

The New York State
Nurses Association

Benefits Fund

Summary Plan Description



New York State Nurses Association

N Y S N A
Benefits Fund

July 2019

New York State Nurses Association Benefits Fund

Summary Plan Description

This booklet is a summary of the health benefits plan offered by the New York State Nurses Association Benefits Fund as a result of collective bargaining agreements between NYSNA and its members' participating employers, and is effective as of July 1, 2019.

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

This Summary Plan Description replaces all previous Summary Plan Descriptions and Summary Material Modifications issued by the New York State Nurses Association Benefits Fund. All changes to this plan after July 1, 2019, will appear as Summary Material Modifications printed in the bimonthly *For Your Benefit* newsletter or in separate publications.

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Chapter 1: Introduction and Administration

This Summary Plan Description explains the plan of benefits provided through the New York State Nurses Association Benefits Fund, which also is referred to in this book as the “Benefits Fund,” “Fund” or “Plan.” It is important that you read this book carefully and share it with your family so that you are aware of the valuable benefits available to you through the Fund and you understand the benefits, rules, provisions, limitations, and exclusions of the Fund.

This Summary Plan Description is effective July 1, 2019, and supersedes all prior NYSNA Benefits Fund Summary Plan Descriptions. This SPD constitutes the Fund’s governing plan documents.

The Benefits Fund is established pursuant to collective bargaining agreements between the New York State Nurses Association (NYSNA) and participating employers. Participants and beneficiaries may obtain a copy of the applicable collective bargaining agreement upon written request to the plan administrator and also can view a collective bargaining agreement at the Fund office and at each participating employer’s worksite (in locations that have at least 50 covered participants). In addition, copies may be obtained upon request from NYSNA.

The Benefits Fund is jointly administered by the Board of 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 made up of representatives of NYSNA, including registered nurses covered by the Fund, and representatives of hospitals that participate in the Fund. A list of current members of the Board of Trustees can be found on Page 13.

The Trustees of the Benefits Fund are responsible for setting the benefits, rules and regulations of the Fund and generally overseeing the Fund’s operations. They meet to review the financial and administrative status of the Fund, receive reports from the Fund’s various administrative and professional vendors and partners, consider appeals from participants, and amend the Fund’s plans as necessary to reflect the economic, social, and technical changes affecting the healthcare industry. The Fund’s Trustees and staff are assisted by professional consultants, including legal counsel, health benefit consultants and actuaries, investment advisors and managers, and certified public accountants.

The Board has delegated responsibility for the day-to-day operation and overall administration of the Fund to the Chief Executive Officer. You can contact the Board of Trustees or the Chief Executive Officer by writing them at PO

Box 12430, Albany, NY, 12212-2430, or by calling them at (877) RN BENEFITS [762-3633], or (518) 869-9501.

The Fund counsel is Albert Kalter, PC, 1325 Avenue of the Americas, 28th Floor, New York, NY, 10019-6026, (212) 964-5485.

The Fund benefit consultant is Milliman, One Pennsylvania Plaza, 38th Floor, New York, NY, 10119.

The Benefits Fund was established to protect you, your spouse, and eligible dependents from the high cost of catastrophic health care needs. The NYSNA Benefits Fund provides nine types of benefit plans for participants:

- Medical,
- Vision,
- Dental,
- Prescription and maintenance drug,
- Short-term disability,
- Long-term disability,
- Paid family leave,
- Life insurance, and
- Accidental death and dismemberment.

Of the benefits listed above, the NYSNA Benefits Fund provides the following four types of benefits for your legal spouse and eligible dependents:

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

If you disagree with a decision made on a request for preauthorization or a claim for benefits, or a decision based upon eligibility or a rescission of coverage, you must use the claims and appeals procedures set forth in this Summary Plan Description. Please note that separate claims and appeals procedures apply to each type of benefit offered under the Fund, so be sure to check the appropriate section of this booklet to determine the applicable procedures to follow. Also note that, under certain circumstances, you have the option to appeal to the Board of Trustees of the Fund, and for certain issues, an appeal to the Board of Trustees is required. Please refer to the various appeals procedures throughout this Summary Plan Description and, if you have any questions regarding the processes, please contact the Fund office at (877) RN BENEFITS [762-3633].

Appeals procedure - Claims involving eligibility and rescissions of coverage

If a claim is denied due to determination that you or your dependent is ineligible for coverage under the

Plan (or if you have considered it denied because you did not receive a written response from the Plan Administrator by the applicable deadline), or if coverage for you or your dependents is rescinded (retroactively terminated), you or your dependents may write to the Trustees of the Fund to appeal the determination or rescission.

You must appeal the determination within 180 days of the date you receive notice from the Fund of the determination or the date you deemed it denied (i.e., the applicable deadline for your having received a denial). Your appeal should include an explanation of why you think the denial is incorrect. Send your appeal and all relevant documents to the NYSNA Benefits Fund at PO Box 12430, Albany, NY, 12212-2430. You and your dependents may request copies of all documents, guidelines, and other materials that relate to your claim, submit any issues and comments in writing to the Trustees, and, if you wish, have someone act as your representative in the review procedure.

Your appeal will be given a full and fair review by the Fund Trustees.

You will receive a written notification from the Trustees on the decision after the next meeting of the Trustees, unless the request is received less than 30 days before such a meeting. In that case, a decision will be made at the following Trustee meeting.

However, special circumstances may require an extension of the deadlines. In that event, a decision will be made by the third meeting following receipt of your request. You will receive written notice of the extension before the date the extension begins, an explanation of the special circumstances, and the date by which you may expect a decision.

While the Trustees will endeavor to provide you with a determination in a timely manner, if the Trustees' decision on your appeal is somehow not submitted to you by the deadlines described above, you may be permitted to consider your appeal to have been denied. If your appeal is denied (or it is determined to be deemed denied), you will be considered to have exhausted your administrative remedies under the Plan and may bring a civil action in state or federal court under Section 502(a) of ERISA.

If you do not comply with the Plan's procedures for review of your denied claim as described above, a court may find that you failed to exhaust your administrative remedies under the Plan and dismiss your lawsuit for that reason.

Appeals procedure - Voluntary appeal to the Board of Trustees of the Fund on claims for benefits (other than claims involving medical judgment)

If a claim for benefits (other than a claim involving medical judgment, such as medical necessity or experimental/investigational) is denied in full or in part by one of the Fund's service providers (i.e., Oxford, Express Scripts) and you exhaust the appeals procedures described elsewhere in this SPD with those service providers, you may (but are not required to) appeal the determination to the Board of Trustees of the Fund.

You must appeal the determination within 180 days of the date you receive notice from the provider of its final determination on your appeal (including a second level appeal, if applicable). Your appeal should include an explanation of why you think the denial is incorrect. Send your appeal and all relevant documents to the NYSNA Benefits Fund at PO Box 12430, Albany, NY, 12212-2430. You and your dependents may request copies of all documents, guidelines, and other materials that relate to your claim, submit any issues and comments in writing to the Trustees, and, if you wish, have someone act as your representative in the review procedure.

Your appeal will be given a full and fair review by the Fund Trustees.

You will receive a written notification from the Trustees on the decision after the next meeting of the Trustees, unless the request is received less than 30 days before such a meeting. In that case, a decision will be made at the following Trustee meeting.

However, special circumstances may require an extension of the deadlines. In that event, a decision will be made by the third meeting following receipt of your request. You will receive written notice of the extension before the date the extension begins, an explanation of the special circumstances, and the date by which you may expect a decision.

While the Trustees will endeavor to provide you with a determination in a timely manner, if the Trustees' decision on your appeal is somehow not submitted to you by the deadlines described above, you may be permitted to consider your appeal to have been denied. If your appeal is denied (or it is determined to be deemed denied), you will be considered to have exhausted your administrative remedies under the Plan and may bring a civil action in state or federal court under Section 502(a) of ERISA.

If you do not comply with the Plan's procedures for review of your denied claim as described above, a court may find that you failed to exhaust your administrative remedies under the Plan and dismiss your lawsuit for that reason.

Other Requests for Consideration by the Board of Trustees of the Fund

If you have a request for consideration of an issue that does not involve an adverse eligibility determination, a rescission of coverage, or a claim for benefits, you can direct that request to the Board of Trustees of the Fund at PO Box 12430, Albany, NY, 12212-2430. Your request must be in writing and should contain any information or documentation that you think would support your request. Be advised, however, that this type of request is not considered an “appeal” and is not subject to any specific legal time frames or other requirements that would apply to appeals. That being said, the Fund will do its best to advise you of the Trustees’ response to your request as soon as possible.

The NYSNA Benefits Fund intends to continue this Plan but reserves the right, in its sole discretion, to change, interpret, withdraw, or add Benefits or to end the Plan, as permitted by law, without your approval, subject to any collective bargaining agreements, if applicable.

If there is a conflict between the information contained in this Summary Plan Description and any benefit summaries (other than Summaries of Material Modifications) provided to you, this document will prevail.

If you have any questions regarding your NYSNA Benefits Fund benefits, please call the Fund office toll-free at (877) RN BENEFITS [762-3633]. You may also write to the NYSNA Benefits Fund at PO Box 12430, Albany, NY, 12212-2430, or e-mail the Fund office at benefit@rnbenefits.org.

Additional information regarding the Benefits Fund is available on the Fund’s Web site at www.rnbenefits.org. The site includes the latest benefits updates, an in-depth schedule of benefits, a list of participating employers, links to benefits providers, in addition to current and past newsletter issues, a copy of this Summary Plan Description, and various Benefits Fund forms.

Participating employers that are obligated to provide NYSNA Benefits Fund coverage for Registered Nurses and other healthcare professionals (“participants”) at their facilities make monthly contributions to the Fund on your behalf pursuant to the terms of the collective bargaining agreement that NYSNA negotiates with the employer. 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 level 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.

Note that the NYSNA Benefits Fund is a separate legal entity from the New York State Nurses Association. Please remember that all communications regarding your Benefits Fund coverage should be sent directly to the NYSNA Benefits Fund, not to NYSNA.

Chapter 2 of this SPD includes a list of participating employers as of July 1, 2019. In addition, an up-to-date list of the employers and employee organizations (and their addresses) participating in the Benefits Fund may be obtained free of charge upon written request to the Fund office.

Fund administration

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 Fund’s self-funded dental benefit.

Express Scripts, Inc. (ESI)

One Express Way
St. Louis, MO 63121
Express Scripts, Inc. administers the Fund’s self-funded prescription drug benefit.

Davis Vision, Inc.

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

Davis Vision insures the Fund’s vision coverage.

