Summary Plan Description

New York State Nurses Association

Benefits Fund

Summary Plan Description

New York State Nurses Association

NYSNA Benefits Fund

(877) RN BENEFITS

rnbenefits.org

New York State Nurses Association Benefits Fund

Summary Plan Description

Effective January 1, 2014

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 January 1, 2014.

In this booklet, you will find summaries of the medical, 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 January 1, 2014, will appear as Summary Material Modifications printed in the bimonthly *For Your Benefit* newsletter or in separate publications.

Table of Contents

Chapter 1: Participating Employers

Facility	Plan	Eligibility date*
Albert Einstein College of Medicine of Yeshiva University	Benefit Coverage Plan A	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	Benefit Coverage Plan A	First day of the month following date of hire
Bronx-Lebanon Hospital Center	Benefit Coverage Plan A	First day of the month following date of hire
Bronx-Lebanon Special Care Center	Benefit Coverage Plan A	First day of the month following date of hire
The Brooklyn Hospital Center	Benefit Coverage Plan A	90 days after date of hire
Corizon/Correctional Medical Associates (formerly PHS)	Benefit Coverage Plan A	90 days after date of hire
County of Sullivan	Benefit Coverage Plan A	First day of the month following date of hire
County of Westchester	Benefit Coverage Plan A	First day of the month following date of hire
Flushing Hospital Medical Center	Benefit Coverage Plan A	90 days after date of hire
Gracie Square Hospital	Benefit Coverage Plan A	First of the month following 60 days after date of hire
Interfaith Medical Center	Benefit Coverage Plan A	First day of the month following date of hire
Kingsbrook Jewish Medical Center	Benefit Coverage Plan A	Full time: 60 days; part time: 90 days after date of hire
The Mount Sinai Hospital	Benefit Coverage Plan A	First day of the month following date of hire for medical and weekly disability; full benefit coverage 90 days after date of hire
Nephro Care, Inc.	Benefit Coverage Plan B	First day of the month following date of hire
New York Dialysis Management, Inc.	Benefit Coverage Plan B	First day of the month following date of hire
New York Dialysis Services	Benefit Coverage Plan B	First day of the month following date of hire
New York Dialysis Services, Inc./ ABC	Benefit Coverage Plan B	First day of the month following date of hire
New York Methodist Hospital	Benefit Coverage Plan A	90 days after date of hire
New York Presbyterian Hospital	Benefit Coverage Plan A	First day of the month following date of hire

*As determined by the collective bargaining agreement between NYSNA and the participating employer and modified, as necessary, to comply with the conditions for eligibility under the Affordable Care Act.

Facility	Plan	Eligibility date*
Opioid Treatment Center	Benefit Coverage Plan A	60 days after date of hire
Parker Jewish Institute for Health Care and Rehabilitation	Benefit Coverage Plan A	First day of the month following date of hire (employees are eligible if they work at least 975 hours per year)
Richmond University Medical Center	Benefit Coverage Plan A	90 days after date of hire
Southside Hospital	Benefit Coverage Plan A	60th day following date of hire
St. Cabrini Nursing Home	Benefit Coverage Plan A	First day of the month following date of hire
St. John's Riverside Hospital	Benefit Coverage Plan A	First day of the month following date of hire
St. Joseph Hospital	Benefit Coverage Plan A	30th day following date of hire
St. Luke's – Roosevelt Hospital Center	Benefit Coverage Plan A	First day of the month following date of hire
Staten Island University Hospital - North	Benefit Coverage Plan A	60th day following date of hire
Syosset Hospital	Benefit Coverage Plan A	90 days after date of hire
Terence Cardinal Cooke Health Care Center	Benefit Coverage Plan B	First day of the month following date of hire
Union Community Health Center, Inc.	Benefit Coverage Plan A	90 days after date of hire
US Family Health Center at Mitchell Field/Ft. Wadsworth	Benefit Coverage Plan A	90 days after date of hire
Vassar Brothers Hospital	Benefit Coverage Plan A	First day of the month following date of hire
Visiting Nurse Association Health Care Services, Inc.	Benefit Coverage Plan A	First day of the month following date of hire
Wyckoff Heights Medical Center	Benefit Coverage Plan A	First day of the month following date of hire

*As determined by the collective bargaining agreement between NYSNA and the participating employer and modified, as necessary, to comply with the conditions for eligibility under the Affordable Care Act.

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," and is effective as of January 1, 2014. It is your responsibility to read this book carefully so you can understand, use, and comply with all provisions in this SPD.

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 UnitedHealthcare/Oxford),
- Vision (administered through Davis Vision),
- Dental (administered through Aetna),
- Prescription and maintenance drug (administered through OptumRx, Inc.),
- 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 by the Benefits Fund through a self-funded program).

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.

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 may be required, in accordance with their collective bargaining agreement, to contribute toward their Benefits Fund coverage through payroll deduction. Part-time participants who are required to contribute toward their Benefits Fund coverage also do so through payroll deduction.

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.

Chapter 1 of this SPD includes a list of participating employers as of December 2013. In addition, an up-to-date list of the employers and employee organizations (and their addresses) 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
Ronald F. Lamy, CPA
New York State Nurses Association Benefits Fund
PO Box 12430
Albany, NY 12212-2430
(877) RN BENEFITS [762-3633] or (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, Inc.
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
277 Park Ave., 16th Floor
New York, NY 10172
(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 coverage.

OptumRx, Inc.
2300 Main St.
Irvine, CA 92614
(949) 442-8081

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

UnitedHealthcare/Oxford
One Penn Plaza, 8th Floor
New York, NY 10121
(212) 216-6400

The Fund provides medical coverage to participants under a self-funded plan with UnitedHealthcare/Oxford.

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.

Your rights

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your choices

You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

Our uses and disclosures

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues

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

- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say "no" if it would affect your care.

You can ask us not to use or share certain health information for treatment, payment, or our operations.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on Page 13.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling (877) 696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/**.
- We will not retaliate against you for filing a complaint.

Your choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

You have rights regarding the health information the Fund maintains.

Our uses and disclosures

We typically use or share your health information in the following ways.

Help manage the health care treatment you receive

We can use your health information and share it with professionals who are treating you.

Run our organization

- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage.

For example: We use health information about you to develop better services for you.

Pay for your health services

We can use and disclose your health information as we pay for your health services.

Administer your plan

We may use or disclose your health information for the administration of the Fund as necessary to provide coverage and service to all participants.

For example: We may use your health information for general administrative activities such as customer service and the resolution of internal grievances.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many

conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

We are required by law to maintain the privacy and security of your protected health information.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information go to: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Changes to the terms of this notice

We can change the terms of this notice, and the changes will apply to all information

we have about you. The new notice will be available upon request, on our Web site, and we will mail a copy to you.

Other instructions for notice

- This notice was effective September 23, 2013.
- The Benefits Fund has designated Linda M. Whelton, Benefits Department Manager, as its contact person for all issues regarding participant privacy and you privacy rights. You may contact Ms. Whelton by letter at PO Box 12430, Albany, NY 12212-2430, or by toll-free phone 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

Association Trustees

John Barrett
Director of Finance
New York State Nurses Association
Latham, NY

Michelle H. Green
Asst. Director for Special Projects
New York State Nurses Association
New York, NY

Patricia Leo Holloman, RN
The Mount Sinai Hospital
New York, NY

Nancy Kaleda
Deputy Director
New York State Nurses Association
New York, NY

Betty Ann Lynch, RN
St. Luke's-Roosevelt Hospital
New York, NY

Ari Moma, RN
Interfaith Medical Center
Brooklyn, NY

Allyson Selby, RN
New York Methodist Hospital
Brooklyn, NY

Employer Trustees

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

Jeffrey Cohen
Vice President, Labor Relations
The Mount Sinai Hospital
New York, NY

Rebecca Gordon
Vice President, Labor/Employee Relations
North Shore – LIJ Health System
Lake Success, NY

Howard Green
Howard Green Consulting
Mt. Kisco, NY

Bruce McIver
President
League of Voluntary Hospitals and Homes of NY
New York, NY

Ronald Phillips
Senior Vice President and Chief Human Resources Officer
New York Presbyterian Hospital
New York, NY

Carmen Suardy
Vice President, Labor/Employee Relations
St. Luke's-Roosevelt Hospital
New York, NY

Christopher Berner
(*Alternate Trustee*)
Asst. Vice President Human Resources
Montefiore Medical Center
Bronx, NY

Chapter 4: Summary of Benefits

	Benefit	Benefit Coverage Plan A		Benefit Coverage Plan B		Benefit Coverage Plan C	
		In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Financial	Deductible	None	$250 Single; $500 Family	None	$300 Single; $600 Family	None	$400 Single; $800 Family
	Maximum out-of-pocket cost (does not include charges in excess of allowed amount, non-covered benefits, or pharmacy benefits)	$1,000 Single; $2,000 Family copayment maximum	None	$1,000 Single; $2,000 Family copayment maximum	None	$1,000 Single; $2,000 Family copayment maximum	None
	Coinsurance	None	70%/30%	None	70%/30%	None	70%/30%
Preventive Care	Routine physical exams for children through age 18 (includes hearing exam)	No cost	Paid at 70% of UCR	No cost	Paid at 70% of UCR	No cost	Paid at 70% of UCR
	Routine gynecological care for children through age 18	No cost	Paid at 70% of UCR	No cost	Paid at 70% of UCR	No cost	Paid at 70% of UCR
	Routine physical exams for adults age 19 and older	No cost	Paid at 70% of UCR	No cost	Paid at 70% of UCR	No cost	Paid at 70% of UCR
	Routine gynecological care for adults age 19 and older	No cost	Paid at 70% of UCR	No cost	Paid at 70% of UCR	No cost	Paid at 70% of UCR
	Immunizations	No cost	Paid at 70% of UCR	No cost	Paid at 70% of UCR	No cost	Paid at 70% of UCR

	Benefit	Benefit Coverage Plan A		Benefit Coverage Plan B		Benefit Coverage Plan C	
		In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Maternity Care	Routine obstectrical, prenatal care, delivery, and postnatal care for mother*	$10 copayment for initial visit only	Paid at 100% of UCR	$10 copayment for initial visit only	Paid at 100% of UCR	$15 copayment for initial visit only	Paid at 100% of UCR
Inpatient Care	Room and board*	No cost	$500 copay/ admission up to a copay max of $1,000 per individual or $2,000 per family (no deductible) Paid at 70%	No cost	$500 copay/ admission up to a copay max of $1,500 per individual (no deductible) Paid at 70%	$300 copay/ admission up to a maximum of $750 per individual	$500 copay/ admission up to a copay max of $2,000 per individual (no deductible) Paid at 70%
	Private Room	No cost	Paid at 100% of UCR	No cost	Paid at 50% of UCR up to a maximum of $75/day	No cost	Paid at 50% of UCR up to a maximum of $75/day
	Physician's services*	No cost	Paid at 70% of UCR	No cost	Paid at 70% of UCR	No cost	Paid at 70% of UCR
	Physician surgical services and anesthesia*	No cost	Paid at 100% of UCR	No cost	Paid at 100% of UCR	No cost	Paid at 100% of UCR
	Restorative physical and occupational therapy*	No cost	$500 copay/ admission up to $1,000 max per individual or up to $2,000 max per family (no deductible) Paid at 70%	No cost	$500 copay/ admission up to $1,500 max per individual (no deductible) Paid at 70%	$300 copay/ admission up to a maximum of $750 per individual	$500 copay/ admission up to $2,000 max per individual (no deductible) Paid at 70%
	Skilled Nursing Facility (up to 60 consecutive days per condition per calendar year)*	No cost	$500 per continuos confinement to a maximum of $1,000 per individual /$2,000 per family, then 30% coinsurance (no deductible)	No cost	$500 per continuos confinement to a maximum of $1,500 per individual /$2,000 per family, then 30% coinsurance (no deductible)	No cost	$500 per continuos confinement to a maximum of $2,000 per individual /$2,000 per family, then 30% coinsurance (no deductible)

*May require precertification

	Benefit	Benefit Coverage Plan A		Benefit Coverage Plan B		Benefit Coverage Plan C	
		In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Outpatient Care	Office visits	$10 copay/visit PCP; $25 copay/visit specialist	Paid at 70% of UCR	$10 copay/visit PCP; $30 copay/visit specialist	Paid at 70% of UCR	$15 copay/visit PCP; $30 copay/visit specialist	Paid at 70% of UCR
	Chiropractic care*	$25 copayment per visit	Paid at 70% of UCR	$30 copayment per visit	Paid at 70% of UCR	$30 copayment per visit	Paid at 70% of UCR
	Acupuncture	$25 copayment per visit	Paid at 70% of UCR	$30 copayment per visit	Paid at 70% of UCR	$30 copayment per visit	Paid at 70% of UCR
	Allergy treatment	$25 copayment per visit	Paid at 70% of UCR	$30 copayment per visit	Paid at 70% of UCR	$30 copayment per visit	Paid at 70% of UCR
	Restorative physical, occupational, and cognitive therapy*	$25 copayment per visit	Paid at 70% of UCR	$30 copayment per visit	Paid at 70% of UCR	$30 copayment per visit	Paid at 70% of UCR
	Cardiac rehabilitation*	$25 copayment per visit	Paid at 70% of UCR	$30 copayment per visit	Paid at 70% of UCR	$30 copayment per visit	Paid at 70% of UCR
	Radiology*	No cost	Paid at 70% of UCR	$25 copayment	Paid at 70% of UCR	$25 copayment	Paid at 70% of UCR
	Laboratory tests	No cost	Paid at 70% of UCR	No cost	Paid at 70% of UCR	$10 copayment	Paid at 70% of UCR
	Restorative speech therapy for up to 60 consecutive days	$25 copayment per visit	Paid at 70% of UCR	$30 copayment per visit	Paid at 70% of UCR	$30 copayment per visit	Paid at 70% of UCR
	Surgery (physician's services)*	No cost	Paid at 100% of UCR	No cost	Paid at 100% of UCR	No cost	Paid at 100% of UCR
	Surgery (facility charges)	No cost	Paid at 70% of UCR	No cost	Paid at 70% of UCR	20% coinsurance up to a maximum of $200	Paid at 70% of UCR
	Physician surgical services and anesthesia*	No cost	Paid at 100% of UCR	No cost	Paid at 100% of UCR	No cost	Paid at 100% of UCR
	Second surgical opinion	No cost	Paid at 100% of UCR	No cost	Paid at 100% of UCR	No cost	Paid at 100% of UCR
	Radiation, chemotherapy, and dialysis*	No cost	Paid at 70% of UCR	No cost	Paid at 70% of UCR	No cost	Paid at 70% of UCR
	Oxygen	Paid at 80%	Paid at 70% of billed charges (no deductible)	Paid at 80%	Paid at 70% of billed charges (no deductible)	Paid at 80%	Paid at 70% of billed charges (no deductible)

*May require precertification

	Benefit	Benefit Coverage Plan A		Benefit Coverage Plan B		Benefit Coverage Plan C	
		In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Other Services	Skilled home health care*	No cost	Paid at 75%	No cost	Paid at 75%	No cost	Paid at 75% of UCR
	Home hospice care (up to 210 days)*	No cost	Paid at 75%	No cost	Paid at 75%	No cost	Paid at 75% of UCR
	Inpatient hospice care (up to 210 days)*	No cost	$500 copay/ admission up to $1,000 max per individual (no deductible). Paid at 70%	No cost	$500 copay/ admission up to $1,500 max per individual (no deductible). Paid at 70%	No cost	$500 copay/ admission up to $2,000 max per individual (no deductible). Paid at 70%
	Durable medical equipment*	Paid at 80% of contracted amount	Paid at 70% of cost of covered items	Paid at 80% of contracted amount	Paid at 70% of cost of covered items	Paid at 80% of contracted amount	Paid at 70% of cost of covered items
	Prosthetic devices, external*	Paid at 80%;	30% coinsurance on billed charges (no deductible)	Paid at 80%	30% coinsurance on billed charges (no deductible)	Paid at 80%;	30% coinsurance on billed charges (no deductible)
	Orthotics*	Paid at 80% per item	Paid at 70% of billed charges (no deductible)	Paid at 80% per item	Paid at 70% of billed charges (no deductible)	Paid at 80% per item	Paid at 70% of billed charges (no deductible)
	Diabetic equipment	$10 copay	Paid at 70% of cost of covered items after deductible	$10 copay	Paid at 70% of cost of covered items after deductible	$15 copay	Paid at 70% of cost of covered items after deductible
	Diabetes education and nutritional counseling	$25 copayment	Paid at 70% of UCR	$30 copayment	Paid at 70% of UCR	30% copayment	Paid at 70% of UCR
	In vitro fertilization services or covered fertility drugs+ (up to a $5,000 lifetime max benefit*+	No cost for IVF services; prescription copays may apply	Paid at 70% of UCR	No cost for IVF services; prescription copays may apply	Paid at 70% of UCR	No cost for IVF services; prescription copays may apply	Paid at 70% of UCR
	Ambulance transport (non-emergent)	Covered in full (if authorized)					

*May require precertification

+ Participants covered under facilities adhering to principles of the Ethical and Religious Directives for Catholic Health Services as approved by the United States Conference of Catholic Bishops do not have coverage for Advanced Infertility Services, including in vitro fertilization services and infertility drugs.

	Benefit	Benefit Coverage Plan A		Benefit Coverage Plan B		Benefit Coverage Plan C	
		In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Other Services	Medically necessary dental care or treatment only in the case of accidental injury to sound natural teeth or when due to congenital disease or anomaly*	$25 copayment per office visit	Surgical charges are covered at 100% of UCR. Other services are covered at 70% of UCR.	$30 copayment per office visit	Surgical charges are covered at 100% of UCR. Other services are covered at 70% of UCR.	$30 copayment per office visit	Surgical charges are covered at 100% of UCR. Other services are covered at 70% of UCR.
	Gym reimbursement	Partial reimbursement for participant and spouse only for completing 50 visits every six-month period to an approved exercise facility.					
Mental Health	Outpatient mental health*	$25 copayment/ visit	Paid at 70% of UCR	$30 copayment/ visit	Paid at 70% of UCR	$30 copayment/ visit	Paid at 70% of UCR
	Inpatient mental health care*	No cost	$500 copay/ admission up to $1,000 max/individual /$2,000 max /family (no deductible) Paid at 70%	No cost	$500 copay/ admission up to $1,500 max/ individual (no deductible) Paid at 70%	$300 copay/ admission up to a maximum of $750 per individual	$500 copay/ admission up to $2,000 max per individual (no deductible) Paid at 70%
Substance Abuse	Outpatient medical rehabilitative care for substance abuse/ alcohol addiction	$25 copayment per visit	Paid at 70% of UCR	$30 copayment/ visit	Paid at 70% of UCR	$30 copayment/ visit	Paid at 70% of UCR
	Inpatient medical rehabilitative care for substance abuse/ alcohol addiction*	No cost	$500 copay/ admission up to $1,000 max per individual /$2,000 max per family (no deductible) Paid at 70%	No cost	$500 copay/ admission up to $1,500 max per individual (no deductible) Paid at 70%	$300 copay/ admission up to a maximum of $750 per individual	$500 copay/ admission up to $2,000 max per individual (no deductible) Paid at 70%
Emergency Care	At hospital emergency room (waived if admitted)	$75 copayment per visit		$100 copayment per visit		$100 copayment per visit	
	Urgent care center	$25 copayment/visit		$30 copayment/visit		$30 copayment/visit	
	Ambulance service	Covered in full					

*May require precertification

	Benefit	Benefit Coverage Plan A		Benefit Coverage Plan B		Benefit Coverage Plan C	
		In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Dental Care	Yearly deductible	None	$50/person; $150/family	None	$50/person; $150/family	None	$50/person; $150/family
	Maximum yearly benefit	$1,200	$1,200	$1,200	$1,200	$1,200	$1,200
	Orthodontia maximum	$1,000 per course of treatment separated by two years	$1,000 per course of treatment separated by two years	$1,000 per course of treatment separated by two years	$1,000 per course of treatment separated by two years	$1,000 per course of treatment separated by two years	$1,000 per course of treatment separated by two years
	Diagnostic and preventive services	No cost	Paid at 80% of the recognized charge	No cost	Paid at 80% of the recognized charge	No cost	Paid at 80% of the recognized charge
	Basic restorative services, endodontics, periodontics, maintenance of prosthodontics, and oral surgery	Paid at 80% of the negotiated fee schedule	Paid at 80% of the recognized charge	Paid at 80% of the negotiated fee schedule	Paid at 80% of the recognized charge	Paid at 80% of the negotiated fee schedule	Paid at 80% of the recognized charge
	Major restorative services, installation of prosthodontics, and orthodontics	Paid at 50% of the negotiated fee schedule	Paid at 50% of the recognized charge	Paid at 50% of the negotiated fee schedule	Paid at 50% of the recognized charge	Paid at 50% of the negotiated fee schedule	Paid at 50% of the recognized charge
Prescription Drugs	Yearly deductible	None	None	None	None	$100/person $250/family	$100/person $250/family
	Prescription drugs at retail pharmacy (up to a 34-day supply)	Tier 1: $0 Generic Tier 2: $10 Preferred Tier 3: $20 Non-preferred	Reimbursed at contracted amount minus applicable in-network copayment	Tier 1: $7 Generic Tier 2: $20 Preferred Tier 3: $35 Non-preferred	Reimbursed at contracted amount minus applicable in-network copayment	Tier 1: $12 Generic Tier 2: $25 Preferred Tier 3: $40 Non-preferred	Reimbursed at contracted amount minus applicable in-network copayment
	Mail-order prescription drug program (mandatory for all maintenance prescription medications for up to a 90-day supply)	Tier 1: $0 Generic Tier 2: $20 Preferred Tier 3: $40 Non-preferred	Not applicable	Tier 1: $15 Generic Tier 2: $40 Preferred Tier 3: $70 Non-preferred	Not applicable	Tier 1: $25 Generic Tier 2: $50 Preferred Tier 3: $80 Non-preferred	Not applicable

	Benefit	Benefit Coverage Plan A	Benefit Coverage Plan B	Benefit Coverage Plan C
Prescription Drug Programs	Mandatory generics	Applies to all drugs filled at a retail pharmacy or by mail-order. If brand-name is selected instead of generic, participant pays applicable copay and cost difference between generic and brand-name. This applies even if the physician writes "DAW."	Applies to all drugs filled at a retail pharmacy or by mail-order. If brand-name is selected instead of generic, participant pays applicable copay and cost difference between generic and brand-name. This applies even if the physician writes "DAW."	Applies to all drugs filled at a retail pharmacy or by mail-order. If brand-name is selected instead of generic, participant pays applicable copay and cost difference between generic and brand-name. This applies even if the physician writes "DAW."
	Preferred specialty drugs	Same copays as non-specialty drugs (retail and mail-order)	Same copays as non-specialty drugs (retail and mail-order)	10% coinsurance up to $75 maximum
	High performance step therapy (The practice of beginning drug therapy for a medical condition with the most cost-effective and safest drug therapy and progressing to other more costly therapy, only if necesaary.)	Four therapeutic classes of drugs applies. Copay applies if step therapy guidelines are not followed: Retail copay - 25% or $50 max; Mail-order copay - 50% or $100 max (Automatic override will be applied for first or subsequent steps if the physician determines medical necessity; participant will pay only the copay associated with the prescribed drug, not the amount cited above for failing to follow step therapy guidelines.)	Full list of therapeutic classes applies. Copay applies if step therapy guidelines are not followed: Retail copay - 25% or $50 max; Mail-order copay - 50% or $100 max (Automatic override of first or subsequent steps will be applied for five therapeutic classes if the physician determines medical necessity. For all other drugs, waiver of first step is possible only if OptumRx determines an exception.)	Full list of therapeutic classes applies. Copay applies if step therapy guidelines are not followed: Retail copay - 25% or $50 max; Mail-order copay - 50% or $100 max (Automatic override of first or subsequent steps will be applied for five therapeutic classes if the physician determines medical necessity. For all other drugs, waiver of first step is possible only if OptumRx determines an exception.)
	Preferred specialty pharmacy program	For growth hormone deficiency and reumatoid arthritis class. Preferred specialty copay is standard specialty copay; non-preferred specialty copay is 10% of drug cost ($200 max)	For growth hormone deficiency and reumatoid arthritis class. Preferred specialty copay is standard specialty copay; non-preferred specialty copay is 10% of drug cost ($200 max)	For growth hormone deficiency and reumatoid arthritis class. Preferred specialty copay is standard specialty copay; non-preferred specialty copay is 10% of drug cost ($200 max)

	Benefit	Benefit Coverage Plans A, B, and C In-network Plan	Benefit Coverage Plans A, B, and C Out-of-network Plan
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)
	Eyeglasses or contact lenses every 2 years (through Davis Vision)	$30 copay for lenses and/or Designer selection frames within the Davis Collection, or $150 credit toward non-plan frames, or $45 copay for disposable/planned replacement lenses	
	Benefit	**Benefit Coverage Plans A, B, and C**	
Disability	Short-term, nonoccupational disability	Paid at two-thirds of regular, weekly compensation, up to $215 per week for a maximum period of 26 weeks	
	Long-term disability that extends beyond the qualifying period of six consecutive months	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.	
	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 and do not opt out of coverage (see Chapter 6 for information on opting in and out of coverage), you will be given a Benefits Fund enrollment form. This form must be completed and returned to the Benefits Fund so you can participate in the Fund and become eligible for benefits coverage.

