding.
- **Dentist –** A legally qualified dentist or a physician who is licensed to do the dental work he or she performs.
- **Directory –** A list of all PPO providers for Benefits Fund participants.
- **Hospital –** A place that mainly provides inpatient facilities for the surgical and medical diagnosis, treatment, and care of injured and sick people; is supervised by a staff of physicians; provides 24-hour-a-day RN service; is not mainly a place for rest, the aged, drug addicts, or alcoholics; is not a nursing home; and makes charges.
- **Jaw joint disorder –** A temporomandibular joint dysfunction or any similar disorder of the jaw joint; or a myofacial pain dysfunction; or any similar disorder in the relationship between the jaw joint and the related muscles and nerves.
- **Necessary –** A service or supply furnished by a particular provider is necessary if Aetna determines that it is appropriate for the diagnosis, care, or treatment of the disease or injury involved. To be appropriate, the service or supply must:
  - Be care or treatment as likely to produce a significant positive outcome as, and no more likely to produce a negative outcome than, any alternative service or supply, both as to the disease or injury involved and the person's overall health condition;
  - Be a diagnostic procedure indicated by the health status of the person and be as likely to result in information that could affect the course of treatment as, and no more likely to produce a negative outcome than, any alternative service or supply, both as to the disease or injury involved and the person's overall health condition; and
  - As to diagnosis, care, and treatment be no more costly (taking into account all health expenses incurred in connection with the service or supply) than any alternative service or supply to meet the above tests.

  In determining if a service or supply is appropriate under the circumstances, Aetna will take into consideration:
  - Information provided on the affected person's health status;
  - Reports in peer-reviewed medical literature;
  - Reports and guidelines published by nationally recognized health care organizations that include supporting scientific data;
  - Generally recognized professional standards of safety and effectiveness in the United States for diagnosis, care, or treatment;
  - The opinion of health professionals in the generally recognized health specialty involved; and
  - Any other relevant information brought to Aetna's attention.

  In no event will the following services or supplies be considered as necessary:
  - Those that do not require the technical skills of a medical or dental professional; or
  - Those furnished mainly for the personal comfort or convenience of the person, any person who cares for him/her, any person who is part of his/her family, any health care provider or facility; or

- Those furnished solely because the person is an inpatient on any day on which the person's disease or injury could safely and adequately be diagnosed or treated while not confined; or
- Those furnished solely because of the setting if the service or supply could safely and adequately be furnished in a physician's or dentist's office or other less costly setting.

- **Negotiated charge –** The maximum charge a preferred care provider has agreed to make as to any service or supply for the purpose of the benefits under this Plan.
- **Nonoccupational disease –** A disease that does not arise out of (or in the course of) any work for pay or profit, or result in any way from a disease that does. A disease will be deemed to be nonoccupational regardless of cause if proof is furnished that the person is covered under any type of workers' compensation law, and is not covered for that disease under such law.
- **Nonoccupational injury –** An accidental bodily injury that does not arise out of (or in the course of) any work for pay or profit, or result in any way from an injury which does.
- **Nonpreferred care –** A health care service or supply furnished by a health care provider who is not a preferred care provider if, as determined by Aetna, the service or supply could have been provided by a preferred care provider, and the provider is not listed in the Directory.
- **Orthodontic treatment –** Any medical or dental service or supply furnished to prevent, diagnose, or correct a misalignment of the teeth, the bite, the jaws, or jaw-joint relationship, whether or not for the purpose of relieving pain. Not included is the installation of a space maintainer or a surgical procedure to correct malocclusion.
- **Physician –** A legally qualified physician.
- **Preferred care –** A health care service or supply furnished by a preferred care provider or a health care provider who is not a preferred care provider for a dental emergency when travel to a preferred care provider is not feasible.
- **Preferred care provider –** A health care provider who has contracted to furnish services or supplies for a negotiated charge, but only if the provider is, with Aetna's consent, included in the directory as a preferred care provider for the service or supply involved for Benefits Fund participants.
- **Reasonable charge –** Only that part of a charge which is reasonable is covered. The reasonable charge for a service or supply is the lowest of:
  - The provider's usual charge for furnishing it; and
  - The charge Aetna determines to be appropriate, based on factors such as the cost of providing the same or similar service or supply and the manner in which charges for the service or supply are made; and
  - The charge Aetna determines to be the prevailing charge level made for it in the geographic area where it is furnished.

  In determining the reasonable charge for a service or supply that is unusual, or not often provided in the area, or provided by only a small number of providers in the area, Aetna may take into account factors such as the:
  - Complexity,
  - Degree of skill needed,
  - Type of provider specialty,
  - Range of services or supplies provided by a facility, and
  - Prevailing charge in other areas.

Chapter 11: Prescription Drug Benefits

There is a $5,000 lifetime maximum combined benefit for IVF and/or covered fertility drugs.

The Benefits Fund contracts with CVS Caremark to provide prescription drug coverage, including a mail-order program that is mandatory for filling maintenance medications, for you, your spouse, and your eligible dependents. For questions or service regarding your prescription drug benefits, contact the Benefits Fund at (877) RN BENEFITS [762-3633].

