This comprehensive Summary Material Modification reflects changes made to the New York State Nurses Association Benefits Fund since the Fund published its most recent Summary Plan Description in 2008. It also replaces or restates any Summary Material Modifications published since 2008.

Specifically, the following chapters being replaced are:
Chapter 1: Participating Employers
Chapter 2: Administration
Chapter 4: Summary of Benefits
Chapter 5: Enrollment
Chapter 6: Eligibility
Chapter 8: Benefits Following Termination
Chapter 10: Dental Benefits
Chapter 11: Prescription Drug Benefits

Please keep this booklet with your copy of the 2008 Summary Plan Description.
# Table of Contents

Chapter One: Participating Employers ................................................................. 4
  Facilities ........................................................................................................ 4
  Plans ............................................................................................................ 4
  Eligibility dates ............................................................................................ 4

Chapter Two: Administration .............................................................................. 7
  Fund administration ...................................................................................... 8
  Amending or eliminating benefits or terminating the plan ......................... 9
  Notice of Privacy Practices .......................................................................... 9

Chapter Four: Summary of Benefits .................................................................. 13
  Financial ...................................................................................................... 13
  Medical care benefits .................................................................................. 14
    Preventive care ......................................................................................... 14
    Maternity care ......................................................................................... 14
    Inpatient care ......................................................................................... 14
    Outpatient care ....................................................................................... 15
    Other services ......................................................................................... 16
  Emergency care .......................................................................................... 16
  Mental health .............................................................................................. 17
  Substance abuse .......................................................................................... 17
  Dental care benefits .................................................................................... 18
  Prescription drug benefits .......................................................................... 18
  Vision care benefits .................................................................................... 20
  Disability benefits ...................................................................................... 21
  Other insurance benefits ............................................................................ 21

Chapter Five: Enrollment .................................................................................... 22

Chapter Six: Eligibility ....................................................................................... 23
  Full-time employees effective date ............................................................. 23
  Full-time employees who opt out ............................................................... 23
  Part-time employees effective date ............................................................. 24
  Eligible dependents ................................................................................... 24
    Stepchildren ............................................................................................. 25
    Foster children and legal wards ............................................................... 25
    Disabled dependents .............................................................................. 25
    Qualified Medical Child Support Order .................................................. 25
  Termination, denial, and reduction of coverage .......................................... 26

Chapter Eight: Benefits Following Termination .................................................. 28
  COBRA continuation coverage .................................................................. 28
  Conversion options ..................................................................................... 30

Chapter Ten: Dental Benefits .............................................................................. 31
  In-network benefits .................................................................................... 36
  Out-of-network benefits ............................................................................ 30
  Claims .......................................................................................................... 36
  Exclusions .................................................................................................. 39
  Exclusions and limitations ........................................................................ 40
  Definitions .................................................................................................. 41

Chapter Eleven: Prescription Drug Benefits ...................................................... 44
  Covered medications ................................................................................... 44
  Exclusions .................................................................................................. 45
  In-network benefits .................................................................................... 45
  Out-of-network benefits .......................................................................... 47
  Mandatory generics .................................................................................... 47
  Step therapy ............................................................................................... 48
  Claims ........................................................................................................ 49
Chapter 1: Participating Employers

<table>
<thead>
<tr>
<th>Facility</th>
<th>Plan</th>
<th>Eligibility date*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Albert Einstein College of Medicine of Yeshiva University</td>
<td>Benefit Coverage Plan A</td>
<td>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</td>
</tr>
<tr>
<td>Beth Abraham Health Services</td>
<td>Benefit Coverage Plan A</td>
<td>First day of the month following date of hire</td>
</tr>
<tr>
<td>Bronx-Lebanon Hospital Center</td>
<td>Benefit Coverage Plan A</td>
<td>First day of the month following date of hire</td>
</tr>
<tr>
<td>Bronx-Lebanon Special Care Center</td>
<td>Benefit Coverage Plan A</td>
<td>First day of the month following date of hire</td>
</tr>
<tr>
<td>The Brooklyn Hospital Center</td>
<td>Benefit Coverage Plan B</td>
<td>90 days after date of hire</td>
</tr>
<tr>
<td>Corizon/Correctional Medical Associates (formerly PHS)</td>
<td>Benefit Coverage Plan A</td>
<td>First day of the month following date of hire</td>
</tr>
<tr>
<td>County of Sullivan</td>
<td>Benefit Coverage Plan A</td>
<td>First day of the month following date of hire</td>
</tr>
<tr>
<td>Flushing Hospital Medical Center</td>
<td>Benefit Coverage Plan A</td>
<td>First day of the month three months after date of hire</td>
</tr>
<tr>
<td>Gracie Square Hospital</td>
<td>Benefit Coverage Plan A</td>
<td>First of the month following 60 days after date of hire</td>
</tr>
<tr>
<td>Interfaith Medical Center</td>
<td>Benefit Coverage Plan A</td>
<td>First day of the month following date of hire</td>
</tr>
<tr>
<td>Kingsbrook Jewish Medical Center</td>
<td>Benefit Coverage Plan A</td>
<td>Full time: 60 days; part time: after four months</td>
</tr>
<tr>
<td>The Mount Sinai Hospital</td>
<td>Benefit Coverage Plan A</td>
<td>First day of the month following date of hire for medical and weekly disability; full benefit coverage after three months</td>
</tr>
</tbody>
</table>