Oxford Health Plans LLC

One Penn Plaza, 8th Floor
New York, NY 10121
(212) 216-6400
Oxford Health Plans LLC administers the Fund’s self-funded medical coverage benefit.

The Hartford Life Insurance Company

277 Park Ave., 16th Floor
New York, NY 10172
(212) 553-8000
The Hartford administers the Fund’s self-funded short-term disability benefit and insures the Fund’s paid family leave benefit and life insurance coverage.

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 Benefits Fund.

The Fund 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 Fund, 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 protected health information about you may be used and disclosed and how you can get access to this information.

Your rights

You have the right to:

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

Your choices

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

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

Our uses and disclosures

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan

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

Your rights

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

Get a copy of health and claims records

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

Ask us to correct health and claims records

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

Request confidential communications

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

Ask us to limit what we use or share

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

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

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

cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

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

Choose someone to act for you

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

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on Page 10.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling (877) 696-6775, or visiting www.hhs.gov/filing-a-complaint/index.html.
- We will not retaliate against you for filing a complaint.

Your choices

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

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

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

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

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

- Marketing purposes
- Sale of your information

Our uses and disclosures

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

Help manage the health care treatment you receive

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

Administration and operations of the Fund

- We can use and disclose your information as necessary for the administration and operations of the Benefits Fund and to contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage.

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

Pay for your health services

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

Administer your plan

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

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

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/hipaa/for-individuals/notice-privacy-practices/index.html.

Help with public health and safety issues

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

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

Do research

We can use or share your information for health research.

Comply with the law

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

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

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

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

We can use or share health information about you:

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

Respond to lawsuits and legal actions

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

Our responsibilities

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

For more information go to: www.hhs.gov/ocr/privacy/hipaa/for-individuals/notice-privacy-practices/index.html.

Changes to the terms of this notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our Web site, and we will mail a copy to you.

Other instructions for notice

- This notice was effective September 23, 2013.
- The Benefits Fund has designated Linda M. Whelton, Benefits Department Manager, as its contact person for all issues regarding participant privacy and your privacy rights. You may contact Ms. Whelton by letter at PO Box 12430, Albany, NY 12212-2430, or by toll-free phone at (877) RN BENEFITS [762-3633].

Chapter 2: Participating Employers

The following is a list of the employers that contribute to the NYSNA Benefits Fund pursuant to collective bargaining agreements with NYSNA as of July 1, 2019; the Plan benefit level that employees of those employers are eligible for; and the eligibility date for participation in the Plan pursuant to each collective bargaining agreement.

Facility	Plan	Eligibility date*
Albert Einstein College of Medicine of Yeshiva University	Benefit Coverage Plan A	If hired within first 15 days of month: first day of the month after date of hire; if hired within last 15 days of month: first day of the month following one full month employment
Alice Hyde Medical Center	Benefit Coverage Plan B	First day of the month after date of hire
AO Fox Memorial Hospital	Benefit Coverage Plan A	First day of the month following two months after date of hire
BronxCare Health System	Benefit Coverage Plan A	First day of the month after date of hire
BronxCare Special Care Center	Benefit Coverage Plan A	First day of the month after date of hire
The Brooklyn Hospital Center	Benefit Coverage Plan A	90 days after date of hire
Cabrini of Westchester	Benefit Coverage Plan A	First day of the month after date of hire
Catskill Regional Medical Center	Benefit Coverage Plan A	84 days after date of hire
Centerlight Health Services	Benefit Coverage Plan A	First day of the month after date of hire
Champlain Valley Physicians Hospital	Benefit Coverage Plan A	First day of the month after date of hire
County of Sullivan	Benefit Coverage Plan A	First day of the month after date of hire
County of Westchester	Benefit Coverage Plan A	First day of the month 30 days after date of hire
Flushing Hospital Medical Center	Benefit Coverage Plan A	90 days after date of hire
Gracie Square Hospital	Benefit Coverage Plan A	First day of the month 60 days after date of hire
Interfaith Medical Center	Benefit Coverage Plan A	First day of the month after date of hire
Kingsbrook Jewish Medical Center	Benefit Coverage Plan A	Full time: 60 days after date of hire; part time: 90 days after date of hire
Maimonides Medical Center	Benefit Coverage Plan A	First day of the second month following date of hire
Massena Memorial Hospital	Benefit Coverage Plan B	First day of the month after date of hire
Montefiore Nyack Hospital	Benefit Coverage Plan A	90 days after date of hire
The Mount Sinai Hospital	Benefit Coverage Plan A	First day of the month following date of hire for medical and weekly disability; full benefit coverage 90 days after date of hire
Mount Sinai St. Luke's	Benefit Coverage Plan A	First day of the month after date of hire
Mount Sinai West	Benefit Coverage Plan A	First day of the month after date of hire

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

Facility	Plan	Eligibility date*
Nephro Care, Inc.	Benefit Coverage Plan B	First day of the month after date of hire
New Jewish Home	Benefit Coverage Plan A	90 days after date of hire
New York Dialysis Management, Inc.	Benefit Coverage Plan B	First day of the month after date of hire
New York Dialysis Services, Inc.	Benefit Coverage Plan B	First day of the month after date of hire
New York Dialysis Services, Inc./ ABC	Benefit Coverage Plan B	First day of the month after date of hire
New York Eye & Ear Infirmary of Mount Sinai	Benefit Coverage Plan A	First day of the month after date of hire
New York-Presbyterian Brooklyn Methodist Hospital	Benefit Coverage Plan A	90 days after date of hire
New York Presbyterian Hospital	Benefit Coverage Plan A	First day of the month after date of hire
Parker Jewish Institute for Health Care and Rehabilitation	Benefit Coverage Plan A	First day of the month 60 days after date of hire
Peconic Bay Medical Center	Benefit Coverage Plan A	First day of the month 30 days after date of hire
Richmond University Medical Center	Benefit Coverage Plan A	90 days after date of hire
St. John's Riverside Hospital	Benefit Coverage Plan A	First day of the month after date of hire
St. Joseph Hospital	Benefit Coverage Plan A	30 days after date of hire
St. Vincent's Hospital Westchester	Benefit Coverage Plan A	First day of the month after date of hire
St. Vincent's Opioid Treatment Center	Benefit Coverage Plan A	60 days after date of hire
Samaritan Medical Center	Benefit Coverage Plan B	First day of the month 30 days after date of hire
Southside Hospital	Benefit Coverage Plan A	60 days after date of hire
Staffco of Brooklyn	Benefit Coverage Plan A	90 days after date of hire
Staten Island University Hospital - North	Benefit Coverage Plan A	60 days after date of hire
Syosset Hospital	Benefit Coverage Plan A	89 days after date of hire
Terence Cardinal Cooke Health Care Center	Benefit Coverage Plan B	90 days after date of hire
Union Community Health Center, Inc.	Benefit Coverage Plan A	90 days after date of hire
US Family Health Center at Mitchell Field/Ft. Wadsworth	Benefit Coverage Plan A	90 days after date of hire
Vassar Brothers Hospital	Benefit Coverage Plan A	First day of the month after date of hire
Visiting Nurse Association Health Care Services, Inc.	Benefit Coverage Plan A	First day of the month after date of hire
Wyckoff Heights Medical Center	Benefit Coverage Plan A	First day of the month 30 days after date of hire

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

Chapter 3: Board of Trustees

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New York State Nurses Association
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Chapter 4: Schedule of Benefits

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

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

*May require Preauthorization

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

*May require Preauthorization

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

*May require Preauthorization

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

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

*May require Preauthorization

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

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

	Benefit	Benefit Coverage Plans A and B In-network Plan	Benefit Coverage Plans A and B Out-of-network Plan
Vision Care	Routine eye exam every two years (every year for children up to age 18)	\$10 copayment per visit	
	Eyeglasses or contact lenses every 2 years (through Davis Vision)	<p>\$30 copay for lenses and/or Designer selection frames within the Davis Collection,</p> <p>or</p> <p>\$150 credit toward non-plan frames,</p> <p>or</p> <p>\$25 copay for disposable/planned replacement lenses</p>	Paid at up to \$75 for exam and glasses or contact lenses (every two years)
	Benefit	Benefit Coverage Plans A and B	
Disability	Short-term, nonoccupational disability	Paid at two-thirds of regular, weekly compensation, up to \$215 per week for a maximum period of 26 weeks	
	Long-term disability that extends beyond the qualifying period of six consecutive months	Paid at 50% of monthly base compensation, up to \$350 per month, less other disability payments, to age 65 (age 70 if disabled after age 60)	
Other Insurance	Life	Paid at a minimum of \$20,000 and a maximum of \$50,000, computed by taking 150% of current base compensation, to the maximum allowable. Benefit is reduced 35% at age 65 and 50% at age 70.	
	Accidental death and dismemberment and loss of sight	Paid at 100% or 50% of maximum benefit, according to specific loss	

	Benefit	Benefit Coverage Plans A and B												
Paid Family Leave	Job protected, partial wage replacement to bond with a new child, care for a loved one with a serious health condition, or to help relieve family pressures when someone is called to active military service.	<table border="1" data-bbox="812 210 1494 409"> <thead> <tr> <th data-bbox="812 210 993 294">Year</th> <th data-bbox="993 210 1201 294">Weeks of Leave</th> <th data-bbox="1201 210 1494 294">Maximum of Employee Weekly Wage</th> </tr> </thead> <tbody> <tr> <td data-bbox="812 294 993 331">2019</td> <td data-bbox="993 294 1201 331">10 weeks</td> <td data-bbox="1201 294 1494 331">55%</td> </tr> <tr> <td data-bbox="812 331 993 369">2020</td> <td data-bbox="993 331 1201 369">10 weeks</td> <td data-bbox="1201 331 1494 369">60%</td> </tr> <tr> <td data-bbox="812 369 993 409">2021</td> <td data-bbox="993 369 1201 409">12 weeks</td> <td data-bbox="1201 369 1494 409">67%</td> </tr> </tbody> </table> <p data-bbox="836 504 1469 535">In 2021, PFL caps at 12 weeks of leave and 67 percent benefit.</p>	Year	Weeks of Leave	Maximum of Employee Weekly Wage	2019	10 weeks	55%	2020	10 weeks	60%	2021	12 weeks	67%
Year	Weeks of Leave	Maximum of Employee Weekly Wage												
2019	10 weeks	55%												
2020	10 weeks	60%												
2021	12 weeks	67%												

Chapter 5: Enrollment

When you enter covered employment within a collective bargaining unit represented by the New York State Nurses Association you will receive a Benefits Fund enrollment form. This form must be completed, signed and dated, 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 designated life insurance beneficiary, and
- Provides a verification of your signature.