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

- Establishes your personal data record,
- Identifies your covered dependents,
- Records your proper beneficiary.

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 UnitedHealthcare/Oxford and is for your medical coverage, while the other card will come from OptumRx 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

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, provided you authorize payroll deductions by your employer, if applicable. 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.

Cost sharing

You may be responsible for sharing the cost of your Benefits Fund coverage with your employer by making payroll deduction contributions as outlined in the first collective bargaining agreement containing an Employee Premium Option ratified after September 1, 2011.

Upon enrollment in the Benefits Fund, you may be required to sign a payroll deduction form (available at your place of employment) authorizing your employer to make payroll deductions as stipulated in the collective bargaining agreement. Should you fail to sign a payroll deduction form, you will not be eligible to participate in the Benefits Fund at this time and must wait until the annual open enrollment period between November 1 and December 31 to enroll.

Opting out of coverage

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. Full-time employees opting out of coverage have the right to opt out of health benefit coverage for:

- yourself and all of your dependents and spouse, or
- only your dependents and spouse

as long as you and your dependents and spouse are covered under another group health plan. You will be required to provide proof of other coverage and complete an opt-out application available at your place of employment within 60 days of your date of hire. If you opt out, 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 the Fund's annual open enrollment period to re-enroll, unless you involuntarily lose coverage due to a qualifying event.

If you choose to opt out of health coverage at the time of eligibility, you and your dependents (including your spouse) must wait until the annual November 1 through December 31 open enrollment period to re-enroll in the Benefits Fund and have coverage reinstated effective January 1 of the following 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 (including your spouse) in this plan, provided you request enrollment within 60 days after your other coverage

ends due to the following:

- Death of the covered individual (death certificate and COBRA notification or letter from the covered individual's employer must be provided within 60 days of the event).
- 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 with 60 days of the event).
- 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 60 days of the event).
- Covered individual's employer discontinues group health insurance coverage (a letter or notification from the covered individual's employer must be provided within 60 days of the event).

For purposes of this explanation, the "covered individual" is the person who currently provides the coverage.

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

Eligibility

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.

Cost sharing

You will be required to make payroll deduction contributions toward the cost of your coverage as defined in the current collective bargaining agreement.

Opting out of coverage

You have the right to discontinue coverage at any time. If you choose not to enroll at the time of eligibility or to discontinue coverage, you must wait until the annual open enrollment period between November 1 and December 31 of any plan year to re-enroll in the Benefits Fund and have coverage reinstated January 1 of the following year.

If you decline coverage 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 the plan, provided you request enrollment within 60 days after your other coverage ends for any of the reasons previously stated in the "Full-time employees" section.

The Benefits Fund's annual open enrollment period extends from November 1 to December 31 with an effective coverage date of January 1 of the following year.

Open enrollment

The Benefits Fund's annual open enrollment period extends from November 1 to December 31 with an effective coverage date of January 1 of the following year.

Individuals who are eligible to enroll during the annual open enrollment period include:

- Full- or part-time employees who previously opted out of Benefits Fund coverage,
- Dependents who were not added when they first became eligible.

If you choose not to enroll in the Benefits Fund during the open enrollment period between November 1 and December 31 of any year, you will not be able to opt in to the Fund again until the next open enrollment period unless you lose other coverage due to one of the qualifying events listed in the "Full-time employees" section above and request enrollment within 60 days after that event.

Eligible dependents

Eligibility for dependents varies, according to their age and relationship to you:

- Your spouse is eligible for medical, dental, vision, and prescription drug benefits through the Benefits Fund.
- Your children, stepchildren, foster children, and legal wards also are eligible for medical, dental, vision, and prescription drug benefits from birth until their 26th birthday.
- Dependent children living with you while awaiting your legal adoption are eligible for these benefits until their 26th birthday.

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 60 days of the marriage, birth, adoption, or placement for adoption. If notification of a new dependent is not received within 60 days of the marriage, birth, adoption, or placement for adoption, the dependent will need to wait until the next open enrollment period between November 1 and December 31 to be eligible for the Benefits Fund with an effective date of January 1 of the following year.

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.

Eligible dependents include your spouse and children. You'll be eligible for dependent coverage on the day you acquire a new dependent, provided you request enrollment within 60 days. Otherwise your dependent will need to wait until the next open enrollment period to enroll in the Fund.

Stepchildren

Stepchildren are eligible for medical, dental, vision, and prescription drug coverage until they reach their 26th birthday. Birth and marriage certificates are required by the Fund office for documentation.

Foster children and legal wards

Foster children and legal wards under your custody or guardianship are covered until they reach age 26. To effect coverage for legal wards, the participant must submit a copy of the ward's birth certificate and a certified copy of the guardianship or custody appointment.

Disabled dependents

Coverage for any of your unmarried children who are disabled and incapable of earning their own living will be extended beyond the 26-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 fails 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 of this SPD 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 12 of this SPD for detailed information on medical necessity and prior authorization requirements for medical, vision, dental, and prescription drug care);
- The plan's claims reimbursement procedures weren't followed (please see Chapters 9 through 16 of this Summary Plan Description for information on claims reimbursement procedures for medical, 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 16 for detailed information);
- You exceed the $1,200 maximum amount payable per individual per calendar year for covered dental expenses (please see Chapter 11 for details);
- You exceed the $1,000 maximum amount payable per individual per course of ortho-

dontic treatment separated by two years (please see Chapter 11 for details);

- You exceed the $5,000 lifetime maximum combined benefit for in vitro fertilization and/or covered fertility drugs (please see Chapters 9 and 10 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 10 for details);
- The service is excluded from Benefits Fund coverage (please see Chapters 9 through 16 for a list of exclusions for medical, vision, dental, prescription drug, short- and long-term disability, life insurance, and accidental death and dismemberment benefits);
- 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.

COB and Medicare

Generally, the Benefits Fund will be the primary plan and Medicare the secondary plan for Medicare-eligible individuals in the following situations:

- Participants with active current employment status who are age 65 or older and their spouses age 65 or older;
- Spouses under age 65 who are disabled; or
- Individuals with end-stage renal disease, for up to 30 months.

Furthermore, if a Medicare-eligible participant loses Fund coverage due to a COBRA-qualifying event and subsequently elects COBRA continuation coverage, Medicare will be the primary plan and the Benefits Fund the secondary plan. (However, participants receiving benefits through COBRA continuation coverage prior to becoming Medicare-eligible will be terminated from Fund coverage upon enrollment in Medicare.)

Chapter 8: Benefits Following Termination

Your Benefits Fund coverage terminates when you voluntarily or involuntarily terminate employment, transfer out of the bargaining unit, take an uncovered leave of absence, opt out of coverage, or become a part-time, noncontributing employee. You and your eligible dependents may qualify for COBRA continuation of benefits.

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 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 percent of the total cost of the coverage in certain instances where coverage under the plan would otherwise end.

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.

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 or her 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. 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, federal law requires that qualified beneficiaries be afforded the opportunity to maintain continuation coverage for all Fund coverages except life insurance, short-term disability, long-term disability, and accidental death and dismemberment insurance 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 dependent beneficiaries be given the opportunity to maintain continuation coverage for up to 36 months.

However, New York's 36-month state continuation benefit (mini COBRA) permits a person who is an employee or member of a group to continue group health insurance for up to an additional 18 months once the initial 18 months of federal COBRA is exhausted (for a maximum of 36 months), regardless of the reason that the person lost eligibility for coverage. For Fund coverage, this means **medical** coverage only.

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

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.

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. Under the New York mini-COBRA law, participants who are on disability and have 29 months of COBRA eligibility have an additional seven months of medical-only coverage.

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;
- 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;
- 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.

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

How much will COBRA coverage cost?

Under the law, you may be required to pay up to 102 percent 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 percent 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 with payments due on the 1st of every month.

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.

Conversion options

If you do not choose COBRA continuation coverage, your Benefits Fund group coverage will end. Benefits Fund participants may, however, convert your life insurance coverage to an individual policy.

Medical and prescription drug coverage through the Health Insurance Marketplace

You may choose to obtain medical and prescription drug coverage through the Health Insurance Marketplace established under the Affordable Care Act. The marketplace allows individuals to compare and evaluate health plan and prescription drug coverage options, including your eligibility for coverage and costs, and enroll in plans that cover essential benefits, pre-existing conditions, and more. Visit **Healthcare.gov** or **nystateofhealth.ny.gov** for more information and an online application.

Chapter 9: Medical Benefits

This chapter of your Summary Plan Description describes the medical benefits available to you and your covered family members under the Plan. It includes summaries of:

- services that are covered, called Covered Services;
- services that are not covered, called Exclusions;
- how Benefits are paid; and
- your rights and responsibilities under the Plan.

You should be familiar with all of the Plan's terms and conditions. They determine what coverage you have and what amounts the Plan will pay.

Oxford is a private health care claims administrator and helps the Benefits Fund to administer claims. Although Oxford will assist you in many ways, it does not guarantee any Benefits. The Benefits Fund, which is the Plan Administrator, is solely responsible for paying Benefits described in this chapter. If there is a conflict between the information contained in this chapter and any benefit summaries (other than Summaries of Material Modifications) provided to you, this document will prevail.

Please read this chapter thoroughly to learn about your medical Benefits. If you have questions, call the Benefits Fund at (877) RN BENEFITS [762-3633].

- Many sections in this chapter of the SPD are related to other sections. You may not have all the information you need by reading just one section.
- Capitalized words in this chapter of your SPD have special meanings and are defined by Sections or in the Glossary at the end of the chapter.
- If eligible for coverage, the words "you" and "your" refer to Covered Persons as defined in the Glossary.
- As an Oxford Participant, you have access to additional programs and resources to help you along your road to health, including:
  - A robust network of hospitals and providers from a local health plan with over 20 years of experience. Because your plan offers out-of-area coverage, you also have network national access outside of Oxford's tri-state service area through the UnitedHealthcare Choice Plus network.
  - Oxford's *Healthy Bonus*® program, which consists of special offers and discounts that help you stay healthy and manage special conditions. Participants can save on services such as weight loss programs, fitness equipment, and publications.
  - *Healthy Mind Healthy Body*® magazine, your source for health information on prevention, nutrition, and exercise, as well as important benefit and coverage information, available at **www.oxfordhealth.com**.

If you want to learn more about Oxford's programs and resources, logon to **www.oxfordhealth.com** or call the Benefits Fund at (877) RN BENEFITS [762-3633].

You can choose to receive covered services in "network" from Oxford's network providers or you can receive covered services "out-of-network" from non-network providers.

SECTION 1: HOW THE PLAN WORKS

Whenever you need Covered Services, the Plan gives you a choice. This Plan provides access to Covered Services from Providers within Oxford's Freedom Network, which is Oxford's largest network. Under the Plan, you can choose to receive Covered Services in "Network" from Oxford's Network Providers or you can receive Covered Services "Out-of-Network" from non-Network Providers.

Your out-of-pocket responsibility differs depending upon whether Covered Services are obtained through your Network or Out-of-Network Benefits. Generally, you will be

responsible for paying a higher portion of your medical expenses when you obtain Out-of-Network Benefits. Please refer to your Summary of Benefits for specific out-of-pocket expenses.

Your share of the costs will depend on the following:

1. Annual Deductible

The Annual Deductible is the amount of Eligible Expenses you must pay each Calendar Year for Out-of-Network Covered Services before you are eligible to begin receiving Benefits. The amounts you pay toward your Annual Out-of-Network Deductible accumulate over the course of the Calendar year.

2. Copayment

A Copayment (Copay) is the amount you pay each time you receive certain Network Covered Services. The Copay is a flat dollar amount and is paid at the time of service or when billed by the Provider. Copays count toward the Network Out-of-Pocket Maximum.

3. Coinsurance

Coinsurance is the percentage of Eligible Expenses that you are responsible for paying for Out-of-Network Covered Services. Coinsurance is a fixed percentage that applies to certain Covered Services after you meet the Annual Deductible.

Coinsurance – Example

Let's assume that you receive Plan Benefits for outpatient surgery from an Out-of-Network Provider. Since the Plan pays 70 percent after you meet the Annual Deductible, you are responsible for paying the other 30 percent. This 30 percent is your Coinsurance.

4. Network out-of-pocket maximum

The annual Network Out-of-Pocket Maximum is the most you pay each Calendar Year for Covered Services. If your eligible out-of-pocket expenses in a Calendar year exceed the annual maximum, the Plan pays 100 percent of Eligible Expenses for Covered Services through the end of the Calendar year.

As a Participant of the Plan, you may seek primary or specialty care from any Network Provider without a referral.

Eligible expenses

Eligible Expenses are charges for Covered Services that are provided while the Plan is in effect, determined according to the definition in the Glossary (please see the Section titled "Glossary" at the end of this chapter). The Benefits Fund has delegated to Oxford the discretion and authority to decide whether a treatment or supply is a Covered Service and how the Eligible Expenses will be determined and otherwise covered under the Plan.

Your ID card

Remember to show your Oxford identification card every time you receive health care services from a Provider. If you do not show your ID card, a Provider has no way of knowing that you are enrolled under the Plan.

Network services

As a Participant of the Plan, you may seek primary or specialty care from any Network Provider without a referral. You and your eligible Dependents are required to select a Primary Care Physician. The Benefits Fund encourages you to use your PCP when you need primary or preventive care and allow your PCP to coordinate your specialty care needs. In this manner, continuity of care can be maintained.

While referrals are not required, any requirements pertaining to Precertification, as described

in this SPD, must be followed.

To receive the highest level of benefits, contact a Network Physician when you need medical assistance. In most instances, he or she will be able to provide the care you need. If you require services from another Provider, be sure that he or she is also a Network Provider by checking the roster of Network Providers or by calling the Benefits Fund at (877) RN BENEFITS [762-3633].

Except for Emergencies and Precertified visits to Out-of-Network Providers, only services provided by a Network Provider are Covered on a Network basis.

If a Network Provider recommends Hospital or surgical services, the Hospital or Services Provider will need an approval from Oxford before you obtain those services. This process is referred to as Precertification. Before entering the Hospital, you may want to check with the Benefits Fund to verify that the Hospital is a Network Provider and that the services have been Precertified.

Looking for a Network Provider?

In addition to other helpful information, **www.oxfordhealth.com**, Oxford's consumer Web site, contains a directory of health care professionals and facilities in Oxford's Network. While Network status may change from time to time, **www.oxfordhealth.com** has the most current source of Network information. Use **www.oxfordhealth.com** to search for Oxford Freedom Network Providers.

You are responsible for obtaining any required surgical procedure or hospitalization precertifications out-of-network.

Out-of-network services

If you decide you do not want to use a Network Provider, the Plan still provides coverage for a broad range of medical services. However, Covered Services not obtained from Network Providers will be subject to Deductible, Coinsurance, and an Out-of-Network Reimbursement Amount. Further, Out-of-Network Providers may not be familiar with Oxford's Plan. Therefore, you should review the "Covered Services" and "Limitations and Exclusions" sections of this SPD. You may also contact the Benefits Fund if you have any questions concerning Covered Services under this Plan.

Surgical procedures and Hospitalizations still require Precertification. You are responsible for obtaining any required Precertification. You must call the Provider services number on the back of your ID card to obtain the Precertification. Failure to Precertify will result in a 50 percent reduction in benefits, up to $500, whichever is less.

Network exceptions

If a Network Provider cannot perform or deliver the Covered Services you need, you may receive Network coverage for Medically Necessary Covered Services from an Out-of-Network Provider. First, you must contact Oxford and Precertify the use of an Out-of-Network Provider. Before Precertifying the use of an Out-of-Network Provider for Network Covered Services, Oxford may recommend another Network Provider who is able to render the services you need. However, if Oxford agrees that it is necessary for you to use an Out-of-Network Provider (and Precertifies the services), there will be no additional cost to you beyond your required Copayment.

Additionally, Precertification requests for admissions to Out-of-Network facilities (e.g., hospitals, rehabilitation centers) to be Covered on a Network basis will not be approved unless Oxford agrees that a Network Provider is unable to meet your specific medical needs. While you and your Network Provider may discuss having a procedure performed at a specific Out-of-Network facility, Network coverage is only available if Oxford agrees that the

procedure cannot be safely performed at any Network facility. Any non-emergency Covered Services received at an Out-of-Network facility will be subject to the Out-of-Network level of benefits.

Precertification

Certain Covered Services require Precertification. When you receive services from Network Providers, obtaining Precertification is never your responsibility and you will never be penalized or held liable for any charges because your Network Provider failed to obtain any required Precertification. However, if you receive services from Out-of-Network Providers, obtaining Precertification is your responsibility, subject to any denials and/or penalties. If you are unsure whether a procedure requires Precertification, please call the Benefits Fund.

Precertification starts with a call to Oxford's medical management department by the Network Provider involved. One of Oxford's experienced Medical Management professionals examines the case, consults with your Network Provider, and discusses the clinical findings. If all agree, the requested test, procedure, or admission is Precertified. This comprehensive evaluation ensures that the treatment you receive is appropriate for your needs and is delivered in the most cost-effective setting.

Your network provider is responsible for obtaining any required precertification. However, we recommend that you call the Benefits Fund to ensure that your services have been precertified.

Covered inpatient services are Precertified for a specific number of days. If your Network Provider believes that a longer stay is Medically Necessary, the extension must be Precertified in order for it to be Covered.

Your Network Provider is responsible for obtaining any required Precertification. However, we recommend that you call the Benefits Fund to ensure that your services have been Precertified.

Please note: *Any Precertification you receive will not be valid if your coverage under the Plan terminates. This means that Covered Services received after your coverage has terminated will not be Covered even if they were Precertified.*

Precertification is valid only for the services that were actually requested and approved by Oxford. If you receive a non-Covered Service instead of the Covered Service that Oxford Precertified, that Precertification will not be honored. Additionally, the Plan will not reimburse non-Covered Services if Oxford Precertified a procedure based on inaccurate or misleading information.

Second opinions

Oxford reserves the right to require a second opinion for any surgical procedure. At the time of Precertification, you may be advised that a second opinion will be required in order for the services to be Covered. If a second opinion is required, Oxford will refer you to a Network Provider for a second opinion.

In the event that the first and second opinions differ, a third opinion will be required. Oxford will designate a new Network Provider. The third opinion will determine whether or not the surgery is Precertified. There will be no cost to you for the second or third opinion. You may also request a second opinion for an additional cost, which would be a Network copayment or Out-of-Network coinsurance.

Emergencies

If you have an Emergency, you should obtain medical assistance immediately or call 911. Emergency room care is not subject to Precertification. **However, only Emergencies**

as defined in this SPD are Covered in an Emergency room. Therefore, before you seek treatment, you may want to be certain that this is the most appropriate place to receive care.

Urgent care

This coverage will be provided regardless of where you are (in or out of the Service Area) when the need for Covered Services occurs.

Ambulance services

Ambulance services may include land, water, or air ambulance when a Participant is in need of Medically Necessary Covered Services. Ambulance services for 911 transportation or Emergencies as defined previously in this section are Covered and do not require Precertification. Precertification is required, however, for non-Emergency ambulance services.

For example, such services may be Covered if the Participant is bed-confined and other means of transportation are inappropriate or if the Participant has a medical condition that makes transportation by ambulance medically required. Non-Emergency ambulance services may not be Covered for Hospital transfers that are not Medically Necessary. This may include transfers that are based on Participant preference or convenience and not related to certain services or discharges from a Hospital to the home or recovery facility.

Diagnostic testing and laboratory services

If your Network Provider recommends laboratory testing, remind him or her to use a Network Provider. Please remember, Hospitals are not Network Providers for laboratory procedures and tests, unless contracted to provide these services.

Hospitals are not network providers for laboratory procedures and tests, unless contracted to provide these services.

The Benefits Fund

All coverage is subject to the terms and conditions contained in your Plan documents. You should understand your rights and obligations before you obtain services. If you have questions, the Benefits Fund will be pleased to help you.

Selecting a Primary Care Physician

Selecting your PCP

As described on Page 34, you are required to select a PCP when you enroll. You have the right to designate any Primary Care Physician who participates in Oxford's network and who is available to accept you or your family members. For information on how to select a Primary Care Physician and for a list of the participating Primary Care Physicians, call the Benefits Fund at (877) RN BENEFITS [762-3633].

For children, you may designate a pediatrician as the Primary Care Physician.

Primary provider of OB/GYN care

In addition to a PCP, female Participants should select a Network Provider of OB/GYN Care. You do not need Precertification from Oxford or from any other person (including a Primary Care Physician) in order to obtain access to obstetrical or gynecological care from a health care professional in Oxford's network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining Precertification for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals specializing in obstetrics or gynecology, call the Benefits Fund at (877) RN BENEFITS [762-3633].

Network specialists as PCPs

Participants who have a life-threatening condition or disease and Participants who have a degenerative and disabling condition or disease may request to elect a Network Specialist as their PCP. The designated Network Specialist will become responsible for providing and coordinating all of the Participant's Primary Care and Specialty Care. He or she will be able to order tests, arrange procedures, and provide medical services in the same capacity as a PCP.

This election is available only if the condition or disease requires specialized medical care over a prolonged period of time. The desired Network Specialist must have the necessary qualifications and expertise to treat the Participant's condition or disease. A Participant may request this election at the time of enrollment or upon diagnosis. You will be charged the Specialist Copayment.

Changing your PCP

You may change your PCP (or Provider of OB/GYN Care) at any time. Select a new Provider from the roster of Network Physicians, then call the Benefits Fund to update your selection. The change will become effective immediately.

Participants who have a life-threatening condition/ disease or a degenerative and disabling condition/ disease may request to elect a network specialist as their PCP.

Provider participation and transitional care

Provider participation

Oxford cannot promise that a specific Provider, even though listed in the roster of participating physicians, will be available. A Network Provider may end his or her contract with Oxford or decide not to accept additional patients. If you have any questions about whether or not a particular Provider is currently participating or accepting new patients, please feel free to call the Benefits Fund and inquire.

If your Network PCP or Specialist leaves Oxford's Network, you should choose another Network PCP or Specialist in order to continue receiving care on a Network basis. However, if you are undergoing a course of treatment at the time your Network Provider leaves the Network, you may be eligible for Transitional Care as described below.

Transitional Care

Your provider leaves the network

If you are undergoing a course of treatment when your Provider leaves the Network, you may be able to continue to receive Covered Services from your former Network Provider. Depending on your condition, you may receive Covered Services for up to 120 days after you receive notification from Oxford that the Provider is no longer in the Network. Regarding pregnancy, if the Provider leaves the Network while you are in your second trimester, you may receive Covered Services through delivery and any post-partum care directly related to the delivery.

However, Transitional Care is available only if the Provider agrees to continue to accept as payment the negotiated fee that was in effect just prior to the termination of Oxford's relationship with the Provider. Further, the Provider must agree to adhere to all of Oxford's Quality Assurance procedures, as well as all other policies and procedures required by Oxford regarding the delivery of Covered Services. If the Provider agrees to these conditions, you will receive these Covered Services as if they are being provided by a Network Provider. You will only be responsible for any applicable Copayments. Pregnancies that are affected by this provision are automatically Covered on a Network basis. You will only be responsible for any applicable Copayments.

Please note: *If the Provider was terminated by Oxford due to a quality-of-care issue,*

Transitional Care is not available.

New participants currently undergoing a course of treatment

If you are undergoing a course of treatment with an Out-of-Network Provider at the time your coverage under this SPD becomes effective, you may be able to receive Covered Services from the Out-of-Network Provider for up to 60 days from the effective date of your coverage under the SPD. This coverage is available only if the course of treatment is for a life-threatening disease/condition or a degenerative and disabling disease/condition. Coverage is limited to the disease/condition.

Regarding pregnancy, if your coverage becomes effective while you are in your second trimester, you may receive Covered Services from your Out-of-Network Provider through delivery and any post-partum care directly related to the delivery.

However, Transitional Care is available **only if the Provider agrees to accept as payment Oxford's negotiated fees for such services**. Further, the Provider must agree to adhere to all of Oxford's Quality Assurance procedures as well as all other policies and procedures required by Oxford regarding the delivery of Covered Services. If the Provider agrees to these conditions, you will receive these Covered Services as if they are being provided by a Network Provider. You will only be responsible for any applicable Copayments.

In order to obtain Transitional Care, you or your Provider should call Medical Management at (800) 444-6222 and request this coverage.

Receiving Transitional Care

Before coverage is provided for any transitional care as described above, your Provider must submit the required Transitional Care Forms to Oxford and agree in writing to:

- adhere to Oxford's quality assurance procedures;
- adhere to Oxford's reimbursement rates as payment in full; and
- accept Oxford's policies and procedures regarding delivery of Covered Services.

If the Provider does not agree to the above terms, the Plan is not obligated to approve coverage for transitional care.