* As determined by the collective bargaining agreement between NYSNA and the participating employer.
<table>
<thead>
<tr>
<th>Facility</th>
<th>Plan</th>
<th>Eligibility date*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nephro Care, Inc.</td>
<td>Benefit Coverage Plan B</td>
<td>First day of the month following date of hire</td>
</tr>
<tr>
<td>New York Dialysis Management, Inc.</td>
<td>Benefit Coverage Plan B</td>
<td>First day of the month following date of hire</td>
</tr>
<tr>
<td>New York Dialysis Services</td>
<td>Benefit Coverage Plan B</td>
<td>First day of the month following date of hire</td>
</tr>
<tr>
<td>New York Dialysis Services, Inc./ABC</td>
<td>Benefit Coverage Plan B</td>
<td>First day of the month following date of hire</td>
</tr>
<tr>
<td>New York Methodist Hospital</td>
<td>Benefit Coverage Plan A</td>
<td>First day of the first month following date of hire</td>
</tr>
<tr>
<td>New York Presbyterian Hospital</td>
<td>Benefit Coverage Plan A</td>
<td>First day of the month following date of hire</td>
</tr>
<tr>
<td>New York Westchester Square Medical Center</td>
<td>Benefit Coverage Plan A</td>
<td>First day of the first month following date of hire</td>
</tr>
<tr>
<td>Opioid Treatment Center</td>
<td>Benefit Coverage Plan A</td>
<td>First day of the month three months after date of hire</td>
</tr>
<tr>
<td>Parker Jewish Institute for Health Care and Rehabilitation</td>
<td>Benefit Coverage Plan A</td>
<td>First day of the month following date of hire (employees are eligible if they work at least 975 hours per year)</td>
</tr>
<tr>
<td>Richmond University Medical Center</td>
<td>Benefit Coverage Plan A</td>
<td>First day of the month following three months' employment</td>
</tr>
<tr>
<td>Southside Hospital</td>
<td>Benefit Coverage Plan A</td>
<td>60th day following date of hire</td>
</tr>
<tr>
<td>St. Cabrini Nursing Home</td>
<td>Benefit Coverage Plan A</td>
<td>First day of the month following date of hire</td>
</tr>
<tr>
<td>St. John's Riverside Hospital</td>
<td>Benefit Coverage Plan A</td>
<td>First day of the month following date of hire</td>
</tr>
</tbody>
</table>

* As determined by the collective bargaining agreement between NYSNA and the participating employer.
<table>
<thead>
<tr>
<th>Facility</th>
<th>Plan</th>
<th>Eligibility date*</th>
</tr>
</thead>
<tbody>
<tr>
<td>St. Luke's – Roosevelt Hospital Center</td>
<td>Benefit Coverage Plan A</td>
<td>First day of the month following date of hire</td>
</tr>
<tr>
<td>Staten Island University Hospital - North</td>
<td>Benefit Coverage Plan A</td>
<td>60th day following date of hire</td>
</tr>
<tr>
<td>Syosset Hospital</td>
<td>Benefit Coverage Plan A</td>
<td>First day of the month following three months' employment</td>
</tr>
<tr>
<td>Terence Cardinal Cooke Health Care Center</td>
<td>Benefit Coverage Plan B</td>
<td>First day of the month following date of hire</td>
</tr>
<tr>
<td>Union Community Health Center, Inc.</td>
<td>Benefit Coverage Plan A</td>
<td>First day of the month following four months' employment</td>
</tr>
<tr>
<td>US Family Health Center at Mitchell Field/Ft. Wadsworth</td>
<td>Benefit Coverage Plan A</td>
<td>First day of the month following three months' employment</td>
</tr>
<tr>
<td>Vassar Brothers Hospital</td>
<td>Benefit Coverage Plan A</td>
<td>First day of the month following date of hire</td>
</tr>
<tr>
<td>Visiting Nurse Association Health Care Services, Inc.</td>
<td>Benefit Coverage Plan A</td>
<td>First day of the month following date of hire</td>
</tr>
<tr>
<td>Wyckoff Heights Medical Center</td>
<td>Benefit Coverage Plan A</td>
<td>First day of the month following date of hire</td>
</tr>
</tbody>
</table>

* As determined by the collective bargaining agreement between NYSNA and the participating employer.
Chapter 2: Administration

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

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 through The Hartford).

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

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

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

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

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.

Chapter 1 of this SMM includes a list of participating employers as of July 2012. In
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.

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

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

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

Aetna, 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
2 Park Ave.
New York, NY 10016-5602
(212) 553-8000

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

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 an insured 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.

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

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

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

– Accreditation, certification, licensing, or credentialing activities.
– Underwriting, premium rating, or related functions to create, renew, or replace health insurance or health benefits.
– Review and auditing, including compliance reviews, medical reviews, legal services, and compliance programs.
– Business planning and development, including cost management and planning-related analyses and formulary development.
– Business management and general administrative activities of the Fund, including customer service and resolution of internal grievances.

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

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

Authorization to use or disclose health information

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

Your rights with respect to your health information

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

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

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

- Right to inspect and copy your health information. You have the right to inspect and copy your health information. A request to inspect and copy records containing your health information must be made in writing and faxed to our privacy official at (518) 869-2317, or sent to the NYSNA Benefits Fund, PO Box 12430, Albany, NY 12212-2430. If you request a copy of your health information, the Fund may charge a reasonable fee for copying, assembling costs, and postage, if applicable, associated with your request.

- Right to amend your health information. If you believe that your health information records are inaccurate or incomplete, you may request that the Fund amend the records. That request may be made as long as the information is maintained by the Fund. A request for an amendment of records must be made in writing and faxed to our privacy official at (518) 869-2317 or sent to the NYSNA Benefits Fund, PO Box 12430, Albany, NY 12212-2430. The Fund may deny the request if it does not include a reason to support the amendment. The request also may be denied if your health information records were not created by the Fund, if the health information you are requesting to amend is not part of the Fund’s records, if the health information you wish to amend falls within an exception to the health information you are permitted to inspect and copy, or if the Fund determines that the records containing your health information are accurate and complete.

- Right to an accounting. You have the right to request a list of certain disclosures of your health information that the Fund is required to keep a copy of under the Privacy Rule, such as disclosures for public purposes authorized by law or disclosures that are not in accordance with the Fund’s privacy policies and applicable law. The request must be made in writing and faxed to our privacy official at (518) 869-2317 or sent to the NYSNA Benefits Fund, PO Box 12430, Albany, NY 12212-2430. The request should specify the time period for which you are requesting the information, but may not start earlier than April 14, 2003. Accounting requests may not be made for periods of time going back more than six years. The Fund will provide the first accounting you request during any 12-month period without charge. Subsequent accounting requests may be subject to a reasonable cost-based fee. The Fund will inform you in advance of the fee, if applicable.