If you are enrolling a legal spouse or eligible dependents, the Benefits Fund requires a copy of your marriage certificate (for spouse) and birth certificates (for dependents) and Social Security numbers. If these documents are not provided with your enrollment form, the Fund will send a written request for you to submit the documents within 30 days. If documents are not received within this time-frame, coverage for your spouse and/or children will be terminated.

Accurate enrollment data on you and your covered dependents allows the issuance of identification cards for your various coverages, and to quickly and efficiently process your claims. Identification cards for you and each covered dependent will come from Oxford for your medical coverage, in addition to ID cards from Express Scripts for your prescription drug coverage and Davis Vision for vision coverage. If you wish, you may print paper identification cards for your dental coverage through Aetna and vision coverage through Davis Vision by logging in as a member to each benefit provider's Web site. Aetna's member Web site is www.aetna.com and Davis Vision's Web site can be accessed at www.davisvision.com.

Once you're enrolled in the Fund, if you change your name, address, or marital status, including divorce; acquire a new dependent; or wish to make any change in your enrollment record information, you must call or write the Benefits Fund and indicate the change to be made. Paper documentation confirming these changes may be required (see Chapter 6: Eligibility on next page).

Chapter 6: Eligibility

You, your legal spouse, and your eligible dependents are covered for the benefits in this Summary Plan Description 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 on your behalf in the amount determined by the Trustees, or are on COBRA continuation benefits and timely maintain your premium payments (if you are required to make a premium payment).

Newly hired participants are eligible for coverage as indicated in Chapter 2 of this Summary Plan Description and your NYSNA contract.

Full-time employees

Effective date

Your coverage will become effective on your eligibility date, provided you submit an enrollment form to the Fund and authorize payroll deductions by your employer for Fund premiums, if applicable. To check your eligibility date, find your facility listed in Chapter 2 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 your collective bargaining agreement.

Upon enrollment in the Benefits Fund, you may be required to authorize your employer to make payroll deductions as stipulated in the collective bargaining agreement. Should you fail to do so, you will be unable to participate in the Benefits Fund when eligible and must wait until the annual open enrollment period between November 1 and December 31 to enroll (see next page for more information on open enrollment).

Opting out of coverage

Full-time employees have the right to opt out of health benefit coverage under the Benefits Fund for:

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

as long as the individuals opting out of coverage under the Benefits Fund are covered under another group health plan. Your opt-out application and supporting documentation (proof of other coverage) must be received by the Fund office within 60 days of your date of hire.

If you opt out, you will continue to be covered by the Fund for disability, life, paid family leave, 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, your spouse, and any eligible dependents because you have other health insurance coverage (medical, dental, vision, and prescription drug), you may in the future be able to enroll yourself, your spouse, and eligible dependents in this plan, provided you request enrollment within 60 days after your other coverage ends due to the following qualifying events:

- If you gain a new dependent as a result of marriage, or the birth, adoption or placement for adoption or legal guardianship of a child, you may enroll yourself (if you are not already enrolled) and the new spouse or dependent in your Benefits Fund coverage provided you notify the Fund within 60 days of the life event and provide a certified copy of the marriage certificate, birth certificate, adoption papers or guardianship documents, as applicable.
- If you, your spouse or other dependents do not enroll in the Benefits Fund because of other group health plan coverage, you can enroll yourself, your spouse or other dependent (whoever declined coverage due to other coverage) if your other coverage ends because of a termination of employment or reduction of hours, divorce or legal separation, loss of dependent status under the other plan or death, but not if the loss of coverage was due to a failure to pay premiums. If the other coverage is under COBRA continuation coverage and you exhaust that coverage, you may be allowed to enroll in this Fund. You must submit a written request for coverage to the Benefits Fund within 60 days after the other coverage ends, along with written documentation of the loss of coverage.
- CHIP and Medicaid are government programs designed to provide health care coverage for uninsured children and some adults. One of the benefits offered by some state Medicaid or CHIP programs is assistance with paying for health premiums. Special enrollment opportunities are available to:
 - Participants and their dependents who

- lose coverage under Medicaid or CHIP; and
- Participants and their dependents who are determined eligible for premium assistance under Medicaid or CHIP.

If you experience either of these CHIP/Medicaid enrollment events and you would like to enroll in the Benefits Fund, you must submit a written request to the Fund within 60 days of the event. If you think that you or any of your dependents might be eligible for Medicaid or CHIP, or if you or your dependents are already enrolled in Medicaid or CHIP but not receiving premium assistance, contact your Medicaid or CHIP office or call (877) KIDSNOW or visit www.insurekidsnow.gov to learn how to apply. If you qualify, ask if there is a program that might help you pay the Fund's premium (if applicable).

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, if applicable.

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, if applicable.

Waiving coverage

As a new part-time employee, you have the right to waive coverage at the time of eligibility without providing proof of other coverage. If you elect coverage, you may later waive benefits at any time without providing proof of other coverage. As a part-time employee waiving coverage, you will have no benefits through the Fund. Disability and paid family leave benefits will be provided through your employer. You must wait until the annual open enrollment period of any plan year to re-enroll in the Benefits Fund (see below).

If you waive coverage because you have other health insurance coverage and you involuntarily lose that coverage for any of the qualifying events previously stated in the Full-time employee section (see previous page), you may request enrollment for yourself, your spouse, and your dependents. Proof of the loss of coverage (termination date and reason why) must be received within 60 days after your other coverage ends.

Open enrollment

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

Individuals who are eligible to enroll during the annual

open enrollment period include:

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

If you choose not to enroll in the Benefits Fund during the open enrollment period between November 1 and December 31 of any year, you will not be able to opt in to the Fund again until the next open enrollment period unless you lose other coverage due to one of the qualifying events listed in the Full-time employee section (see Page 24) and request enrollment with supporting documentation within 60 days after that event.

Eligible dependents

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

- Your legal spouse is eligible for medical, dental, vision, and prescription drug benefits through the Benefits Fund.
- Your children, stepchildren, foster children, and children for whom you are the legal guardian also are eligible for medical, dental, vision, and prescription drug benefits from birth until the end of the month in which they turn age 26.
- Dependent children living with you while awaiting your legal adoption are eligible for these benefits until the end of the month in which they turn age 26.

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), as well as your dependent's Social Security number.

Stepchildren

Stepchildren are eligible for medical, dental, vision, and prescription drug coverage until the end of the month in which they turn 26. Coverage will also end in the event of divorce or death of the parent. Birth and marriage certificates are required by the Fund office for documentation.

Foster children and legal guardianship

Foster children and children under your legal custody or guardianship are covered until the end of the month in which they turn 26. To effect coverage through legal guardianship, the participant must submit a copy of the child's birth certificate and a certified copy of the guardianship or custody appointment. For foster children, you will need to provide documentation from the New York State Office of Children and Family Services showing placement of the foster child in your care.

Disabled dependents

Coverage for any of your unmarried children who continue to be dependent on you or your spouse due to an inability to engage in any substantial gainful activity by reason of a medically determinable physical or mental permanent disability may 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 and dependent status no later than 60 days after the end of the month in which they turn 26. Proof of the disability includes a completed Disability Questionnaire provided to you by the Fund; proof of court-appointed guardianship of your disabled child; copy of the most recent year's federal income tax filing showing the disabled child as a dependent; and information from the disabled dependent's healthcare provider indicating the condition and symptoms of the disability. Proof of continued disability must be updated periodically as required.

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 of coverage

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

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

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

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

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

Reduction or denial of benefits

Benefits under this Plan may be denied or reduced, including but not limited to whenever:

- A utilization review determines that the proposed service, the service currently being provided, or the service that was provided is not medically necessary, deemed to be appropriate, or wasn't properly authorized (please refer to Chapters 10, 11, and 12 of this SPD for detailed information on medical necessity and prior authorization requirements for medical, vision, dental, and prescription drug care);
- The plan's claims reimbursement procedures weren't followed (please see Chapters 9 through 17 of your Summary Plan Description for information on claims reimbursement procedures for medical, vision, dental, prescription drug, paid family leave, 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);
- The claim is subject to subrogation or reimbursement (please refer to Chapters 9 through 16 for detailed information);
- You exceed the \$1,200 maximum amount payable per individual per calendar year for covered dental expenses (please see Chapter 11 for details);
- You exceed the \$1,000 maximum amount payable per individual per course of orthodontic treatment separated by two years (please see Chapter 11 for details);
- You exceed the \$5,000 lifetime maximum combined benefit for in vitro fertilization and/or covered fertility drugs (please see Chapters 9 and 10 for details);
- Your prescription is for off-label use; refilled too soon; filled above dispensing limits or beyond FDA recommendations or approval; up to a 34-day supply of a maintenance prescription filled more than two times at retail, or has an over-the-counter equivalent available (please see Chapter 10 for details);
- The service is excluded from Benefits Fund coverage (please see Chapters 9 through 16 for a list of exclusions);
- A dental or orthodontic course of treatment was started prior to your entry in the plan.

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

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

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

Chapter 7: Coordination of Benefits

Coordination of benefits (COB) determines the amount payable by each health plan when a participant, spouse, or dependent are covered by two different plans.

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

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

COB guidelines

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

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

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

COB and Medicare

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

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

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

Chapter 8: Benefits Following Termination

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

COBRA continuation coverage

The Consolidated Omnibus Budget Reconciliation Act (Public Law 99-272, Title X), also known as COBRA, was enacted April 7, 1986. This law requires that the Benefits Fund offer participants, their spouses, and eligible dependents who were covered under the Benefits Fund as of the date of a qualifying event (described below) 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 Benefits Fund 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 Benefits Fund at your own expense if you lose health plan 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 participant or spouse of continuation rights, it will assume that all dependent children who live with the participant or spouse have been notified by the participant or 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 right to elect COBRA. Qualified beneficiaries who fail to notify the plan within 60 days of a qualifying event (or whose employer fails to notify the Fund of a qualifying event) also will lose their right to elect COBRA.

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, the Fund permits any qualified beneficiary who would be eligible for up to 18 months of continuation coverage under COBRA (based on termination of coverage or reduction of hours qualifying event) to continue medical coverage only for up to an additional 18 months once the initial 18 months of federal COBRA is exhausted (for a maximum of 36 months), regardless of the reason that the person lost eligibility for coverage. This does not include dental, vision, or prescription drug coverage.

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

Disability extension

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

Can COBRA continuation coverage be cut short for any reason?

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

- The Benefits Fund no longer provides group health coverage to its participants;
- The premium for continuation coverage is not paid in a timely fashion (please see "How much will COBRA coverage cost?" section below for more information);
- The continuation enrollee becomes covered as an employee or dependent under another group health plan, 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.

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.

Conversion options

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

Further information

Further information about COBRA continuation coverage and conversion options is available from the Benefits Fund.