Patient/Provider relationship

Network Providers are solely responsible for all health services that you receive. If you refuse to follow a recommended treatment, and the Network Provider believes that no professionally acceptable alternative exists, you will be so advised. In such a case, subject to the second opinion process, neither Oxford nor the Network Provider will have any further responsibility to provide care for the condition under treatment.

Provider reimbursement

The Plan reimburses our Network Providers in a variety of ways. The most common is a discount off the Provider's usual fee. This means the Provider agrees to accept less than what he or she would usually be paid for that service. In return, the Provider's name appears in Oxford's roster, which gives the Provider an opportunity to gain new patients from among our Membership.

SECTION 2: COVERED SERVICES

You will receive Covered Services in accordance with the terms and conditions of this SPD only when the Covered Service is:

- Medically Necessary;
- Properly Precertified, when required;
- Received while your coverage is in force;

- Not excluded under this SPD; and
- Not in excess of the benefit limitations described in this SPD or your Summary of Benefits.

All Covered Services are subject to the Copayments, Coinsurance, and Deductibles specified in your Summary of Benefits. All reimbursement for services rendered by Out-of-Network Providers is subject to an Out-of-Network Reimbursement Amount.

Except for Emergencies or when Oxford Precertifies the use of an Out-of-Network Provider, **any Covered Service you obtain from an Out-of-Network Provider will be Covered on an Out-of-Network basis.**

Please note: *The Plan reserves the right to provide Benefits in the manner the Plan determines to be the most cost effective. Based on Oxford's medical policies, Oxford reserves the right to provide Benefits in the manner and to the extent that Oxford believes is Medically Necessary.*

The Plan will partially reimburse the participant and the participant's covered spouse for certain exercise facility fees or membership fees for programs which promote cardiovascular wellness.

Primary and Preventive Care

Primary Care consists of office visits, house calls, and Hospital visits provided by your Provider for consultations, diagnosis and treatment of medical conditions, Injury, and disease that do not require the services of a specialist. Preventive Care consists of the following services, performed by your Provider for the purpose of promoting good health and early detection of disease:

Exercise facility reimbursement – The Plan will partially reimburse the Participant and the Participant's Covered spouse for certain exercise facility fees or membership fees but only if such fees are paid to facilities that maintain equipment and programs which promote cardiovascular wellness. In order to obtain reimbursement, you must first call the Benefits Fund to obtain a reimbursement form or print one from the Benefits Fund Web site at **www.rnbenefits.org**.

- You must complete a minimum of 50 visits per six-month period. Reimbursements will not be issued until six months have passed, even if 50 visits are completed sooner than six months.
- Participants may be reimbursed up to a $200 maximum per six-month period; Covered spouses may receive up to a maximum of $100 per six-month period.
- You need a copy of your current gym bill, showing the monthly cost of your membership; proof of payment for each of the six months you are submitting for reimbursement (i.e., credit card statement, payroll deduction, automatic bank withdrawal, etc.); and a copy of the brochure that outlines the services the gym offers.
- Fill out and submit a Gym Reimbursement Form. Remember to provide the dates of your gym visits completed within the six-month period for which you are making a claim. Also, a representative from your gym must sign the form.
- Submit the Gym Reimbursement Form, a copy of your current gym bill, proof of payment, and a copy of the gym's brochure within six months (180 days) to the following address: **Oxford Gym Reimbursement P.O. Box 29130, Hot Springs, AR 71903.** Please complete the form in its entirety, or the processing of your claim may be delayed or denied. Complete one form per member for each six-month period for which you are making a claim.

Coverage is limited to facilities/programs that promote cardiovascular wellness, as deter-

mined by Oxford. Memberships to tennis clubs, country clubs, weight loss clinics or spas or any other similar facilities will not be reimbursed. The Participant seeking reimbursement must be an active member of the facility. Lifetime memberships are not eligible for reimbursement.

Only the Participant and the Participant's Covered spouse are eligible for this benefit. "Covered" means that the spouse must be enrolled under the Plan. All other Covered Dependents are not eligible.

You will be reimbursed for only those visits that were completed while you were a Participant of the Plan. Visits that occurred before your coverage became effective or after your coverage terminates will not be reimbursed. No pro rata reimbursement will be paid.

Reimbursement is limited to actual work-out visits. You will not be reimbursed for equipment, clothing, vitamins or other services that may be offered at the facility (massages, yoga, etc.)

Preventive Care – The Plan pays Benefits for Preventive care services provided on an outpatient basis at a Physician's office, an alternate facility, or a Hospital. Preventive care services encompass medical services that have been demonstrated by clinical evidence to be safe and effective in the early detection of disease or the prevention of disease, have been proven to have a beneficial effect on health outcomes, and include the following as required under applicable law:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force;
- Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
- Evidence-informed preventive care and screenings for infants, children, and adolescents provided for in the comprehensive guidelines supported by the Health Resources and Services Administration;
- Additional preventive care and screenings for women as provided for in comprehensive guidelines supported by the HRSA; and
- Preventive care Benefits for women defined under the HRSA requirement, including the cost of renting one breast pump per Pregnancy in conjunction with childbirth. Benefits for breast pumps also include the cost of purchasing one breast pump per Pregnancy in conjunction with childbirth. Benefits are only available if breast pumps are obtained from a DME Provider, Hospital, or Physician.

The Plan pays Benefits for preventive care services provided on an outpatient basis at a physician's office, an alternate facility, or a hospital.

Screening for prostate cancer – An annual standard diagnostic examination including, but not limited to, a digital rectal examination and a prostate specific antigen test for all men over age 40.

Well-woman exams – Well-woman examinations that consist of a routine gynecological examination, breast examination, and pap smear. The plan also will cover a screening mammogram for all adult women regardless of age.

If a woman of any age has a history of breast cancer or her mother or sister has a history of breast cancer, the Plan will Cover mammograms as recommended by her Provider of OB/GYN Care. One screening per Calendar year will be Covered unless it is determined that additional screenings are Medically Necessary.

Diabetic equipment, supplies, and education – Diabetic supplies, education, and self-management are Covered as follows:

Supplies: The following equipment and related supplies will be Covered for insulin dependent and non-insulin dependent Participants when Medically Necessary as determined by the Participant's Physician:

Acetone Reagent Strips
Acetone Reagent Tablets
Alcohol Wipes
All insulin preparations
Automatic Blood Lance Kit
Blood Glucose Kit
Blood Glucose Strips (Test or Reagent)
Blood Glucose Monitor with or without special features for visually impaired, control solutions, and strips for home blood glucose monitor (models with special features for the visually impaired **must be Precertified by Oxford's Medical Director**)
Cartridges for the visually impaired Diabetes data management systems
Disposable insulin and pen cartridges
Drawing-up devices for the visually impaired
Equipment for use of the Pump
Glucose Acetone Reagent Strips
Glucose Reagent Strips
Glucose Reagent Tape
Injection Aides
Injector (Busher) Automatic
Insulin Cartridge Delivery
Insulin Infusion Devices (Precertification is required for this item)
Insulin Pump
Lancets
Oral agents such as glucose tablets or gels
Syringe with needle; sterile 1 cc box
Urine testing products for glucose and ketones.

Additional items may also be Covered if the Participant's Physician determines they are Medically Necessary and prescribes them for the Participant. Such additional items must be Precertified by one of Oxford's Medical Directors and be in accordance with the treatment plan developed by the Physician for the Participant.

Self-management and education: Education on self-management and treatment of diabetes is Covered: upon the initial diagnosis; if there is a significant change in the Participant's condition; or the Physician decides that a refresher course is necessary. It must be provided:

- in a Physician's office either by the Physician or his/her qualified nurse during an office visit or in a group setting.
- upon a Physician's referral to the following non-Physician, medical educators (qualified health Providers): certified diabetes nurse educators; certified nutritionists; certified dietitians; and registered dietitians.
- whenever possible, in a group setting, regardless of whether the Provider is a Physician or a qualified health Provider. Education also will be provided in the Participant's home if the Participant is homebound.

Health Education – Health Education, information, and health care literature made available to Participants through various programs provided and developed by Oxford. These programs and information are provided without cost to Participants, and include Oxford's *Healthy Mother, Healthy Baby Program*; Oxford's *Better Breathing Program*, and Oxford's *Healthy Mind, Healthy Body* magazine.

Nutritional counseling – Medical nutritional counseling for diabetes in which dietary adjustment has a therapeutic role when it is prescribed by your Provider.

Foot care – Routine foot care related to diabetes, peripheral vascular disease, or peripheral neuritis.

Specialty Care

Specialty Care consists of medical care and services, including office visits, house calls, Hospital visits, and consultations for the diagnosis and treatment of disease or injury as described below.

Allergy testing and treatment – The Plan Covers testing and evaluations to determine the existence of an allergy. Routine allergy injections, including serums, are Covered.

The Plan covers testing and evaluations to determine the existence of an allergy. Routine allergy injections, including serums, are also covered.

Ear care services – Medical care for Injury and Illness to the ear (including medical hearing exam, routine hearing exams, and medical screening).

Eye care services – Medical care for Injury and Illness to the eye.

Home Health Care – (Precertification required)

The Plan Covers care provided in your home by a home health service or agency licensed by the appropriate state agency. The care must be provided by Physician-supervised health professionals pursuant to your Physician's written treatment plan and **must be in lieu of Hospitalization or confinement in a Skilled Nursing Facility.** Home care includes: (1) part-time or intermittent nursing care by or under the supervisions of a registered professional nurse, (2) part-time or intermittent services of a home health aide, (3) physical, occupational, or speech therapy provided by the home health service or agency, and (4) medical supplies, drugs, and medications prescribed by a Network Physician, and laboratory services by or on behalf of the Home Health Agency to the extent such items would have been Covered during a hospitalization or confinement in a Skilled Nursing Facility.

Home Health Care is limited to 140 visits for Out-of-Network only. Each visit of up to two hours by a registered nurse or therapist is one visit. Each visit up to four hours by a home health aide is one visit.

Please note: *Any rehabilitation services received under this benefit will not reduce the amount of services available under the Outpatient Rehabilitation Therapy Section of this SPD.*

Medications administered by a Physician – Medications that are administered on an outpatient basis in a Hospital, Outpatient Facility, Physician's office, or the Participant's home. Benefits under this section are provided only for medications which, due to their characteristics (as determined by Oxford), must typically be administered or directly supervised by a

qualified Provider or licensed/certified health professional. Benefits under this section do not include medications that are typically available by prescription order or refill at a pharmacy.

Obesity /weight reduction services – Bariatric surgical procedures for morbid obesity, when provided under the direction of a Physician and when determined by Oxford to be Medically Necessary.

Oral surgery – General dental services are not Covered. The following limited dental and oral surgical procedures are Covered in either an inpatient or outpatient setting:

- Oral surgical procedures for jaw bones or surrounding tissue and dental services for the repair or replacement of sound natural teeth that are required due to "accidental injury." Replacement is Covered only when the repair is not possible. Dental services must be obtained within 12 months of the injury. "Accidental injury" does not include damage caused to a tooth while biting or chewing or the intentional misuse of the tooth.
- Boney impacted wisdom teeth extraction with precertification as secondary.
- Oral surgical procedures for jaw bones or surrounding tissue and dental services necessary due to congenital disease or anomaly.
- Oral surgical procedures required for the correction of a non-dental physiological condition that has resulted in a severe functional impairment.
- Removal of tumors and cysts requiring pathological examination of the jaws, cheeks, lips, tongue, roof, and floor of the mouth. Cysts related to teeth are not Covered.

Outpatient therapeutic treatments (chemotherapy, radiation therapy, and dialysis) – Therapeutic treatments received on an outpatient basis at a Hospital, Outpatient facility, or in a Physician's office, including but not limited to dialysis (both hemodialysis and peritoneal dialysis), intravenous chemotherapy, or other intravenous infusion therapy and radiation oncology.

The Plan Covers medical education services that are provided on an outpatient basis at a Hospital or outpatient facility by appropriately licensed or registered healthcare professionals when both of the following are true:

- Education is required for a disease in which patient self-management is an important component of treatment.
- There exists a knowledge deficit regarding the disease that requires the intervention of a trained health professional.

Pain mangement services – Services provided by a Provider who is credentialed by the American Academy of Pain Management or who is a board-eligible anesthesiologist, neurologist, oncologist, or radiation oncologist with additional training in pain management. Covered Services are available to members who experience severe discomfort, distress, or suffering due to provocation of sensory nerves.

Physician house calls – Services provided by a Physician in the Participant's home for diagnosis and treatment of an Illness or Injury.

Physician office visits – Services provided by a Physician in the Physician's office for the diagnosis and treatment of an Illness or Injury.

Private duty nursing – Private duty nursing is only available under very strict standards. PDN will only be covered in the home and under extraordinary circumstances upon evidence of a clear and convincing objective need. PDN must be ordered by a doctor and provided by one of the following:

- Registered nurse, other than you, your spouse, your child, brother, sister, or parent of you or your spouse.
- Licensed practical nurse, other than you, your spouse, your child, brother, sister, or parent of you or your spouse.

PDN will not be covered if the care is:

- the type of care normally provided by or that should be provided by Hospital nursing staff;
- rendered by or could be provided by home health aides or any other nurses aides; or
- custodial care or assistance in the activities of daily living in a home or facility of any kind.

Second opinions – There may be instances when you will disagree with a Provider's recommended course of treatment. In such cases, you may request that Oxford designate another Provider to render a second opinion. If the first and second opinions do not agree, Oxford will designate another Provider to render a third opinion. After completion of the second opinion process, Oxford will Precertify Covered Services supported by the majority of the Providers reviewing your case. You must pay any Copayment for a second opinion that you request.

If the first opinion concerns a diagnosis of cancer (either negative or positive) or treatment for cancer, you may obtain a second opinion from an Out-of-Network Provider on a Network basis.

Please note: *Providers who render a second or third opinion cannot perform the Precertified service. If Oxford Precertifies a service that is recommended by the second (or second and third) Provider, you will be asked to select another Provider to perform the actual service.*

A second opinion may be required before Oxford Precertifies a surgical procedure. There will be no cost to you when Oxford requests a second opinion.

A second opinion may be required before Oxford precertifies a surgical procedure.

Transplants – The Plan Covers only those transplants that Oxford determines to be non-experimental and non-investigational. Covered transplants include but are not limited to: kidney, corneal, liver, heart, and heart/lung transplants; and bone marrow transplants for aplastic anemia, leukemia, severe combined immunodeficiency disease, and Wiskott-Aldrich Syndrome.

All transplants must be prescribed by your Specialist(s) and Precertified by Oxford's Medical Director. Additionally, all transplants must be performed at Hospitals that Oxford has specifically approved and designated to perform these procedures.

The Plan will Cover the Hospital and medical expenses, including donor search fees, of the recipient. The Plan will Cover transplant services required by a Participant when the Participant serves as an organ donor **only if the recipient is a Participant**. The medical expenses of a non-Participant acting as a donor for a Participant are not Covered if the

non-Participant's expenses will be covered under another health plan or program.

The Plan will cover autologous bone marrow transplants combined with high-dose chemotherapy when medically appropriate for the treatment of advance neuroblastoma, second remission acute leukemia, relapsed Hodgkin's disease, relapsed non-Hodgkin's lymphoma, and metastatic breast cancer, or any other diagnosis that Oxford's Medical Advisory Board determines to be appropriate. Oxford will determine when such treatment is medically appropriate.

The Plan does not Cover travel expenses, lodging, meals, or other accommodations for donors or guests.

TMJ services (diagnosis and treatment) – The Plan Covers services for the evaluation and treatment of temporomandibular joint syndrome and associated muscles. Covered Services include diagnosis, examination, radiographs, and applicable imaging studies and consultations. Non-surgical treatment, including clinical examinations, oral appliances (orthotic splints), arthrocentesis, and trigger point injections are Covered. Benefits are provided for surgical treatment only if the following criteria are met:

- There is clearly demonstrated radiographic evidence of significant joint abnormality;
- Non-surgical treatment has failed to adequately resolve the symptoms; and
- Pain or dysfunction is moderate or severe.

The Plan will Cover such surgical services as arthrocentesis, arthroscopy, arthroplasty, arthrotomy/ open joint surgery, injections of corticosteroids for rheumatoid arthritis-related TMJ disorders and stabilization and repositioning splint therapy.

The Plan covers the diagnosis and treatment (surgical and medical) to correct malformation, disease, and dysfunction that has resulted in infertility.

Family planning, maternity, and infertility services

The Plan Covers the following family planning, maternity, and infertility services if they are received in accordance with the terms and conditions of this SPD:

Family planning services – Family planning services that consist of counseling on use of contraceptives and related topics. The costs related to the measuring and fitting of a contraceptive device are also Covered. The Plan covers contraceptive devices such as the IUD, diaphragm, Depo Provera, and Norplant. If the services are performed during an annual well-woman examination, you will only be responsible for the well-woman examination cost share. The Plan also covers vasectomies and tubal ligations.

Infertility services – The Plan Covers the diagnosis and treatment (surgical and medical) to correct malformation, disease, and dysfunction that has resulted in infertility. Participants must be between the ages of 21 and 44 (inclusive) in order to be considered a candidate for these services. Infertility services provided to Participants who are not between the ages of 21 and 44 (inclusive) are not Covered Services under this section.

Basic and comprehensive infertility services – Basic infertility services consist of initial evaluation, semen analysis, laboratory evaluation, evaluation of ovulatory function, postcoital test, endometrial biopsy, hysterosalpingogram, sonohystogram, testis biopsy, blood tests, and medically appropriate treatment of ovulatory dysfunction.

If basic services do not result in increased fertility, Oxford may Precertify comprehensive infertility services. These services include ovulation induction and monitoring, pelvic ultrasound, artificial insemination, hysteroscopy, laparoscopy, and laparotomy.

Advanced infertility services* – Should the comprehensive infertility services fail to increase fertility, Oxford may Precertify the following advanced infertility services:

- in-vitro fertilization;
- gamete intrafallopian transfer and zygote intrafallopian transfer;
- culture and fertilization of oocyte(s);
- culture and fertilization of oocyte(s) with co-culture of embryos;
- assisted oocyte fertilization microtechnique (any method);
- assisted embryo hatching microtechnique (any method);
- oocyte identification from follicular fluid;
- preparation of embryo for transfer (any method); and
- ultrasonic guidance for aspiration of ova, imaging and supervision.

Advanced services are limited to a lifetime maximum of $5,000 in medical or prescription drugs.*

**Participants covered under facilities adhering to principles of the Ethical and Religious Directives for Catholic Health Services as approved by the United States Conference of Catholic Bishops do not have coverage for Advanced Infertility Services, including in vitro fertilization services and infertility drugs.*

The Plan covers obstetrical services including all maternity-related medical services for prenatal care, postnatal care, delivery, and any related complications.

Obstetrical services (hospital services for mother and baby) – The Plan Covers obstetrical services including all maternity-related medical services for prenatal care, postnatal care, delivery, and any related complications.

Hospital services for mother and baby – Physicians' services for surgical and obstetrical procedures on an inpatient and outpatient basis, including the services of the surgeon or specialist, assistant, and anesthetist or anesthesiologist, together with preoperative and postoperative care. Deliveries and related services that are performed by a certified nurse midwife also are Covered.

Please note: *Elective surgery and Hospital admissions, including maternity admissions, require Precertification.*

The Plan provides a minimum inpatient stay of 48 hours following a vaginal delivery and 96 hours following a cesarean delivery for both the mother and the newly born child or children. While in the hospital, maternity care also includes, at a minimum, parent education, assistance and training in breast or bottle-feeding, and the performance of any necessary maternal and newborn clinical assessments.

The mother has the option to leave the hospital sooner than described above. If she decides to be discharged early, she will be provided with one home visit. The home visit must be requested by the mother within 48 hours of a vaginal birth or within 96 hours of a cesarean birth. The visit will occur within 24 hours of the later of the mother's request or her discharge from the hospital. This visit is not subject to deductible or Copayment. Additionally, the visit will not be deducted from the home health care visits Covered under the SPD.

The home visit consists of a visit by a professional RN to provide the following post-delivery care: an assessment of the mother and child; instruction on breastfeeding, cleaning and care for child; and any required blood tests ordered by either the mother's or the child's Provider.

Newborn Care – Care for newborns includes preventive health care services, routine nursery care, and treatment of disease or Injury. Treatment of disease or Injury includes treatment of prematurity and diagnosed congenital defects and birth abnormalities that cause anatomical

functional impairment. The Plan also Covers, within the limits of this SPD, necessary transportation costs from place of birth to the nearest specialized treatment center.

Prenatal and Postnatal Services – Services and supplies for maternity care provided by a Physician in the office or in an outpatient facility will be Covered for prenatal care (including one visit for genetic testing) and postnatal care.

Termination of Pregnancy* – Therapeutic and elective abortions are Covered.

**Participants covered under facilities adhering to principles of the Ethical and Religious Directives for Catholic Health Services as approved by the United States Conference of Catholic Bishops do not have coverage for termination of pregnancy.*

Outpatient rehabilitation therapy services

Acupuncture services – The Plan Covers acupuncture services when rendered for pain therapy. The Plan also covers acupuncture for the treatment of nausea that is related to surgery, pregnancy, or chemotherapy. Acupuncture must be performed in an office setting by a Provider who is one of the following, either practicing within the scope of his/her license or who is certified by a national accrediting body:

- Doctor of Medicine
- Doctor of Osteopathy
- Chiropractor
- Acupuncturist.

Cardiac rehabilitation –The Plan Covers outpatient cardiac rehabilitation if a Participant has an acute myocardial infarction within the preceding 12 months, chronic angina pectoris, or has had coronary bypass surgery within the preceding six months. Therapy may be available for valve surgery or any other major open-heart surgical procedure, angioplasty or atherectomy, heart or lung transplant, congestive heart failure, or if the Participant has Peripheral Arterial Disease.

Clinical evidence must show that the Participant is able to exercise at least three times a week for at least 20 minutes per session. Additionally, the Participant must have the potential to attain at least 70 percent of the age adjusted exercise heart rate goal.

The Plan will Cover up to 36 visits (three visits a week over a 12-week period). Up to 36 additional sessions can be obtained if Oxford determines:

- There is a clear demonstration that the Participant is benefitting from the therapy,
- The exit criteria established in Oxford's medical policy has not been met, and
- There is a reasonable expectation that the Participant can meet our exit criteria with additional sessions.

Chiropractic services – The Plan will Cover spinal subluxation and related services when performed by a doctor of chiropractic ("chiropractor"). This includes assessment, manipulation, and any modalities. Any Medically Necessary laboratory tests will be Covered in accordance with the terms and conditions of this SPD.

Physical therapy, occupational therapy, and cognitive therapy – Coverage on an outpatient basis is provided as medically necessary. For the purposes of this Benefit (both inpatient and outpatient), "per condition" means the disease or injury causing the need for the therapy.

Occupational therapy is Covered only when it is necessary to correct a condition that is the result of a disease, Injury, or a congenital defect for which surgery has been performed. Covered Services must begin within six months of the later of the following events. In no case will the therapy continue beyond 365 days after:

- the date of the Injury or Illness that caused the need for the therapy; or
- the date the Member is discharged from a Hospital where surgical treatment was rendered; or
- the date outpatient surgical care is rendered.

Speech therapy – Speech therapy is Covered only when it is necessary to correct a condition that is the result of a disease, Injury, or a congenital defect for which surgery has been performed. Covered Services must begin within six months of the later of the following events. In no case will the therapy continue beyond 365 days after:

- the date of the Injury or Illness that caused the need for the therapy; or
- the date the Member is discharged from a Hospital where surgical treatment was rendered; or
- the date outpatient surgical care is rendered.

Speech therapy services are also Covered for the treatment of disorders of speech, language, voice, communication, and auditory processing only when the disorder results from injury, stroke, cancer, congenital anomaly, or autism spectrum disorders.

Durable Medical Equipment, prosthetics, and medical supplies

Precertification is required for DME items over $500.

Durable Medical Equipment and braces – The Plan Covers Durable Medical Equipment. Durable Medical Equipment is equipment that is: designed and intended for repeated use; primarily and customarily used to serve a medical purpose; generally not useful to a person in the absence of disease or injury; and is appropriate for use in the home.

Coverage is for standard equipment only. The Plan Covers custom made and custom molded DME, orthotics, etc. with authorization. All maintenance and repairs that result from a Participant's misuse are the Participant's responsibility. The decision to rent or purchase such equipment will be made solely at Oxford's discretion. Precertification is required for items over $500.

Braces – The Plan Covers braces that are worn externally and temporarily or permanently assist all or part of an external body-part function which has been lost or damaged because of an Injury, disease, or defect. Coverage is for standard equipment only. Replacements are Covered when growth or a change in the Participant's medical condition make replacement Medically Necessary. The Plan does not otherwise Cover the cost of repairs or replacement (e.g., the Plan does not Cover repairs or replacement that result from the misuse or abuse by the Participant). Precertification is required for items over $500.

Medical supplies – The Plan Covers medical supplies that are required for the treatment of a disease or Injury which is Covered under this SPD. Maintenance supplies (e.g., ostomy supplies) also are Covered for conditions Covered under this SPD. All such supplies must be Medically Necessary and in the appropriate amount for the treatment or maintenance program in progress. Diabetic supplies are not Covered under this provision.