- Right to a paper copy of this notice. You have a right to request and receive a paper copy of this notice at any time, even if you have received this notice previously or agreed to receive the notice electronically. To obtain a paper copy, please contact the Fund office at (877) RN BENEFITS [762-3633]. You also may obtain a copy of the current version of the Fund’s notice from its Web site at www.rnbenefits.org.

Duties of the Benefits Fund

The Benefits Fund is required by law to maintain the privacy of your health information as set forth in this notice and to provide you this notice of its duties and privacy practices. The Fund is required to abide by the terms of this notice, which may be amended.
You have rights regarding the health information the Fund maintains. From time to time. The Fund reserves the right to change the terms of this notice and to make the new notice provisions effective for all health information that it maintains. If the Fund changes its policies and procedures, the Fund will revise the notice and provide a copy of the revised notice to you within 60 days of the change. You have the right to express complaints to the Fund and to the Secretary of the Department of Health and Human Services if you believe that your privacy rights have been violated. All complaints to the Fund should be made in writing and sent to the privacy official at the NYSNA Benefits Fund, PO Box 12430, Albany, NY 12212-2430. The Fund encourages you to express any concerns you may have regarding the privacy of your information. You will not be retaliated against in any way for filing a complaint.

Contact person
The Fund has designated Linda M. Whelton, Benefits Department manager, as its contact person for all issues regarding participant privacy and your privacy rights. You may contact Ms. Whelton by letter at PO Box 12430, Albany, NY 12212-2430, or calling her toll-free at (877) RN BENEFITS [762-3633].
<table>
<thead>
<tr>
<th>Benefit</th>
<th>Benefit Coverage Plan A</th>
<th>Benefit Coverage Plan B</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductible</td>
<td>$250 Single; $500 Family</td>
<td>None</td>
</tr>
<tr>
<td>Maximum out-of-pocket cost (does not include charges in excess of allowed amount, noncovered benefits, or pharmacy benefits)</td>
<td>$1,000 Single; $2,000 Family</td>
<td>None</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Reimbursement rate</td>
<td>70%/30%</td>
<td>70th percentile</td>
</tr>
<tr>
<td>Routine physical exams for children through age 18</td>
<td>No cost</td>
<td>Paid at 70% of UCR</td>
</tr>
<tr>
<td>Routine gynecological care for children through age 18</td>
<td>No cost</td>
<td>Paid at 70% of UCR</td>
</tr>
<tr>
<td>Routine physical exams for adults age 19 and older</td>
<td>No cost</td>
<td>Paid at 70% of UCR</td>
</tr>
<tr>
<td>Routine gynecological care for adults age 19 and older</td>
<td>No cost</td>
<td>Paid at 70% of UCR</td>
</tr>
<tr>
<td>Immunizations</td>
<td>No cost</td>
<td>No cost</td>
</tr>
</tbody>
</table>

**Chapter 4: Summary of Benefits**

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Benefit Coverage Plan A</th>
<th>Benefit Coverage Plan B</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductible</td>
<td>$250 Single; $500 Family</td>
<td>None</td>
</tr>
<tr>
<td>Maximum out-of-pocket cost (does not include charges in excess of allowed amount, noncovered benefits, or pharmacy benefits)</td>
<td>$1,000 Single; $2,000 Family</td>
<td>None</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Reimbursement rate</td>
<td>70%/30%</td>
<td>70th percentile</td>
</tr>
<tr>
<td>Routine physical exams for children through age 18</td>
<td>No cost</td>
<td>Paid at 70% of UCR</td>
</tr>
<tr>
<td>Routine gynecological care for children through age 18</td>
<td>No cost</td>
<td>Paid at 70% of UCR</td>
</tr>
<tr>
<td>Routine physical exams for adults age 19 and older</td>
<td>No cost</td>
<td>Paid at 70% of UCR</td>
</tr>
<tr>
<td>Routine gynecological care for adults age 19 and older</td>
<td>No cost</td>
<td>Paid at 70% of UCR</td>
</tr>
<tr>
<td>Immunizations</td>
<td>No cost</td>
<td>No cost</td>
</tr>
</tbody>
</table>

Financial Preventive Care
<table>
<thead>
<tr>
<th>Benefit Coverage Plan A</th>
<th>Benefit Coverage Plan B</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>In-Network</strong></td>
<td><strong>Out-of-Network</strong></td>
</tr>
<tr>
<td>Obstetrical, prenatal care, delivery, and postnatal care for mother</td>
<td>$10 copayment for initial visit only</td>
</tr>
<tr>
<td>Room and board</td>
<td>No cost</td>
</tr>
<tr>
<td>Physician’s services</td>
<td>No cost</td>
</tr>
<tr>
<td>Surgery (Physician’s services)</td>
<td>No cost</td>
</tr>
<tr>
<td>Restorative physical and occupational therapy</td>
<td>No cost</td>
</tr>
<tr>
<td>Benefit</td>
<td>Plan A</td>
</tr>
<tr>
<td>------------------</td>
<td>----------------------------</td>
</tr>
<tr>
<td></td>
<td>In-Network</td>
</tr>
<tr>
<td></td>
<td>In-Network</td>
</tr>
<tr>
<td>Office visits</td>
<td>$10 copay/visit PCP; $25 copay/visit specialist</td>
</tr>
<tr>
<td></td>
<td>$25 copayment per visit</td>
</tr>
<tr>
<td>Chiropractic care*</td>
<td>$25 copayment per visit</td>
</tr>
<tr>
<td>Allergy treatment*</td>
<td>$25 copayment per visit</td>
</tr>
<tr>
<td>Restorative physical and occupational therapy*</td>
<td>$25 copayment per visit</td>
</tr>
<tr>
<td>Cardiac rehabilitation*</td>
<td>$25 copayment per visit</td>
</tr>
<tr>
<td>Laboratory tests</td>
<td>No cost</td>
</tr>
<tr>
<td>Surgery (physician’s service)</td>
<td>No cost</td>
</tr>
<tr>
<td>Surgery (facility charges)</td>
<td>No cost</td>
</tr>
</tbody>
</table>