Continuation of medical coverage for young adults between age 26 to 30

The Fund allows for the continuation of medical coverage only to unmarried dependent children through age 29 (referred to herein as "Young Adult Coverage.") This coverage is in lieu of the COBRA continuation coverage described on Page 29 of this chapter. In order to be eligible for Young Adult Coverage the dependent child must be:

- Unmarried;
- Under age 30;
- Living, working, or residing in the State of New York;
- And must not be insured or eligible for any other employer-sponsored health plan or be covered by Medicare.

The young adult does not have to live with their

parent, be financially dependent on their parent, or be a student in order to be eligible for this limited continuation coverage.

The parent participant of the young adult must be covered under the Plan in order for the young adult to be on Young Adult Coverage. Losing eligibility for Fund coverage under this continuation option is not a COBRA-qualifying event.

The dependent child or parent is responsible for payment of a separate premium for this continuation of medical coverage. This extension of coverage may be elected when the child ceases to be an eligible dependent under the Plan due to reaching the maximum age for dependent coverage (end of the month in which they turn age 26). The child has 60 days from termination of coverage or during the Fund's Open Enrollment period (see Page 25 for information on Open Enrollment) to elect the extension of medical coverage. To enroll, you may contact the Fund to request a Young Adult Election form or find one on the Fund's Web site at www.rnbenefits.org.

Young Adult Coverage terminates if the:

- child gets married;
- child turns age 30;
- child is no longer living, working, or residing in the State of New York;
- child becomes insured or eligible for any other employer-sponsored health plan or covered by Medicare;
- parent participant is no longer covered under the Plan.

Medical and prescription drug coverage through the Health Insurance Marketplace

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

Chapter 9: Medical Benefits

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

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

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

Oxford Health Plans LLC is a private health claims administrator that the Benefits Fund partners with to administer claims. Although Oxford can assist you in many ways with respect to your hospital and medical benefits available under the Fund, it does not guarantee the payment of any Benefits. The Benefits Fund is solely responsible for funding payment of Benefits described in this chapter.

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

- Many sections in this chapter of the SPD are related to other sections. You may not have all the information you need by reading just one section.
- Capitalized words in this chapter of your SPD have special meanings and are defined by Sections or in the Glossary at the end of the chapter.
- If eligible for coverage, the words “you” and “your” refer to Covered Persons as defined in the Glossary.

As an Oxford Participant, you have access to additional programs and resources to help you along your road to good health, including:

A robust network of hospitals and providers from a preferred provider organization with over 20 years of experience. Because your plan offers out-of-area coverage, you also have network national access outside of Oxford's tri-state service area through the UnitedHealthcare Choice Plus network.

Oxford's Healthy Bonus[®] program, which consists of special offers and discounts that help you stay healthy and manage special conditions. Participants can save on services such as weight loss programs, fitness equipment, and publications.

Gym Reimbursement - The Plan will partially reimburse you and your Covered spouse for your participation in qualifying exercise classes or attendance at qualifying exercise facilities.

To be eligible for reimbursement:

- You must go to the exercise facility and/or exercise classes 50 times in a six-month period. You may complete 50 classes, 50 visits, or a mix of visits and classes that add up to 50.
- The qualifying facility or classes you choose must be available to the general public and promote cardiovascular wellness, as determined by Oxford.

Participants may be reimbursed up to a \$200 maximum per six-month period. Covered spouses may receive up to a maximum of \$100 per six-month period. In order to obtain reimbursement, at the end of the six-month period you must:

- Fill out an Oxford Sweat Equity Program Reimbursement Form (To get a form, you may call the Benefits Fund at [877] RN BENEFITS [762-3633] or print one at our Web site, www.rnbenefits.org).
- Submit the Oxford Sweat Equity Program Reimbursement Form and proof of payment for the gym fee or any money paid for fitness classes to the following address: **Oxford Gym Reimbursement P.O. Box 29130, Hot Springs, AR 71903.**

These documents must be postmarked no later than 180 days from the last date of the six-month period for which you are asking for reimbursement. Complete one form per member for each six-month period for which you are making a claim.

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

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

SECTION 1: HOW THE FUND'S HOSPITAL AND MEDICAL BENEFITS WORK

Whenever you need Covered Services, the Fund gives you a choice. Under the Fund, you can choose to receive Covered Services “In-Network” from Oxford's In-Network Providers or you can receive Covered Services “Out-of-Network” from non-Network Providers. Your out-of-pocket responsibility differs depending upon whether Covered Services are obtained through your In-Network or Out-of-Network Benefits. Generally, you will be responsible for paying a higher portion of your medical expenses when you obtain Out-of-Network Benefits. Both you and the Fund enjoy savings when you utilize In-Network Providers, so it is important to try to

use In-Network Providers when possible. Please refer to your Schedule of Benefits (see Page 14) for specific out-of-pocket expenses.

In-Network Benefits

In-Network Benefits are the highest level of coverage available. In-Network Benefits apply when your care is provided by In-Network Providers. For those who live in the New York City area, Long Island, Connecticut, New Jersey, or Dutchess, Orange, Westchester, Rockland, and Ulster Counties in New York, the Plan provides access to Covered Services from Providers within Oxford's Freedom Network, which is Oxford's largest network. If you live or are seeking care outside the Oxford service area, as outlined above, the Plan provides access to Covered Services from In-Network Providers in the UnitedHealthcare Choice Plus Network. You should always first consider receiving health care services first through In-Network Providers under the In-Network Benefits portion of this SPD.

Use www.oxfordhealth.com to search for Oxford Freedom Network Providers. To find UnitedHealthcare Choice Plus In-Network Providers search on www.uhc.com. While In-Network status may change from time to time, www.oxfordhealth.com and www.uhc.com are the most current sources of In-Network information.

Out-of-Network Benefits

The Out-of-Network Benefits portion of this Fund provides coverage when you receive Covered Services from Out-of-Network Providers – Providers that do not participate in the Oxford or UnitedHealthcare networks listed above. Your out-of-pocket expenses will be higher when you receive Out-of-Network Benefits. It is important to note that when you use an Out-of-Network Provider, you are subject to balance billing, meaning, the Provider can require you to pay the difference between the amount charged by the Provider and the amount paid by the Fund.

Your ID Card

Remember to show your Oxford ID card every time you receive health care services from a Provider. If you do not show your ID card, a Provider has no way of knowing that you are enrolled under the Fund. In addition, you may be held financially responsible if you do not provide your Benefits Fund coverage information to providers in a timely manner.

Cost-sharing and Eligible Expense

Your share of the costs for services will depend on the following:

1. Annual deductible

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

2. Copayment

A Copayment (Copay) is the amount you pay each time you receive certain In-Network Covered Services. The Copay is a flat dollar amount and is paid at the time of service or when billed by the Provider. Copays count toward the In-Network Out-of-Pocket Maximum. Copays don't count toward the Out-of-Network Annual Deductible. If the Eligible Expense is less than the Copay, you are only responsible for paying the Eligible Expense and not the Copay (i.e. you are responsible for the lesser amount).

3. Coinsurance

Coinsurance is the percentage of Eligible Expenses that you are responsible for paying for Out-of-Network Covered Services. Coinsurance is a fixed percentage that applies to certain Covered Services after you meet the Annual Deductible. You must also pay any charges of an Out-of-Network Provider that are in excess of the Eligible Expense.

4. Out-of-Pocket Maximum

In-Network Out-of-Pocket Maximum

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

If you have other than individual coverage, the individual Out-of-Pocket Maximum applies to each person covered under this Plan. Once a person within a family meets the individual Out-of-Pocket Maximum with respect to their own expenses, the Plan will provide coverage for 100 percent of the Eligible Expense for the rest of that Plan Year for that person. If other than individual coverage applies, when members of the same family covered under this SPD have collectively met the family Out-of-Pocket Maximum in payment of Copayments and Coinsurance for a Plan Year, the Plan will provide coverage for 100 percent of the Eligible Expense for the rest of that Plan Year for all members of the family cov-

ered under the Fund. Cost-sharing for Out-of-Network services, except for Emergency Services does not apply toward your In-Network Out-of-Pocket Maximum. The In-Network Out-of-Pocket Maximum runs from January 1 to December 31 of each calendar year.

5. Additional Payments for Out-of-Network Benefits

When you receive Covered Services from an Out-of-Network Provider, in addition to the applicable Copayments, Coinsurance, and Deductible, you must also pay the amount, if any, by which the Out-of-Network Provider's actual charge exceeds the Eligible Expense. This means that the total of the Plans coverage and any amounts you pay under your applicable Deductible, Copayment, and Coinsurance may be less than the Out-of-Network Provider's actual charge.

When you receive Covered Services from an Out-of-Network Provider, the Plan will apply nationally-recognized payment rules to the claim submitted for those services. These rules evaluate the claim information and determine the accuracy of the procedure codes and diagnosis code for the services you received. Sometimes, applying these rules will change the way that the Plan pays for the services. This does not mean that the services were not Medically Necessary. It only means that the claim should have been submitted differently. As an example, your Provider may have billed using several procedure codes when there is a single code that includes all of the separate procedures. Oxford will make one inclusive payment in that case, rather than a separate payment for each billed code. Another example of when Oxford will apply the payment rules to a claim is when you have surgery that involves two surgeons acting as "co-surgeons." Under the payment rules, the claim from each Provider should have a "modifier" on it that identifies it as coming from a co-surgeon. If Oxford receives a claim that does not have the correct modifier, Oxford will change it and make the appropriate payment.

6. Eligible Expenses

In-Network: The Eligible Expense is the amount Oxford negotiated with the In-Network Provider.

Out-of-Network: The Eligible Expense is 70 percent of the reasonable and customary rate based on information provided by a third-party vendor based on the geographic area where the services were rendered. Any charges of an Out-of-Network Provider that are in excess of the Eligible Expenses do not apply towards the Deductible or Out-of-Pocket Limit. You must pay the amount by which the Out-of-Network Provider's charge exceeds Oxford's Eligible Expenses.

Depending on the geographic area and the type of service you receive, you may have access through Oxford's Shared Savings Program to Out-of-Network Providers who have agreed to discounts negotiated from their billed charges on certain claims for Covered Health Care Services. The Shared Savings Program is a program through which Oxford may obtain a discount on an Out-of-Network Provider's billed charges. This discount is usually based on a schedule previously agreed to by the Out-of-Network Provider.

