Summary Material Modification: Effects of Health Care Reform

A s 2010 draws to a close, the NYSNA Benefits Fund is busy preparing for some changes coming to the Fund in 2011, as required by the Patient Protection and Affordable Care Act. These important alterations will affect each and every participating RN, so we encourage you to take a few minutes out of your busy schedule to read the following information and brush up on the modifications that lie ahead. If you have any questions regarding these updates, please contact the Benefits Fund office at (877) RN BENEFITS.

Eligible Dependents
Please add the following Summary Material Modification to the Eligibility section (Chapter 6) of your Summary Plan Description. This information replaces the Eligible dependents subsection, which runs from Page 25 to Page 27 and is effective January 1, 2011.

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

• Your spouse or your same-sex domestic partner 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, provided the dependent is not offered healthcare benefits by his or her employer.
• Dependent children living with you while awaiting your legal adoption are eligible for these benefits until their 26th birthday as long as they are not offered healthcare benefits by their employer.
• The children of your same-sex domestic partner are eligible for coverage until December 31 of the year in which they turn age 19 or until December 31 of the year they turn 23 if they are full-time students.

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

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

Stepchildren
Stepchildren are eligible for medical, dental, vision and prescription drug coverage until 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.

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

• Be age 18 or older;
• Not be married;
• Not be related by blood to the participant in a manner that would bar marriage in New York state;
• Have a close and committed personal relationship with the participant;
• Have been living with the participant on a continuous basis for at least six months;
• Be financially interdependent with the participant and submit evidence of at least two of the following:
  – Joint bank account,
  – Joint credit card,
  – Joint loan obligation,
  – Joint mortgage or lease,
  – Joint ownership of a residence,
  – Joint household expenses such as utility and telephone bills,
  – Joint ownership of a motor vehicle,
  – Wills naming each other as executor and/or beneficiary,
  – Granting each other powers of attorney,
  – Designation of one or the other as beneficiary under a retirement benefits account,
  – Proof of other joint responsibility.

In addition, the participant must provide an affidavit of domestic partnership. Affidavits are available from the Benefits Fund. Call (877) RN BENEFITS [762-5633] or logon to www.nrnbenefits.org and go to the Forms page.

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

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

Dependent children of the participant’s same-sex domestic partner also are extended Benefits Fund coverage until December 31 of the year they reach age 19. If the dependent child is a full-time college student, he may be eligible for coverage up to age 23.

Full-time college students (this only applies to children of same-sex domestic partners)

Dependent children of a same-sex domestic partner who are unmarried, full-time students, and primarily dependent on your domestic partner for support, remain eligible for benefits through December 31 of the year they reach their 23rd birthday. To be considered full-time, a student must take at least 12 credit hours or four academic courses.

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

The verification letter must be an original, must be mailed (faxes will not be accepted), and should include your name, the dependent’s full name and Social Security number, and verify that she is a full-time college student for the semester. Failure to have the school registrar send a letter confirming the student’s...
Sorry little brother, first-borns are smarter

Birth order, it seems, may have an effect on your children’s personality and intelligence, with first-born siblings generally being the smartest while younger siblings get better grades and are more outgoing. A new study conducted at Adelphi University found that first-born children tended to do better on measures of intelligence but younger siblings achieved higher overall grade point averages.

Researchers believe the older siblings may perform better on tests because at some point in their lives they were the only child receiving the total attention of their parents. Younger brothers or sisters, however, may earn better grades because they’ve received mentoring from their older sibling who have already learned the subject. Later born children may also feel pressure to excel to keep up with their older siblings or get extra attention from their parents.

Researchers also looked at differences in personality between 76 pairs of high-school aged siblings. Younger siblings turned out to be generally more extroverted, sentimental, forgiving, and open to new experiences than their older siblings. The study discovered first-borns tend to be more perfectionistic than their younger siblings.

Younger siblings, researchers suggest, may be more open to new experiences because they’ve already seen what their older siblings have gone through and feel more secure in attempting challenges themselves.

Are you sure you need those dental X-rays?

Yearly dental X-rays are unnecessary and can expose patients to needless radiation, according to Consumer Reports’ OnHealth.

By showing what’s happening beneath the surface of your teeth and gums, dental X-rays provide helpful information to assist your dentist in evaluating your oral health. Most people need full-mouth X-rays just once every 5 to 8 years, OnHealth reports, while bitewing X-rays of specific teeth can be done every 2 to 3 years.

Specifically, the American Dental Association recommends the following regarding dental X-rays:

• All new patients should have a complete set of X-rays;
• Patients without cavities and those who brush and floss regularly should receive a set of posterior bitewing X-rays every 2 to 3 years;
• Patients with cavities or other dental problems may need X-rays every 6 to 18 months;
• Children and adolescents should have X-rays more often (usually every 6 to 12 months).

If your dentist is recommending more X-rays than outlined above for you or a family member, be sure to question his reason. Depending on your oral health, it may be just fine to wait until a future visit for additional X-rays.