* If services are provided by a PCP (family general practitioner, internist, OB/GYN, or pediatrician) $10 copay applies.
<table>
<thead>
<tr>
<th>Benefit</th>
<th>Benefit Coverage Plan A</th>
<th>Benefit Coverage Plan B</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>In-Network</td>
<td>Out-of-Network</td>
</tr>
<tr>
<td>Physician house calls</td>
<td>No cost</td>
<td>Paid at 70% of UCR</td>
</tr>
<tr>
<td>Skilled home health care services</td>
<td>No cost</td>
<td>Paid at 75%</td>
</tr>
<tr>
<td>Home hospice care (up to 210 days)</td>
<td>No cost</td>
<td>Paid at 75%</td>
</tr>
<tr>
<td>Inpatient hospice care (up to 210 days)</td>
<td>No cost</td>
<td>$500 copay/admission up to $1,000 max per individual or up to $2,000 max per family (deductible does not apply)</td>
</tr>
<tr>
<td>Durable medical equipment</td>
<td>Paid at 80% of cost of covered items to an unlimited maximum per participant or dependent per calendar year</td>
<td>Paid at 70% of cost of covered items to an unlimited maximum/ participant or dependent per calendar year</td>
</tr>
<tr>
<td>In vitro fertilization services and covered fertility drugs* (up to a $5,000 lifetime maximum benefit. May elect to use the $5,000 max for prescriptions, if desired.)</td>
<td>No cost</td>
<td>Paid at 70% of UCR</td>
</tr>
<tr>
<td>ER</td>
<td>$75 copayment per visit</td>
<td>$100 copayment per visit</td>
</tr>
</tbody>
</table>

* RNs at St. Joseph Hospital do not have coverage for infertility, including in vitro fertilization services and infertility drugs
<table>
<thead>
<tr>
<th>Benefit</th>
<th>Benefit Coverage Plan A</th>
<th>Benefit Coverage Plan B</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>In-Network</td>
<td>Out-of-Network</td>
</tr>
<tr>
<td><strong>Mental Health</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient mental health</td>
<td></td>
<td>$25 copayment per visit</td>
</tr>
<tr>
<td>Inpatient mental health care</td>
<td></td>
<td>No cost</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$500 copay/admission up to $1,000 max per individual or up to $2,000 max per family (deductible does not apply)</td>
</tr>
<tr>
<td><strong>Substance Abuse</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient medical rehabilitative care for substance abuse/alcohol addiction</td>
<td></td>
<td>$25 copayment per visit</td>
</tr>
<tr>
<td>Inpatient medical rehabilitative care for substance abuse/alcohol addiction</td>
<td></td>
<td>No cost</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$500 copay/admission up to $1,000 max per individual or up to $2,000 max per family (deductible does not apply)</td>
</tr>
<tr>
<td>Benefit</td>
<td>Benefit Coverage Plan A</td>
<td>Benefit Coverage Plan B</td>
</tr>
<tr>
<td>----------------------------------------</td>
<td>-------------------------------------------------------------</td>
<td>-------------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td><strong>In-Network</strong></td>
<td><strong>Out-of-Network</strong></td>
</tr>
<tr>
<td>Yearly deductible</td>
<td>None</td>
<td>$50/person; $150/family</td>
</tr>
<tr>
<td>Maximum yearly benefit</td>
<td>$1,200</td>
<td>$1,200</td>
</tr>
<tr>
<td>Orthodontia maximum</td>
<td>$1,000 per course of treatment separated by two years</td>
<td>$1,000 per course of treatment separated by two years</td>
</tr>
<tr>
<td>Diagnostic and preventive services</td>
<td>No cost</td>
<td>Paid at 80% of usual and prevailing fee</td>
</tr>
<tr>
<td>Basic restorative services, endodontics, periodontics, maintenance of prosthodontics, and oral surgery</td>
<td>Paid at 80% of fee schedule</td>
<td>Paid at 80% of usual and prevailing fee</td>
</tr>
<tr>
<td>Major restorative services, installation of prosthodontics, and orthodontics</td>
<td>Paid at 50% of fee schedule</td>
<td>Paid at 50% of usual and prevailing fee</td>
</tr>
<tr>
<td>Yearly deductible</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Prescription drugs at retail pharmacy (up to a 34-day supply)</td>
<td>Tier 1: $0 Generic Tier 2: $10 Preferred Tier 3: $20 Non-preferred</td>
<td>Reimbursed at contracted amount minus applicable in-network copayment</td>
</tr>
<tr>
<td>Mail-order prescription drug program (mandatory for all maintenance prescription medications for up to a 90-day supply)</td>
<td>Tier 1: $0 Generic Tier 2: $20 Preferred Tier 3: $40 Non-preferred</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Prescription Drug Programs</td>
<td>Benefit Coverage Plan A</td>
<td>Benefit Coverage Plan B</td>
</tr>
<tr>
<td>----------------------------</td>
<td>-------------------------</td>
<td>-------------------------</td>
</tr>
<tr>
<td><strong>Benefit</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Mandatory generics</strong></td>
<td>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.”</td>
<td>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.”</td>
</tr>
<tr>
<td><strong>Preferred specialty drugs</strong></td>
<td>Same copays as non-specialty drugs (retail and mail-order)</td>
<td>Same copays as non-specialty drugs (retail and mail-order)</td>
</tr>
<tr>
<td><strong>High performance step therapy</strong> (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 necessary.)</td>
<td>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.)</td>
<td>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.)</td>
</tr>
<tr>
<td><strong>Preferred specialty pharmacy program</strong></td>
<td>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)</td>
<td>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)</td>
</tr>
<tr>
<td>Vision Care</td>
<td>Benefit Coverage Plans A and B</td>
<td>Benefit Coverage Plans A and B</td>
</tr>
<tr>
<td>-------------------------------------------------</td>
<td>---------------------------------</td>
<td>--------------------------------</td>
</tr>
<tr>
<td>Routine eye exam every two years</td>
<td>Benefit In-network Plan</td>
<td>Benefit Out-of-network Plan</td>
</tr>
<tr>
<td>(every year for children up to age 18)</td>
<td>$10 copayment per visit</td>
<td>Paid at up to $75 for exam and</td>
</tr>
<tr>
<td></td>
<td></td>
<td>glasses or contact lenses</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(every two years)</td>
</tr>
<tr>
<td>Eyeglasses or contact lenses every 2 years</td>
<td>$30 copay for lenses and/or</td>
<td></td>
</tr>
<tr>
<td>(through Davis Vision)</td>
<td>Designer selection frames within the Tower Collection,</td>
<td></td>
</tr>
<tr>
<td></td>
<td>or</td>
<td></td>
</tr>
<tr>
<td></td>
<td>$150 credit toward non-plan frames,</td>
<td></td>
</tr>
<tr>
<td></td>
<td>or</td>
<td></td>
</tr>
<tr>
<td></td>
<td>$25 copay for standard, soft, daily wear contact lenses,</td>
<td></td>
</tr>
<tr>
<td></td>
<td>or</td>
<td></td>
</tr>
<tr>
<td></td>
<td>$45 copay for disposable/ planned replacement lenses</td>
<td></td>
</tr>
<tr>
<td>Benefit</td>
<td>Benefit Coverage Plans A and B</td>
<td></td>
</tr>
<tr>
<td>---------</td>
<td>--------------------------------</td>
<td></td>
</tr>
<tr>
<td><strong>Disability</strong>&lt;br&gt;Short-term, nonoccupational disability</td>
<td>Paid at two-thirds of regular, weekly compensation, up to $215 per week for a maximum period of 26 weeks</td>
<td></td>
</tr>
<tr>
<td>Long-term disability that extends beyond the qualifying period of six consecutive months (through the NYSNA Benefits Fund)</td>
<td>Paid 50% of monthly base compensation, up to $350 per month, less other disability payments, to age 65 (age 70 if disabled after age 60)</td>
<td></td>
</tr>
<tr>
<td><strong>Life</strong>&lt;br&gt;Life</td>
<td>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.</td>
<td></td>
</tr>
<tr>
<td><strong>Accidental death and dismemberment and loss of sight</strong>&lt;br&gt;Accidental death and dismemberment and loss of sight</td>
<td>Paid at 100% or 50% of maximum benefit, according to specific loss</td>
<td></td>
</tr>
</tbody>
</table>
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: Eligibility for information on opting in and out of coverage), your employer will give you 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, and
- Provides a verification of your signature.