When this happens, you may experience lower out-of-pocket amounts. Coinsurance and any applicable deductible would still apply to the reduced charge. Plan provisions or administrative practices supersede the scheduled rate, and a different rate is determined by Oxford. This means, when contractually permitted, the Plan may pay the lesser of the Shared Savings Program discount or an amount determined by Oxford, such as a percentage of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for the same or similar service within the geographic market, an amount determined based on available data resources of competitive fees in that geographic area, a fee schedule established by a third-party vendor, or a negotiated rate with the provider.

In this case, the Out-of-Network Provider may bill you for the difference between the billed amount and the rate determined by Oxford. If this happens, please call the Benefits Fund office. Shared Savings Program providers are not In-Network Providers and are not credentialed by Oxford.

Eligible Expenses (Allowed Amounts) are the amount Oxford determines that the Plan will pay for Benefits. For In-Network Benefits, except for your cost-sharing obligations, you are not responsible for any difference between Eligible Expenses and the amount the Provider bills. For Out-of-Network Benefits, you are responsible for paying, directly to the Out-of-Network Provider, any difference between the amount the provider bills you, and the amount the Plan will pay for Eligible Expenses. Allowed Amounts are determined solely in accordance with Oxford's reimbursement policy guidelines, as described in this SPD.

For In-Network Benefits, Allowed Amounts are based on the following:

- When Covered healthcare services are received from an In-Network Provider, Allowed Amounts are Oxford's contracted fee(s) with that Provider.
- When Covered healthcare services are received from an Out-of-Network Provider as arranged by Oxford, Allowed Amounts are an amount

negotiated by Oxford or an amount permitted by law. Please contact the Fund office if you are billed for amounts in excess of your applicable Coinsurance, Copayment, or any deductible. The Plan will not pay for excessive charges or amounts you are not legally obligated to pay.

For Out-of-Network Benefits, Allowed Amounts are based on either of the following:

When Covered healthcare services are received from an Out-of-Network Provider, Allowed Amounts are determined, based on:

- Negotiated rates agreed to by the Out-of-Network Provider and either Oxford or one of Oxford’s vendors, affiliates, or subcontractors.
- If rates have not been negotiated, then one of the following amounts applies based on the claim type:
- For Covered healthcare services other than pharmaceutical products, Allowed Amounts are determined based on available data resources of competitive fees in that geographic area.
- When Covered healthcare services are pharmaceutical products, Allowed Amounts are determined based on 110 percent of the published rates allowed by CMS for Medicare for the same or similar service within the geographic market.
- When a rate is not published by CMS or data resources of competitive fees in a geographic area are not available for the service, Oxford uses a gap methodology established by OptumInsight and/or a third-party vendor that uses a relative value scale or similar methodology. The relative value scale is usually based on the difficulty, time, work, risk, and resources of the service. If the relative value scale currently in use becomes no longer available, Oxford will use a comparable scale(s). Oxford and OptumInsight are related companies through common ownership by UnitedHealth Group. Refer to the Oxford’s Web site at www.oxfordhealth.com for information regarding the vendor that provides the applicable gap fill relative value scale information.

Please note: *Out-of-Network Providers may bill you for any difference between the Provider’s billed charges and the Allowed Amount described here.*

In-Network Services

As a Participant of the Plan, you may seek primary, preventative, or specialty care from any In-Network Provider without a referral. You and your eligible Dependents may, but are not required to, select a Primary Care Physician (PCP). The Benefits Fund encourages you to use your PCP when you need primary or preventive care and allow your PCP to coordinate your specialty care needs. In this manner, continuity of care can be maintained.

While referrals are not required, any requirements pertaining to Preauthorization, as described in this SPD (see Page 36), must be followed.

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

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

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

Out-of-Network Services

If you decide you do not want to use an In-Network Provider, the Plan still provides coverage for a broad range of medical services. However, Covered Services not obtained from In-Network Providers will be subject to Deductible, Coinsurance, and the amount, if any, by which the Out-of-Network Provider’s actual charge exceeds the Eligible Expenses. This means that the total of the Plan coverage and any amounts you pay under your applicable Deductible, Copayment, and Coinsurance may be less than the Out-of-Network Provider’s actual charge. Further, Out-of-Network Providers may not be familiar with Oxford’s Plan. Therefore, you should review the “Covered Services” and “Limitations and Exclusions” sections of this chapter of your SPD. You may also contact the Benefits Fund if you have any questions concerning Covered Services under this Plan. In any case where benefits are limited to a certain number of days or visits, such limits apply in the aggregate to In-Network and Out-of-Net-

work services.

Surgical procedures and Hospitalizations still require Preauthorization. You are responsible for ensuring your provider calls the Provider services number on the back of your ID card to obtain the Preauthorization. Failure to Preauthorize will result in a 50 percent reduction in benefits, up to \$500, whichever is less.

In-Network exceptions

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

Additionally, Preauthorization requests for admissions to Out-of-Network facilities (e.g., hospitals, rehabilitation centers) to be Covered on an In-Network basis will not be approved unless Oxford agrees that an In-Network facility is unable to meet your specific medical needs. While you and your In-Network Provider may discuss having a procedure performed at a specific Out-of-Network facility, In-Network coverage is only available if Oxford agrees that the procedure cannot be safely performed at any In-Network facility. Any non-emergency Covered Services received at an Out-of-Network facility will be subject to the Out-of-Network level of benefits.

Preauthorization

All admissions to health care facilities and certain diagnostic tests and therapeutic procedures must be Preauthorized by Oxford before you are admitted or receive treatment. If you are unsure whether a procedure requires Preauthorization, please call the Benefits Fund.

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

Covered inpatient services are Preauthorized for a specific number of days. If your In-Network Provider

believes that a longer stay is Medically Necessary, the extension must be Preauthorized in order for it to be Covered.

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

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

Preauthorization Procedure

If you seek coverage for Out-of-Network services you're responsible for ensuring your provider calls the Provider services number on the back of your ID card to obtain Preauthorization. After receiving a request for approval, Oxford will review the reasons for your planned treatment and determine if benefits are available. Criteria will be based on multiple sources including medical policy, clinical guidelines, and pharmacy and therapeutic guidelines.

Failure to Seek Preauthorization

If you fail to seek Preauthorization for Out-of-Network benefits subject to this section, Oxford will reduce the amount your Plan would otherwise have paid for the Out-of-Network care as reflected in the Schedule of Benefits of this SPD. You must pay the remaining charges. Your Plan will pay the amount specified above only if Oxford determines the care was Medically Necessary even though you did not seek Preauthorization. If Oxford determines that the services were not Medically Necessary, you will be responsible for paying the entire charge for the service.

Medical Management

The benefits available to you under this SPD are subject to pre-service, concurrent, and retrospective reviews to determine when services should be covered by your Plan. Their purpose is to promote the delivery of cost-effective medical care by reviewing the use of procedures and, where appropriate, the setting or place of service that they are performed. Covered Services must be Medically Necessary for benefits to be provided.

Medical Necessity

The Plan Covers benefits described in this SPD as long as the health care service, procedure, treatment, test, device, or supply (collectively, "service") is Medically Necessary. The fact that a Provider has furnished, prescribed, ordered, recommended, or approved the service does not make it Medically Necessary or mean that the Plan has to Cover it.

Oxford may base its decision on a review of:

- Your medical records;

- Oxford medical policies and clinical guidelines;
- Medical opinions of a professional society, peer review committee, or other groups of Physicians;
- Reports in peer-reviewed medical literature;
- Reports and guidelines published by nationally-recognized health care organizations that include supporting scientific data;
- Professional standards of safety and effectiveness, which are generally-recognized in the United States for diagnosis, care, or treatment;
- The opinion of health care professionals in the generally-recognized health specialty involved;
- The opinion of the attending Providers, which have credence but do not overrule contrary opinions.

Services will be deemed Medically Necessary only if:

- They are clinically appropriate in terms of type, frequency, extent, site, and duration, and considered effective for your illness, injury, or disease;
- They are required for the direct care and treatment or management of that condition;
- Your condition would be adversely affected if the services were not provided;
- They are provided in accordance with generally-accepted standards of medical practice;
- They are not primarily for the convenience of you, your family, or your Provider;
- They are not more costly than an alternative service or sequence of services, that is they are at least as likely to produce equivalent therapeutic or diagnostic results. When setting or place of service is part of the review, services that can be safely provided to you in a lower cost setting will not be Medically Necessary if they're performed in a higher cost setting. For example, the Plan will not provide coverage for an inpatient admission for surgery if the surgery could have been performed on an outpatient basis or an infusion or injection of a specialty drug provided in the outpatient department of a Hospital if the drug could be provided in a Physician's office or the home setting.

See the section on Claims Procedures on Page 56 for your right to an internal appeal and external appeal of Oxford's determination that a service is not Medically Necessary.

Selecting a Primary Care Physician

1. Selecting your PCP

You may, but are not required to, select a PCP when you enroll. Please refer to the roster of In-Network Providers when selecting a PCP.

2. Primary provider of OB/GYN care

In addition to a PCP, female Participants should select an In-Network Provider of OB/GYN Care.

3. In-Network specialists as PCPs

Participants who have a life-threatening condition or disease and Participants who have a degenerative and disabling condition or disease may request that a Specialist who is an In-Network Provider be their PCP. Oxford will consult with the Specialist and your PCP and decide whether the Specialist should be your PCP. Any Referral will be pursuant to a treatment plan approved by Oxford in consultation with your PCP, the Specialist, and you. Oxford will not approve an Out-of-Network Specialist unless Oxford determines an appropriate Provider isn't available in Oxford's Network. If Oxford approves an Out-of-Network Specialist, Covered Services rendered by the Out-of-Network Specialist pursuant to the approved treatment plan will be paid as if they were provided by an In-Network Provider. You'll only be responsible for any applicable In-Network Cost-Sharing. The designated In-Network Specialist will become responsible for providing and coordinating all of the Participant's Primary Care and Specialty Care. He or she will be able to order tests, arrange procedures, and provide medical services in the same capacity as a PCP.

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

4. Changing your PCP

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

Provider participation, access to care, and transitional care

1. Provider participation

Oxford cannot promise that a specific Provider, even though listed in the roster of In-Network physicians, will be available. An In-Network Provider may end his or her contract with Oxford or decide not to accept additional patients. If you have any questions about whether or not a particular Provider is currently In-Network or accepting new patients, please feel free to call the Benefits Fund and inquire. If your In-Network PCP or Specialist leaves Oxford's Network, you should choose another In-Network

PCP or Specialist in order to continue receiving care on an In-Network basis. However, if you are undergoing a course of treatment at the time your In-Network Provider leaves the Network, you may be eligible for Transitional Care as described below.