You and your eligible dependents have prescription drug benefits as described in this chapter.

Covered medications

The medications covered under this plan include:

- **Prescribed legend drugs** (including injectable insulin).
- **Compound medications**, of which at least one ingredient is a prescribed drug.
- **State restricted drugs** that require a prescription.
- **Oral contraceptives** (including contraceptive tablets, vaginal rings, and transdermal patches).
- **Genetically engineered drugs** (growth hormones).
- **Fertility drugs**. There is a $5,000 lifetime maximum combined benefit for in vitro fertilization and/or covered fertility drugs. Fertility drugs must be ordered through the CVS Caremark mail service pharmacy (see the in-network benefits section on the following page for more information). If you are unable to obtain the drugs through the mail-order program, you may purchase them and submit a claim for direct reimbursement, but you may not be reimbursed the full amount.
- **Male sexual dysfunction drugs.** Impotency treatment for men with medically diagnosed erectile dysfunction is covered when the prescription is written by a urologist as a result of an in-person exam. Such treatment will be covered on a case-by-case basis, subject to these conditions:
  - All impotency treatment drugs must be prior authorized by CVS Caremark and filled through the CVS Caremark mail service pharmacy (see Page 50 for more information).
  - Coverage is limited to six pills per 30-day period.
- **Approved diabetic medicines and supplies**, including:
  - Insulin,
  - Oral hypoglycemic agents,
  - Glucose-elevating agents,
  - Syringes and pens,
  - Alcohol swabs,
  - Glucose/acetone test strips/agents,
  - Lancets and lancet devices.

  Diabetic medicines and supplies must be ordered through the CVS Caremark Mail Service pharmacy.
- **New drugs** coming on the market will be covered or excluded pursuant to the NYSNA Benefits Fund plan design as described in this chapter.

Prescriptions will be filled in the amount normally prescribed by your physician, but not to exceed a 34-day supply or 100 unit doses, whichever is greater. The duration of coverage for any drug therapy is limited to the manufacturer's recommendations.

Exclusions

Prescription benefit payments will not be made for:

- Birth control devices such as diaphragms and intrauterine devices (may be covered under medical services);
- Drugs or medicines lawfully obtainable without a prescription order from a physician or dentist;
- Support garments;
- Drugs provided while confined in a hospital, rest home, sanitorium, extended care facility, or convalescent home (may be covered under medical services);
- Any charge for the administration of prescription legend drugs or injectable insulin;
- Immunization agents, biological sera, blood, or blood plasma (may be covered under medical services);
- Any medication, legend or not, which is consumed or administered at the place where it is dispensed (may be covered under medical services);
- Refilling a prescription in excess of the number specified by the physician or dentist, or any refill dispensed following one year of the physician's or dentist's order;
- Refills on a prescription unless 75% of the current prescription is scheduled to have been used (65% for maintenance medications ordered by mail);
- Maintenance medications filled more than two times at a retail pharmacy;
- Drugs labeled: "Caution: limited by federal law to investigational use," or experimental drugs, even though a charge is made to the individual;
- Drugs that may properly be received without charge under local, state and federal programs, including workers' compensation;
- Drugs that are not FDA-approved for the condition for which they are being prescribed;
- Drugs that are not prescribed according to the manufacturer's specifications;
- Services or items required by an employer; and
- Drugs solely used for cosmetic purposes.

Coverage of prescription drugs can be denied for any of the following reasons:

- Off-label use (any drug that is not approved by the Food and Drug Administration for the diagnosis for which it is being prescribed),
- Refill too soon,
- Request for prescription to be filled above dispensing limits,
- Request for prescription to be filled beyond FDA recommendations or approval,
- An over-the-counter equivalent is available.

Two options

Two different prescription drug benefit options are available. The in-network option allows you to get your prescriptions filled at an in-network pharmacy for no copayment or a low copayment. The out-of-network option allows you to have your prescription filled at any pharmacy of your choice. You may choose either benefit option each time you or your dependents receive prescription drugs, unless the prescription is for maintenance medication.

In-network benefits

The CVS Caremark network of participating, in-network pharmacies includes practically every large pharmacy where you live.

A complete list of network pharmacies will be furnished to each participant, without charge, as a separate document. To obtain a list, call the Fund office toll-free at (877) RN BENEFITS [762-3633]. A list of in-network pharmacies also is available through the CVS Caremark Web site at www.caremark.com.

To obtain a list of CVS Caremark network pharmacies, visit caremark.com. Most pharmacies participate with CVS Caremark.

There is no deductible to meet for prescription drugs received from a CVS Caremark-participating pharmacy. If you receive prescription drugs from an in-network pharmacy, present your prescription drug identification card, along with your prescription. You will be charged the following copayment. (Refer to Chapter 1 for your facility's plan.)