Accurate enrollment data on you and your covered dependents allow us to properly issue two separate identification cards for your various coverages, and to quickly and efficiently process your claims. One of your identification cards will come from 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.
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
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 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:
1. 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).
2. Termination of employment or reduction of hours that would cause loss of coverage for the covered individual (COBRA notification or letter from the covered individual’s employer must be provided with 60 days of the event).
3. Divorce or legal separation from the covered individual, causing a loss of coverage (a copy of the divorce or legal separation decree must be provided within 60 days of the event).
4. Covered individual’s employer discontinues group health insurance coverage (a letter or notification from the covered individual’s employer must be provided within 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 employee section.

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.

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.

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 SMM 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 Chapter 9 of your Summary Plan Description and Chapters 10 and 11 of this SMM for detailed information on medical necessity and prior authorization requirements for vision, dental, and prescription drug care);
• The plan’s claims reimbursement procedures weren’t followed (please see Chapters 10 and 11 of this SMM and Chapters 9, 12., 13, 14, and 15 of your Summary Plan Description for information on claims reimbursement procedures for vision, dental, prescription drug, short- and long-term disability, life insurance, and accidental death and dismemberment benefits);
• The coordination of benefits guidelines used when a claimant is covered by more than one plan reduces or excludes benefits (please refer to Chapter 7 of your Summary Plan Description);
• Subrogation activity reduces or excludes benefits (please refer to Chapters 9, 12, 13, 14 and 15 of your Summary Plan Description and Chapters 10 and 11 of this SMM for detailed information);
• You exceed the $1,200 maximum amount payable per individual per calendar year for covered dental expenses (please see Chapter 10 for details);
• You exceed the $1,000 maximum amount payable per individual per course of orthodontic treatment separated by two years (please see Chapter 10 for details);
• You exceed the $5,000 lifetime maximum combined benefit for in vitro fertilization and/or covered fertility drugs (please see Chapter 11 for details);
• Your prescription is for off-label use, refilled too soon, filled above dispensing limits or beyond FDA recommendations or approval, a maintenance prescription filled more than two times at retail, or has an over-the-counter equivalent available (please see Chapter 11 for details);
• The service is excluded from Benefits Fund coverage (please see Chapters 9, 12, 13, and 15 of your Summary Plan Description and Chapters 10 and 11 of this SMM for a list of exclusions);
• A dental or orthodontic course of treatment was started prior to your entry in the plan.
In addition, dental services given after the covered person's coverage terminates are not covered. However, ordered inlays, onlays, crowns, removable bridges, cast or processed restorations, dentures, fixed bridgework, and root canals will be covered when ordered if the item is installed or delivered no later than 30 days after coverage terminates.

“Ordered” means that prior to the date coverage ends:

- Impressions have been taken from which a denture will be prepared;
- The pulp chamber was opened in preparation for a root canal; and
- The teeth that will serve as retainers or support or are being restored have been fully prepared to receive the item, and impressions have been taken from which the item will be prepared for any other item listed above.
Chapter 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, or become a part-time, noncontributing employee. You and your eligible dependents may qualify for COBRA continuation of benefits or one of several conversion options offered by UnitedHealthcare/Oxford.

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

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

Who's eligible for COBRA?
If you are a Benefits Fund participant, you have the right to continue your health coverage under the health insurance plan at your own expense if you lose coverage due to:
• A reduction in your hours of employment, or
• The voluntary or involuntary termination of your employment (for reasons other than gross misconduct on your part).

If you are the spouse of an eligible participant, you are a “qualified beneficiary” and have the right to choose continuation coverage for yourself under the health insurance plan at your own expense if you lose health insurance coverage due to any of the following qualifying events:
• Your spouse dies,
• Your spouse's employment is terminated (for reasons other than gross misconduct) or he/she experiences a reduction in hours of employment,
• You and your spouse get a divorce or legal separation,
• Your spouse enrolls in Medicare.