Don’t forget to start using your new Oxford ID card* after January 1 when seeking medical services at a doctor’s office, hospital, laboratory, or any other healthcare facility.

*If you have not yet received your Oxford ID card, it will be arriving in your mailbox by the end of December.
Plan changes cont.

full-time status will cause the dependent’s coverage to be terminated.
A certificate from the National Student Clearinghouse” also is acceptable as proof of full-time enrollment. The same due dates and criteria for student letters apply to certificates.
Once the dependent child’s student status changes (she is no longer unmarried or a full-time student), benefits will be terminated as of the date the change of status occurred.
If the dependent student needs to take a medically necessary leave of absence or requires a change to part-time class status due to illness, he may continue health coverage with the Benefits Fund for up to one year.
To continue benefits through the Fund, we must receive written confirmation from the dependent student’s treating physician stating that the student is suffering from a serious illness or injury and that the leave or change in student enrollment status is medically necessary. The Fund also must receive notification from the school confirming the student is on approved medical leave of absence or other medically approved change of enrollment status.
The coverage period begins on the first day of the medical leave and extends for one year after that date or until coverage would otherwise terminate, whichever happens first.

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 the dependent 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.

Elimination of annual or lifetime limit on benefits
Please add the following Summary Material Modification to the Summary of Benefits section (Chapter 4) of your Summary Plan Description. It is effective January 1, 2011.
As of January 1, 2011, there will no longer be an annual or lifetime limit on out-of-network benefits. If you had previously met the lifetime or annual out-of-network limit, you will once again have out-of-network coverage starting January 1.
In addition to the above changes, the Benefits Fund Trustees also decided this year to make a change in the Fund’s medical provider starting in 2011.

Change to Oxford Health Insurance
Effective January 1, 2011, the NYSNA Benefits Fund has a new medical care provider, Oxford Health Insurance Inc., a UnitedHealthcare company, to replace Health Net.
Please add the Summary Material Modification below to the Summary Plan Description you received in 2008 or when you became a participant of the Benefits Fund.
Please replace any mention of “Health Net” with “Oxford Health Insurance Inc., a UnitedHealthcare company” wherever it is found within your Summary Plan Description.
In addition, under the “Fund administration” section on Page 8, the reference to Health Net should be removed and replaced with Oxford Health Plans, 48 Monte Turnpike, Trumbull, CT, 06611, (203) 459-0000. The Fund provides medical coverage to participants under an insured plan with Oxford Health Insurance Inc., a UnitedHealthcare company.

Statement of Fund’s grandfathered health plan status
The NYSNA Benefits Fund believes our plan is a grandfathered health plan under the Patient Protection and Affordable Care Act. As permitted by PPACA, a grandfathered health plan can preserve certain basic health coverage that was already in effect when the law was enacted. Being a grandfathered health plan means that the plan may exclude certain consumer protections of PPACA that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing such as copayments or coinsurance. However, grandfathered health plans must comply with certain other consumer protections in PPACA, such as expanded coverage for adult children up to age 26, beginning January 1, 2011.

Questions regarding which protections apply and do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at PO Box 12430, Albany, NY 12212-2430 or by calling (518) 869-9501.
You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at (866) 444-3272 or www.dol.gov/ebsa/healthreform, which contains a table summarizing the protections that do and do not apply to grandfathered health plans. FYB
Inpatient hospital care

**In-network:** Charges are generally paid at 100 percent. Any applicable deductibles are paid at 100 percent once any applicable deductibles have been met. Any cost of facility charges described in the benefit plan description are paid at 100 percent. An independent health plan may pay any applicable deductibles.

**Out-of-pocket facility charges:** Charges are generally paid at 100 percent. Any applicable deductibles are paid at 100 percent once any applicable deductibles have been met. Any cost of facility charges described in the benefit plan description are paid at 100 percent. An independent health plan may pay any applicable deductibles.

**Spotlight in the Benefits Fund**

**Room and board and other services:** Charges are generally paid at 100 percent. Any applicable deductibles are paid at 100 percent once any applicable deductibles have been met. Any cost of facility charges described in the benefit plan description are paid at 100 percent. An independent health plan may pay any applicable deductibles.

**Physicians’ services:** Charges are generally paid at 100 percent. Any applicable deductibles are paid at 100 percent once any applicable deductibles have been met. Any cost of facility charges described in the benefit plan description are paid at 100 percent. An independent health plan may pay any applicable deductibles.

**Other services:** Charges are generally paid at 100 percent. Any applicable deductibles are paid at 100 percent once any applicable deductibles have been met. Any cost of facility charges described in the benefit plan description are paid at 100 percent. An independent health plan may pay any applicable deductibles.

**Out-of-network charges:** Charges are generally paid at 100 percent. Any applicable deductibles are paid at 100 percent once any applicable deductibles have been met. Any cost of facility charges described in the benefit plan description are paid at 100 percent. An independent health plan may pay any applicable deductibles.