2. Transitional care

Your provider leaves the Network

If you are undergoing a course of treatment when your Provider leaves the Network, you may be able to continue to receive Covered Services from your former In-Network Provider for up to 90 days from the date your Provider's contractual obligation to provide services to you terminates. Regarding pregnancy, if the Provider leaves the Network while you are in your second or third trimester, you may be able to continue care with a former In-Network Provider through delivery and any post-partum care directly related to the delivery.

In order for you to continue to receive Covered Services for up to 90 days or through pregnancy with a former In-Network Provider, the Provider must agree to accept as payment the negotiated fee that was in effect just prior to the termination of Oxford's relationship with the Provider. Further, the Provider must agree to provide Oxford necessary medical information related to your care and adhere to Oxford's policies and procedures, including those for assuring quality of care, obtaining Pre-authorization, and a treatment plan approved by Oxford. If the Provider agrees to these conditions, you will receive these Covered Services as if they are being provided by an In-Network Provider. You will only be responsible for any applicable In-Network Cost-Sharing.

Please note: *If the Provider was terminated by Oxford due to fraud, imminent harm to patients, or final disciplinary action by a state board or agency that impairs the Provider's ability to practice, continued treatment is not available.*

New participants currently undergoing a course of treatment

If you are undergoing a course of treatment with an Out-of-Network Provider at the time your coverage under this SPD becomes effective, you may be able to receive Covered Services from the Out-of-Network Provider for up to 60 days from the effective date of your coverage under the SPD. This coverage is available only if the course of treatment is for a life-threatening disease/condition or a degenerative and disabling disease/condition. Coverage is limited to the disease/condition. Regarding pregnancy, if your coverage becomes effective while you are in your second or third trimester, you may receive Covered Services from your Out-of-Network Provider through delivery and any post-partum care directly related to the delivery.

However, Transitional Care is available only if the Pro-

vider agrees to accept as payment Oxford's negotiated fees for such services. Further, the Provider must agree to adhere to all of the applicable policies and procedures required by Oxford regarding the delivery of Covered Services. If the Provider agrees to these conditions, you will receive these Covered Services as if they are being provided by an In-Network Provider. You will only be responsible for any applicable Copayments.

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

SECTION 2: COVERED MEDICAL SERVICES

Acupuncture Services

The Plan Covers Medically Necessary Acupuncture services (with the diagnosis of pain management or nausea only) that are performed in an office setting by a Provider who is either practicing within the scope of his/her license (if state license is available) or who is certified by a national accrediting body and is one of the following:

- A licensed acupuncturist (LAC)
- A licensed naturopath
- A Physician (Doctor of Medicine or Doctor of Osteopathy) who has been credentialed as Physician acupuncturists.

Coverage does not include any treatment rendered outside of the state the practitioner is licensed to practice.

Preventive Care

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

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force;
- Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
- With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA);
- With respect to women, such additional preven-

tive care and screenings as provided for in comprehensive guidelines supported by the HRSA; and

- Benefits defined under the HRSA requirement, including the cost of purchasing one breast pump per Pregnancy in conjunction with childbirth. If more than one breast pump can meet your needs, Covered Services are available only for the most cost-effective pump. Oxford will determine the following:
 - Which pump is the most cost-effective;
 - Timing of an acquisition.

Ambulance and Pre-Hospital Emergency Medical Services

Please refer to the Schedule of Benefits chapter of this SPD (Page 14) for cost-sharing requirements and day or visit limits that apply to these benefits. Pre-hospital emergency medical services and ambulance services for the treatment of an Emergency Condition do not require Preauthorization.

Emergency Ambulance Transportation

The Plan covers pre-hospital emergency medical services for the treatment of an emergency condition when such services are provided by an ambulance service.

Pre-hospital emergency medical services means the prompt evaluation and treatment of an emergency condition and/or non-airborne transportation to a Hospital. The services must be provided by an ambulance service issued a certificate under the New York Public Health Law. The Plan will, however, only cover transportation to a Hospital provided by such an ambulance service when a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of such transportation to result in:

- Placing the health of the person afflicted with such condition or, with
- Respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy;
- Serious impairment to such person's bodily functions;
- Serious dysfunction of any bodily organ or part of such person; or
- Serious disfigurement of such person.

An ambulance service may not charge or seek reimbursement from you for pre-hospital emergency medical services. In the absence of negotiated rates, the Plan will pay an Out-of-Network Provider the usual and customary

charge for pre-hospital emergency medical services, which shall not be excessive or unreasonable.

The Plan also covers emergency ambulance transportation by a licensed ambulance service (either ground, water, or air ambulance) to the nearest Hospital where Emergency services can be performed. The Plan covers pre-hospital emergency medical services and Emergency ambulance transportation worldwide.

Non-Emergency Ambulance Transportation

The Plan covers non-emergency ambulance transportation by a licensed ambulance service (either ground or air ambulance, as appropriate) between facilities when the transport is any of the following:

- From an Out-of-Network Hospital to an In-Network Hospital;
- To a Hospital that provides a higher level of care that was not available at the original Hospital;
- To a more cost-effective acute facility;
- From an acute facility to a sub-acute setting.

Preauthorization is required for non-emergency ambulance services.

Limitations/Terms of Coverage

- The Plan does not cover travel or transportation expenses, unless connected to an Emergency Condition or due to a facility transfer approved by Oxford, even though prescribed by a Physician.
- The Plan does not cover non-ambulance transportation such as ambulette, van, or taxi cab.
- Coverage for air ambulance related to an Emergency Condition or air ambulance related to non-emergency transportation is provided when your medical condition is such that transportation by land ambulance is not appropriate; and your medical condition requires immediate and rapid ambulance transportation that cannot be provided by land ambulance; and one of the following is met:
 - The point of pick-up is inaccessible by land vehicle; or
 - Great distances or other obstacles (for example, heavy traffic) prevent your timely transfer to the nearest Hospital with appropriate facilities.

Emergency services and urgent care

Please refer to the Schedule of Benefits chapter of this SPD (Page 14) for cost-sharing requirements and day or visit limits that apply to these benefits.

Emergency Services

The Plan Covers Emergency Services for the treatment of an Emergency condition in a Hospital.

An Emergency condition means a medical or behavioral condition that manifests itself by Acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the person afflicted with such condition or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy;
- Serious impairment to such person's bodily functions;
- Serious dysfunction of any bodily organ or part of such person; or
- Serious disfigurement of such person.

For example, an Emergency condition may include, but is not limited to, the following conditions:

- Severe chest pain
- Severe or multiple injuries
- Severe shortness of breath
- Sudden change in mental status (e.g., disorientation)
- Severe bleeding
- Acute pain or conditions requiring immediate attention such as suspected heart attack or appendicitis
- Poisonings
- Convulsions

Coverage of Emergency Services for treatment of your Emergency condition will be provided regardless of whether the Provider is an In-Network Provider. The Plan will also cover Emergency Services to treat your Emergency condition worldwide. However, the Plan will cover only those Emergency Services and supplies that are Medically Necessary and are performed to treat or stabilize your Emergency condition in a Hospital.

Please follow the instructions below regardless of whether or not you're in Oxford's service area at the time your Emergency condition occurs.

Hospital Emergency Department Visits. In the event that you require treatment for an Emergency condition, seek immediate care at the nearest Hospital emergency department or call 911. Emergency department care does not require Preauthorization. However, only Emergency Services for the treatment of an Emergency condition are Covered in an emergency department.

The Plan doesn't cover follow-up care or routine care provided in a Hospital emergency department. You should contact Oxford to make sure you receive the ap-

propriate follow-up care.

Emergency Hospital Admissions. In the event you're admitted to the Hospital, you or someone on your behalf must notify Oxford at the number listed on your ID card within 48 hours of your admission, or as soon as is reasonably possible. The Plan Covers inpatient Hospital services at an Out-of-Network Hospital at the In-Network Cost-Sharing for as long as your medical condition prevents your transfer to an In-Network Hospital. Any inpatient Hospital services received from an Out-of-Network Hospital after your medical condition no longer prevents your transfer to an In-Network Hospital will be Covered at the Out-of-Network Cost-Sharing, unless the Plan authorizes continued treatment at the Out-of-Network Hospital.

Urgent Care

Urgent Care is medical care for an illness, injury, or condition serious enough that a reasonable person would seek care right away but not so severe as to require Emergency Department Care.

- **In-Network.** The Plan Covers Urgent Care from an In-Network Physician or an In-Network Urgent Care Center. You don't need to contact Oxford prior to, or after, your visit.
- **Out-of-Network.** The Plan Covers Urgent Care from an Out-of-Network Urgent Care Center or Physician.

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

Outpatient and Professional Services

Please refer to the Schedule of Benefits chapter of this SPD (Page 14) for Cost-Sharing requirements and day or visit limits that apply to these benefits.

A. Advanced Imaging Services. The Plan Covers PET scans, MRI, nuclear medicine, and CAT scans.

B. Allergy Testing and Treatment. The Plan Covers testing and evaluations, including injections and scratch and prick tests, to determine the existence of an allergy. The Plan also covers allergy treatment, including desensitization treatments, routine allergy injections, and serums.

C. Ambulatory Surgery Center. The Plan Covers surgical procedures performed at Ambulatory Surgical Centers including services and supplies provided by the center the day the surgery is performed.

D. Chemotherapy. The Plan Covers chemotherapy in an outpatient Facility or in a Health Care Professional's office. Orally-administered anti-cancer drugs are Covered

under the Fund's prescription drug benefit through Express Scripts (see the Prescription Drug Benefits chapter of this SPD on Page 77).

E. Chiropractic Services. The Plan Covers chiropractic care when performed by a Doctor of Chiropractic ("chiropractor") or other Provider acting within the scope of his/her license in connection with the detection or correction by manual or mechanical means of structural imbalance, distortion, or subluxation in the human body for the purpose of removing nerve interference and the effects thereof, where such interference is the result of or related to distortion, misalignment or subluxation of the vertebral column. This includes assessment, manipulation, and any modalities. Any laboratory tests will be Covered in accordance with the terms and conditions of this SPD.

F. Clinical Trials. The Plan Covers the routine patient costs for your participation in an approved clinical trial and such coverage shall not be subject to Utilization Review if you're:

- Eligible to participate in an approved clinical trial to treat either cancer or other life-threatening disease or condition; and
- Referred by an In-Network Provider who has concluded that your participation in the approved clinical trial would be appropriate.

All other clinical trials, including when you don't have cancer or other life-threatening disease or condition, may be subject to the Utilization Review and External Appeal sections of this SPD.

The Plan does not cover the costs of investigational drugs or devices, the costs of non-health care services required for you to receive the services, the costs of managing the research, or costs that would not be Covered under this SPD for non-investigational treatments provided in the clinical trial.