An eligible dependent child (including any children born to or placed for adoption with a covered participant while the participant is on continuation coverage) of a participant has the right to continue coverage under the group health plan at his 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, but still may be eligible for a conversion option. Qualified beneficiaries who fail to notify the plan within 60 days of a qualifying event also will lose their COBRA rights.

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

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

**How long can COBRA coverage be maintained?**

If group health coverage is lost because of a termination of employment or reduction in hours of employment, 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 36 months once 18 months of federal COBRA is exhausted, regardless of the reason that the person lost eligibility for coverage. For Fund coverage, this means medical 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 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

---

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.
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, RNs 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, unless the plan contains pre-existing condition exclusions or limitations;
- The continuation enrollee becomes enrolled in Medicare;
- Coverage has been extended for up to 29 months due to disability and there has been a final determination that the individual no longer is disabled.

How much will COBRA coverage cost?
Under the law, you may be required to pay up to 102 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. You will be offered the opportunity to convert your Benefits Fund medical benefits to one of several individual pay programs offered by UnitedHealthcare/Oxford. A letter extending this conversion offer will be sent to participants or their dependents when UnitedHealthcare/Oxford is notified of the termination. The participant or dependent will have a specific time period in which to accept the offer and continue coverage. The participant or dependent will be responsible for making monthly payments to UnitedHealthcare/Oxford’s third-party administrator for the conversion plan.

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

You also can convert life insurance to an individual policy.
Chapter 10: Dental Benefits

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

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

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

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

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

The maximum amount payable for each individual for all covered dental expenses incurred during a calendar year is $1,200. The orthodontia maximum is $1,000 per course of treatment separated by two years. See Page 35 for more information about orthodontics.

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

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

Covered services

Covered dental services include only the following services.

Type A expenses (diagnostic and preventive)

Visits and X-rays

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

• Periodontal maintenance procedures (eligible with no history or surgery required and limited to two per year; limit is combined with the prophylaxis frequency).

**Type B expenses (basic)**

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

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

**Oral surgery (Includes local anesthetics and routine post-operative care)**
- Extractions
  - Exposed root or erupted tooth
  - Coronal remnants
  - Surgical removal of erupted tooth
  - Postoperative visit (sutures and complications) after multiple extractions and impaction

- Impacted teeth
  - Removal of tooth

- Alveolar or gingival reconstructions
  - Alveolectomy (edentulous) per quadrant
  - Alveolectomy (in addition to removal of teeth) per quadrant
  - Alveoplasty with ridge extension, per arch
  - Removal of exostosis
  - Excision of hyperplastic tissue per arch
  - Excision of pericoronal gingiva

- Odontogenic cysts and neoplasms
  - Incision and drainage of abscess
  - Removal of odontogenic cyst or tumor

- Other surgical procedures
  - Sialolithotomy: removal of salivary calculus
  - Closure of salivary fistula
  - Dilation of salivary duct
  - Transplantation of tooth or tooth bud
  - Removal of foreign body from bone (independent procedure)
  - Maxillary sinusotomy for removal of tooth fragment or foreign body
  - Closure of oral fistula of maxillary sinus
  - Sequestrectomy for osteomyelitis or bone 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.
The maximum amount payable per calendar year for each individual for all covered dental expenses is $1,200. The orthodontia maximum is $1,000 per course of treatment separated by two years.

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

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

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

Restorative dentistry (Excludes inlays, crowns [other than prefabricated stainless steel or resin] and bridges; multiple restorations in one surface will be considered as a single restoration.)
- Amalgam restorations
- Resin restorations
- Sedative fillings
- Pins
  - Pin retention, per tooth, in addition to amalgam or resin restoration
- Crowns (when tooth cannot be restored with a filling material)
  - Prefabricated stainless steel
  - Prefabricated resin crown (excluding temporary crowns)
- Recementation
  - Inlay
  - Crown
  - Bridge
- Repairs
  - Crowns
  - Bridges
- Full and partial denture repairs
  - Broken dentures, no teeth involved
  - Repair cast framework
  - Replacing missing or broken teeth, each tooth.

Space maintainers (Includes all adjustments within six months after installation.)
- Fixed (unilateral or bilateral)
- Removable (unilateral or bilateral)
• Removable inhibiting appliance to correct thumbsucking
• Fixed or cemented inhibiting appliance to correct thumbsucking.

Prosthodontics
• Occlusal guard (for bruxism only).

Type C expenses (major)

Restorative (Cast or processed restorations and crowns are covered only as treatment for decay or acute traumatic injury and only when teeth cannot be restored with a filling material or when the tooth is an abutment to a fixed bridge.)
• Inlays/onlays, metallic or porcelain/ceramic
  – Inlay, one or more surfaces
  – Onlay, two or more surfaces
• Inlays/onlays, resin
  – Inlay, one or more surfaces
  – Onlay, two or more surfaces
• Labial veneers
  – Laminate, chairside
  – Resin laminate, laboratory
  – Porcelain laminate, laboratory
• Crowns
  – Resin
  – Resin with noble metal
  – Resin with base metal
  – Porcelain
  – Porcelain with noble metal
  – Porcelain with base metal
  – Base metal (full cast)
  – Noble metal (full cast)
  – Metallic (3/4 cast)
• Post and core
• Core buildup, including pins.

Prosthodontics
• Bridge abutments (see Inlays and Crowns)
• Pontics
  – Base metal (full cast)
  – Noble metal (full cast)
  – Porcelain with noble metal
  – Porcelain with base metal
  – Resin with noble metal
  – Resin with base metal
• Removable bridge (unilateral)
  – One piece casting, chrome cobalt alloy clasp attachment (all types) per unit, including pontics
• Dentures and partials (Fees for dentures and partial dentures include relines, rebases, and adjustments within six months after installation; fees for relines and rebases include adjustments within six months after installation; specialized techniques and characterizations are not eligible)
  – Complete upper denture
  – Complete lower denture
  – 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
• 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, 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, which 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 the temporary denture was installed.
• The “Missing Tooth and Not Replaced” rule does not apply to the dental plan. The dentures, bridges, or other prosthetic services needed to replace one or more natural teeth that were removed prior to becoming a participant in the plan will be covered.