Plan	Brand-name	Generic
96 1A	$0	$0
97 1A	$0	$0
96 1B	$5	$3
97 1B	$5	$3
97 2B	$5	$3
97 2A	$1	$1
98	10% coinsurance	$5

Benefits Fund participants and their covered dependents taking maintenance medications must have them filled by CVS Caremark's Mail Service Pharmacy. To use the service, send a mail service order form (call [877] RN BENEFITS or visit rnbenefits.org) and your prescription to: Caremark, PO Box 94467, Palatine, IL 60094-4467.

CVS Caremark mail-order prescription drug program

Benefits Fund participants and their covered dependants taking maintenance medications must have those prescriptions filled by CVS Caremark's Mail Service Pharmacy. This applies to existing maintenance medications as well as future maintenance medications prescribed by your doctor. Maintenance medications are drugs that have approved Federal Drug Administration guidelines for the treatment of chronic medical conditions and generally would be prescribed by a physician for regularly scheduled use by a patient for greater than one month.

You can get a one-month supply for maintenance medications filled two times at a retail pharmacy before necessitating transfer to mail order. (These two retail fills apply only to the initial prescription and cannot be used when the prescription is renewed.)

With the exception of getting the first two 34-day supplies of maintenance medications filled at your local pharmacy, prescriptions that are required to be filled thereafter at mail-order but instead are filled at an in-network or out-of-network pharmacy are not eligible for reimbursement.

If you need medication immediately, but will be taking it on an ongoing basis, ask your doctor for two prescriptions. One would be for a limited supply that you can have filled immediately at a local pharmacy. The second would be for the balance of the prescription, to be filled in 90-day supplies.

To use the CVS Caremark mail-order service:

- Request a mail service order form from the Fund office or download a form from the Fund's Web site at www.rnbenefits.org or CVS Caremark's Web site at www.caremark.com;
- Fill in all of the information requested, including your complete return address; and
- Enclose your doctor's prescription.

Send the form, along with the prescription, to CVS Caremark, PO Box 94467, Palatine, IL 60094-4467.

Your order should be delivered within 14 days of the date CVS Caremark receives your envelope. You also will receive another mail service order form and envelope to use for requesting your next refill. In addition, you can obtain refills by calling CVS Caremark's toll-free number at (866) 694-5188 or by accessing CVS Caremark's Web site at www.caremark.com. There is no copayment when you order your prescription drugs through the CVS Caremark mail service phamacy. Delivery charges apply only if you request expedited delivery.

Out-of-network benefits

The out-of-network benefits allow you to use any pharmacy that doesn't participate in the CVS Caremark network. If you choose to use a nonparticipating pharmacy or if you go to an in-network pharmacy and don't have your identification card, you must pay for the prescription and have a CVS Caremark claim form completed by your pharmacist. Send the completed form and paid receipt to the CVS Caremark Claims Department, PO Box 52196, Phoenix, AZ 85072-2196 for reimbursement. You will be reimbursed based on what a participating pharmacy would have been reimbursed. If your costs exceed that amount, you may not receive 100% reimbursement. Claim forms are available from the Benefits Fund and on the Fund Web site at www.rnbenefits.org. Claims for services performed outside the United States must be submitted for payment in English, with charges indicated in U.S. dollars.

Prescription drug claims

You do not have to file claims for prescription drugs that do not require prior authorization and are provided by CVS Caremark. Presenting a prescription for a prescription drug at a pharmacy is not considered submission of a claim for benefits to the plan.

Prior authorization claims

If your provider orders a prescription drug that requires prior authorization before you can receive the prescription drug, the provider who prescribed the medication must contact CVS Caremark at (866) 694-5188.

An initial decision on your prior authorization claim will be made no later than:

- 72 hours for an urgent claim (any claim that, if not provided in a timely manner would threaten your life or health, or would cause you severe pain that would be unmanageable without the claim-related treatment);
- 15 days for nonurgent claims.

The above time frames begin on the date CVS Caremark receives complete information.

Post-service claims

If you receive covered prescription drugs from an in- or out-of-network pharmacy and pay up front, submit a claim to CVS Caremark to receive a reimbursement of the applicable amount permitted under the plan.

To receive your reimbursement, complete a prescription drug claim form (available from the Fund office or the Fund's Web site at www.rnbenefits.org). Send the completed form, along with an itemized bill for the covered drugs, to: CVS Caremark Claims Department, PO Box 52196, Phoenix, AZ 85072-2196. Claims must be submitted within one year of the date of service for which the claim is made.

An initial decision on your post-service claim will be made within 30 days of the date on which CVS Caremark receives complete information.

Appealing denied claims

If your prior authorization, urgent concurrent care, or post-service claim is denied, you will receive written notice from CVS Caremark describing, among other things, the reason for the denial.

To appeal a denied claim, submit a written request within 180 days of the date of the denial to: CVS Caremark Inc. Appeals Department, MC 109, PO Box 52084, Phoenix, AZ 85072-2084.