Orthotics – The Plan Covers custom fitted and custom molded orthotic appliances that are worn externally and temporarily or permanently assist all or part of an external body-part function which has been lost or damaged because of an Injury, disease, or defect. The Plan also Covers foot orthotics with authorization. Precertification is required for items over $500 and for all custom-made items.

Ostomy supplies – The Plan Covers the following ostomy supplies:

- Pouches, face plates, and belts;
- Irrigation sleeves, bags, and catheters;
- Skin barriers.

Coverage is not available for deodorants, filters, lubricants, tape, appliance cleaners, adhesive, adhesive remover, or other items not listed in this section.

The Plan covers custom fitted and custom molded orthotic appliances that are worn externally and temporarily or permanently assist all or part of an external body-part function which has been lost or damaged because of an injury, disease, or defect.

Oxygen – The Plan Covers therapeutic oxygen and equipment for the administration of oxygen, including tubing, connectors, and masks.

Internal and external prosthetic devices –
Internal prosthesis – Surgically implanted prosthetic devices and special appliances will be Covered if they improve or restore the function of an internal body part that has been removed or damaged due to disease or Injury. This includes implanted breast prostheses following a Covered mastectomy. Coverage also includes repair and replacement due to normal growth or normal wear and tear. Coverage does not include artificial organs.
External prosthetic devices –The Plan Covers prosthetic devices that are worn externally and temporarily or permanently replace all or part of an external body part which has been lost or damaged because of an Injury or disease.

For children, the cost of replacements is also Covered but only if the previous device has been outgrown. Purchase of the device must be Precertified. Coverage is for standard equipment only. The Plan Covers the repair, maintenance, or replacement of a prosthetic device. Only functionally necessary replacements will be Covered. The Plan does not otherwise Cover the cost of repairs or replacement.

External breast prostheses following a Covered mastectomy also are Covered. Coverage under this provision includes mastectomy bras and lymphedema stockings for the arm.

Wigs – The Plan Covers wigs and other scalp hair prosthesis only when a Participant has severe hair loss due to Injury or disease or as a side effect of the treatment of a disease (e.g. chemotherapy). The Plan does not Cover wigs made from human hair unless the Participant is allergic to all synthetic wig materials.

Outpatient laboratory and imaging services

Benefits are available for the following outpatient laboratory and imaging services if they are received in accordance with the terms and conditions of this SPD:

- Diagnostic mammography
- Laboratory procedures
- Radiology services
- X-ray examinations
- Bone mineral density measurements and tests.

Hospital and other facility-based services

Benefits are available for the following Hospital and facility-based services if they are received in accordance with the terms and conditions of this SPD.

Hospital services (excluding mental health services, alcohol, and substance abuse) – ***Inpatient services*** – Covered Hospital inpatient services for Medically Necessary acute-care includes private room and board; unlimited days; general nursing care; and the following additional facilities, services, and supplies:

- Meals and special diets;
- Use of operating room and related facilities;
- Use of intensive care or cardiac care units and related services;
- X-ray services;
- Laboratory and other diagnostic tests;
- Drugs;
- Medications;
- Biologicals;
- Anesthesia and oxygen services;
- Short-term physical, speech, and occupational therapy;
- Radiation therapy;
- Inhalation therapy;
- Chemotherapy;
- Whole blood and blood products; and
- The administration of whole blood and blood products.

Covered hospital inpatient services for medically necessary acute-care includes private room and board, unlimited days, and general nursing care.

Coverage includes preadmission testing performed in hospital facilities prior to a scheduled surgery. Tests ordered by Physicians performed in the outpatient facilities of a Hospital as a planned preliminary to admission of the patient as an inpatient for surgery in the same hospital are Covered provided:

- the tests are necessary for and consistent with the diagnosis and treatment of the condition for which surgery is to be performed;
- reservations for a Hospital bed and for an operating room were made prior to the performance of the tests;
- the surgery actually takes place within 14 days of such presurgical tests; and
- the member is physically present at the hospital for the tests.

Autologous blood banking services are Covered only when they are being provided in connection with a scheduled, Covered inpatient procedure for the treatment of a disease or Injury. In such instances, the Plan will Cover storage fees for what Oxford determines to be a reasonable storage period that is Medically Necessary and appropriate for having the blood available when it is needed.

The Hospital services and supplies listed above that can be provided to you while being treated in the outpatient facility are Covered as Outpatient Services. Please remember, unless you are receiving preadmission testing, Hospitals are not Network Providers for laboratory procedures and tests, unless contracted to provide these services.

Inpatient short-term rehabilitative services – Rehabilitation therapy, including physical therapy, speech therapy, and occupational therapy, is Covered on an inpatient basis. Coverage is based on medical necessity. Admission to a Rehabilitation Facility requires Precertification. For the purposes of this Benefit, "per condition" means the disease or Injury causing

the need for therapy.

Speech or occupational therapy is Covered only when it is necessary to correct a condition that is the result of a disease, Injury or a congenital defect for which surgery has been performed.

Covered Services for all short-term rehabilitative services must begin within six months of the later of the following events. Therapy will not continue beyond 365 days after:

- the date of the Injury or Illness that caused the need for the therapy; or
- the date the Participant is discharged from a Hospital where the surgical treatment was rendered; or
- the date outpatient surgical care is rendered.

Mastectomy and breast cancer treatment – The Plan Covers inpatient services for Participants undergoing a lymph node dissection or lumpectomy for the treatment of breast cancer or a mastectomy and any physical complications arising from the mastectomy, including lymphedema, for a period of time determined to be Medically Necessary by the Participant and their Physician.

The Plan covers inpatient services for participants undergoing a lymph node dissection or lumpectomy for the treatment of breast cancer or a mastectomy and any physical complications arising from the mastectomy, including lymphedema.

Coverage is also provided for breast reconstructive surgery after a mastectomy in the manner determined by the Participant and the attending Physician to be appropriate for:

- all stages of reconstruction of the breast on which the mastectomy has been performed; and
- surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- prostheses and physical complications of mastectomy including lymphedemas.

Outpatient Hospital and Ambulatory Surgical Center services – The Plan Covers surgical procedures performed at Ambulatory Surgical Centers. The Plan also covers the Covered Services and supplies provided by the Center the day the surgery is performed.

Reconstructive and corrective surgery is Covered only when it is:

- performed to correct a congenital birth defect of a Covered Dependent child that has resulted in a functional defect; or
- incidental to surgery or follows surgery that was necessitated by trauma, infection, or disease of the involved part; or
- breast reconstruction on one or both breasts (including surgery on the healthy breast to restore and achieve symmetry). Implanted breast prostheses following a mastectomy also are Covered.

Physician surgical services and anesthesia – The Plan Covers fees for surgical procedures and other medical care when received in a Hospital, Skilled Nursing Facility, inpatient Rehabilitation Facility, or outpatient facility.

Skilled Nursing Facility – The Plan Covers non-custodial services provided in a Skilled Nursing Facility, including care and treatment in a Private Room, as described in "Hospital services" above. In addition to Precertification, an admission to a Skilled Nursing Facility must be supported by a treatment plan prepared by your Provider and approved by Oxford. The Plan Covers noncustodial care for up to 60 consecutive days per condition per calendar year.

Hospice – Hospice care is available to Participants who have a prognosis of six months or

less to live. Coverage consists of palliative care rather than curative treatment. The Plan Covers a total of five visits for supportive care and guidance for the purpose of helping the Participant and the Participant's immediate family cope with the emotional and social issues related to the Participant's death. Hospice care will be Covered only when provided as part of a hospice care program certified by the appropriate state agency. Such certified programs may include hospice care delivered by a Hospital (inpatient or outpatient), Home Health Care Agency, Skilled Nursing Facility, or a licensed hospice facility.

Coverage is not provided for funeral arrangements; pastoral, financial or legal counseling; homemaker, caretaker, or respite care.

Home hospice - The Plan provides coverage for hospice services as described in the previous section when rendered in the home as part of a hospice care program certified by the State of New York or other appropriate agency.

Mental Health and Substance Use Disorder Services

Mental Health Services – Mental Health Services include those received on an inpatient basis in a Hospital or Alternate Facility, and those received on an outpatient basis in a Provider's office or at an Alternate Facility.

Benefits include the following services provided on either an outpatient or inpatient basis:

- Diagnostic evaluations and assessment;
- Treatment planning;
- Referral services;
- Medication management;
- Individual, family, therapeutic group and provider-based case management services; and
- Crisis intervention.

Partial inpatient hospitalization/day treatment and inpatient services at a residential treatment facility are covered. Intensive outpatient treatment also is covered.

The Mental Health/Substance Use Disorder Administrator determines coverage for the inpatient treatment. If an inpatient stay is required, it is covered on a Private Room basis.

You are encouraged to contact the Mental Health/Substance Use Disorder Administrator for referrals to providers and coordination of care.

Hospice care is available to participants who have a prognosis of six months or less to live.

Substance Use Disorder Services – Substance Use Disorder Services include those received on an inpatient basis in a Hospital or an Alternate Facility and those received on an outpatient basis in a Provider's office or at an Alternate Facility.

The following services are covered whether provided on an inpatient or outpatient basis:

- Diagnostic evaluations and assessment;
- Treatment planning;
- Referral services;
- Medication management;
- Individual, family, therapeutic group and provider-based case management;
- Crisis intervention; and
- Detoxification (sub-acute/non-medical).

Partial inpatient hospitalization/day treatment and inpatient services at a residential

treatment facility are covered. Intensive outpatient treatment also is covered. The Mental Health/Substance Use Disorder Administrator determines coverage for the inpatient treatment. If an Inpatient Stay is required, it is covered on a Private Room basis. You are encouraged to contact the Mental Health/Substance Use Disorder Administrator for referrals to providers and coordination of care.

Emergencies and Urgent Care

In order to obtain Coverage for Emergencies, you should follow the instructions below, regardless of whether or not you are in the service area at the time of the Emergency.

The Plan defines an Emergency as a serious medical condition or symptom resulting from Injury, sickness, or mental illness or substance use disorder that arises suddenly and, in the judgment of a reasonable person, requires immediate care and treatment (generally received within 24 hours of onset) to avoid jeopardy to life or health. Oxford reserves the right to review all appropriate medical records and make the final decision regarding the existence of an Emergency. Regarding such retrospective reviews, the Plan will Cover only those services and supplies that are Medically Necessary and are performed to treat or stabilize an Emergency condition.

When you receive Covered Services for an Emergency or Urgent Care situation from a Non-Network Provider, the Plan will limit reimbursement to the Out-of-Network reimbursement amount for those expenses incurred up to the time the Participant is determined to be able to travel to a Network Provider for Medically Necessary follow-up services. Additionally, reimbursement is subject to all applicable Copayments as similar services provided by a Network Provider.

In the event you are admitted to the hospital from the ER, you or someone on your behalf must notify Oxford within 48 hours of your admission or as soon as is reasonably possible.

Hospital emergency room visits – In the event of an Emergency, seek immediate care at the nearest emergency room or call 911.

However, only Emergencies as defined above are Covered in an emergency room. If you would like assistance assessing the situation, you may call your Network Provider (if applicable). Your Network Provider will direct you to the emergency room of a Hospital or other appropriate facility. **Follow-up care provided in a Hospital emergency room is not Covered.**

In the event you are admitted to the Hospital, you or someone on your behalf must notify Oxford at the Emergency telephone number listed on Page 127 of this SPD within 48 hours of your admission or as soon as is reasonably possible.

If you have been admitted to an Out-of-Network facility, Oxford may request that you be moved to a Network Hospital as soon as your medical condition permits in order to continue receiving Network benefits for Medically Necessary follow-up care. If you decline the request, your hospitalization for Medically Necessary follow-up care will be Covered on an Out-of-Network basis from that time forward.

It is important to remember that only those conditions that meet all of the requirements contained in the definition of Emergency will be Covered as an Emergency. Routine care received in an emergency room is not Covered.

Ambulance services – Ambulance services for life-threatening Emergencies will be Covered. Ambulance services for all other Emergencies will be Covered when Medically Necessary.

The Plan also Covers pre-Hospital Emergency medical services. This means the Plan

Covers the prompt evaluation and treatment of an Emergency in addition to non-air-borne transportation of the patient.

Inter-facility ambulance transfers also will be Covered if they are Precertified.

Urgent Care – The Plan defines Urgent Care as medical care for a condition that needs immediate attention to minimize severity and prevent complications but is not an Emergency. Urgent Care is Covered in or out of the service area. You are not required to get Precertification prior to obtaining Urgent Care.

If an Urgent Care visit results in an emergency admission, please follow the instructions for Emergency Hospital Admissions described above.

Experimental or Investigational Services

To be eligible for coverage under this section, your attending Physician must certify that you have a life threatening or disabling condition or disease and your condition or disease is one for which standard health services are ineffective or medically inappropriate; or one for which there does not exist a more beneficial standard service or procedure that is a Covered Service; or one for which there exists a clinical trial or rare disease treatment (as defined by law). In addition, your attending Physician must have recommended one of the following:

- A service, procedure, or treatment that two documents from available medical and scientific evidence indicate is likely to be more beneficial to you than any standard Covered Service (only certain documents will be considered in support of this recommendation); or
- A clinical trial for which you are eligible (only certain clinical trials can be considered); or
- A rare disease treatment for which your attending Physician certifies that there is no standard treatment likely to be more clinically beneficial to you than the requested service, the requested service is likely to benefit you in the treatment of your rare disease, and such benefit outweighs the risk of the service. In addition, your attending Physician must certify that your condition is a rare disease which is currently or was previously subject to a research study by the National Institutes of Health Rare Disease Clinical Research of Network or affects fewer than 200,000 U.S. residents per year.

If an experimental or investigational treatment is part of a clinical trial, the Plan will Cover the cost of services required to provide treatment to you according to the design of the trial. The Plan will not be responsible for the costs of investigational drugs or devices, the costs of non-health care services, the costs of managing research, or that which would not be Covered under this SPD for non-experimental or non-investigational treatments provided in such clinical trial.

SECTION 3: EXCLUSIONS AND LIMITATIONS

Unless coverage is specifically provided under this SPD or provided under a rider or attachment to this SPD, the following services and Benefits are not Covered.

1. Services that are not Medically Necessary. If there is a dispute between a Provider and Oxford about the Medical Necessity of a service or supply, you or your Provider may appeal Oxford's decision. Any disputed service or supply will not be Covered during the appeal process.
2. Health services received as a result of illness, accident treatment, or medical condition arising out of: war or any act of war, (whether declared or undeclared); participation in a felony, riot or insurrection; service in the armed forces or units auxiliary thereto; suicide, attempted suicide, or intentionally self-inflicted injury (except with respect to treatment of injuries that result from a medical condition such as depression or from an act of domestic violence); aviation other than as a fare-paying passenger on a scheduled or charter flight operated by a scheduled airliner.
3. Treatment provided in a government hospital.
4. Benefits provided under Medicare or other governmental program (except Medicaid), any state or federal workers' compensation, employers' liability, or occupational disease law.
5. Services rendered and separately billed by employees of hospitals, laboratories, and other institutions.
6. Services performed by a member of the covered person's immediate family.
7. Services for which no charge is normally made.
8. Cosmetic procedures, unless Medically Necessary. Certain cosmetic procedures as listed in Part 56 of New York Regulation 183 will be denied and will not be subject to a Medical Necessity review if we receive the claim with no accompanying medical information after services were performed. Cosmetic surgery will not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection, or diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a Dependent child that has resulted in a functional defect.
9. Custodial Care or rest cures.
10. Dental care or treatment, except for such care or treatment due to accidental injury to sound natural teeth within 12 months of the accident and except for dental care or treatment necessary due to congenital disease.
11. Cost of hearing aids or the examination for the prescription or fitting of a hearing aid.
12. No-fault automobile insurance. The Plan does not cover any Covered Services to the extent provided for any loss or portion thereof for which mandatory automobile no-fault benefits are recovered or recoverable.
13. Routine foot care in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain, or symptomatic complaints of the feet unless performed in connection with diabetes or peripheral neuritis as described in this SPD.
14. Coverage outside of the United States and its possessions, Mexico, and Canada unless required as Emergency Services.
15. Vision correction services and supplies including, but not limited to, eyeglasses (lenses and frames) and all manner of contact lenses or corrective lenses.
16. An adopted newly born infant's initial hospital stay if the natural parent has coverage available for the infant's care.
17. Blood, blood plasma, and blood derivatives other than those described as Covered

Services. Synthetic blood, apheresis, or plasmapheresis, the collection and storage of blood, and the cost of securing the services of blood donors are not Covered.

18. Care for conditions that by federal, state, or local law must be treated in a public facility including, but not limited to, commitments for mental illness. Additionally, to the extent allowed by law, the Plan does not Cover care or treatment provided in an Out-of-Network Hospital that is owned or operated by any federal, state, or other governmental entity.
19. Comfort or convenience items including, but not limited to, barber services; guest meals and accommodations; telephone, television or radio charges; travel expenses; or take-home supplies. The Plan also does not Cover the purchase or rental of household fixtures or equipment including, but not limited to, escalators; elevators; swimming pools; exercise cycles; treadmills, weight training or muscle strengthening equipment; air purifiers; air conditioners; water purifiers; allergenic pillows, mattresses or waterbeds.
20. Court ordered services or services that have been ordered as a condition of probation or parole. However, these services may be Covered if Oxford agrees that the services are Medically Necessary, are otherwise Covered, the Participant has not exhausted his/her benefit for the contract/Calendar Year, and the treatment is provided in accordance with our policies and procedures.
21. Diabetic services or supplies that are not both Medically Necessary and prescribed by the Participant's Physician or qualified health professional; membership in health clubs, diet plans, or clubs even if recommended by a Physician or any other Provider for purpose of losing weight; any counseling or courses in diabetes management other than as described as Covered under this SPD; stays at special facilities or spas for the purpose of diabetes education/management; special foods, diet aids and supplements related to dieting.
22. Durable Medical Equipment (other than as specifically Covered under this SPD). The Plan also does not cover car seats; arch supports; corrective shoes; false teeth; hearing aids; tilt tables; electronic communication devices; in-flight oxygen for non-emergency travel; special supplies or equipment; or special appliances.
23. Experimental, investigational, or ineffective surgical or medical treatments, procedures, drugs, or research studies including, but not limited to: transplants, stem cell retrieval, cancer chemotherapy protocols, AIDS clinical trials, or I.V. therapies that are not recognized as acceptable medical practice and any such services where federal or other governmental agency approval is required but has not been granted. Oxford will make the determination as to whether the requested service is excluded in accordance with this provision. In certain instances, such procedures may be Covered if they are approved in advance by Oxford's Medical Advisory Board and provided in accordance with the provisions of this SPD. The Plan will only Cover autologous bone marrow transplants combined with high-dose chemotherapy when medically appropriate for the treatment of advanced neuroblastoma, second remission acute leukemia, relapsed Hodgkin's disease, relapsed non-Hodgkin's lymphoma, and metastatic breast cancer or any other diagnosis that Oxford's Medical Advisory Board determines to be appropriate. Such treatment must be approved in advance by Oxford's Medical Advisory Board and provided in accordance with this SPD.

24. Improper use of an emergency room or emergency admissions. Routine care and treatment for conditions that Oxford determines were not Emergencies, when received in an emergency room, are not Covered.
25. Infertility treatments and supplies (except as otherwise Covered under this SPD), even if the treatment or supply is for a purpose other than the correction of infertility. The following services and supplies are not Covered:
    - Cost for an ovum donor or donor sperm;
    - Sperm storage costs;
    - Chromosomal analyses;
    - Testicular biopsy;
    - Elective abdominal surgeries related to lysis of adhesions or asymptomatic varicoceles;
    - Radiographic imaging to determine tubal patency;
    - Blood analyses related to immunological diagnosis of infertility;
    - Cryopreservation and storage of embryos (unless the participant has not yet reached her lifetime limit of four egg retrievals);
    - In-vitro services for women who have undergone tubal ligation;
    - Any infertility services if the male has undergone a vasectomy; and
    - All costs for and relating to surrogate motherhood (maternity services are covered for participants acting as surrogate mothers).

    The Plan also does not Cover services to reverse voluntary sterilization. Treatment of an underlying medical condition will not be denied (if the treatment is otherwise covered under the SPD) solely because the medical condition results in infertility.

    Furthermore, No. 26 and 27 below are Exclusions only for facilities adhering to principles of the Ethical and Religious Directives for Catholic Health Services as approved by the United States Conference of Catholic Bishops.
26. Advanced infertility services including: in-vitro fertilization (IVF), gamete intrafallopian transfer (GIFT) and zygote intrafallopian transfer (ZIFT), culture and fertilization of oocyte(s), culture and fertilization of oocyte(s) with co-culture of embryos, assisted oocyte fertilization microtechnique (any method), assisted embryo hating microtechnique (any method), oocyte identification from follicular fluid, preparation of embryo for transfer (any method), and ultrasonic guidance for aspiration of ova, imaging and supervision.
27. Therapeutic and elective terminations of pregnancy.
28. Learning and behavioral disorders. Services for the evaluation or treatment (including remedial education) of: learning disabilities or minimal brain dysfunction; mental retardation; developmental and learning disorders or behavioral problems. The Plan also does not Cover behavioral training, visual perceptual or visual motor training related to learning disabilities or cognitive rehabilitation. Behavioral and learning disorders related to congenital abnormalities such as Down's Syndrome are not Covered.
29. Applied Behavior Analysis. The Plan does not cover ABA therapy, including the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, including the use of direct observation, measurement and functional analysis of the relationship between environment and behavior

to produce socially significant improvement in human behavior.

30. Any services or supplies furnished by a non-eligible institution, which is defined as other than a Hospital or Skilled Nursing Facility, and which is primarily a place of rest, a place for the aged, or any similar institution, regardless of how denominated.
31. Non-medical services and long-term rehabilitation services for physical therapy or the treatment of alcoholism or drug abuse, including rehabilitation services in a specialized inpatient or residential facility, except as specifically Covered under this SPD.
32. No-show charges. If a Provider charges a fee for a missed appointment, you will be responsible for the payment of the fee.
33. Occupational conditions, ailments, or injuries, arising out of and in the course of employment. Such conditions, ailments, or injuries are not Covered if they are subject to coverage, in whole or in part, under any workers' compensation, occupational disease, or similar law. This applies even if the Participant's rights have been waived or qualified.
34. Outpatient prescription drugs.
35. Rehabilitation services or physical therapy on a long-term basis. Speech or occupational therapy to correct a condition that is not the result of a disease, Injury, or a congenital defect for which surgery has been performed.
36. Services for which the day or visit limit identified in the Summary of Benefits has been met.
37. Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Services performed as treatment for VCode conditions as listed in the Diagnostic and Statistical Manual of the American Psychiatric Association are also not Covered.
38. Services, solely because such services are ordered by a court.
39. Sex, marital, or religious counseling, including sex therapy and treatment of sexual dysfunction.
40. Sex Transformations. Any procedure or treatment designed to alter the physical characteristics of a Participant from the Participant's biological sex to those of the opposite sex regardless of any diagnosis of gender role or psychosexual orientation problems.
41. Special foods and diets, supplements, vitamins, and enteral feedings, except as what is otherwise outlined in this SPD. When coverage of special foods, diets, and enteral feedings are available, it is subject to periodic review for Medical Necessity. Infant formulas are not Covered.
42. Special medical reports not directly related to treatment. Appearances in court or at a hearing.
43. Third-party requests for physical examinations, diagnostic services, and immunizations in connection with: obtaining or continuing employment; obtaining or maintaining any license issued by a municipality, state, or federal government; obtaining insurance coverage; foreign travel; school admissions or attendance, including examinations required for participation in athletic activities. Court ordered psychological or behavioral evaluations or counseling related to marital disputes, divorce proceedings, or child custody proceedings are not Covered.
44. Transplant services required by a Participant when the Participant serves as an organ donor are not Covered unless the recipient is a Participant. The medical

expenses of a non-Participant acting as a donor for a Participant are not Covered if the non-Participant's expenses will be covered under another health plan or program. Donor fees in connection with organ transplant surgery are excluded. The Plan does not Cover travel expenses, lodging, meals, or other accommodations for donors or guests. Transplants performed in facilities other than those designated by Oxford for the transplant procedure are not Covered.

45. Treatment provided in connection with services for individuals who are presently incarcerated, confined, or committed to a local correctional facility or prison, or a custodial facility for youth operated by the office of children and family services.
46. Unnecessary Care. In general, the Plan will not Cover any health care service that Oxford determines is not Medically Necessary. However, if an external appeal agent certified by the state overturns Oxford's denial, the Plan shall Cover the procedure, treatment, service, pharmaceutical product, or Durable Medical Equipment for which coverage has been denied, to the extent that such procedure, treatment, service, pharmaceutical product, or Durable Medical Equipment is otherwise Covered under the terms of this SPD.
47. Any charges by an Out-of-Network Provider for Covered Services that are in excess of Oxford's Out-of-Network Reimbursement Amount are the Participant's responsibility.
48. Weight control. All services, supplies, programs, and surgical procedures for the purpose of weight control other than as specifically covered in this SPD.