An approved clinical trial means a phase I, II, III, or IV clinical trial that is:

- A federally funded or approved trial;
- Conducted under an investigational drug application reviewed by the federal Food and Drug Administration; or
- A drug trial that is exempt from having to make an investigational new drug application.

G. Dialysis. The Plan Covers dialysis treatments of an Acute or chronic kidney ailment.

The Plan also Covers dialysis treatments provided by an Out-of-Network Provider subject to all the following conditions:

- The Out-of-Network Provider is duly licensed to practice and authorized to provide such treatment.
- The Out-of-Network Provider is located outside Oxford's Service Area.
- The In-Network Provider who is treating you has issued a written order indicating that dialysis treatment by the Out-of-Network Provider is necessary.
- You notify Oxford in writing at least 30 days in advance of the proposed treatment date(s) and include the written order referred to above. The 30-day advance notice period may be shortened when you need to travel on sudden notice due to a family or other emergency, provided that Oxford has a reasonable opportunity to review your travel and treatment plans.
- The Plan has the right to Preauthorize the dialysis treatment and schedule.
- The Plan will provide benefits for no more than 10 dialysis treatments by an Out-of-Network Provider per participant per calendar year.

Preauthorization is required if you receive dialysis treatment out of the country.

Benefits for services of an Out-of-Network Provider are Covered when all the above conditions are met and are subject to any applicable Cost-Sharing that applies to dialysis treatments by an In-Network Provider. However, you are also responsible for paying any difference between the amount the Plan would have paid had the service been provided by an In-Network Provider and the Out-of-Network Provider's charge.

H. Habilitative Services. The Plan covers Habilitation Services consisting of physical therapy, speech therapy, and occupational therapy in the outpatient department of a Facility or in a Health Care Professional's office.

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

such items would have been Covered during a Hospitalization or confinement in a Skilled Nursing Facility.

Home Health Care is limited to 140 visits for Out-of-Network only. In-Network Home Health Care has no limit based on medical necessity. Each visit by a member of the Home Health Agency is considered one visit. Each visit of up to four hours by a home health aide is considered one visit.

Please note: Any rehabilitation services received under this benefit will not reduce the amount of services available under the Rehabilitation Services benefits.

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

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

PDN will not be covered if the care is:

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

J. Infertility Treatment. The Plan Covers services for the diagnosis and treatment (surgical and medical) of infertility when such infertility is the result of malformation, disease, or dysfunction.

Basic Infertility Services. Basic Infertility Services will be provided to a Participant who is an appropriate candidate for infertility treatment. In order to determine eligibility, the Plan will use guidelines established by the American College of Obstetricians and Gynecologists, the American Society for Reproductive Medicine, and the State of New York. However, Participants must be between the ages of 21 and 44 (inclusive) in order to be considered a candidate for these services. Infertility services provided to Participants who are not between the ages of 21 and 44 (inclusive) are not Covered Services under this section.

- Basic Infertility Services include:
- Initial evaluation,
- Semen analysis,
- Laboratory evaluation,
- Evaluation of ovulatory function,

- Postcoital test,
- Endometrial biopsy,
- Pelvic ultrasound
- Hysterosalpingogram,
- Sonohystogram,
- Testis biopsy,
- Blood tests, and
- Medically appropriate treatment of ovulatory dysfunction.

Additional tests may be covered if the tests are determined to be Medically Necessary.

Comprehensive Infertility Services. If basic services do not result in increased fertility, the Plan covers comprehensive infertility services. These services include:

- Ovulation induction and monitoring,
- Pelvic ultrasound,
- Artificial insemination,
- Hysteroscopy,
- Laparoscopy, and
- Laparotomy.

Advanced Infertility Services.* Should the Comprehensive Infertility Services fail to increase fertility, Oxford may obtain Preauthorization for the following Advanced Infertility Services:

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

Advanced services are limited to a lifetime maximum of \$5,000 in medical or prescription drugs. Medical and prescription drug benefits cannot be combined. All services must be provided by Providers who are qualified to provide such services in accordance with the guidelines established and adopted by the American Society for Reproductive Medicine.

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

Exclusions and Limitations. The Plan does not Cover:

- Costs for an ovum donor or donor sperm;
- Sperm storage costs;
- Cryopreservation and storage of embryos;
- Ovulation predictor kits;
- Reversal of tubal ligations;
- Reversal of vasectomies;
- The following services related to a Gestational Carrier or Surrogate:
 - Fees for the use of a Gestational Carrier or Surrogate.
 - Insemination costs of Surrogate or transfer embryo to Gestational Carrier
 - Pregnancy services for a Gestational Carrier or Surrogate who is not a Covered Person.

The Plan defines a Gestational Carrier as a female who becomes pregnant via fertilized egg (embryo) implanted in her uterus for the purpose of carrying the fetus to term for another person. The carrier does not provide the egg and is, therefore not biologically (genetically), related to the child. The Plan defines Surrogate as a female who becomes pregnant usually by artificial insemination or transfer of a fertilized egg (embryo) for the purpose of carrying the fetus for another person. The surrogate provides the egg and is therefore biologically (genetically) related to the child.

- Cloning; or
- Medical and surgical procedures that are experimental or investigational, unless the Plan's denial is overturned by an External Appeal Agent.

K. Infusion Therapy. The Plan Covers infusion therapy, which is the administration of drugs using specialized delivery systems which otherwise would have required you to be hospitalized. Drugs or nutrients administered directly into the veins are considered infusion therapy. Drugs taken by mouth or self-injected into the muscles are not considered infusion therapy. The services must be ordered by a Physician or other authorized Health Care Professional and provided in an office or by an agency licensed or certified to provide infusion therapy. Any visits for home infusion therapy count toward your home health care visit limit.

L. Interruption of Pregnancy*. The Plan Covers therapeutic abortions including abortions in cases of rape, incest, or fetal malformation (i.e., medically necessary abortions).

**Participants covered under facilities adhering to principles of the Ethical and Religious Directives for Catholic Health Services as approved by the United States Conference of*

Catholic Bishops do not have coverage for interruption of pregnancy.

M. Laboratory Procedures, Diagnostic Testing, and Imaging Services. The Plan Covers x-ray, laboratory procedures and diagnostic testing, services and materials, including diagnostic x-rays, x-ray therapy, fluoroscopy, electrocardiograms, electroencephalograms, laboratory tests and therapeutic radiology services. Benefits include Presumptive Drug Tests and Definitive Drug Tests.

N. Maternity and Newborn Care. The Plan Covers services for maternity care provided by a Physician or midwife, nurse practitioner, Hospital, or birthing center. The Plan Covers prenatal care (including one visit for genetic testing), postnatal care, delivery, and complications of pregnancy. In order for services of a midwife to be Covered, the midwife must be licensed pursuant to Article 140 of the New York Education Law, practicing consistent with Section 6951 of the New York Education Law and affiliated or practicing in conjunction with a Facility licensed pursuant to Article 28 of the New York Public Health Law. The Plan will not pay for duplicative routine services provided by both a midwife and a Physician. See the Inpatient Services section of this SPD (Page 48) for Coverage of inpatient maternity care.

The Plan Covers breastfeeding support, counseling, and supplies, including the purchase of one breast pump per pregnancy for the duration of breastfeeding from an In-Network Provider or designated vendor.

O. Office visits. The Plan Covers office visits for the diagnosis and treatment of injury, disease, and medical conditions. Office visits may include house calls.

P. Outpatient Hospital Services. The Plan Covers Hospital services and supplies as described in the Inpatient Services section of this SPD (see Page 48) that can be provided to you while being treated in an outpatient facility. For example, Covered Services include, but are not limited to, inhalation therapy, pulmonary rehabilitation, infusion therapy, and cardiac rehabilitation. Unless you're receiving preadmission testing, Hospitals may not be In-Network Providers for outpatient laboratory procedures and tests.

Q. Preadmission Testing. The Plan Covers preadmission testing ordered by your Physician and performed in Hospital outpatient facilities prior to a scheduled surgery in the same Hospital provided that:

- The tests are necessary for and consistent with the diagnosis and treatment of the condition for which the surgery is to be performed;

- Reservations for a Hospital bed and operating room were made prior to the performance of the tests;
- Surgery takes place within 14 days of the tests; and
- The patient is physically present at the Hospital for the tests.

R. Prescription Drugs for Use in the Office or Outpatient Facilities. The Plan Covers Prescription Drugs (excluding self-injectable drugs) used by your Provider in the Provider's office or Outpatient Facility for preventive and therapeutic purposes. This benefit applies when your Provider orders the prescription drug and administers it to you. When prescription drugs are Covered under this benefit, they will not be Covered under the prescription drug plan (if that Addendum has been purchased).

S. Rehabilitation Services. The Plan Covers Rehabilitation Services consisting of physical therapy, speech therapy, and occupational therapy, in the outpatient department of a Facility or in a healthcare professional's office. Refer to the Schedule of Benefits section of this SPD (Page 14) to determine if a limit applies. For the purposes of this benefit, "per condition" means the disease or injury causing the need for the therapy.

T. Second Opinions

Second Cancer Opinion. The Plan Covers a second medical opinion by an appropriate Specialist, including but not limited to a Specialist affiliated with a specialty care center, in the event of a positive or negative diagnosis of cancer or a recurrence of cancer or a recommendation of a course of treatment for cancer. You may obtain a second opinion from an Out-of-Network Provider on an In-Network basis when your attending Physician provides a written Referral to an Out-of-Network Specialist.

Second Surgical Opinion. The Plan Covers a second surgical opinion by a qualified Physician on the need for surgery.

Required Second Surgical Opinion. The Plan may require a second opinion before Oxford Preauthorizes a surgical procedure. There is no cost to you when Oxford requests a second opinion.

- The second opinion must be given by a board-certified Specialist who personally examines you.
- If the first and second opinions do not agree, you may obtain a third opinion.
- The second and third surgical opinion consultants may not perform the surgery on you.

Second Opinions in Other Cases. There may be other instances when you will disagree with a Provider's rec-

ommended course of treatment. In such cases, you may request that Oxford designate another Provider to render a second opinion. If the first and second opinions do not agree, Oxford will designate another Provider to render a third opinion. After completion of the second opinion process, Oxford will Preauthorize Covered Services supported by the majority of the Providers reviewing your case.

U. Surgical Services. The Plan Covers Physicians' services for surgical procedures, including operating and cutting procedures for the treatment of a sickness or injury, and closed reduction of fractures and dislocations of bones, endoscopies, incisions, or punctures of the skin on an inpatient and outpatient basis, including the services of the surgeon or Specialist, assistant (including a Physician's assistant or a nurse practitioner), and anesthetist or anesthesiologist, together with preoperative and post-operative care. Benefits are not available for anesthesia services provided as part of a surgical procedure, when rendered by the surgeon or the surgeon's assistant.