Orthodontics
• Comprehensive orthodontic treatment
• Post treatment stabilization
• Interceptive orthodontic treatment
• Limited orthodontic treatment.
  The maximum amount payable for each individual for orthodontic treatment is $1,000 per course of treatment separated by two years. The orthodontic treatment maximum is separate from the yearly maximum. A course of treatment is a plan of care prepared by a physician or dentist with a specific goal to be accomplished over a particular period of time. A course of orthodontia refers to the period of time that begins with the placement of the first orthodontic appliance, and ends when the last one is removed, in accordance with the plan prepared by the provider of service. A course of treatment that begins more than two years after the preceding course ended will be considered a new course of treatment. Covered expenses for a course of orthodontic treatment will be prorated in quarterly installments for the number of quarters it takes to complete the course of treatment. Consideration will be given for the additional expenses during the first quarter for preliminary charges for diagnosis and evaluation. Quarterly payments will be made for claims filed for orthodontic services performed during each quarter while you are insured. If you started an orthodontic course of treatment prior to your
entry in the plan, your benefit may be reduced.
(The above list of covered services, which begins on Page 31, is subject to change.)

Alternate treatment
If your dental care provider charges for an unlisted service for care of a specific condition, or if more than one service can be used to treat a covered person's dental condition, Aetna may decide to authorize coverage only for a less costly covered service, provided the service selected is deemed by the dental profession to be an appropriate method of treatment and meets broadly accepted national standards of dental practice.

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

In-network benefits
The Aetna Preferred Provider Organization includes licensed dentists. A complete list of network providers will be furnished to each participant, without charge, as a separate document. To obtain a list, call the Fund office toll-free at (877) RN BENEFITS [762-3633]. A list of in-network providers also is available through the DocFind® feature on Aetna’s Web site at www.aetna.com. When making an appointment, always verify that the dentist is an Aetna PPO provider.

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

If you receive services from a PPO provider, benefits are paid in accordance with the schedule of dental services at:
• 100% for covered diagnostic and preventive services;
• 80% of the fee schedule for covered basic restorative, endodontic, periodontic, prosthodontic maintenance, and oral surgery services;
• 50% of the fee schedule for covered major restorative, prosthodontic installation, and orthodontic services.

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

There is a yearly deductible for dental services provided by a dentist who is not a participating provider in the PPO. Your yearly deductible for dental expenses is $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, your covered expenses for that calendar year will be paid in accordance with the schedule of dental services at:
• 80% of the usual and prevailing fee for covered diagnostic, preventive, basic restorative, endodontic, periodontic, prosthodontic maintenance, and oral surgery services; and
• 50% of the usual and prevailing fee for covered major restorative, prosthodontic installation, and orthodontic services.

Payments are made on a usual and prevailing basis. In determining what the U&P fee will be, the dental program will take into consideration:
• The usual fee charged by the provider for similar services or procedures when there is no coverage (except in the case of participating dentists);
• The prevailing range of fees charged by most providers with similar training in the same locality; and
• Unusual circumstances or complications requiring additional time, skills and experience, and the complexity of the service performed.
  Charges in excess of the U&P charge will not be covered.
  To receive out-of-network benefits, you must file an Aetna dental claim form. You can obtain claim forms by calling the Benefits Fund or printing them from the Fund’s Web site at www.rnbenefits.org. Send the claim form to: Aetna, PO Box 14094, Lexington, KY 40512-4094. Claims for services performed outside the United States must be submitted for payment in English, with charges indicated in U.S. dollars.

Dental care claims
You may file claims for Fund benefits and appeal adverse claim decisions either yourself or through an authorized representative. If your claim is denied in whole or in part, you will receive a written notice of the denial from Aetna. The notice will explain the reason for the denial and the review procedures.
  An authorized representative is any person you authorize in writing to act on your behalf. The Fund also will recognize a court order giving a person authority to submit claims on your behalf. In addition, a health care professional with knowledge of your condition always may act as your authorized representative regarding an urgent care claim.

Urgent care claims
  If the Fund requires advance approval of a service, supply, or procedure before a benefit will be payable, and if Aetna or your dentist determines the claim is an urgent care claim, you will be notified of the decision no later than 72 hours after the claim is received by Aetna.
  An urgent care claim is any claim for dental care or treatment that, if delayed due to the application of time periods for making nonurgent determinations, could seriously jeopardize your life, health, or ability to regain maximum function, or in the opinion of a dentist with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment specified in the claim.
  If there is not sufficient information to decide the claim, you will be notified of the information necessary to complete the claim as soon as possible, but no later than 24 hours after receipt of the claim. You will be given a reasonable additional amount of time, but not less than 48 hours, to provide the information, and you will be notified of the decision no later than 48 hours after the end of that additional time period (or after receipt of the information, if earlier).

Other claims (pre-service and post-service)
  If the Fund requires you to obtain advance approval of a service, supply, or procedure before a benefit will be payable, a request for advance approval is considered a pre-service claim. You will be notified of the decision no later than 15 days after receipt of the pre-service claim.
  For other claims (post-service claims), you will be notified of the decision no later than 30 days after receipt of the claim.
  For either a pre-service or a post-service claim, these time periods may be extended up to an additional 15 days due to circumstances outside Aetna’s control. In that case, you will be notified of the extension before the end of the initial 15- or 30-day period. For example, time periods may be extended because you have not submitted sufficient information. In that case, you will be notified of the specific information necessary and given an additional period of at least 45 days after receiving the notice to provide that information. You will be notified of Aetna’s claim decision no later than 15 days after the end of that additional period (or after receipt of the information, if earlier).
  For pre-service claims that name a specific participant, dental condition, and service
or supply for which approval is requested and submitted to Aetna, but otherwise fail to follow
Aetna’s procedures for filing pre-service claims, you will be notified of the failure within five
days (within 24 hours in the case of an urgent care claim) and of the proper procedures to be
followed. The notice may be oral unless you request written notification.