As a participant, you have the right to quality health care services, which are provided in a professional manner that respects your dignity and protects your privacy.

SECTION 4: PARTICIPANT RIGHTS AND RESPONSIBILITIES

What are my rights as a participant?

As a Participant you have the following rights:

1. The right to obtain complete and current information concerning a diagnosis, treatment, and prognosis from any Network Provider in terms that you or your authorized representative can readily understand. You have the right to be given the name, professional status, and function of any personnel delivering Covered Services to you. You have the right to receive all information from a Network Provider necessary for you to give your informed consent prior to the start of any procedure or treatment. You also have the right to refuse treatment to the extent permitted by law. Oxford and your Physician will make every effort to arrange a professionally acceptable alternative treatment. However, if you still refuse the recommended treatment and Oxford and your Network Provider believe no professionally acceptable alternative exists, Oxford will not be responsible for the cost of further treatment for that condition. You will be notified accordingly. If a Participant is not capable of understanding any of this information, an explanation will be provided to his or her guardian, designee, or a family member.
2. The right to be provided with information about Oxford's services, policies, procedures, and grievance and appeal procedures, and Oxford's Network Providers that accurately provide relevant information in a manner which is easily understood.
3. The right to quality health care services, which are provided in a professional manner that respects your dignity and protects your privacy. You also have the right to participate in decision-making regarding your health care.

4. The right to privacy and confidentiality of your health records, except as otherwise provided by law or contract. You have the right to all information contained in your medical records unless access is specifically restricted by the attending physician for medical reasons.
5. The right to initiate disenrollment from the Plan.
6. The right to file a formal grievance or appeal if complaints or concerns arise about Oxford's medical or administrative services or policies.
7. The right, when Medically Necessary, to emergency care without unnecessary delay.
8. The right to be advised if any of the Network Providers participating in your care propose to engage in or perform human experimentation or research affecting your care or treatment. You or a legally responsible party acting on your behalf may, at any time, refuse to participate in or continue in any experimentation or research program to which you have previously given informed consent.
9. The right to sign-language interpreter services in accordance with applicable laws and regulations, when such services are necessary to enable you as a person with special communication needs to communicate effectively with your Provider.

What are my responsibilities?

Your responsibilities include:

- Entering into this Plan with the intent of following the policies and procedures as outlined in this SPD.
- Taking an active role in your health care through maintaining good relations with your Provider and following prescribed treatments and guidelines.
- Providing, to the extent possible, information that professional staff need in order to care for you as a Participant.
- Using the emergency room only as described in this SPD.
- Notifying your Plan Administrator of any change in name, address, or any other important information.

If a network provider bills you for any covered service other than your copay or coinsurance, please call the Benefits Fund at (877) RN BENEFITS.

SECTION 5: CLAIMS PROCEDURES

Network Benefits

In general, if you receive Covered Services from a Network Provider, Oxford will pay the Physician or facility directly. If a Network Provider bills you for any Covered Service other than your Copay or Coinsurance, please contact the Provider or call the Benefits Fund at (877) RN BENEFITS [762-3633].

If you receive Covered Services from a Network Provider but not in accordance with the terms and conditions of this SPD, coverage will be provided as described in this SPD. When you see a Network Provider under these circumstances, the Covered Services will be treated as if they were delivered by an Out-of-Network Provider and you must file a claim as described below.

Out-of-Network Benefits

If you receive a bill for Covered Services from an Out-of-Network Provider, you (or the Provider, if he/she prefers) must send the bill to Oxford for processing. To make sure the claim is processed promptly and accurately, a completed claim form must be attached and

mailed to Oxford at the address on the back of your ID card.

How to submit a claim

You can obtain a claim form by visiting **www.rnbenefits.org** or calling the Benefits Fund at (877) RN BENEFITS [762-3633]. If you do not have a claim form, you may attach a brief letter of explanation to the bill and verify the bill contains the information listed below. If any of these items are missing from the bill, you can include them in your letter:

- Your name and address;
- Patient's name, age, and relationship to the Participant;
- ID number as shown on the front of your ID card;
- Name, address, and tax identification number of the Provider of the service(s);
- Diagnosis from the Physician;
- Date of service; and
- Itemized bill from the Provider that includes the Current Procedural Terminology codes; description of, and the charge for, each service; and the date the sickness or injury began.

Failure to provide all the information listed above may delay any reimbursement. The above information should be filed with Oxford at the address on the back of your ID card.

All requests for claims reimbursement must be made within 120 days of the date covered services were rendered.

Payment options

When you receive Covered Services from an Out-of-Network Provider, the Plan will reimburse you and you will then be responsible for reimbursing the Provider. However, in Oxford's discretion, the Plan may pay an Out-of-Network Provider directly.

Limitations

All requests for reimbursement must be made within 120 days of the date Covered Services were rendered. Failure to request reimbursement within the required time will not invalidate or reduce any claim if it was not reasonably possible to provide such proof within the 120-day period. However, such request must be made as soon as reasonably possible thereafter. Under no circumstances will the Plan be liable for a claim that is submitted more than six months after the date services were rendered, unless you are legally incapacitated and unable to submit the request. All reimbursements to Out-of-Network Providers are subject to an Out-of-Network Reimbursement Amount **unless** you were referred to an Out-of-Network Provider precertified by your PCP or Oxford.

If you receive a bill from a Network Provider

The cost of Covered Services provided by Network Providers in accordance with the terms of this SPD will be billed directly to Oxford. **No claim forms are necessary.**

If you should receive a bill from a Network Provider for Covered Services, please contact the Benefits Fund at (877) RN BENEFITS [762-3633] immediately.

Explanation of Benefits

Oxford sends you a paper copy of an Explanation of Benefits after processing the claim. The EOB will let you know if there is any portion of the claim you need to pay. If any claims are denied in whole or in part, the EOB will include the reason for the denial or partial payment.

You can also view and print all of your EOBs online at **www.oxfordhealth.com.**

Limitation of action

You cannot bring any legal action against the Benefits Fund or Oxford for any other reason unless you first complete all the steps in the appeal process described in this section. After completing that process, if you want to bring a legal action against the Benefits Fund or Oxford you must do so within three years of the date you are notified of the final decision on your appeal or you lose any rights to bring such an action against the Benefits Fund or Oxford.

Claim denials and Appeals

The Plan's Grievance Procedure provides for a meaningful, dignified, and confidential procedure to hear and resolve Grievances between Participants, Oxford and, when necessary, Network Providers. This Grievance Procedure also assures that Grievances are handled in a timely manner.

To make this process more accessible to non-English speaking Participants, Oxford will arrange to have an interpreter available who speaks your language. Because the interpreter will be an employee of an independent translating service, Oxford's ability to provide this service depends on the availability of the interpreter. Oxford may need to arrange to call you at a time when an appropriate interpreter is available. Additionally, you always have the right to designate a representative to represent you during the Grievance Procedure. You must provide us with a written consent in order for the designee to act on your behalf. A copy of the Grievance Procedure is available in many languages. Depending on availability, a copy in your language can be forwarded to you upon your request.

Please note: *All complaints and First Level Appeals must be initiated 180 days from the receipt of the Explanation of Benefits, Denial Notice, or the date when the Participant became aware of the issue that initiated the complaint or Appeal.*

Grievance overview

Grievances and complaints are classified into two categories. The category of the specific issue will determine which process you will need to follow in resolving your issue. The two categories are:

Benefit/Administrative Issues – The types of items that fall under this category include, but are not limited to, problems with any of Oxford's administrative policies, issues concerning access to Providers, denials based on benefit exclusions or limitations, claims payment disputes, and administrative inquiries.

Utilization Review Issues – This category includes those items that concern Medically Necessary determinations. The Utilization Review category also includes determinations involving Experimental or Investigational Services or treatments.

Grievance procedure for Benefit/Administrative Issues

Time frames for Initial Determinations for Benefit/Administrative Issues

- **A request for Service (Pre-Service)**: Oxford will inform you and your Provider of Oxford's decision by telephone and in writing no later than 15 calendar days from receipt of the request.
- **Coverage for a service already rendered (Post-Service)**: Oxford will inform you

of Oxford's decision within 30 calendar days of Oxford's receipt of the claim.

- **A request for Urgent Care**: Oxford will inform you or your Provider, subject to Medical Necessity, no later than 72 hours after the receipt of the claim. This includes any claim for medical service, which if subjected to the standard time frames, could seriously jeopardize the life or health of the covered person, the ability to regain maximum function, or in the opinion of a physician with knowledge of the Participant's condition, would subject the Participant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the determination.

Please note: *The Grievance Procedure described below should be used when you have a problem with any of Oxford's policies, procedures, or determinations (Oxford's administrative procedures, access to Providers, failure to use a Network Provider, Covered Benefits under the SPD, etc.) except for issues concerning Medical Necessity. All issues concerning Oxford's determination of Medical Necessity must be resolved through the "Grievance Procedure for Utilization Review Issues" process described on the next page.*

There are two basic elements to the "Grievance Procedure for Benefit/Administrative Issues" for Participants, complaints, and appeals, as described below:

If your claim is denied

Complaints

If a claim for Benefits is denied in part or in whole, you may call the Benefits Fund at (877) RN BENEFITS [762-3633] before requesting a formal Appeal. If the Benefits Fund cannot resolve the issue to your satisfaction over the phone, you have the right to file a formal Appeal as described below.

How to appeal a denied claim

If you wish to appeal a denied Pre-Service request for Benefits, Post-Service claim, or a rescission of coverage as described below, you or your authorized representative must submit your appeal in writing within 180 calendar days of receiving the adverse benefit determination. You do not need to submit Urgent Care appeals in writing. This communication should include:

- Patient's name and ID number as shown on the ID card;
- Provider's name;
- Date of medical service;
- Reason you disagree with the denial; and
- Documentation or other written information to support your request.

You or your authorized representative may send a written request for an appeal to:

Correspondence Department
P.O. Box 29134
Hot Springs, AR 71903

For Urgent Care requests about Benefits that have been denied, you or your Provider can call the Benefits Fund at (877) RN BENEFITS [762-3633] to request an appeal.

Review of an Appeal

When the Appeal Administrator receives your appeal, he/she will assign an Appeal Coordinator to manage your appeal process. The Appeal Administrator will send you a letter that identifies your Appeal Coordinator and include detailed information on the appeal process. Feel free to contact your Appeal Coordinator if you have any questions or concerns about this process.

A qualified individual who was not involved in the decision being appealed will be

appointed to decide the Appeal. If your Appeal is related to clinical matters, the review will be done in consultation with a health care professional who has appropriate expertise in the field and was not involved in the prior determination. The Appeal Administrator may consult with, or seek the participation of, medical experts as part of the Appeal resolution process. You must consent to this referral and the sharing of pertinent medical claim information. Upon your request and free of charge, you have the right to reasonable access to (including copies of) all documents, records, and other information relevant to your claim for Benefits.

If Oxford upholds the denial, once the review is complete, you will receive a written explanation of the reasons and facts relating to the denial and information on how to file a Second Level Appeal.

Filing a Second Appeal

Your Plan offers two levels of Appeal. If you are not satisfied with the First Level Appeal decision, you have the right to request a Second Level Appeal from Oxford within 60 business days from receipt of the First Level Appeal determination.

The Plan offers two levels of appeal. If you are not satisfied with the First Level Appeal decision, you have the right to request a Second Level Appeal from Oxford within 60 business days from receipt of the First Level Appeal determination.

The Appeal Coordinator will make his/her decision on the Second Level Appeal within 15 calendar days after receiving the completed appeal for a Pre-Service denial and 30 calendar days after receiving the completed Post-Service appeal. The Appeal Coordinator will rule that either the Appeal is valid and recommend corrective action to resolve the matter or rule that the Appeal is without merit and does not require further action.

Please note: *Upon written request and free of charge, any Covered Persons may examine documents relevant to their claim and/or Appeals and submit opinions and comments. Oxford will review all claims in accordance with the rules established by the U.S. Department of Labor.*

You or your authorized representative may send a written request for a Second Level Appeal to:

Grievance Review Board
P.O. Box 29134
Hot Springs, AR 71903

Grievance Procedure for Utilization Review Issues

Please note: *This procedure must be used whenever your issue concerns Oxford's determination that a Covered Service is not Medically Necessary.*

For complaints and Appeals concerning all other determinations, you or your authorized representative may send a written letter stating your issue to:

Oxford Health Plans
Clinical Appeals Department
P.O. Box 29139
Hot Springs, AR 71903

Utilization Review

Covered Services are subject to Utilization Review. This means that Oxford's Medical Management Department reviews pertinent medical information in order to determine whether or not the proposed service (request for Precertification), the service currently being provided (Concurrent Review), or the service that was provided (Retrospective Review) is a Covered Service under this SPD and Medically Necessary. If any of the following occur because Oxford has made the determination that such service is not Medically Necessary

(Adverse Determination), you may appeal that determination:

- *A request for* ***Precertification***. Oxford will inform you and your Provider of its decision, by telephone and in writing, no later than two business days from receipt of the necessary information.
- *Coverage for a* ***current service for a Participant in an ongoing course of treatment.*** Oxford will inform you and/or your Provider of its decision, by phone and in writing, within one business day of its receipt of all necessary information. Coverage for an urgent current service for a Participant in an ongoing course of treatment will be decided as soon as possible, taking into account the medical emergency. Oxford will notify the claimant of the benefit determination, whether adverse or not, within 24 hours after receipt of the claim by the Plan, provided that any such claim is made to the Plan at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.
- *Coverage for a* ***service already received is denied (Retrospective Review).*** Oxford will inform you of its decision within 30 calendar days of Oxford's receipt of the claim. The time frames stated in this section might change if Oxford needs additional information from you in order to process your claim, or request for Precertification. You will have up to 45 calendar days to provide the additional information. The 45-calendar day period is calculated from the date you receive Oxford's request for information. A determination will be rendered within 15 calendar days of receipt of the additional information, if received within 45 days, or 15 calendar days from the expiration of the period of time allowed to provide the information.
- ***A request for Service (Pre-Service)***: Oxford will notify you or your Provider within **two business days** that there is a lack of information to process your request for service. You will have up to 45 calendar days to provide the additional information. The 45-day period is calculated from the date you receive Oxford's request for information. A determination will be rendered within two business days of receipt of the additional information, if received within 45 days, or 15 calendar days from the expiration of the period of time allowed to provide the information.
- ***A request for Urgent Care:*** For Urgent Care Services, information will be requested by Oxford within 24 hours of receipt of the request; you will have 48 hours to provide Oxford with the information necessary to complete your request for service. Oxford will render a decision within 48 hours of receipt of the information or the expiration of the original request for additional information, whichever is sooner.

In all cases, if no information is received within the required time frames, the claim or request for service will be denied.

Appeal procedure for Utilization Review issues

Adverse Determinations relating to Precertification and Concurrent Review may be appealed by the Participant's Provider, Participant, or the Participant's designee. You must provide us with a written consent in order for the designee to act on your behalf.

Retrospective Adverse Determinations may be appealed by either the Participant, the Participant's designee, or the Participant's Provider.

All Appeals may be initiated either in writing or by telephone. Clinical personnel who

did not participate in the initial review will review all Appeals.

First Level Appeal

After you are informed of the Adverse Determination, you, your designee, or your Provider (if applicable) have up to 180 calendar days to initiate the Appeal process. The person initiating the Appeal must write or telephone Oxford within this 180-calendar-day period. To initiate an Appeal, please call the Benefits Fund at (877) RN BENEFITS [762-3633] or write to Clinical Appeals Department at P.O. Box 29139, Hot Springs, AR 71903. Oxford will acknowledge the receipt of your Appeal within five business days (not to exceed 15 calendar days) of the receipt of the Appeal request. The acknowledgment will include the name, address, and telephone number of the individual who has been designated to investigate your Appeal. Oxford will advise you, your designee, or your Provider (if applicable) of its decision:

- No later than 15 calendar days for Pre-Service Appeals; or
- No later than 30 calendar days for services that have already been received or for the request for Precertification or Concurrent Care; or
- No later than 72 hours of receipt of a request for Urgent Precertification or Concurrent services.

If the Adverse Determination is upheld, you will receive written or electronic notification. Oxford's response will include its decision on the Appeal as well as the detailed reasons for the decision, along with references to any applicable specific plan provisions on which the benefit determination was based. It also will include information on how to file a Second Level Appeal, along with information on how to obtain information relevant to the claimant's claim for benefits. If you disagree with the First Level Appeal determination you may appeal to the Grievance Review Board described below under "Second Level Appeal."

Second Level Appeal

If you are still dissatisfied with the results after the First Level Appeal has been completed, you or your designee may file your written Appeal with the Grievance Review Board. This Appeal must be filed within 60 business days from the First Level Appeal determination. The Grievance Review Board will make its decisions no later than:

- 30 calendar days from the Board's receipt of an Appeal for services that have already been received.
- 15 calendar days from the Board's receipt of an Appeal for the request for Precertification or Concurrent Care.
- 72 hours of receipt of a request for Urgent Precertification or Concurrent services.

The Board will:

- Rule that the Appeal is valid and recommend corrective action to resolve the matter; or
- Rule that the Appeal is without merit and does not require further action.

You will receive written notice of the Board's decision. The written notice will include detailed reasons for the determination and clinical rationale when applicable, along with references to any applicable specific plan provisions on which the benefit determination was based. It also will include information on the Participant's right to file an External Appeal, along with any forms required to initiate such an appeal.

The ruling of the Grievance Review Board will be the Plan's final position.

All information pertaining to each initial Adverse Determination and Appeal will be

fully documented and Oxford will retain such records for at least three years.

In the event Oxford fails to comply with any of the deadlines for completion of the internal utilization management determination appeals, or in the event that the Plan for any reason expressly waives its rights to an internal review of any appeal, then the Participant and /or Provider shall be relieved of his or her obligation to complete the Plan internal review process and may at his or her option, proceed directly to the external appeal process.

Employee Retirement Income Security Act Rights

After all levels of Appeals have been completed, the Participant may have the right to file a civil action under 502(a) of the Employee Retirement Income Security Act. ERISA rights do not apply if the Participant's coverage for health benefits was:

- Obtained through employment with a church or government group; or
- Purchased as an individual plan from Oxford.

If, after exhausting your internal appeals, you are not satisfied with the determination made by Oxford, or if Oxford fails to respond to your appeal in accordance with applicable regulations regarding timing, you may be entitled to request an external review of Oxford's determination.

Federal external review program

If, after exhausting your internal appeals, you are not satisfied with the determination made by Oxford, or if Oxford fails to respond to your appeal in accordance with applicable regulations regarding timing, you may be entitled to request an external review of Oxford's determination. The process is available at no charge to you.

If one of the above conditions is met, you may request an external review of Adverse Benefit Determinations based upon any of the following:

- Clinical reasons;
- The exclusions for Experimental or Investigational Services or unproven services;
- Rescission of coverage (coverage that was cancelled or discontinued retroactively); or
- As otherwise required by applicable law.

You or your representative may request a standard external review by sending a written request to the address provided in the determination letter. You or your representative may request an expedited external review, in urgent situations as detailed below, by calling Oxford at the toll-free number on the back of your ID card or by sending a written request to the address provided in the determination letter. A request must be made within four months after the date you received Oxford's decision.

An external review request should include all of the following:

- Specific request for an external review;
- Covered Person's name, address, and insurance ID number;
- Your designated representative's name and address, when applicable;
- Service that was denied; and
- Any new, relevant information that was not provided during the internal appeal.

An external review will be performed by an Independent Review Organization. Oxford has entered into agreements with three or more IROs that have agreed to perform such reviews. Two types of external reviews are available: a standard external review and an expedited external review.

Standard external review

A standard external review is comprised of all of the following:

- A preliminary review by Oxford of the request;
- A referral of the request by Oxford to the IRO; and
- A decision by the IRO.

Within the applicable time frame after receipt of the request, Oxford will complete a preliminary review to determine whether the participant meets all of the following:

- Is or was covered under the Plan at the time the health care service or procedure that is at issue in the request was provided;
- Has exhausted the applicable internal appeals process; and
- Has provided all the information and forms required so that Oxford may process the request.

After completing the preliminary review, Oxford will issue a notification in writing to you. If the request is eligible for external review, Oxford will assign an IRO to conduct the review. Oxford will assign requests by either rotating claims assignments among the IROs or by using a random selection process.

The IRO will notify you in writing of the request's eligibility and acceptance for external review. You may submit in writing to the IRO within 10 business days following the date of receipt of the notice additional information that the IRO will consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted by you after 10 business days.

Oxford will provide to the assigned IRO the documents and information considered in making Oxford's determination. The documents include all:

- relevant medical records;
- other documents relied upon by Oxford; and
- other information or evidence that you or your Physician submitted. If there is any information or evidence you or your Physician wish to submit that was not previously provided, you may include this information with your external review request and Oxford will include it with the documents forwarded to the IRO.

In reaching a decision, the IRO will review the claim anew and not be bound by any decisions or conclusions reached by Oxford. The IRO will provide written notice of its determination (the final external review decision) within 30 calendar days after it receives the request for the external review (unless it requests additional time and you agree). The IRO will deliver the notice of final external review decision to you and Oxford, which will include the clinical basis for the determination.

Upon receipt of a final external review decision reversing an Oxford determination, the Plan will immediately provide coverage or payment for the benefit claim at issue in accordance with the terms and conditions of the Plan, and any applicable law regarding plan remedies. If the final external review decision is that payment or referral will not be made, the Plan will not be obligated to provide Benefits for the health care service or procedure.

Expedited external review

An expedited external review is similar to a standard external review. The most significant difference between the two is that the time periods for completing certain portions of the review process are much shorter, and in some instances you may file an expedited external review before completing the internal appeals process.

You may make a written or verbal request for an expedited external review if you receive either of the following:

- An adverse benefit determination of a claim or appeal if the adverse benefit determination involves a medical condition for which the time frame for completion of an expedited internal appeal would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function and you have filed a request

for an expedited internal appeal; or

- A final appeal decision, if the determination involves a medical condition where the time frame for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, or if the final appeal decision concerns an admission, availability of care, continued stay, or health care service, procedure or product for which you received emergency services but have not been discharged from a facility.

Immediately upon receipt of the request, Oxford will determine whether you meet both of the following:

- You are or were covered under the Plan at the time the health care service or procedure that is at issue in the request was provided.
- You have provided all the information and forms required so that Oxford may process the request.

After completing the review, Oxford will immediately send you a written notice. Upon a determination that a request is eligible for expedited external review, Oxford will assign an IRO in the same manner Oxford assigns standard external reviews to IROs. Oxford will provide all necessary documents and information considered in making the adverse benefit determination or final adverse benefit determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method. The IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the same type of information and documents considered in a standard external review.

In reaching a decision, the IRO will review the claim anew and not be bound by any decisions or conclusions reached by Oxford. The IRO will provide notice of the final external review decision for an expedited external review as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request. If the initial notice is not in writing, within 48 hours after the date of providing the initial notice, the assigned IRO will provide written confirmation of the decision to you and to Oxford.

You may contact Oxford at the toll-free number on the back of your ID card for more information regarding external review rights or if making a verbal request for an expedited external review.

The Plan has the right to recover benefits it has paid on your or your dependent's behalf that were made in error or due to a mistake in fact.

SECTION 6: SUBROGATION AND REIMBURSEMENT

The Plan has a right to subrogation and reimbursement, as defined below.

Right of recovery

The Plan has the right to recover benefits it has paid on your or your Dependent's behalf that were:

- made in error;
- due to a mistake in fact;
- paid during the time period of meeting the Deductible; or
- paid during the time period of meeting the Out-of-Pocket Maximum for the Calendar Year.

Benefits paid because you or your Dependent misrepresented facts are also subject to recovery.

If the Benefits Fund provides a Benefit for you or your Dependent that exceeds the amount which should have been paid, the Benefits Fund will require that the overpayment be returned when requested or reduce a future benefit payment for you or your Dependent by the amount of the overpayment.

The Benefits Fund has the right to recover Benefits it has advanced by submitting a reminder letter to you or a Covered Dependent that details any outstanding balance owed to the Benefits Fund; and conducting courtesy calls to you or a Covered Dependent to discuss any outstanding balance owed to the Benefits Fund.

Right to subrogation

The right to subrogation means the Benefits Fund is substituted to, and shall succeed to, any and all legal claims that you may be entitled to pursue against any third party for Benefits that the Plan has paid related to the sickness or Injury for which a third party is considered responsible. Subrogation applies when the Plan has paid on your behalf Benefits for a sickness or Injury for which a third party is considered responsible (an insurance carrier if you are involved in an auto accident).

The Plan will be subrogated to, and shall succeed to, all rights of recovery from any or all third parties, under any legal theory of any type, for 100 percent of any services and Benefits the Plan has paid on your behalf relating to any sickness or Injury caused by any third party.

Right to reimbursement

The right to reimbursement means that if a third party causes a sickness or Injury for which you receive a settlement, judgment, or other recovery from any third party, you must use those proceeds to fully return to the Plan 100 percent of any Benefits you received for that sickness or Injury.