There are two appeals levels. The first level is a Benefit Reconsideration Review, which begins when a participant or physician decides to appeal a denied claim. The participant or authorized representative (any person you authorize in writing to act on your behalf) requests a Prescription Claims Appeal form from CVS Caremark by contacting the Member Services Department at (866) 694-5188. After completing the form, the participant mails or faxes the

For out-of-network services, send completed prescription drug claim forms (available at [877] RN BENEFITS or rnbenefits .org) and an itemized bill to: CVS Caremark Claims Department, PO Box 52196, Phoenix, AZ 85072-2196 within one year of the date of service.

form and any relevant and supporting documentation to: CVS Caremark Inc. Appeal Department, MC 109, PO Box 52084, Phoenix, AZ 85072-2084 or (866) 689-3092. Supporting documentation may include a letter written by your provider in support of the appeal, a copy of the denial letter sent by CVS Caremark, and a copy of your payment receipt or medical records, among other things.

If the denial is for a prescription that required prior authorization, the participant or physician submits an appeal via fax or mail based on instructions directed in the prior authorization denial letter.

Upon receipt of the supporting documentation by CVS Caremark's Medical Affairs department, an appeals analyst reviews and determines appeals relating to nonclinical benefits such as eligibility determinations, copayments, and explicit exclusions under this plan. Appeal determination regarding clinical knowledge such as prior authorization denials are reviewed by an appeals pharmacist. All appeal determinations will be final, subject to any provisions for additional review by the Fund.

The participant (or physician) is notified in writing of the appeal decision.

The second level of appeal is the Medical Necessity Review, which is only performed for denials of prior authorization requests upheld on the initial Benefit Reconsideration Review, and begins when the participant or physician submits a second appeal.

The appeal is forwarded to a peer review organization, along with supporting documentation submitted by the participant and/or physician, where an independent specialist physician will review it and make a decision. CVS Caremark will be advised of the decision and send the participant and physician a letter confirming the peer review's final determination.

If the independent specialist concludes that your claim should have been approved, you will be reimbursed according to the terms of the plan.

If the independent specialist company denies your claim again, you will receive a written notice describing, among other things, the specific reason for the denial and references to the section of the plan upon which the denial is based.

A decision on the appeal of a denied claim will be made no later than:

- 72 hours for urgent prior authorization claims (cumulative for both first and second levels);
- 30 days for nonurgent prior authorization claims (maximum 15 days at each level);
- 60 days for post-service and nonurgent concurrent care claims (maximum 30 days at each level).

The above time frames begin on the date CVS Caremark receives complete information.

If you still are unsatisfied with the denial of your claim for a prescription drug benefit, the appeals process has been exhausted, but you still have the right to sue.

Drug Quantity Management program

All participants and dependants who use the plan's prescription drug program automatically are enrolled in the Drug Quantity Management program administered by CVS Caremark. The program reviews whether participants and their dependants are taking the optimum dose of certain medications prescribed by their doctor. Each dose recommendation is proven safe and effective according to guidelines developed by the Food and Drug Administration.

Participants affected by the Drug Quantity Management program have three choices:

- Have your pharmacist fill the prescription as written and possibly incur higher out-of-pocket costs to recieve a month's supply.
- Ask the pharmacist to call your doctor to discuss switching to a more optimum dose so you can obtain a month's supply of medications at your usual payment, if any.
- Ask your doctor about getting prior authorization from CVS Caremark to keep the current dose without incurring any additional costs. Physicians may call (866) 694-5188.

Chapter 12: Short-Term Disability Benefits

The Benefits Fund has contracted with The Hartford Life Insurance Company to provide short-term disability coverage for you. For questions or service regarding your short-term disability benefits, contact the Benefits Fund at (877) RN BENEFITS [762-3633].

You have short-term disability benefits as described in this section.

This plan has been designed to meet the requirements of the New York State Disability Benefits Law and the provisions and limitations of the law generally are applicable. In no case will you receive lower benefits than the benefits required by law.

You are entitled to this benefit if you become totally disabled because of a nonoccupational, accidental injury, sickness, or pregnancy while covered by the Fund. You must be under the care of an appropriate licensed medical professional, satisfy the waiting period, and have worked for your employer for at least four weeks to be eligible for this benefit.

Short-term disability benefit payments begin when you have reached:

- The eighth calendar day of sickness or disability, or
- The first day of accidental injury disability.

Successive periods of disability will be treated as one period of disability unless:

- The periods of disability are due to different and unrelated causes, or
- The periods of disability due to the same or related causes are separated by three months or more.

Benefits are payable for each period of disability at the weekly rate of 66⅔% of regular weekly compensation up to a maximum of $215 per week, and for the maximum period of 26 weeks in a 52-week period.

The short-term disability benefit you receive from the Fund is fully taxable as regular income. You'll receive a W-2 form at the end of the year to file with your federal and state income tax returns. In some instances, your employer may include your disability benefits in your regular W-2.

No benefits are payable for disability due to injury or sickness connected with your employment, self-inflicted injuries, war, illegal acts, and surgery that was not medically necessary.

If you leave employment with a New York state-covered employer and become disabled within four weeks after termination, you still may be eligible for disability benefits. Coverage will be discontinued under this plan beginning with:

- The first day you are employed by another employer subject to New York State Disability Benefits Law, or
- The sixth day of work for a noncovered employer.