**Ongoing course of treatment**

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

**Filing an appeal of an adverse benefit determination**

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

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

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

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

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

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

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

**Exhaustion of process**

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

Exclusions

General exclusions to dental coverage

Coverage is not provided for the following charges:

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

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

These excluded charges will not be used when figuring benefits.

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

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

• Any dental services and supplies that are covered in whole or in part or under any other plan of group benefits provided by the Fund, or to the extent that the charges are otherwise payable as fully described under coordination of benefits.

• Services and supplies to diagnose or treat an occupational disease or injury.

• Services not listed in the dental care schedule that applies, except as specifically provided.

• Replacement of a lost, missing, or stolen appliance, and those for replacement of appliances that have been damaged due to abuse, misuse, or neglect.

• Dentures, crowns, inlays, onlays, bridgework, or other appliances or services used for the purpose of splinting; to alter vertical dimension to restore occlusion; or correcting attrition, abrasion, or erosion.

• Any of the following services:
  – An appliance, or modification of one, if an impression for it was made before the person became a covered person;
  – A crown, bridge, or cast or processed restoration, if a tooth was prepared for it before the person became a covered person;
  – Root canal therapy, if the pulp chamber for it was opened before the person became a covered person.

• Services intended for treatment of any jaw joint disorder, except as specifically provided.

• Orthodontic treatment, except as specifically provided.

• General anesthesia and intravenous sedation, unless done in conjunction with another necessary covered service.

• Treatment by other than a dentist, except that scaling or cleaning of teeth and topical application of fluoride may be done by a licensed dental hygienist. In this case, the treatment must be given under the supervision and guidance of a dentist.

• Charges in connection with a service given to a person age 5 or more if that person becomes a covered person other than during the first 31 days the person is eligible for this coverage, or as prescribed for any period of open enrollment agreed to by the Benefits Fund and Aetna. This does not apply to charges incurred:
  – As a result of accidental injuries sustained while the person was a covered person, or
  – For a service in the dental care schedule that applies as shown under the headings “Visits and X-rays,” “Visits and Exams,” and “X-ray and Pathology.”

• Services given by a non-preferred provider to the extent that the charges exceed the amount payable for the services shown in the dental care schedule that applies.

• Crown, cast, or processed restoration unless:
  – It is treatment for decay or traumatic injury and teeth cannot be restored with a filling material, or
  – The tooth is an abutment to a covered partial denture or fixed bridge.
• Pontics, crowns, cast, or processed restorations made with high noble metals, except as specifically provided.
• Surgical removal of impacted wisdom teeth only for orthodontic reasons, except as specifically provided.
• Services needed solely in connection with non-covered services.
• Services done where there is no evidence of pathology, dysfunction, or disease other than covered preventive services.

Definitions
• Dental emergency – Any traumatic dental condition that occurs unexpectedly, requires immediate diagnosis and treatment, and is characterized by symptoms such as severe pain and bleeding.
• 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 or 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 medial 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 disease** – A disease that does not arise out of (or in the course of) any work for pay or profit, or result in any way from a disease that does. A disease will be deemed to be nonoccupational regardless of cause if proof is furnished that the person is covered under any type of workers’ compensation law, and is not covered for that disease under such law.

• **Nonoccupational 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.

• **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 to furnish services or supplies at a negotiated charge.

• **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.

• **Recognized charge** – Only that part of a charge which is less than or equal to the recognized charge is a covered benefit. The recognized charge for a service or supply is the lowest of:
  – The provider’s usual charge for furnishing it; and
  – The charge Aetna determines to be appropriate based on factors such as the cost of providing the same or a similar service or supply and the manner in which charges for the service or supply are made, billed, or coded; or the provider charge data from the Prevailing HealthCare Charges System at the 80th percentile of PHCS data. This PHCS data is generally updated at least every six months;
  – The charge Aetna determines to be the usual charge level made for it in the geographic area where it is furnished.

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

In some circumstances, Aetna may have an agreement with a provider (either directly or indirectly through a third party) that sets the rate Aetna will pay for a service or supply. In these instances, in spite of the methodology described above, the recognized charge is the rate established in this agreement.

As used above, the term “geographic area” means a Prevailing HealthCare Charges System expense area grouping. Expense areas are 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, PHCS never crosses state lines. This data is produced semi-annually. Current procedure codes that have been developed by the American Medical Association, the American Dental Association, and the Centers for Medicare and Medicaid Services are used.

- **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.
Chapter 11: 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 (see the in-network benefits section beginning on Page 45 for more information).

If you are unable to obtain the drugs through the mail-order program, you may purchase them and submit a claim for direct reimbursement, but you may not be reimbursed the full amount.

• Male sexual dysfunction drugs. Impotency treatment for men with medically diagnosed erectile dysfunction is covered and must be filled through the OptumRx mail service pharmacy (see Page 46 for more information).
  – Coverage is limited to six pills or treatments per 30-day period.

• Approved diabetic medicines and supplies, including:
  – Insulin,
  – Oral hypoglycemic agents,
  – Glucose-elevating agents,
  – Syringes and pens,
  – Alcohol swabs,
  – Glucose/acetone test strips/agents,
  – Lancets and lancet devices.

Diabetic medicines and supplies must be ordered through the 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
not to exceed a 34-day supply at a retail pharmacy. The duration of coverage for any drug therapy is limited to the manufacturer’s recommendations.

* Prescription drug benefits excluded from coverage for St. Joseph Hospital participants due to the requirements of Catholic Health Services of Long Island are:
  - Oral, injectable, insertable, and transdermal contraceptives;
  - Emergency Kit contraceptives;
  - Infertility drugs.

**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.

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
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 [762-3633] or visit rnbenefits.org) and your prescription to: OptumRx, PO Box 2975, Shawnee Mission, KS 66201-9375.

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 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, Shawnee 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 (800) 562-6223 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

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 (800) 797-9791 for confirmation.

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.

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 49.

**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).

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 RNs 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 (800) 797-9791. 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 both 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.