Third parties

The following persons and entities are considered third parties:

- A person or entity alleged to have caused you to suffer a sickness, Injury or damages, or who is legally responsible for the sickness, Injury, or damages;
- Any insurer or other indemnifier of any person or entity alleged to have caused or caused the sickness, Injury, or damages;
- Your employer in workers' compensation cases; or
- Any person or entity who is or may be obligated to provide you with Benefits or payments under:
  - underinsured or uninsured motorist insurance;
  - medical provisions of no-fault or traditional insurance (auto, homeowners or otherwise);
  - workers' compensation coverage; or
  - any other insurance carrier or third party administrator.

Subrogation and reimbursement provisions

As a Covered Person, you agree to the following:

- The Benefits Fund has a first priority right to receive payment on any claim against a third party before you receive payment from that third party. Further, the Plan's first

priority right to payment is superior to any and all claims, debts, or liens asserted by any medical Providers, including but not limited to, hospitals or emergency treatment facilities, that assert a right to payment from funds you recover from a third party.

- The Benefits Fund's subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to you or your representative, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, and punitive damages. The Benefits Fund is not required to help pursue your claim for damages or personal injuries, or pay any of your associated costs, including attorneys' fees. No so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" will defeat this right.
- Regardless of whether you have been fully compensated or made whole, the Benefits Fund may collect from you the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, no matter how those proceeds are captioned or characterized. Proceeds from which the Plan may collect include, but are not limited to, economic, non-economic, and punitive damages. No "collateral source" rule shall limit the Plan's subrogation and reimbursement rights.
- Benefits paid by the Benefits Fund also may be considered to be Benefits advanced.
- You will cooperate with the Benefits Fund and its agents in a timely manner to protect its legal and equitable rights to subrogation and reimbursement, including:
  - Complying with the terms of this section;
  - Providing any relevant information requested;
  - Signing and/or delivering documents at its request;
  - Notifying the Plan in writing of any potential legal claim(s) you may have against any third party for acts that caused Benefits to be paid or become payable;
  - Responding to requests for information about any accident or injuries;
  - Appearing at medical examinations and legal proceedings, such as depositions or hearings; and
  - Obtaining the Plan's consent before releasing any party from liability or payment of medical expenses.
- If you receive payment as part of a settlement or judgment from any third party as a result of a sickness or Injury, and the Benefits Fund alleges some or all of those funds are due and owed to it, you agree to hold those settlement funds in trust, either in a separate bank account in your name or in your attorney's trust account. You agree that you will serve as a trustee over those funds to the extent of the Benefits the Plan has paid.
- If the Benefits Fund incurs attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, the Plan has the right to recover those fees and costs from you.
- You may not accept any settlement that does not fully reimburse the Plan without its written approval.
- Upon the Benefits Fund's request, you will assign to the Plan all rights of recovery against third parties to the extent of the Benefits the Plan has provided for a sickness or Injury caused by a third party.
- The Benefits Fund's rights will not be reduced due to your own negligence.

- The Benefits Fund may, at its option, take necessary and appropriate action to assert its rights under this section, including filing suit in your name, which does not obligate it in any way to pay you part of any recovery the Plan might obtain.
- The provisions of this section apply to the parents, guardian, or other representative of a Dependent child who incurs a sickness or Injury caused by a third party. If a parent or guardian may bring a claim for damages arising out of a minor's sickness or Injury, the terms of this subrogation and reimbursement clause shall apply to that claim.
- In case of your wrongful death or survival claim, the provisions of this section apply to your estate, the personal representative of your estate, and your heirs or beneficiaries.
- No allocation of damages, settlement funds, or any other recovery, by you, your estate, the personal representative of your estate, your heirs, your beneficiaries or any other person or party, shall be valid if it does not reimburse the Plan for 100 percent of its interest unless the Benefits Fund provides written consent to the allocation.
- Your failure to cooperate with the Benefits Fund or its agents is considered a breach of contract. As such, the Plan has the right to terminate your Benefits, deny future Benefits, take legal action against you, and/or set off from any future Benefits the value of Benefits the Plan has paid relating to any sickness or Injury caused by any third party to the extent not recovered by the Plan due to you or your representative not cooperating with the Plan.
- If a third party causes you to suffer a sickness or Injury while you are covered under this Plan, the provisions of this section continue to apply, even after you are no longer a Covered Person.

The Benefits Fund and all Administrators administering the terms and conditions of the Plan's subrogation and reimbursement rights have such powers and duties as are necessary to discharge its duties and functions, including the exercise of its discretionary authority to construe and enforce the terms of the Plan's subrogation and reimbursement rights and make determinations with respect to the subrogation amounts and reimbursements owed to the Plan.

Subrogation – example

You are injured in a car accident that is not your fault and you receive Benefits under the Plan to treat your injuries. Under subrogation, the Plan has the right to take legal action in your name against the driver who caused the accident and the driver's insurance carrier to recover the cost of those Benefits.

SECTION 7: OTHER IMPORTANT INFORMATION

Qualified Medical Child Support Orders

A qualified medical child support order is a judgment, decree, or order issued by a court or appropriate state agency that requires a child to be covered for medical benefits. Generally, a QMCSO is issued as part of a paternity, divorce, or other child support settlement.

If the Plan receives a medical child support order for your child that instructs the Plan to cover the child, the Plan Administrator will review it to determine if it meets the require-

ments for a QMCSO. If it determines that it does, your child will be enrolled in the Plan as your Dependent, and the Plan will be required to pay Benefits as directed by the order.

You may obtain, without charge, a copy of the procedures governing QMCSOs from the Plan Administrator.

Please note: *A National Medical Support Notice will be recognized as a QMCSO if it meets the requirements of a QMCSO.*

Your relationship with Oxford and the Benefits Fund

In order to make choices about your health care coverage and treatment, the Benefits Fund believes that it is important for you to understand how Oxford interacts with the Benefits Fund's Benefit Plan and how it may affect you. Oxford helps administer the Benefits Fund's Benefit Plan in which you are enrolled. Oxford does not provide medical services or make treatment decisions. This means:

- The NYSNA Benefits Fund and Oxford do not decide what care you need or will receive. You and your Physician make those decisions;
- Oxford communicates to you decisions about whether the Benefits Fund will cover or pay for the health care that you may receive (the Benefits Fund pays for Covered Services, which are more fully described in this SPD); and
- The Benefits Fund may not pay for all treatments you or your Physician may believe are necessary. If the Benefits Fund does not pay, you will be responsible for the cost.

The NYSNA Benefits Fund and Oxford do not decide what care you need or will receive. You and your physician make those decisions.

The Benefits Fund and Oxford may use individually identifiable information about you to identify for you (and you alone) procedures, products, or services that you may find valuable. The Benefits Fund and Oxford will use individually identifiable information about you as permitted or required by law, including in operations and in research. The Benefits Fund and Oxford will use de-identified data for commercial purposes, including research.

Relationship with providers

The relationships between the Benefits Fund, Oxford, and Network Providers are solely contractual relationships between independent contractors. Network Providers are not the Benefits Fund's agents or employees, nor are they agents or employees of Oxford. The Benefits Fund and any of its employees are not agents or employees of Network Providers, nor does Oxford and any of its employees act as agents or employees of Network Providers.

The Benefits Fund and Oxford do not provide health care services or supplies, nor do they practice medicine. Instead, the Plan and Oxford arrange for health care Providers to participate in a Network and pay Benefits. Network Providers are independent practitioners who run their own offices and facilities. Oxford's credentialing process confirms public information about the Providers' licenses and other credentials, but does not assure the quality of the services provided. They are not the Benefits Fund's employees nor are they employees of Oxford. The Benefits Fund and Oxford do not have any other relationship with Network Providers, such as principal-agent or joint venture. The Benefits Fund and Oxford are not liable for any act or omission of any Provider.

Oxford is not considered to be an employer of the Benefits Fund for any purpose with respect to the administration or provision of benefits under this Plan.

The Benefits Fund is solely responsible for:

- enrollment and classification changes (including classification changes resulting in your enrollment or the termination of your coverage);

- the timely payment of Benefits; and
- notifying you of the termination or modifications to the Plan.

Your relationship with providers

The relationship between you and any Provider is that of Provider and patient. Your Provider is solely responsible for the quality of the services provided to you. You:

- are responsible for choosing your own Provider;
- are responsible for paying, directly to your Provider, any amount identified as a member responsibility, including Copayments, Coinsurance, any Annual Deductible, and any amount that exceeds Eligible Expenses;
- are responsible for paying, directly to your Provider, the cost of any non-Covered Service;
- must decide if any Provider treating you is right for you (this includes Network Providers you choose and Providers to whom you have been referred); and
- must decide with your Provider what care you should receive.

Interpretation of Benefits

The Benefits Fund and Oxford have the sole and exclusive discretion to:

- interpret Benefits under the Plan;
- interpret the other terms, conditions, limitations, and exclusions of the Plan, including this SPD and any Riders and/or Amendments; and
- make factual determinations related to the Plan and its Benefits.

The Benefits Fund and Oxford may delegate this discretionary authority to other persons or entities that provide services in regard to the administration of the Plan.

In certain circumstances, for purposes of overall cost savings or efficiency, the Benefits Fund may, in its discretion, offer Benefits for services that would otherwise not be Covered Services. The fact that the Benefits Fund does so in any particular case shall not in any way be deemed to require the Benefits Fund to do so in other similar cases.

Information and records

Your medical records are confidential documents. The Benefits Fund and Oxford may use your individually identifiable health information to administer the Plan and pay claims, to identify procedures, products, or services that you may find valuable, and as otherwise permitted or required by law. The Benefits Fund and Oxford may request additional information from you to decide your claim for Benefits. The Benefits Fund and Oxford will keep this information confidential. The Benefits Fund and Oxford may also use your de-identified data for commercial purposes, including research, as permitted by law.

By accepting Benefits under the Plan, you authorize and direct any person or institution that has provided services to you to furnish the Benefits Fund and Oxford with all information or copies of records relating to the services provided to you. The Benefits Fund and Oxford have the right to request this information at any reasonable time. This applies to all Covered Persons, including enrolled Dependents, whether or not they have signed the Participant's enrollment form. The Benefits Fund and Oxford agree that such information and records will be considered confidential.

The Benefits Fund and Oxford have the right to release any and all records concerning health care services that are necessary to implement and administer the terms of the Plan,

The Benefits Fund and Oxford may use your individually identifiable health information to administer the Plan and pay claims, to identify procedures, products, or services that you may find valuable.

for appropriate medical review or quality assessment, or as the Benefits Fund is required to do by law or regulation. During and after the term of the Plan, the Benefits Fund and Oxford and its related entities may use and transfer the information gathered under the Plan in a de-identified format for commercial purposes, including research and analytic purposes.

For complete listings of your medical records or billing statements, the Benefits Fund recommends that you contact your health care Provider. Providers may charge you reasonable fees to cover their costs for providing records or completing requested forms.

If you request medical forms or records from Oxford, you may be charged reasonable fees to cover costs for completing the forms or providing the records.

In some cases, the Benefits Fund and Oxford will designate other persons or entities to request records or information from or related to you, and to release those records as necessary. Oxford's designees have the same rights to this information as does the Plan Administrator.

Incentives to providers

Network Providers may be provided financial incentives by the Oxford to promote the delivery of health care in a cost efficient and effective manner. These financial incentives are not intended to affect your access to health care.

Examples of financial incentives for Network Providers are:

- Bonuses for performance based on factors that may include quality, member satisfaction, and/or cost-effectiveness; or
- A practice called capitation, which is when a group of Network Providers receives a monthly payment from the Claims Administrator for each Covered Person who selects a Network Provider within the group to perform or coordinate certain health services. The Network Providers receive this monthly payment regardless of whether the cost of providing or arranging to provide the Covered Person's health care is less than or more than the payment.

Injuries and diseases covered under any Workers' Compensation program are excluded from coverage under this Plan.

Incentives to you

You may be offered coupons or other incentives to encourage you to participate in various wellness programs or certain disease management programs. The decision about whether or not to participate is yours alone but the Benefits Fund recommends that you discuss participating in such programs with your Physician. These incentives are not Benefits and do not alter or affect your Benefits. You may call the Benefits Fund at (877) RN BENEFITS [762-3633] if you have any questions.

Rebates and other payments

The Benefits Fund and the Claims Administrator may receive rebates for certain drugs that are administered to you in a Physician's office, or at a Hospital or alternate facility. The Benefits Fund and the Claims Administrator do not pass these rebates on to you, nor are they applied to your Annual Deductible or taken into account in determining your Copays or Coinsurance.

Workers' compensation

Injuries and diseases covered under any Workers' Compensation program are excluded from coverage under this Plan.

SECTION 8: GLOSSARY

Many of the terms used throughout this SPD may be unfamiliar to you or have a specific meaning with regard to the way the Plan is administered and how Benefits are paid. This section defines terms used throughout this SPD, but it does not describe the Benefits provided by the Plan.

Acute – The sudden onset of disease or injury, or a sudden change in the Participant's condition that would require prompt medical attention.

Addendum – Any attached written description of additional or revised provisions to the Plan. The benefits and exclusions of this SPD and any Amendments thereto shall apply to the Addendum except that in the case of any conflict between the Addendum and SPD and/or Amendments to the SPD, the Addendum shall be controlling.

Adverse Determination – A determination that an admission, extension of stay, or other Health Care Service is not Medically Necessary based on a review of the information provided or if our request for more information receives no response from you.

Alternate Facility – A health care facility that is not a Hospital which provides one or more of the following services on an outpatient basis, as permitted by law:

- Surgical services;
- Emergency health services; or
- Rehabilitation, laboratory, diagnostic, or therapeutic services.

Ambulatory Surgical Centers - A facility currently licensed by the appropriate state regulatory agency for the provisions of surgical and related medical services on an outpatient basis.

Amendment – Any attached written description of additional or alternative provisions to the Plan. Amendments are effective only when distributed by the Benefits Fund. Amendments are subject to all conditions, limitations, and exclusions of the Plan, except for those that the Amendment is specifically changing.

Annual Deductible (or Deductible) – The amount you must pay for Covered Services in a Calendar Year before the Plan will begin paying Out-of-Network Benefits in that Calendar Year.

Benefits – Plan payments for Covered Services, subject to the terms and conditions of the Plan and any Addendums and/or Amendments.

Calendar Year – January 1 through December 31 of the same year.

Claims Administrator – Oxford and its affiliates, which provide certain claim administration services for the Plan.

Clinical Trial – A scientific study designed to identify new health services that improve health outcomes. In a Clinical Trial, two or more treatments are compared to each other and the patient is not allowed to choose which treatment will be received.

COBRA – See Consolidated Omnibus Budget Reconciliation Act of 1985.

Coinsurance – The percentage of Eligible Expenses you are required to pay for certain Covered Services.

Concurrent Review – See Utilization Review.

Congenital Anomaly – A physical developmental defect that is present at birth and is identified within the first 12 months of birth.

Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) – A federal law that requires employers to offer continued health insurance coverage to certain employees and their Dependents whose group health insurance has been terminated.

Copayment (or Copay) – The set dollar amount you are required to pay for certain Covered Services.

Cosmetic Procedures – Procedures or services that change or improve appearance without significantly improving physiological function, as determined by the Claims Administrator. Reshaping a nose with a prominent bump is a good example of a Cosmetic Procedure because appearance would be improved, but there would be no improvement in function, such as breathing.

Covered or Covered Services – The Medically Necessary services paid for or arranged for you by Oxford under the terms and conditions of this SPD.

Covered Person – Either the Participant or an enrolled Dependent only while enrolled and eligible for Benefits under the Plan. References to "you" and "your" throughout this SPD are references to a Covered Person.

Custodial Care – Services that do not require special skills or training and that:

- provide assistance in activities of daily living, including but not limited to, feeding, dressing, bathing, ostomy care, incontinence care, checking of routine vital signs, transferring, and ambulating;
- are provided for the primary purpose of meeting the personal needs of the patient or maintaining a level of function (even if the specific services are considered to be skilled services), as opposed to improving that function to an extent which might allow for a more independent existence; or
- do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

Deductible – See Annual Deductible.

Dependent – An individual who meets the eligibility requirements as described in the *Eligibility* section of this SPD.

Detoxification Facility – A health care facility licensed by the state as a Detoxification Facility for the treatment of alcoholism.

Durable Medical Equipment (DME) – Medical equipment that is:

- used to serve a medical purpose with respect to treatment of a sickness, Injury, or their symptoms;
- not disposable;
- not of use to a person in the absence of a sickness, Injury, or their symptoms;
- durable enough to withstand repeated use;
- not implantable within the body; and
- appropriate for use, and primarily used, within the home.

Eligible Expenses – Charges for Covered Services that are provided while the Plan is in effect. For certain Covered Services, you are required to pay a percentage of Eligible Expenses in the form of a Copay and/or Coinsurance.

Enrollment Date – The Enrollment Date is the Participant's first day of coverage under the SPD or, if earlier, the first day of the waiting period that must pass with respect to the Participant before the Participant is eligible to be covered under the Plan.

Enrollment Form – The Benefits Fund form that Participants must complete to enroll in the Plan.

Emergency – A serious medical condition or symptom resulting from Injury, sickness, or mental illness, or substance use disorder that arises suddenly, and in the judgment of a reasonable person, requires immediate care and treatment, generally received within 24 hours of onset, to avoid jeopardy to life or health.

Emergency Health Services – Health care services and supplies necessary for the treatment

of an Emergency.

Employee Retirement Income Security Act of 1974 (ERISA) – The federal legislation that regulates retirement and employee welfare benefit programs maintained by employers and unions.

EOB – See Explanation of Benefits.

ERISA – See Employee Retirement Income Security Act of 1974.

Exclusions – Services the Plan does not Cover.

Experimental or Investigational Services – Medical, surgical, diagnostic, psychiatric, mental health, substance use disorders, or other health care services, technologies, supplies, treatments, procedures, drug therapies, medications or devices which, at the time Oxford makes a determination regarding coverage in a particular case, are determined to be any of the following:

- Not approved by the U.S. Food and Drug Administration to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use;
- Subject to review and approval by any institutional review board for the proposed use (Devices that are FDA approved under the *Humanitarian Use Device* exemption are not considered to be Experimental or Investigational); or
- The subject of an ongoing Clinical Trial that meets the definition of a Phase 1, 2, or 3 Clinical Trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight.

Exception: If you have a life threatening sickness or condition (one that is likely to cause death within one year of the request for treatment), Oxford may, at its discretion, consider an otherwise Experimental or Investigational Service to be a Covered Service for that sickness or condition. Prior to such consideration, Oxford must determine that, although unproven, the service has significant potential as an effective treatment for that sickness or condition.

Explanation of Benefits (EOB) – A statement provided by Oxford to you, your Physician, or another health care professional that explains:

- the Benefits provided (if any);
- the allowable reimbursement amounts;
- Deductibles;
- Coinsurance;
- any other reductions taken;
- the net amount paid by the Plan; and
- the reason(s) why the service or supply was not covered by the Plan.

External Appeal – An Appeal conducted by an External Appeal Agent.

First Level Appeal – Your initial Appeal to overturn a decision to reduce or deny benefits**.**

Home Health Agency – A program or organization authorized by law to provide health care services in the home.

Hospital – An institution rendering inpatient and outpatient services for the medical care of the sick or injured. It must be accredited as a Hospital by either the Joint Commission on Accreditation of Health Care Facilities or the Bureau of Hospitals of the American Osteopathic Association. A Hospital may be a general, Acute care, or a specialty institution, provided that it is appropriately accredited as such and currently licensed by the proper

state authorities.
Illness – Physical Illness, disease, or pregnancy.
Injury – Bodily damage other than sickness, including all related conditions and recurrent symptoms.
Inpatient Rehabilitation Facility – A long-term acute rehabilitation center, Hospital, or a special unit of a Hospital designated as an Inpatient Rehabilitation Facility, that provides rehabilitation services, including physical therapy, occupational therapy, and/or speech therapy on an inpatient basis, as authorized by law.
Inpatient Stay – An uninterrupted confinement following formal admission to a Hospital, Skilled Nursing Facility, or Inpatient Rehabilitation Facility.
Intensive Outpatient Treatment - A structured outpatient Mental Health or Substance Use Disorder treatment program that may be free-standing or Hospital-based and provides services for at least three hours per day, two or more days per week.
Medicaid – A federal program administered and operated individually by participating state and territorial governments that provides medical benefits to eligible low-income people needing health care. The federal and state governments share the program's costs.
Medically Necessary – Healthcare services provided for the purpose of preventing, evaluating, diagnosing, or treating a sickness, Injury, Mental Illness, Substance Use Disorder, condition, disease, or symptoms, that are all of the following as determined by Oxford or its designee, within Oxford's sole discretion. The services must be:

- in accordance with *Generally Accepted Standards of Medical Practice*;
- clinically appropriate, in terms of type, frequency, extent, site, and duration, and considered effective for your sickness, Injury, Mental Illness, Substance Use Disorder disease or symptoms;
- not mainly for your convenience or that of your doctor or other health care Provider; and
- not more costly than an alternative drug, service(s), or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your sickness, Injury, disease, or symptoms.

Generally Accepted Standards of Medical Practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials or, if not available, observational studies from more than one institution which suggest a causal relationship between the service or treatment and health outcomes.

If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or professional standards of care may be considered. Oxford reserves the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply Physician specialty society recommendations, the choice of expert, and the determination of when to use any such expert opinion will be within Oxford's sole discretion.

Oxford develops and maintains clinical policies that describe the *Generally Accepted Standards of Medical Practice* scientific evidence, prevailing medical standards, and clinical guidelines supporting its determinations regarding specific services. These clinical policies (as developed by Oxford and revised from time to time), are available to Covered Persons at **www.oxfordhealth.com** or by calling Oxford at the number on the back of your ID card.
Medicare – Parts A, B, C, and D of the insurance program established by Title XVIII, United States Social Security Act, as amended by 42 U.S.C. Sections 1394, et seq. and as later amended.

Mental Health Services – Covered Services for the diagnosis and treatment of Mental Illnesses. The fact that a condition is listed in the current *Diagnostic and Statistical Manual of American Psychiatric Association* does not mean that treatment for the condition is a Covered Service.

Mental Health/Substance Use Disorder Administrator – The organization or individual that provides or arranges Mental Health and Substance Use Disorder Services under the Plan.

Mental Illness – Those mental health or psychiatric diagnostic categories that are listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*, unless those services are specifically excluded under this SPD.

Network – A Provider that has a participation agreement in effect (either directly or indirectly) with Oxford or with its affiliate to participate in the Network.

Network Out-of-Pocket Maximum – The maximum amount you pay every plan year. Refer to your Summary of Benefits for the Out-of-Pocket Maximum amount.

Network Provider – A Physician, Certified Nurse Midwife, Hospital, Skilled Nursing Facility, Home Health Care Agency, or any other duly licensed or certified institution or health professional under contract with Oxford to provide Covered Services to our Participants. A list of Network Providers and their locations is available to you upon enrollment or upon request. This list will be revised from time to time by Oxford.

Non-Occupational Disease or Non-Occupational Injury – A disease or 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 that does.

Open Enrollment Period – A period of time established by the Benefits Fund during which eligible persons may be enrolled. The Benefits Fund's Open Enrollment Period runs annually from November 1 to December 31 for coverage beginning January 1.

Out-of-Network – A Provider that does not have a participation agreement in effect (either directly or indirectly) with the Oxford or with its affiliate to participate in the Network.

Out-of-Network Reimbursement Amount – The Out-of-Network Reimbursement Amount is a compilation of the maximum allowable fees for covered medical services, supplies, and drugs. The maximum allowable fee will be the lesser of:

- the amount charged,
- the amount the provider agrees to accept as reimbursement for the particular Covered Services, supplies, and/or drugs, or
- the amount that in Oxford's discretion is the usual, customary, and reasonable fee for particular Covered Services, supplies, and/or drugs.

When Oxford determines the usual, customary, and reasonable fee, Oxford will consider data compiled by, and guidelines from, Fair Health, Medicare and other sources recognized by the health insurance industry and federal government payers of health care claims as a basis for evaluating and establishing fees for Covered Services, supplies, and drugs. Normally, the data used to compile the Out-of-Network Reimbursement Amount will be based upon the geographic location where the services are provided or a comparable locale. There will be some instances where national data will be used when the data source does not compile data geographically. The data Oxford chooses to consider when establishing an Out-of-Network Reimbursement Amount will be based upon the level of reimbursement purchased by the Plan.

Partial Hospitalization/Day Treatment - A structured free-standing or Hospital-based ambulatory program providing services at least 20 hours per week.

Participant – A full- or part-time Participant at a Participating employer who meets the

eligibility requirements specified in the Plan as described under the *Eligibility* chapter of this SPD. A Participant must live and/or work in the United States.

Physician – Any Doctor of Medicine or Doctor of Osteopathy who is properly licensed and qualified by law.