You must be totally disabled because of a non-occupational, accidental injury, sickness, or pregnancy while covered by the Fund and under the care of an appropriate licensed medical professional. You also must satisfy the waiting period and have worked for your employer for at least four weeks.

Filing a claim

In the event that you become disabled and eligible for benefits under this coverage, you must submit written notice of your claim within six months of the event on which the claim is based. Failure to give written notice within the time specified will neither invalidate nor reduce any claims if it can be shown that it was not reasonably possible to give written notice within that time, and that written notice was given as soon as was reasonably possible. You can obtain a short-term disability claim form from the Fund, on the Fund's Web site at www.rnbenefits.org, or at your place of employment.

The claim form for short-term disability is a three-part form that must be completed by the covered participant, the attending physician, and the employer. The participant should first give the form to the employer, then complete his or her section and bring the form to

the physician for completion. Or, the participant and his or her physician can complete their portions of the form and ask the employer to fill out an employer statement. The covered participant and/or employer should then send the original claim form and/or statement to the NYSNA Benefits Fund, PO Box 12430, Albany, NY 12212-2430. Whether the employer fills out a separate statement or the participant's form, it is up to the participant to see that all required portions are sent to the Fund office.

"Attending Physician's Statement of Functionality" (medical update) forms will be supplied to the covered participant, as required, based on the disabling condition.

The initial decision on your claim will be made within 14 days. If additional proof of disability is required, notification will be made within four days of receipt at the Fund office.

The form must be filled out by your employer, you, and your physician, or your employer may fill out a separate employer statement. You and your employer should then send the completed form(s) to: NYSNA Benefits Fund, PO Box 12430, Albany, NY 12212-2430.

Appealing a denied claim

If your short-term weekly disability claim is denied, you'll receive a Notice of Total or Partial Rejection of Claim for Disability Benefits (Form DB-451) that will explain all necessary instructions for appealing your denied claim.

You have up to 26 weeks to appeal the adverse benefit determination. Following denial of a claim:

- The claimant will have access, upon request, to all relevant information, including the claimant's entire claim file, materials identifying any medical or vocational expert whose advice was used in making the benefit determination, and any other documents that reflect the plan's general policy regarding the claim.
- The plan cannot impose fees or costs as a condition to filing or appealing a claim.
- Arbitration is permitted, but only with full disclosure regarding the process, arbitrator, relationships, right to representation, and only if the claimant agrees after completing internal appeal.
- Review must be de novo (new). The decision-maker on an appealed claim must be different from (and not subordinate to) the person deciding the initial claim. The claimant also must have the opportunity to submit new evidence.
- The plan must consult with appropriate health care professionals in deciding appealed claims involving medical judgment.
- The plan may not require more than two levels of review of denied claims (if there's more than one level, both levels must be completed within the time frame applicable to one level).
- The plan must have procedures and safeguards for ensuring and verifying consistent decision-making.
- If the plan fails to make timely decisions or otherwise fails to comply with the regulation, claimants may go to court to enforce their rights.

To file an appeal, send two copies of a statement to the Workers' Compensation Board, Disability Benefits Bureau, 100 Broadway-Menands, Albany, NY 12241. The statement must say that your claim for disability benefits has been rejected, request a review of the rejection of the claim, and provide complete details on the specific reasons for your request. Attach any pertinent medical or employment records, along with any other evidence that supports your request for review, including any information received from your employer or insurance company. Once an appeal request is received, a decision must be made within 45 days (one 45-day extension is allowed for special circumstances).

Chapter 13: Long-Term Disability Benefits

The New York State Nurses Association Benefits Fund provides long-term disability coverage for you. For questions or service regarding your long-term disability benefits, contact the Benefits Fund at (877) RN BENEFITS [762-3633].

You have long-term disability benefits as described in this section.

You are entitled to this benefit if you become totally disabled by an accidental injury, sickness, or pregnancy while covered by the Fund. You must complete a qualifying period of six consecutive months, and file for and receive a determination of benefits from Social Security before you begin receiving monthly benefits under this coverage.

You must be considered totally disabled in order to receive benefits under this coverage. You will be considered totally disabled if you are completely and continuously unable to perform each and every duty required in your employment. This requirement will apply for the first two years of disability. Thereafter, you must be unable to perform any work for compensation or profit for which you are, or may become, reasonably fitted by training, education, or experience. You are not totally disabled during any period in which you are not under the regular care of an appropriate licensed medical professional, or if you perform any work for compensation or profit.

Only one qualifying period shall be required with respect to successive disability spells that are considered one period of disability. Successive spells of disability that begin while you are covered by the Fund will be treated as one period of disability unless they are:

- Due to different and unrelated causes and separated by a return to active employment with the employer, or
- Due to the same or related cause and separated by more than three months of continuous active employment with the employer.

Benefits are payable until the date you attain age 65, unless you become disabled after age 60, in which case the limit is extended to age 70.