Please note: A*ny podiatrist, dentist, psychologist, chiropractor, optometrist, nurse practitioner, clinical social worker, physician assistant, or other Provider who acts within the scope of his or her license will be considered on the same basis as a Physician. The fact that a Provider is described as a Physician does not mean that Benefits for services from that Provider are available to you under the Plan.*

Plan – The New York State Nurses Association Benefits Fund.

Plan Administrator – The Benefits Fund or its designee.

Precertification – Process that enables Oxford to review the Medical Necessity of a proposed service or treatment, including the determination of a proposed site of care, manage Benefit limitations, and whether the service will be performed by a Network Provider. Precertification allows Oxford to notify the Participant or the Participant's Provider regarding coverage before the service is provided.

Pregnancy – Prenatal care, postnatal care, childbirth, and any associated complications.

Pre-Service – A request for a Service not yet provided.

Post-Service – Coverage for a Service already provided.

Private Room - A room with one bed. When an Inpatient Stay in a Private Room is a Covered Service, the Private Room is necessary in terms of generally accepted medical practice.

Provider - A Physician, Certified Nurse Midwife, Hospital, Skilled Nursing Facility, Home Health Care Agency, or any other duly licensed or certified institution or health professional.

Primary Care Physician – A Network Physician who has a majority of his/her practice in general pediatrics, internal medicine, obstetrics/gynecology, family practice, or general medicine.

Reconstructive Procedure – A procedure performed to address a physical impairment where the expected outcome is restored or improved function. The primary purpose of a Reconstructive Procedure is to treat a medical condition or improve or restore physiologic function. Reconstructive Procedures include surgery or other procedures associated with an Injury, sickness, or Congenital Anomaly. The primary result of the procedure is not changed or improved physical appearance. The fact that a person may suffer psychologically as a result of the impairment does not classify surgery or any other procedure performed to relieve the impairment as a Reconstructive Procedure.

Rehabilitation Facility – A currently licensed and accredited facility that primarily provides physical therapy treatment.

Reimbursement Policy Guidelines or Reimbursement Policies – The reimbursement rules and guidelines that Oxford decides to implement using guidelines and/or evaluation and validation of Provider billings in accordance with one or more of the following methodologies:

- Indicated in the most recent edition of the *Current Procedural Terminology*, a publication of the American Medical Association.
- Reported by generally recognized professionals or publications.
- Used by the Centers for Medicare and Medicaid Services.
- Determined using other sources recognized by the health insurance industry and federal government payers of health care claims as a basis for evaluating and establishing reimbursement rules or reimbursement guidelines.

- Determined by clinical staff and outside medical consultants.
- Use of a rebundling software package licensed from IntelliClaim, Inc. (currently owned by McKesson Health Solutions).

Residential Treatment Facility – A facility that provides a program of effective Mental Health Services treatment and meets all of the following requirements:

- Is established and operated in accordance with subdivision 10 of section 1.03 of the New York Mental Hygiene Law.
- Provides a program of treatment under the active participation and direction of a Physician and is approved by Oxford.
- Has or maintains a written, specific, and detailed treatment program requiring full-time residence and full-time participation by the patient.
- Provides at least the following basic services in a 24-hour, structured environment:
  - Room and board;
  - Evaluation and diagnosis;
  - Counseling; and
  - Referral and orientation to specialized community resources.

A Residential Treatment Facility that qualifies as a Hospital is considered a Hospital.

Retrospective Review – See Utilization Review.

Second Level Appeal – A request by you or your designee for a review of an Adverse Determination rendered after a First Level Appeal. Additional facts and/or information is required.

Services – The Medically Necessary services paid for or arranged for you by Oxford under the terms and conditions of this SPD.

Skilled Care – Skilled nursing, teaching, and rehabilitation services when:

- they are delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome and provide for the safety of the patient;
- a Physician orders them;
- they are not delivered for the purpose of assisting with activities of daily living, including dressing, feeding, bathing, or transferring from a bed to a chair;
- they require clinical training in order to be delivered safely and effectively; and
- they are not Custodial Care, as defined in this section.

Skilled Nursing Facility – A nursing facility that is licensed and operated as required by law. A Skilled Nursing Facility that is part of a Hospital is considered a Skilled Nursing Facility for purposes of the Plan.

Specialized Rehabilitation Facility – A Hospital or other facility that is certified by the New York Division of Alcoholism and Alcohol Abuse or the Division of Substance Abuse Services for the treatment of alcohol or drug dependent individuals, respectively. It provides nursing, medical counseling, and therapeutic services to such individuals according to individualized treatment plans. Transitional living facilities are excluded from this definition.

Substance Use Disorder Services - Covered Services for the diagnosis and treatment of alcoholism and Substance Use Disorders that are listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association,* unless those services are specifically excluded. The fact that a disorder is listed in the *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment of the disorder is a Covered Service.

Summary Plan Description (SPD) – This SPD is administered by the Benefits Fund,

including the Summary of Benefits and any attached Amendments.

Total Disability – A Participant's inability to perform all substantial job duties because of physical or mental impairment, or a Dependent's inability to perform the normal activities of a person of like age and gender.

Unproven Services – Health services, including medications that are determined not to be effective for treatment of the medical condition and/or not to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-conducted, randomized, controlled trials or cohort studies in the prevailing published peer-reviewed medical literature.

- Well-conducted, randomized, controlled trials are two or more treatments compared to each other (with the patient not being allowed to choose which treatment is received).
- Well-conducted cohort studies from more than one institution are studies in which patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.

Oxford has a process by which it compiles and reviews clinical evidence with respect to certain health services. From time to time, Oxford issues medical and drug policies that describe the clinical evidence available with respect to specific health care services. These medical and drug policies are subject to change without prior notice. You can view these policies at **www.oxfordhealth.com.**

Please note: *If you have a life-threatening sickness or condition (one that is likely to cause death within one year of the request for treatment), Oxford and the Benefits Fund may, at their discretion, consider an otherwise Unproven Service to be a Covered Service for that sickness or condition. Prior to such a consideration, Oxford and the Benefits Fund must first establish that there is sufficient evidence to conclude that, although unproven, the service has significant potential as an effective treatment for that sickness or condition.*

The decision about whether such a service can be deemed a Covered Service is solely at Oxford's and the Benefits Fund's discretion. Other apparently similar promising but Unproven Services may not qualify.

Urgent Care – Treatment of an unexpected sickness or Injury that is not life-threatening but requires outpatient medical care which cannot be postponed. An urgent situation requires prompt medical attention to avoid complications and unnecessary suffering, such as high fever, a skin rash, or an ear infection.

Urgent Care Center – A facility that provides Urgent Care services, as previously defined in this section. In general, Urgent Care Centers:

- do not require an appointment;
- are open outside of normal business hours, so you can get medical attention for minor Illnesses that occur at night or on weekends; and
- provide an alternative if you need immediate medical attention but your Physician cannot see you right away.

Utilization Review – A review to determine whether Health Care Services that have been provided (Retrospective), are being provided (Concurrent), or are proposed to be provided (Precertification) are Medically Necessary.

The Plan's Benefits are administered by the Benefits Fund, the Plan Administrator. Oxford is the Claims Administrator and processes claims for the Plan and provides appeal services; however,

Oxford and the Benefits Fund are not responsible for any decision you or your Dependents make to receive treatment, services, or supplies from a Provider. Oxford and the Benefits Fund are neither liable nor responsible for the treatment, services, or supplies you receive from Providers.

SECTION 9: ADDITIONAL HEALTH CARE NOTICES

Reconstructive Breast Surgery Law

Effective October 21, 1998, group and individual benefit plans that cover mastectomies are required to cover reconstructive surgery or related services following a mastectomy in accordance with the Women's Health and Cancer Rights Act of 1998.

The Act guarantees coverage to any Participant who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with that mastectomy. The Plan is required to provide coverage (as determined in consultation with the attending physician and the patient) for individuals receiving mastectomy-related benefits. Coverage will be provided in a manner determined in consultation with the attending physician and the patient for individuals receiving mastectomy-related benefits. Coverage will be provided in a manner determined in consultation with the attending physician and the patient for:

- all stages of reconstruction of the breast on which the mastectomy has been performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance;
- prostheses; and
- treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided in the same manner as other medical and surgical benefits provided under this Plan.

Statement of Rights under the Newborns' and Mothers' Health Protection Act

Under federal law, health insurance carriers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with child-birth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the carrier may pay for a shorter stay if the attending Provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, carriers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a carrier may not, under federal law, require that a physician or other health care Provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain Providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. For information on precertification, please contact the Benefits Fund at (877) RN BENEFITS [762-3633].

Notification of Language Assistance Program

Oxford understands that we service an increasingly diverse membership. More than ever, we believe that it is important to accommodate language preferences, especially when it

comes to our Participants accessing care and services to ensure that language is not an obstacle to receiving proper care. Oxford offers language assistance services to limited English proficiency Participants. Language assistance services are provided free of charge to Participants. If you need assistance or have any questions about these services, please Benefits Fund at (877) RN BENEFITS [762-3633].

Health Care Reform Notice

Patient Protection and Affordable Care Act Patient Protection Notices

Oxford generally allows the designation of a Primary Care Physician. You have the right to designate any Primary Care Physician who participates in Oxford's network and who is available to accept you or your family members. For information on how to select a Primary Care Physician and for a list of the participating Primary Care Physicians, call the Benefits Fund at (877) RN BENEFITS [762-3633].

For children, you may designate a pediatrician as the Primary Care Physician.

You do not need precertification from Oxford or from any other person (including a Primary Care Physician) in order to obtain access to obstetrical or gynecological care from a health care professional in Oxford's network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining precertification for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals specializing in obstetrics or gynecology, call the Benefits Fund at (877) RN BENEFITS [762-3633].

Chapter 10: Prescription Drug Benefits

The Benefits Fund contracts with OptumRx 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 OptumRx mail service pharmacy. 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 and must be filled through the OptumRx mail service pharmacy (see Page 89 for more information).
  - Coverage is limited to six pills or treatments per 30-day period.
  - Daily dose erectile dysfunction drugs are plan exclusions for the treatment of sexual dysfunction.
- **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 OptumRx 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.
- **Specialty medications,** which are primarily used to treat chronic diseases and conditions such as multiple sclerosis, growth hormone deficiency, cancer, rheumatoid arthritis, and infertility. They include high-cost injectable, infused, oral, or inhaled drugs that require special storage or handling and close monitoring. They must be obtained through mail order in 30-day supplies only and have a Tier 2 preferred brand retail copay. Some specialty drugs used to treat rheumatoid arthritis and growth hormone deficiency may be a non-preferred specialty medication and participants will be responsible for 10 percent of the cost of the drug up to a maximum of $200.

Prescriptions will be filled in the amount normally prescribed by your physician, but

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

not to exceed a 34-day supply at a retail pharmacy or a 90-day supply through OptumRx's mail service pharmacy. The duration of coverage for any drug therapy is limited to the manufacturer's recommendations.

**** Fertility drugs are excluded from coverage for facilities adhering to principles of the Ethical and Religious Directives for Catholic Health Care Services as approved by the United States Conference of Catholic Bishops.***

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 percent of the current prescription is scheduled to have been used (65 percent 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 approved by the Food and Drug Administration 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.
- Daily dose erectile dysfunction drugs for the treatment of sexual dysfunction.

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

- Off-label use (any drug that is not approved by the FDA 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.

In-Network Benefits

The OptumRx 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 OptumRx Web site at **www.optumrx.com**.

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 appropriate copayment. (Refer to Chapter 1 for your facility's plan.)

OptumRx mail-order program

Benefits Fund participants and their covered dependents taking maintenance medications must have those prescriptions filled by OptumRx'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 FDA 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.

Generally speaking, you should ask your doctor to write two prescriptions for any new maintenance medication if you need to begin it immediately. The first prescription would be for the initial 34-day supply and one refill that can be submitted to a retail pharmacy. The second prescription would be for the remainder of the year to be filled in 90-day supplies through OptumRx's mail service pharmacy. Any fills more than the first two that are submitted to a retail pharmacy will not be eligible for reimbursement. You can, of course, ask your doctor for just one prescription for mail order if you don't have to begin the medication right away.

To obtain a list of OptumRx network pharmacies, visit OptumRx.com. Most pharmacies participate with OptumRx.

To use the OptumRx 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 OptumRx's Web site at **www.optumrx.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 OptumRx, PO Box 2975, Mission, KS 66201-9375.

Your order should be delivered within 14 days of the date OptumRx 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 OptumRx's toll-free number at (888) 691-0104 or by accessing OptumRx's Web site at **www.optumrx.com**. Delivery charges apply only if you request expedited delivery.

In-network copayments

The Benefit Coverage plans provide participants with a three-tiered formulary design with different pricing for generic drugs (Tier 1), preferred brand drugs (Tier 2), and non-preferred brand drugs (Tier 3). A deductible may apply and copayments are as follows:

Benefit Coverage Plan A – No deductible

Retail pharmacy (30/34 day supply)

Tier 1: $0/generic

Tier 2: $10/preferred brand

Tier 3: $20/non-preferred brand

Mail order pharmacy (3-month supply)
Tier 1: $0/generic
Tier 2: $20/preferred brand
Tier 3: $40/non-preferred brand

Benefit Coverage Plan B – No deductible
Retail pharmacy (30/34 day supply)
Tier 1: $7/generic
Tier 2: $20/preferred brand
Tier 3: $35/non-preferred brand
Mail order pharmacy (3-month supply)
Tier 1: $15/generic
Tier 2: $40/preferred brand
Tier 3: $70/non-preferred brand

Benefit Coverage Plan C – Yearly deductible $100/person; $250/family
Retail pharmacy (30/34 day supply)
Tier 1: $12/generic
Tier 2: $25/preferred brand
Tier 3: $40/non-preferred brand
Mail order pharmacy (3-month supply)
Tier 1: $25/generic
Tier 2: $50/preferred brand
Tier 3: $80/non-preferred brand

OptumRx makes available to all Fund participants a preferred drug list, or formulary, showing the preferred medications within select therapeutic drug categories. This list is available on the OptumRx Web site at **www.optumrx.com** or via a link on the Benefits Fund Web site, **www.rnbenefits.org**. Please be aware, this list may change quarterly and is not all-inclusive. It is a listing only of the most common drugs available on the market. If you don't see your medication listed, call OptumRx Customer Care at (888) 691-0104 for confirmation.

Participants and their covered dependents taking maintenance medications must have them filled by OptumRx'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: OptumRx, PO Box 2975, Mission, KS 66201-9375.

Out-of-network benefits

The out-of-network benefits allow you to use any pharmacy that doesn't participate in the OptumRx 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 an OptumRx claim form completed by your pharmacist. Send the completed form and paid receipt to OptumRx, PO Box 29044, Hot Springs, AR 71903 for reimbursement. You will be reimbursed at the contracted amount minus the applicable in-network copayment for that drug. 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.

Out-of-network coinsurance and deductibles

Benefit Coverage Plan A - No deductible
Retail pharmacy (30/34 day supply)
Reimbursed at the contracted amount minus applicable in-network copayment.

Benefit Coverage Plan B - No deductible
Retail pharmacy (30/34 day supply)
Reimbursed at the contracted amount minus applicable in-network copayment.

Benefit Coverage Plan C - Yearly deductible $100/person; $250/family
Retail pharmacy (30/34 day supply)
Reimbursed at the contracted amount minus applicable in-network copayment.

For out-of-network services, send completed prescription drug claim forms (available at [877] RN BENEFITS or rnbenefits .org) and an itemized bill to: OptumRx, PO Box 29044, Hot Springs, AR 71903 within one year of the date of service.

Mandatory generics

The mandatory generic program targets brand-name drugs that have direct generic equivalents, including drugs labeled "dispense as written." This means that if you choose to fill a prescription for a brand-name drug which has a direct generic alternative available (whether at retail or mail service pharmacies), you'll be required to pay the brand-name copayment plus the cost difference between the brand-name drug and the generic drug. This charge applies:

- if your doctor writes DAW on the script for the brand-name drug, indicating that a generic equivalent shouldn't be substituted for the brand-name drug, or
- if you indicate you don't want the generic equivalent and request the brand-name drug instead.

If there isn't a direct generic equivalent for the brand-name drug you've been prescribed, in most cases you'll pay the Tier 2 preferred drug copayment.

A generic drug must contain the same active ingredients as the original formulation. For example, the diabetes drug metformin is the generic for brand-name Glucophage. Simvastatin is the generic for brand-name Zocor.

In the rare instances in which someone has a reaction to an ingredient in a generic, or the generic is not as effective as the brand-name drug, your physician can request a prior authorization and, if necessary, file a clinical appeal by following the procedures outlined beginning on Page 93.

Step Therapy

This plan encourages participant use of generic drugs and the most cost-effective brand-name drugs within certain classes of prescription drugs. The drug classes that apply for this program in Benefit Coverage Plan A are:

- ACE inhibitors, ARBs (for high blood pressure)
- Antihistamines (for allergies)
- HMG or statins (for high cholesterol)
- Proton Pump Inhibitors (for stomach acid).

Drug classes that apply for the Step Therapy program in Benefit Coverage Plan B include the four above, plus:

- Bisphosphonates (for osteoporosis)
- COX-2 inhibitors and NSAIDS (for pain and inflammation)

- Nasal steroids (for allergies)
- Selective serotonin agonists (for migraines)
- Selective serotonin reuptake inhibitors (for depression)
- Sleeping agents (for insomnia and sleep problems)
- Urinary antispasmodics (for overactive bladder and incontinence).

Drug classes that apply for the Step Therapy program in Benefit Coverage Plan C include the four from Benefit Coverage Plan A, plus:

- Bisphosphonates (for osteoporosis)
- COX-2 inhibitors and NSAIDS (for pain and inflammation)
- Nasal steroids (for allergies)
- Selective serotonin agonists (for migraines)
- Selective serotonin reuptake inhibitors (for depression)
- Sleeping agents (for insomnia and sleep problems)
- Urinary antispasmodics (for overactive bladder and incontinence).

Participants are prompted to try a generic drug or a select preferred drug within the same drug class. The generic may not be a direct generic equivalent of the prescribed medication. However, participants may progress to other brand-name drugs after trying the required generic or select preferred brand drug. If your doctor believes the prescribed brand-name drug is medically necessary, he can call OptumRx and request a prior authorization for approval.

In order to keep your out-of-pocket costs as low as possible, it's important for Benefits Fund participants who are on medications for the above-listed conditions to tell your doctor at the time of your visit that your prescription benefits plan follows a step therapy program and make sure that you're prescribed a generic drug or a select preferred brand, if available, within that particular drug category.

If you don't have this discussion with your doctor during your office visit and accept a prescription for a non-preferred medication, you'll find that it will be flagged later at the pharmacy. When this occurs, the pharmacy will immediately contact your physician to seek a new prescription for a preferred drug, if available, or a generic drug. At this point:

- Your doctor may choose to switch you to the covered generic or select preferred brand, if available, in that therapeutic class and you'll be required to pay the normal copay for that medication.
- If you've already tried the generic or select preferred brand within that class of drugs over the past 180 or 365 days (depending on the therapeutic class of the drug) and they weren't effective for you, the pharmacist will fill the prescription and you'll be required to pay the normal copay for that medication. If you choose to fill the original script and not follow the step therapy guidelines, you'll be required to pay a charge of 25 percent of the drug cost up to a maximum of $50 for a 30-day supply (the cost is 50 percent up to a $100 maximum for a 90-day maintenance prescription).

Example: *Within the high cholesterol class of drugs, if your doctor prescribes brand-name drug Crestor (one of the many brand-name drugs in the class), you must first try one of the available generic drugs in the class – lovastatin, pravastatin, simvastatin, or atorvastatin. Note that the lists of preferred and/or non-preferred brands are subject to change.*

Quantity Limits Program

The Quantity Limits Program is designed to minimize risks associated with over dosing and promote dose-optimization through identifying appropriate maximum quantities for a specific period of time or per prescription fill. The program uses FDA-approved product labeling, nationally recognized clinical practice guidelines, and other published clinical literature to determine if and when a quantity limit should apply.

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 OptumRx at (800) 711-4555.

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 non-urgent claims.

The above time frames begin on the date OptumRx 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 OptumRx 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: OptumRx, PO Box 29044, Hot Springs, AR 71903. 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 OptumRx receives complete information.

Appealing prior authorization denied claims

If your prior authorization claim is denied, you will receive written notice from OptumRx describing, among other things, the reason for the denial.

To appeal a prior authorization denied claim, submit a written request within 180 days of the date of the denial to: OptumRx Appeals & Grievances, CA 106-0286, 3515 Harbor Blvd, Costa Mesa, CA 92626.

There are two clinical appeals levels. The first level (Level 1) is a Prior Authorization Benefit Reconsideration Review, which begins when a participant or physician decides to appeal a prior authorization 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 OptumRx by contacting the Member Services Department at (888) 691-0104. After completing the form, the participant mails or faxes the form and any relevant and supporting documentation to: OptumRx Appeals & Grievances, CA 106-0286, 3515 Harbor Blvd, Costa Mesa, CA 92626.

Supporting documentation may include a letter written by your provider in support of the appeal, a copy of the denial letter sent by OptumRx, 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 following instructions directed in the prior authorization denial letter.

Upon receipt of the supporting documentation by OptumRx's Medical Affairs Department, an appeals analyst reviews and determines appeals relating to clinical benefits such as clinical criteria determinations, prior authorization protocol, and explicit exclusions under this plan. Appeal determination regarding clinical knowledge such as prior authorization denials are reviewed by an appeals pharmacist.

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

The second level of appeal, or clinical Level 2 appeal, has an outside third party MD (independent specialist physician) review the claim to determine medical necessity. A Level 2 appeal can overturn the decision on the initial clinical Level 1 review. The Level 2 appeals process 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. OptumRx will be advised of the decision and send the participant and the participant's physician a letter confirming the peer review's final determination.

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

If the independent specialist physician 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 first and second levels);
- 30 days for non-urgent prior authorization claims (maximum 15 days at each level);
- 60 days for post-service and non-urgent concurrent care claims (maximum 30 days at each level).

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

If you still are unsatisfied with the denial of your claim for a prescription drug benefit after the appeals process has been exhausted, you have the right to bring a civil action in state or federal court under Section 502(a)(1b) of the Employee Retirement Income Security Act.

To appeal a claim denied for reasons other than medical necessity (non-clinical), contact the Fund office.

Chapter 11: 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.

Covered dental services must be medically necessary, performed by or under the direction of a dentist, 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 101 for more information about orthodontics.

Two different benefits options are available: Network and Out-of-network. 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.

To obtain a list of Aetna network providers, call the Fund office toll-free at (877) RN BENEFITS [762-3633]. A list of network providers also is available through the DocFind® feature on Aetna's Web site at www.aetna.com.

Network providers and benefits

The network option allows you to see a provider in the Aetna Preferred Provider Organization network. You may pay less out of your own pocket when you choose a network provider. 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 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.

Network providers have agreed to provide covered services and supplies at a negotiated charge. Participants share the cost of covered services and supplies by paying a portion of certain expenses (the payment percentage). Your payment percentage is based on the negotiated charge. In no event will you have to pay any amounts above the negotiated charge for a covered service or supply. You have no further out-of pocket expenses when the plan covers in network services at 100 percent. You also have no deductible.

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

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

You will not have to submit dental claims for treatment received from network providers. Your network provider will take care of claim submission.

You will receive notification, known as an Explanation of Benefits, outlining what the plan has paid toward your covered expenses. It will indicate any amounts you owe toward your payment percentage or other non-covered expenses you may have incurred. You may elect to receive this notification by e-mail or through the post office.

Out-of-network providers and benefits

The out-of network option allows you the freedom to see a licensed dental provider who is not in the dental network. You may pay more if you choose an out-of-network provider.

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 $50 per individual and $150 per family regardless of which Benefit Coverage Plan you have.

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

Once your yearly deductible has been met, you share the cost of covered services and supplies by paying a portion of certain expenses (your payment percentage). Your covered expenses for that calendar year will be paid in accordance with the schedule of dental services at:

- 80 percent of the recognized charge for covered diagnostic, preventive, basic restorative, endodontic, periodontic, prosthodontic maintenance, and oral surgery services; and
- 50 percent of the recognized charge for covered major restorative, prosthodontic installation, and orthodontic services.

Payments are made based on the recognized charge. In determining what the recognized charge will be, the dental program takes into consideration (for the geographic area where the service is performed):

- what the provider bills or submits for that service or supply; and
- the 80th percentile of the prevailing charge rate.

Charges in excess of the recognized charge will not be covered. (For more information on recognized charges, see Page 109.)

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.

When charges for a proposed dental service or series of dental services are expected to be $350 or more, you may receive an advance claim review from Aetna to determine the benefits the plan will pay for the proposed services.

Advance claim review (Predetermination of benefits)

When charges for a proposed dental service or series of dental services are expected to be $350 or more, you may receive an advance claim review from Aetna to determine the benefits the plan will pay for the proposed services. Your dentist should submit a claim form for an advance claim review (previously known as a predetermination of benefits) to Aetna showing the treatment plan and fees.

Aetna may request supporting X-rays and other diagnostic records. Aetna will then determine the benefits payable for each dental service according to the terms of this dental plan and will notify you and your dentist of the estimated benefits. An advance claim review is recommended whether you go to a PPO dentist or a nonparticipating dentist. It is voluntary and is not necessary for emergency treatment or routine care such as teeth cleaning or check-ups.

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 a 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.

Covered services

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.

Covered dental services include only the following services:

Type A expenses (diagnostic and preventive care)

Visits and X-rays

- Office visit for oral examination (limited to two visits per calendar year)
- Prophylaxis (cleaning, limited to two treatments per calendar year for adults and children; limit is combined with the periodontal maintenance frequency)
- Topical application of fluoride (limited to one course of treatment per year for children to age 18)
- Bitewing X-rays (limited to two sets per calendar 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).
- Sealant (limited to once per tooth every three years for permanent molars only for children to age 18)

X-ray and pathology

- 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
- Biopsy and histopathologic examination of oral tissue
- Diagnostic casts.

Type B expenses (basic restorative care)

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.

Oral surgery (Includes local anesthetics and routine post-operative care)

- Extractions
    - Erupted tooth or exposed root
    - Coronal remnants
    - Surgical removal of erupted tooth/root tip
    - 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 abscess, 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.

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 (limited to once per site every year)
- 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
- Periodontal maintenance procedures, no perio history required (limited to two per calendar year; limit is combined with the prophylaxis frequency)
- Localized delivery of antimicrobial agent
- 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

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-based composite 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 (Only when needed to preserve space resulting from premature loss of primary teeth; 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.
- Occlusal guard (for bruxism only).

Type C expenses (major restorative care)

Restorative (Inlays, onlays, labial veneers, 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. [Limited to one per tooth every five years – see "Replacement Rule" on Page 101].)

- Inlays/onlays

- Labial veneers
  - Laminate, chairside
  - Resin laminate, laboratory
  - Porcelain laminate, laboratory
- Crowns
  - Resin
  - Resin with noble metal
  - Resin with base metal
  - Porcelain/ceramic substrate
  - Porcelain with noble metal
  - Porcelain with base metal
  - Base metal (full cast)
  - Noble metal (full cast)
  - 3/4 cast metallic or porcelain/ceramic
- Post and core

Prosthodontics (Replacement of existing bridges or dentures is limited to one every five years [see "Replacement Rule" on the next page]).

- 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
  - 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 of adolescent dentition
- Comprehensive orthodontic treatment of adult dentition
- Post treatment stabilization.

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 97 *is subject to change.)*

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.

Rules and limits of the dental plan

Several rules apply to the dental plan. Following these rules will help you use the plan to your advantage by avoiding expenses that are not covered by the plan.

Alternate Treatment Rule

Sometimes there are several ways to treat a dental problem, all of which provide acceptable results. When alternate services or supplies can be used, the plan's coverage will be limited to the cost of the least expensive service or supply that is customarily used nationwide for treatment and deemed by the dental profession to be appropriate for treatment of the condition in question. The service or supply must meet broadly accepted standards of dental practice, taking into account your current oral condition.

You should review the differences in the cost of alternate treatment with your dental provider. Of course, you and your dental provider can still choose the more costly treatment method. You are responsible for any charges in excess of what the plan will cover.

Replacement Rule

Crowns, inlays, onlays and veneers, complete dentures, removable partial dentures, fixed partial dentures (bridges), and other prosthetic services are subject to the plan's replacement rule. That means certain replacements of, or additions to, existing crowns, inlays, onlays, veneers, dentures, or bridges are covered only when you give proof to Aetna that:

- while you were covered by the plan, you had a tooth (or teeth) extracted after the existing denture or bridge was installed. As a result, you need to replace or add teeth to your denture or bridge;
- the present crown, inlay and onlay, veneer, complete denture, removable partial denture, fixed partial denture (bridge), or other prosthetic service was installed at

least five years before its replacement and cannot be made serviceable;
- you had a tooth (or teeth) extracted while you were covered by the plan; your present denture is an immediate temporary one that replaces that tooth (or teeth); a permanent denture is needed, and the temporary denture cannot be used as a permanent denture.

Replacement must occur within 12 months from the date that the temporary denture was installed.

Coverage for dental work begun before you are covered by the plan

The plan does not cover dental work that began before you were covered by the plan. This means that the following dental work is not covered:

- An appliance, or modification of an appliance, if an impression for it was made before you were covered by the plan;
- A crown, bridge, or cast or processed restoration if a tooth was prepared for it before you were covered by the plan; or
- Root canal therapy, if the pulp chamber for it was opened before you were covered by the plan.

Coverage for dental work completed after termination of coverage

Your dental coverage may end while you or your covered dependent is in the middle of treatment. The plan does not cover dental services that are given after your coverage terminates. There is an exception, however. The plan will cover the following services if they are ordered while you were covered by the plan and installed within 30 days after your coverage ends:

- Inlays;
- Onlays;
- Crowns;
- Removable bridges;
- Cast or processed restorations;
- Dentures;
- Fixed partial dentures (bridges); and
- Root canals.

Ordered means:

- For a denture, the impressions from which the denture will be made were taken.
- For a root canal, the pulp chamber was opened.
- For any other item, the teeth which will serve as retainers or supports or the teeth which are being restored must have been fully prepared to receive the item and impressions have been taken from which the item will be prepared.

Appeals procedure

Claim determinations

Urgent care claims

Aetna will notify you of an urgent care claim determination as soon as possible, but no more than 72 hours after the claim is made. If more information is needed to make an urgent claim determination, Aetna will notify you within 24 hours of receipt of the claim. You will then have 48 hours after receiving such notice to provide Aetna with the additional information. Aetna will notify you within 48 hours of the receipt of the additional information or at the end of the 48 hour period given to the physician to provide Aetna with the information, whichever is earliest.

If you fail to follow plan procedures for filing a claim, Aetna will notify you within 24

hours following the failure to comply.

Pre-service claims

Aetna will notify you of a claim determination as soon as possible but no later than 15 calendar days after the pre-service claim is made. Aetna may determine that, due to matters beyond its control, an extension of this 15 calendar day claim determination period is required. Such an extension (which will be no longer than 15 additional calendar days) will be allowed if Aetna notifies you within the first 15 calendar day period. If this extension is needed because Aetna requires additional information to make a claim determination, the notice of the extension will specifically describe the required information. You will have 45 calendar days from the date of the notice to provide Aetna with the required information.

Post-service claims

Aetna will notify you of a claim determination as soon as possible, but no later than 30 calendar days after the post-service claim is made. Aetna may determine that, due to matters beyond its control, an extension of this 30 calendar day claim determination period is required. Such an extension (which will be no longer than 15 additional calendar days) will be allowed if Aetna notifies you within the first 30 calendar day period. If this extension is needed because Aetna requests additional information to make a claim determination, the notice of the extension will specifically describe the required information. You will have 45 calendar days from the date of the notice to provide Aetna with the required information.

Concurrent care claim extension (request to extend a previously approved course of treatment)

Following a request for a concurrent care claim extension, Aetna will notify you of a claim determination for emergency or urgent care as soon as possible but no later than 24 hours provided the request is received at least 24 hours prior to the expiration of the approved course of treatment. Aetna will notify you no later than 15 calendar days with respect to all other care.

Concurrent care claim reduction or termination

Aetna will notify you of a claim determination to reduce or terminate a previously approved course of treatment with enough time for you to file an appeal.

Complaints

If you are dissatisfied with the service you receive from the Plan or want to complain about a provider you must write Aetna Customer Service within 30 calendar days of the incident. You must include a detailed description of the matter and include copies of any records or documents that you think are relevant to the matter. Aetna will review the information and provide you with a written response within 30 calendar days of the receipt of the complaint unless additional information is needed and it cannot be obtained within this period. The notice of the decision will tell you what you need to do to seek an additional review.

Appeals of adverse benefit determinations

You may submit an appeal if Aetna gives notice of an adverse benefit determination. This plan provides two levels of appeal. You have 180 calendar days following the receipt of notice of an adverse benefit determination to request your Level One appeal. Your appeal may be submitted verbally or in writing and should include:

- Your name;
- Your employer's name;

- A copy of Aetna's notice of an adverse benefit determination;
- Your reasons for making the appeal; and
- Any other information you would like to have considered.

The notice of an adverse benefit determination will include the address where the appeal can be sent.

You may also choose to have another person (an authorized representative) make the appeal on your behalf by providing verbal or written consent to Aetna.

Level One appeal – Group health claims

A level one appeal of an adverse benefit determination will be provided by Aetna personnel not involved in making the adverse benefit determination.

- **Urgent care claims** (may include concurrent care claim reduction or termination). Aetna will issue a decision within 36 hours of receipt of the request for an appeal.
- **Pre-service claims** (may include concurrent care claim reduction or termination). Aetna will issue a decision within 15 calendar days of receipt of the request for an appeal.
- **Post-service claims.** Aetna will issue a decision within 30 calendar days of receipt of the request for an appeal.

You may submit written comments, documents, records, and other information relating to your claim, whether or not the comments, documents, records, or other information were submitted in connection 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 may also request that the plan provide you, free of charge, copies of all documents, records, and other information relevant to the claim.

Level Two appeal

If Aetna upholds an adverse benefit determination at the first level of appeal, you or your authorized representative have the right to file a Level Two appeal. The appeal must be submitted within 60 calendar days following the receipt of notice of a Level One appeal. A Level Two appeal of an adverse benefit determination of an urgent care claim, a pre-service claim, or a post-service claim will be provided by Aetna personnel not involved in making an adverse benefit determination.

- **Urgent care claims** (may include concurrent care claim reduction or termination). Aetna will issue a decision within 36 hours of receipt of the request for a Level Two appeal.
- **Pre-service claims** (may include concurrent care claim reduction or termination). Aetna will issue a decision within 15 calendar days of receipt of the request for Level Two appeal.
- **Post-service claims**. Aetna will issue a decision within 30 calendar days of receipt of the request for a Level Two appeal.

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 appeals 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.

Exclusions

Not every dental care service or supply is covered by the plan, even if prescribed, recommended, or approved by your physician or dentist. This plan covers only those services and supplies that are medically necessary and included in the Covered Services section on Page 97. In addition, some services are specifically limited or excluded.

Coverage is not provided for the following:

- Any instruction for diet, plaque control, and oral hygiene.
- Cosmetic services and supplies including plastic surgery, reconstructive surgery, cosmetic surgery, personalization or characterization of dentures, or other services and supplies which improve, alter, or enhance appearance, augmentation, and vestibuloplasty. In addition, other substances to protect, clean, whiten, bleach, or alter the appearance of teeth, whether or not for psychological or emotional reasons, are not covered except as outlined in the Covered Services section. Facings on molar crowns and pontics will always be considered cosmetic.
- Crown, inlays and onlays, and veneers 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.
- Dental implants, braces, mouth guards, and other devices to protect, replace, or reposition teeth and removal of implants.
- Dental services and supplies that are covered in whole or in part:
  - Under any other part of this plan; or
  - Under any other plan of group benefits provided by the contractholder.
- Dentures, crowns, inlays, onlays, bridges, or other appliances or services used for the purpose of splinting, to alter vertical dimension, to restore occlusion, or correcting attrition, abrasion, or erosion.
- Except as covered in the Covered Services section, treatment of any jaw joint disorder and treatments to alter bite or the alignment or operation of the jaw, including temporomandibular joint disorder treatment, orthognathic surgery, and treatment of malocclusion or devices to alter bite or alignment.
- First installation of a denture or fixed bridge, and any inlay and crown that serves as an abutment to replace congenitally missing teeth or to replace teeth all of which were lost while the person was not covered.
- General anesthesia and intravenous sedation, unless specifically covered and only when done in connection with another necessary covered service or supply.
- Orthodontic services and supplies, except as covered in the Covered Services section. Service and supplies not covered include:
  - Replacement of broken appliances;
  - Re-treatment of orthodontic cases;
  - Changes in treatment necessitated by an accident;
  - Maxillofacial surgery;
  - Myofunctional therapy;
  - Treatment of cleft palate;
  - Treatment of micrognathia;
  - Treatment of macroglossia;
  - Lingually placed direct bonded appliances and arch wires (i.e. invisible braces); or

  - Removable acrylic aligners (i.e. invisible aligners).
- Pontics, crowns, cast or processed restorations made with high noble metals (gold or titanium).
- Prescribed drugs, pre-medication, or analgesia.
- Replacement of a device or appliance that is lost, missing, or stolen; the replacement of appliances that have been damaged due to abuse, misuse, or neglect; and an extra set of dentures.
- Services and supplies done where there is no evidence of pathology, dysfunction, or disease other than covered preventive services.
- Services and supplies provided for your personal comfort or convenience or the convenience of any other person, including a provider.
- Services and supplies provided in connection with treatment or care that is not covered under the plan.
- Space maintainers except when needed to preserve space resulting from the premature loss of deciduous teeth.
- Surgical removal of impacted wisdom teeth only for orthodontic reasons.
- Treatment by a provider other than a dentist. However, the plan will cover some services provided by a licensed dental hygienist under the supervision and guidance of a dentist. These include scaling of teeth, cleaning of teeth, and topical application of fluoride.

Additional items not covered

Charges made for the following are not covered except to the extent listed under the Covered Services section on Page 97:

- Any charges in excess of the benefit, dollar, day, visit, or supply limits stated in this document.
- Charges submitted for services by an unlicensed hospital, physician, or other provider or not within the scope of the provider's license.
- Charges submitted for services that are not rendered, or charges submitted for services rendered to a person not eligible for coverage under this plan.
- Court ordered services, including those required as a condition of parole or release.
- Any dental examinations:
  - required by a third party, including examinations and treatments required to obtain or maintain employment or which an employer is required to provide under a labor agreement;
  - required by any law of a government, securing insurance or school admissions, or professional or other licenses;
  - required to travel, attend a school, camp, or sporting event, or participate in a sport or other recreational activity; and
  - any special medical reports not directly related to treatment except when provided as part of a covered service.
- Experimental or investigational drugs, devices, treatments or procedures, except as described in the Covered Services section.
- Payment for the portion of the charge for which Medicare or another party is the primary payer.
- Miscellaneous charges for services or supplies including:

  - Cancelled or missed appointment charges or charges to complete claim forms;
  - Charges the recipient has no legal obligation to pay or charges that would not exist if the recipient did not have coverage (to the extent exclusion is permitted by law), including care in charitable institutions; care for conditions related to current or previous military service; or care while in the custody of a governmental authority.
- Non-medically necessary services, including but not limited to, those treatments, services, prescription drugs, and supplies which are not medically necessary as determined by Aetna for the diagnosis and treatment of illness, injury, restoration of physiological functions, or covered preventive services. This applies even if they are prescribed, recommended, or approved by your physician or dentist.
- Routine dental exams and other preventive services and supplies, except as specifically provided in the Covered Services section.
- Services rendered before the effective date or after the termination of coverage, unless coverage is continued under Continuation of Benefits.
- Any illness or injury related to employment or self-employment including any injuries that arise out of (or in the course of) any work for pay or profit, unless no other source of coverage or reimbursement is available to you for the services or supplies. Sources of coverage or reimbursement may include your employer, workers' compensation, or an occupational illness or similar program under local, state, or federal law. A source of coverage or reimbursement will be considered available to you even if you waived your right to payment from that source. If you are also covered under a workers' compensation law or similar law, and submit proof that you are not covered for a particular illness or injury under such law, that illness or injury will be considered "non-occupational" regardless of cause.

Definitions

Adverse benefit determination – A denial, reduction, termination of, or failure to provide or make payment (in whole or in part) for a service, supply, or benefit. Such adverse benefit determination may be based on:

- Your eligibility for coverage;
- The results of any Utilization Review activities;
- A determination that the service or supply is experimental or investigational; or
- A determination that the service or supply is not medically necessary.

Appeal – A written request to Aetna to reconsider an adverse benefit determination.

Concurrent care claim extension – A request to extend a previously approved course of treatment.

Concurrent care claim reduction or termination – A decision to reduce or terminate a previously approved course of treatment.

Cosmetic – Services or supplies that alter, improve, or enhance appearance.

Dental emergency – Any dental condition that occurs unexpectedly, requires immediate diagnosis and treatment in order to stabilize the condition, and is characterized by symptoms such as severe pain and bleeding.

Dental provider – Any dentist, group, organization, dental facility, or other institution or person legally qualified to furnish dental services or supplies.

Dentist – A legally qualified dentist or a physician who is licensed to do the dental work

he/she performs.

Directory – A list of all PPO providers for Benefits Fund participants.

Hospital – An institution that is primarily engaged in providing, on its premises, inpatient medical, surgical, and diagnostic services; is supervised by a staff of physicians; provides 24-hour-a-day RN service; charges patients for its services; and operates in accordance with the laws of the jurisdiction in which it is located.

An institution may still be defined as a hospital if it does not meet all of the requirements above, but does meet the requirements of the jurisdiction in which it operates for licensing as a hospital and is accredited as a hospital by the Joint Commission on the Accreditation of Healthcare Organizations.

In no event does hospital include a convalescent home or any institution or part of one that is used primarily as a convalescent facility, rest facility, nursing facility, facility for the aged, extended care facility, intermediate care facility, skilled nursing facility, hospice, rehabilitative hospital, or facility primarily for rehabilitative or custodial services.

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.

Medically necessary or medical necessity – Health care or dental services, supplies, or prescription drugs that a physician, other health care, or dental provider exercising prudent clinical judgment would provide to a patient for the purpose of preventing, evaluating, diagnosing, or treating an illness, injury, disease, or its symptoms if that provision of the service, supply, or prescription is:

- In accordance with generally accepted standards of dental practice;
- Clinically appropriate, in terms of type, frequency, extent, site, and duration and considered effective for the patient's illness, injury, or disease;
- Not primarily for the convenience of the patient, physician, other health care, or dental provider;
- Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury, or disease.

For these purposes, "generally accepted standards of medical or dental practice" means standards based on credible scientific evidence published in peer-reviewed literature generally recognized by the relevant medical or dental community, or otherwise consistent with physician or dental specialty society recommendations, and the views of physicians or dentists practicing in relevant clinical areas and any other relevant factors.

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.

Network provider – A dental 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 network provider for the service or supply involved and the class of employees to which you belong.

Nonoccupational illness – An illness that does not arise out of (or in the course of) any work for pay or profit or result in any way from an illness that does. An illness 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 illness 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.
Occupational injury/illness – An injury or illness that arises out of (or in the course of any activity in connection with employment or self-employment whether or not on a full-time basis, or results in any way from an injury or illness which does.
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.
Out-of-network provider – A dental provider who has not contracted with Aetna, an affiliate, or a third-party vendor to furnish services or supplies for this plan.
Payment percentage – Both the percentage of covered expenses that the plan pays and the percentage of covered expenses that the participant pays. The percentage that the plan pays is referred to as the "plan payment percentage" and varies by the type of expense.
Physician – A duly licensed member of a medical profession who has an MD or DO degree; is properly licensed or certified to provide medical care under the laws of the jurisdiction where he practices; and provides medical services that are within the scope of her license or certificate.

This also includes a health professional who: is properly licensed or certified to provide medical care under the laws of the jurisdiction where he practices; provides medical services that are within the scope of her license or certificate; under applicable insurance law, is considered a "physician" for purposes of this coverage; has the medical training and clinical expertise suitable to treat your condition; specializes in psychiatry if your illness or injury is caused, to any extent, by alcohol abuse, substance abuse, or a mental disorder; and is not you or related to you.
Pre-service claim – Any claim for medical care or treatment that requires approval before the medical care or treatment is received.
Post-service claim – Any claim that is not a pre-service claim.
Recognized charge – The recognized charge for each service or supply is the lesser of what the provider bills or submits for that service or supply and the 80th percentile of the prevailing charge rate for the geographic area where the service is furnished.

If Aetna has an agreement with a provider (directly, or indirectly through a third party) that sets the rate which Aetna will pay for a service or supply, then the recognized charge is the rate established in such agreement.

Aetna may also reduce the recognized charge by applying Aetna reimbursement policies. Aetna reimbursement policies address the appropriate billing of services, taking into account factors that are relevant to the cost of the service such as:

- the duration and complexity of a service;
- whether multiple procedures are billed at the same time, but no additional overhead is required;
- whether an assistant surgeon is involved and necessary for the service;
- if follow-up care is included;
- whether there are any other characteristics that may modify or make a particular service unique; and
- when a charge includes more than one claim line, whether any services described by a claim line are part of or incidental to the primary service provided.

Aetna reimbursement policies are based on Aetna's review of: the policies developed for

Medicare; the generally accepted standards of medical and dental practice that are based on credible scientific evidence published in peer-reviewed literature generally recognized by the relevant medical or dental community or which is otherwise consistent with physician or dental specialty society recommendations; and the views of physicians and dentists practicing in the relevant clinical areas. Aetna uses a commercial software package to administer some of these policies.

As used above, geographic area and prevailing charge rates are defined as follows:

Geographic area: An expense area grouping defined by the first three digits of the U.S. Postal Service ZIP Codes. If the volume of charges in a single three-digit ZIP code is sufficient to produce a statistically valid sample, an expense area is made up of a single three-digit ZIP code. If the volume of charges is not sufficient to produce a statistically valid sample, two or more three-digit ZIP codes are grouped to produce a statistically valid sample. When it is necessary to group three-digit ZIP codes, the grouping never crosses state lines.

Prevailing charge rates: These are the rates reported by FAIR Health, a nonprofit company, in its database. FAIR Health reviews and, if necessary, changes these rates periodically. Aetna updates its systems with these changes within 180 days after receiving them from FAIR Health.

Specialist dentist – Any dentist who, by virtue of advanced training, is board-eligible or certified by a specialty board as being qualified to practice in a special field of dentistry.

Urgent care claim – Any claim for medical care or treatment in which a delay in treatment could jeopardize your life; jeopardize your ability to regain maximum function; cause you to suffer severe pain that cannot be adequately managed without the requested medical care or treatment; or, in the case of a pregnant woman, cause serious jeopardy to the health of the fetus.

Chapter 12: 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 Davis Collection (available in most in-network doctors' offices), and any lens type (most are included at no additional cost), 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 boxes of either disposable lenses or planned replacement lenses. Existing wearers will receive a reassessment fitting and 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 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
- $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.

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

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 Davis Vision 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 percent discount or
- a 5 percent 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.

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.

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.

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: Davis Vision Quality Assurance, PO Box 791, Latham, NY 12210.

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.

Chapter 13: 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 begins 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 66 $^{2}/_{3}$ percent 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 com-

plete 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 Continued Disability" (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 14: 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.

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.

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 percent 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.

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.

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.

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.

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.
- The 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.
- Claimants may go to court to enforce their rights if the plan fails to make timely decisions or otherwise fails to comply with the regulation.

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 15: Life Insurance Benefits

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 percent 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 percent when the participant reaches age 65 and by 50 percent 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 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.

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 percent 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 16: Accidental Death and Dismemberment Benefits

The New York State Nurses Association Benefits Fund provides an accidental death and dismemberment and loss of sight benefit 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 benefit).

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.

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

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 plan 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 Benefits Department manager 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 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.

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 17: 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.

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 Oxford Health Plan, The Hartford Life Insurance Company, OptumRx, Inc., 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 Ronald F. Lamy, CPA, 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.

Information Directory

Oxford (Medical and hospital care)

Locate an Oxford provider:

• **By Phone** (877) RN BENEFITS [Fund office]

• **Online** www.oxfordhealth.com

Precertification:

• **By phone** (800) 666-1353

TTY/TDD Hotline:

• **By phone** (800) 201-4875

All claim forms may be mailed to:
Oxford Health Plans
Attn: Claims Department
PO Box 29130
Hot Springs, AR 71903

Appeals and grievances may be mailed to:
Oxford Health Plans
Issue Resolution Department
PO Box 29135
Hot Springs, AR 71903

Oxford Grievance Review Board
PO Box 29134
Hot Springs, AR 71903

Oxford Health Plans
Clinical Appeals Department
PO BOx 29139
Hot Springs, AR 71903

To provide notification of an inpatient admission resulting from an emergency:

• **By phone** (877) RN BENEFITS [Fund office]

To confirm eligibility, check claim status, or speak to a representative:

• **By phone** (877) RN BENEFITS [Fund office]

OptumRx (Prescription drug care)

Locate a pharmacy:
• **By phone** (877) RN BENEFITS [Fund office]

• **Online** www.OptumRx.com

Mail claim forms to:
OptumRx
PO Box 29044
Hot Springs, AR 71903

Order a 30+ day supply:
• **By mail**
OptumRx
PO Box 2975
Mission, KS 66201-9375

• **By phone** (800) 691-0104

• **Online** www.OptumRx.com

Davis Vision (Vision care)

Locate a provider:
• **By phone** (800) 999-5431 or
(877) RN BENEFITS (Fund office)

• **Online** www.davisvision.com

Mail claim forms to:
Vision Care Processing Unit
PO Box 1525
Latham, NY 12110

Aetna (Dental care)

Locate a provider:
• **By phone** (877) RN BENEFITS [Fund office]

• **Online** www.aetna.com/docfind/

Mail claim forms to:
Aetna
PO Box 14094
Lexington, KY 40512-4094