The monthly benefit while totally disabled shall be 50% of your monthly base compensation immediately prior to disability, up to a maximum of $350 per month, less what you receive for that month:

- In payment under an annuity or pension plan, except for reduced early retirement benefits;
- From a group life insurance plan because of disability, but only if such benefits do not reduce the amount of your life insurance or if you have an option to refuse them;
- From Social Security, including dependent benefits by reason of your disability or retirement;
- As a periodic benefit for disability under any employee benefit plan, or any government agency or program required by law.

Payments under an individual life insurance or disability policy do not reduce your monthly benefit. The long-term disability benefit you receive from the Benefits Fund is fully taxable as regular income. At the end of the year, you'll receive from the Fund a W-2 form to file with your federal and state income tax returns.

Until you submit proof satisfactory to the Fund that you are not entitled to the Social Security disability benefits noted, the Fund will assume that you are entitled to the maximum amount of such periodic benefit, including dependent benefits, applicable to your status.

If a single sum payment is made as an exchange or substitute for any other periodic benefits or payments, such payment shall be prorated over the disabled period. The monthly benefit equivalent reached in this way will be used in our benefit calculation.

To receive benefits, you must be totally disabled by accidental injury, sickness, or pregnancy, complete a qualifying period of six consecutive months, and file for and receive a determination by Social Security.

No benefits are payable for disabilities due to:

- Self-inflicted injuries (either intentional or while insane),
- War (or any act of war),
- Participation in a felony,
- An injury or sickness that manifested itself within 12 months prior to your eligibility date and causes a disability to begin within two years after your eligibility.

Filing a claim

You are eligible to receive monthly benefits (less any amount received from Social Security, no-fault insurance or other group long-term coverage) for each period of non-work-related disability after you complete the six-month qualifying period and file for and receive a determination of entitlement to benefits from Social Security.

To apply for a long-term disability benefit through the Benefits Fund, complete a claim form, which is available from the Fund or on the Fund's Web site at www.rnbenefits.org. Send the completed claim form to the NYSNA Benefits Fund, PO Box 12430, Albany, NY 12212-2430.

The initial decision on your claim will be made within 45 days (two 30-day extension periods may be allowed under certain circumstances). If the plan requests additional information, it will notify you of the information required within 30 days. You have 45 days in which to furnish the supplemental information.

If you qualify, benefits will be payable monthly while you continue to be so disabled if due proof of the disability is given to the Fund.

Complete a claim form (available by calling [877] RN BENEFITS or online at rnbenefits.org), and send it to: NYSNA Benefits Fund, PO Box 12430, Albany, NY 12212-2430.

Appealing a denied claim

If your long-term disability benefit claim is denied, you will receive a written explanation that will:

- Specify the plan provisions on which the denial is based. If the denial is based on an internal rule, guideline, protocol, or other similar criteria, the rule, guideline, or protocol relied upon in making the decision must be either attached to the denial letter or made available to the claimant free of charge upon request.
- Provide a description of any additional information needed and why, if applicable.
- Explain the plan's appeals procedures and time limits for filing an appeal.
- Inform you of your right to sue after you've exhausted the appeals process.

Claims usually are denied for the following reasons:

- The Social Security Administration determination indicated that the claimant is not disabled and can work at his/her regular occupation;
- The participant has been granted an award from Social Security, no-fault or other automobile insurance coverage, or another group long-term disability plan that is greater than the Benefits Fund's benefit of $350 per month;
- The claim is for a work-related disability or illness; or
- Additional information has been requested and not received within 45 days.

When a claim is denied, you have up to 180 days to appeal the adverse benefit determination. Following denial of a claim:

- The claimant will have access, upon request, to all relevant information, including the claimant's entire claim file, materials identifying any medical or vocational expert whose advice was used in making the benefit determination, and any other documents that reflect the plan's general policy regarding the claim.
- The plan cannot impose fees or costs as a condition to filing or appealing a claim.
- Arbitration is permitted, but only with full disclosure regarding the process, arbitrator,

relationships, right to representation, and only if the claimant agrees after completing internal appeal.

- Review must be de novo (new). The decision-maker on an appealed claim must be different from (and not subordinate to) the person deciding the initial claim. The claimant also must have the opportunity to submit new evidence.
- The plan must consult with appropriate health care professionals in deciding appealed claims involving medical judgment.
- The plan may not require more than two levels of review of denied claims (if there's more than one level, both levels must be completed within the time frame applicable to one level).
- The plan must have procedures and safeguards for ensuring and verifying consistent decision-making.
- If the plan fails to make timely decisions or otherwise fails to comply with the regulation, claimants may go to court to enforce their rights.

To appeal a denied long-term disability claim, file an appeal with the Benefits Department manager, who will review the documentation and make a decision within 45 days (one 45-day extension is allowed for special circumstances). If the denial is upheld, the Fund office will send you a letter of denial and an explanation.

If you wish to pursue the denial further, you must appeal to the Fund's chief executive officer.

To appeal a denied long-term disability claim, file an appeal with the Benefits Department manager, who will review the documentation and make a decision within 45 days.

Chapter 14: Life Insurance Benefits

You can name anyone you wish as your beneficiary, and may change this designation at any time by submitting a notarized letter to the Benefits Fund.

The Benefits Fund contracts with The Hartford Life Insurance Company to provide life insurance coverage for you. For questions or service regarding your life insurance benefit, contact the Benefits Fund at (877) RN BENEFITS [762-3633].

You have a life insurance benefit as described in this section.

Your life insurance benefit will be paid to your beneficiary or beneficiaries in the event of your death while insured.

The life insurance benefit provided to each participant is a minimum of $20,000 and a maximum of $50,000. It is computed by taking 150% of your current annual base compensation, to the maximum amount allowed.

If the amount calculated results in an uneven number, the benefit amount will be raised to the next higher $1,000 level. For example, a calculation amounting to $41,400 would be increased to $42,000.

The benefit amount is reduced by 35% when the participant reaches age 65 and by 50% at age 70. If your benefit amount is reduced, you can convert the amount of the reduction to a personal life insurance policy in an equal amount. You may choose to precede the conversion policy with a one-year term insurance policy. The amount of your benefit will be reduced by any amount of personal life insurance in force as a result of this conversion policy.

You may name anyone you wish as your beneficiary. If you name more than one beneficiary and do not specify otherwise, the benefit amount will be divided equally among the named beneficiaries. If your beneficiary is not living when your life insurance becomes payable, or no beneficiary is named, payment will be made in accordance with the terms of the policy.

You name a beneficiary for this benefit when you become enrolled in the Fund. You may change this designation at any time by submitting a notarized letter to the Fund. The Fund can only release or accept beneficiary information by notarized correspondence.

If you become totally disabled

If you become totally disabled before your 60th birthday, your life insurance coverage will be continued during your disability, up to your normal retirement date, at no cost. Coverage will continue as long as you submit annual proof of disability to The Hartford. The initial proof must be filed between the ninth and twelfth months after the date you stopped working due to disability. Subsequent proofs of total disability must be furnished as required by The Hartford.

If your coverage ends

If your Benefits Fund coverage ends, you have the option of converting your life insurance coverage through The Hartford to an individual policy without having to submit evidence of good health. To qualify, contact the Fund, which will send appropriate forms for you to complete and submit directly to The Hartford within the later of:

- 31 days of the termination of your coverage, or
- 15 days from the date the "Notice of Conversion Privilege" is given to you. If you convert your life insurance policy, you will be billed directly by The Hartford for the required premiums.

Living Benefits Option

A "Living Benefits Option" accelerated death benefit is available through your life insurance coverage. This option allows you to receive up to 80% of your life insurance benefit when you

are diagnosed with a terminal illness by a physician and have 12 months or less to live.

The minimum accelerated payment is $3,000. Funds are paid directly to you and have no policy restrictions on their use. The remaining benefits are payable to your beneficiary when you die.

Filing a claim

If you die, your beneficiary or appropriate representative must contact the Benefits Fund for the claim to be processed. Your beneficiary or appropriate representative must contact the Fund office within 90 days of the date of loss, unless it is not reasonably possible to do so. The Fund requires a notarized letter from the beneficiary or appropriate representative to begin processing a life insurance claim. Send the letter to the NYSNA Benefits Fund, PO Box 12430, Albany, NY 12212-2430.

The initial decision on a life insurance claim will be made within 45 days (two 30-day extensions are allowed under certain circumstances). If the plan requests additional information, it must notify your beneficiary or appropriate representative of the information required within 30 days. Your beneficiary or representative has 45 days in which to furnish the supplemental information.

Appealing a denied claim

If a claim for benefits is wholly or partially denied, notice of the decision shall be furnished to the participant. This written decision will:

- Give the specific reason or reasons for denial,
- Make specific reference to policy provisions on which the denial is based,
- Provide a description of any additional information necessary to prepare the claim and an explanation of why it is necessary, and
- Provide an explanation of the review procedure.

On any denied claim, a participant or his/her representative may appeal to The Hartford for a full and fair review. The claimant may:

- Request a review upon written application within 60 days of receipt of claim denial,
- Review pertinent documents, and
- Submit issues and comments in writing.

A decision will be made by The Hartford no more than 60 days after receipt of the request for review, except in special circumstances (such as the need to hold a hearing), but in no case more than 120 days after the request for review is received. The written decision will include specific reasons on which the decision is based.

The Living Benefits Option allows you to receive up to 80% of your life insurance benefit when you're diagnosed with a terminal illness by a physician and have 12 months or less to live. Funds are paid directly to you and have no policy restrictions on their use.

Chapter 15: Accidental Death and Dismemberment Benefits

The Benefits Fund has contracted with The Hartford Life Insurance Company to provide accidental death and dismemberment and loss of sight coverage for you. For questions or service regarding your AD&D benefit, contact the Benefits Fund at (877) RN BENEFITS [762-3633].

An AD&D benefit (up to the amount of your life insurance benefit) is payable to you or your life insurance beneficiary if you are accidentally injured or die as a result of an accident while insured, or if you suffer a loss within 90 days of the accident and such loss is a direct result of injuries received in the accident.

The amount payable is by specific loss for the loss of:

- Life – the full amount is paid to your beneficiary;
- One hand, one foot (by severance at or above the wrist or ankle, respectively) or the sight of one eye (the entire and irrecoverable loss of sight) – one-half is paid to you;
- More than one of the above resulting from one accident – the full amount is paid to you (not to exceed the full amount of the AD&D insurance benefit).

Claims must be submitted in writing within 90 days of the date of loss, unless it's not reasonably possible to do so.

Filing a claim

You or your beneficiary must contact the Fund office to obtain the appropriate forms. Claims must be submitted in writing within 90 days of the date of loss, unless it is not reasonably possible to do so. Send the completed forms to the NYSNA Benefits Fund, PO Box 12430, Albany, NY 12212-2430.

The initial decision on an accidental death and dismemberment benefits claim will be made within 45 days (two 30-day extensions are allowed under certain circumstances). If the plan requests additional information, it must notify you, your beneficiary, or appropriate representative of the information required within 30 days. You, your beneficiary, or representative has 45 days to furnish the information.

Appealing a denied claim

If a claim for benefits is wholly or partially denied, notice of the decision shall be furnished to the participant. This written decision will:

- Give the specific reason or reasons for denial,
- Make specific reference to policy provisions on which the denial is based,
- Provide a description of any additional information necessary to prepare the claim and an explanation of why it is necessary, and
- Provide an explanation of the review procedure.

On any denied claim, a participant or his/her representative may appeal to The Hartford for a full and fair review. The claimant may:

- Request a review upon written application within 60 days of receipt of claim denial,
- Review pertinent documents, and
- Submit issues and comments in writing.

A decision will be made by The Hartford no more than 60 days after receipt of the request for review, except in special circumstances (such as the need to hold a hearing), but in no case more than 120 days after the request for review is received. The written decision will include specific reasons for the decision.

Exclusions

No benefit will be paid for any loss resulting from:

- Sickness, disease, or any medical treatment for sickness or disease;
- Any infection, unless caused by an accidental cut or wound;
- War or any act of war;
- Any injury received while in any armed service of a country that is at war or engaged in armed conflict;
- Any intentionally self-inflicted injury, suicide, or suicide attempt, while sane or insane.

Chapter 16: Statement of ERISA Rights

As a participant in the NYSNA Benefits Fund, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all participants shall be entitled to:

- Receive information about your plan and benefits.
- Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and an updated Summary Plan Description. The administrator may make a reasonable charge for the copies.
- Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.
- Continue group health plan coverage for yourself, your spouse, or your dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents will have to pay for such coverage. Please refer to Chapter 8 of this book for the rules governing your COBRA continuation coverage rights.
- A reduction or elimination of exclusionary periods of coverage for pre-existing conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your new coverage.

Prudent actions by plan fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce your rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of the plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you

receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with your questions

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue NW, Washington, DC 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Name of the plan

The New York State Nurses Association Benefits Fund.

Plan identification number

The plan identification number assigned by the Internal Revenue Service is 23-7336001.

Policies and contracts

The Benefits Fund is only responsible for the payment of premiums and/or fees to Health Net, The Hartford Life Insurance Company, CVS Caremark, Davis Vision, and Aetna. Each carrier and its insurance products are subject to the laws of the state of New York. Benefits are subject to collection pursuant to the individual insurance policy or contract. At your request, the Benefits Fund will provide you with a copy of the policy or contract.

Plan year

The Plan and all of its fiscal records are kept on a calendar year basis ending on each December 31. The plan administrator and Trustees intend to continue the plan indefinitely, but reserve the right to end or amend it.

Classes included

Eligible participants covered under collective bargaining agreements between the New York State Nurses Association and participating employers (provided that contributions in the amount the Trustees have determined as necessary to fund the plan are required to be made to the Fund on behalf of all employees who are represented by NYSNA), former Benefits Fund participants who are covered under COBRA continuation coverage, and employees of the New York State Nurses Association Benefits Fund and employees of the New York State Nurses Association Pension Plan on whose behalf the Pension Plan is obligated to make contributions to the Fund on such terms as determined by the Trustees.

Legal action

No action at law or in equity may be brought to recover on any plan described herein prior to the expiration of 60 days after proof of loss has been filed in accordance with the requirements set forth, nor may any action be brought at all unless brought within three years from the expiration of the time within the proof of loss is required. Suits can be filed against plan fiduciaries as late as six years after the breach has been discovered under certain circumstances. For example, in cases of fraud and concealment, the limitation period runs for six years after the date of discovery of the breach or violation.

Legal action covering the plan can be served upon Michael E. Behan, CEBS, Chief Executive Officer, New York State Nurses Association Benefits Fund, PO Box 12430, Albany, NY 12212-2430; or Pine West Plaza, Bldg. 3, Washington Ave. Ext., Albany, NY 12205-5531. Legal process also may be served upon Plan counsel or any of the plan's Trustees, all of whom are listed in Chapters 2 and 3 of this book.