Sometimes two or more surgical procedures can be performed during the same operation.

Through the Same Incision. If Covered multiple surgical procedures are performed through the same incision, the Plan will pay for the procedure with the highest Allowed Amount.

Through Different Incisions. If Covered multiple surgical procedures are performed during the same operative session but through different incisions, the Plan will pay:

- For the procedure with the highest Allowed Amount; and
- 50 percent of the amount the Plan would otherwise pay for the other procedures.

V. Oral Surgery. General dental services are not Covered. The Plan covers the following limited dental and oral surgical procedures:

- Oral surgical procedures for jaw bones or surrounding tissue and dental services for the repair or replacement of sound natural teeth that are required due to accidental injury. Replacement is Covered only when the repair is not possible. Dental services must be obtained within 12 months of the injury. "Accidental injury" does not include damage caused to a tooth while biting or chewing or the intentional misuse of the tooth.
- Boney impacted wisdom teeth extraction with precertification as secondary.
- Oral surgical procedures for jaw bones or surrounding tissue and dental services necessary due to congenital disease or anomaly.

- Oral surgical procedures required for the correction of a non-dental physiological condition that has resulted in a severe functional impairment.
- Removal of tumors and cysts requiring pathological examination of the jaws, cheeks, lips, tongue, roof, and floor of the mouth. Cysts related to teeth are not Covered.

W. Reconstructive Breast Surgery. The Plan Covers breast reconstructive surgery after a mastectomy or a partial mastectomy in accordance with the Women's Health and Cancer Rights Act (WHCRA). Coverage includes:

- all stages of reconstruction of the breast on which the mastectomy or partial mastectomy has been performed; and
- surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- implanted breast prostheses following mastectomy or partial mastectomy, and
- physical complications of the mastectomy or partial mastectomy including lymphedemas in a manner determined by you and your attending Physician to be appropriate.

X. Other Reconstructive and Corrective Surgery. The Plan Covers reconstructive and corrective surgery other than reconstructive breast surgery only when it is:

- Performed to correct a congenital birth defect of a covered child which has resulted in a functional defect; or
- Incidental to surgery or follows surgery that was necessitated by trauma, infection, or disease of the involved part; or
- Otherwise Medically Necessary.

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

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

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

medical expenses of a non-Participant acting as a donor for a Participant if the non-Participant's expenses will be Covered under another health plan or program.

The Plan does not Cover travel expenses, lodging, meals, or other accommodations for donors or guests; donor fees in connection with organ transplant surgery; or routine harvesting and storage.

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

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

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

Additional Benefits, Equipment, and Devices

Please refer to the Schedule of Benefits chapter of this SPD (Page 14) for cost-sharing requirements and day or visit limits that apply to these benefits.

A. Autism Spectrum Disorder. The Plan Covers the following services when such services are prescribed or ordered by a licensed Physician or a licensed psychologist and are determined by Oxford to be Medically Necessary for the screening, diagnosis, and treatment of autism spectrum disorder. For purposes of this benefit "autism spectrum disorder" means any pervasive developmental disorder defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders at the time services are rendered.

Screening and Diagnosis. The Plan Covers assessments, evaluations, and tests to determine whether someone has autism spectrum disorder.

Psychiatric and Psychological Care. The Plan Covers direct or consultative services provided by a psychiatrist, psychologist, or a licensed clinical social worker with the experience required by the New York Insurance Law, licensed in the state in which they are practicing.

Therapeutic Care. The Plan Covers therapeutic services

necessary to develop, maintain, or restore, to the greatest extent practicable, functioning of the individual when such services are provided by licensed or certified speech therapists, occupational therapists, physical therapists, and social workers to treat autism spectrum disorder and when the services provided by such Providers are otherwise Covered under this SPD. Except as otherwise prohibited by law, services provided under this paragraph shall be included in any visit maximums applicable to services of such therapists or social workers under this SPD. The Plan does not cover Applied Behavior Analysis therapy. Please see Page 53 for more information regarding this exclusion.

B. Diabetic Equipment, Supplies, and Self-Management Education. Diabetic equipment, supplies, and self-management education if recommended or prescribed by a Physician or other licensed Health Care Professional are Covered as follows:

Equipment and Supplies. The Plan covers the following equipment and related supplies for the treatment of diabetes when prescribed by your Physician or other provider legally authorized to prescribe:

- Acetone Reagent Strips
- Acetone Reagent Tablets
- Alcohol or Peroxide by the pint
- Alcohol Wipes
- All insulin preparations
- Automatic Blood Lance Kit
- Blood Glucose Kit
- Blood Glucose Strips (Test or Reagent)
- Blood Glucose Monitor with or without special features for visually impaired, control solutions, and strips for home blood glucose monitor (must be Preauthorized)
- Cartridges for the visually impaired
- Diabetes data management systems
- Disposable insulin and pen cartridges
- Drawing-up devices for the visually impaired
- Equipment for use of the Pump
- Glucagon for injection to increase blood glucose concentration
- Glucose Acetone Reagent Strips
- Glucose Reagent Strips
- Glucose Reagent Tape
- Injection Aides
- Injector (Busher) Automatic
- Insulin Cartridge Delivery
- Insulin Infusion Devices (Preauthorization is required for this item)
- Insulin Pump

- Lancets
- Oral agents such as glucose tablets or gels
- Syringe with needle; sterile 1 cc box
- Urine testing products for glucose and ketones.

Self-Management Education. Diabetes self-management education is education designed to educate persons with diabetes as to the proper self-management and treatment of their diabetic condition including information on proper diets. The Plan Covers education on self-management and nutrition: 1) upon the initial diagnosis; 2) if a Physician diagnoses a significant change in your symptoms or condition which necessitates a change in your self-management education; or 3) a refresher course is necessary. It must be provided:

- by a Physician, other health care Provider authorized to prescribe under Title 8 of the New York Education Law, or their staff during an office visit;
- upon the referral of your Physician or other health care Provider authorized to prescribe under Title 8 of the New York Education Law to the following non-Physician, medical educators certified diabetes nurse educators; certified nutritionists; certified dietitians; and registered dietitians in a group setting when practicable; and
- Education also will be provided in the Participant's home when Medically Necessary.

Limitations. The items will only be provided in amounts that are in accordance with the treatment plan developed by the Physician for you. The Plan Covers only basic models of blood glucose monitors unless you have special needs relating to poor vision or blindness or as otherwise Medically Necessary.

C. Durable Medical Equipment and Braces. The Plan Covers the rental or purchase of durable medical equipment and braces.

Durable Medical Equipment. Durable Medical Equipment is equipment which is: 1) designed and intended for repeated use; 2) primarily and customarily used to serve a medical purpose; 3) generally not useful to a person in the absence of disease or injury; and 4) is appropriate for use in the home.

Coverage is for standard equipment only. The Plan doesn't cover the cost of repair or replacement that's the result of misuse or abuse by you. The decision to rent or purchase such equipment will be made by Oxford. Preauthorization is required for items over \$500 and all rentals.

The Plan does not Cover equipment designed for your comfort or convenience (such as pools, hot tubs, air conditioners, saunas, humidifiers, dehumidifiers, or exercise equipment), as it does not meet the definition of

durable medical equipment.

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

D. Enteral Nutrition. The Plan covers Medically Necessary enteral formulas or modified solid food products for home use (whether administered orally or via tube feeding) for which a physician has issued a written order under the Fund's Medical Benefits, provided that the following criteria are established:

- The enteral formula or modified solid food product is being used as part of disease-specific treatment; and
- The treatment is for one of the following:
 - Inherited diseases of amino acid and /or organic acid metabolism;
 - Crohn's Disease;
 - Gastroesophageal reflux disease with failure to thrive;
 - Disorders of gastrointestinal motility such as chronic intestinal pseudo-obstruction;
 - Eosinophilic Esophagitis and related Eosinophilic disorders;
 - Multiple, severe food allergies; and
- One of the following:
 - The patient is malnourished;
 - The patient will become malnourished without treatment;
 - The patient's condition, if left untreated, will cause one of the following:
 - a. Chronic physical disability;
 - b. Mental retardation;
 - c. Death.

Nutritional supplements that are taken electively are not included in this coverage.

Nutritional Formulas

Nutritional formulas will be authorized for the treatment of phenylketonuria, branched-chain ketonuria, galactosemia, and homocystinuria.

E. Treatment of Gender Dysphoria*. The Plan pays Benefits for the treatment of gender dysphoria as described under "Non-Surgical treatment" or "Surgical treat-

ment" for gender dysphoria below:

Non-surgical treatment of gender dysphoria

- Psychotherapy for gender dysphoria and associated co-morbid psychiatric diagnoses as described under Mental Health Services in this SPD;
- Continuous cross-sex hormone replacement therapy – hormones of the desired gender injected by a medical provider.

Please note: Coverage is available for oral and self-injected hormones under the prescription drug benefits portion of the Plan provided through Express Scripts as outlined in Chapter 10: Prescription Drug Benefits on Page 77.

- Laboratory testing to monitor the safety of continuous cross-sex hormone therapy.

Surgical treatment of gender dysphoria

The Plan covers surgical treatment for gender dysphoria, subject to medical necessity and in accordance with the guidelines adopted by the Plan for such treatment. The following are covered when the qualifications for surgery are met below:

- Genital surgery and surgery to change secondary sex characteristics (including thyroid chondroplasty [also known as tracheal shave], bilateral mastectomy, and augmentation mammoplasty) and related services.
 - The treatment plan must conform to identifiable external sources, including the World Professional Association for Transgender Health standards and/or evidence-based professional society guidance; and
 - For irreversible surgical interventions, the participant must be 18 years of age or older;
 - Prior to surgery, the participant must complete 12 months of successful, continuous, full-time real-life experience in the desired gender.

Please note: Participants may be required to complete continuous hormone therapy prior to surgery. In consultation with the participant's physician, this will be determined on a case-by-case basis.

Augmentation mammoplasty is allowed if the physician prescribing hormones and the surgeon have documented that the breast enlargement after undergoing hormone treatment for 18 months is not sufficient for comfort in the social role.

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

F. Hospice. Hospice Care is available if your primary attending Physician has certified that you have six months or less to live. The Plan Covers inpatient Hospice Care in a Hospital or hospice, and home care and outpatient services provided by the hospice, including drugs and medical supplies. The Plan Covers a total of five visits for supportive care and guidance for the purpose of helping the Participant and the Participant's immediate family cope with the emotional and social issues related to the Participant's death, either before or after your death. Hospice Care will be Covered only when provided as part of a Hospice Care program certified pursuant to Article 40 of the New York Public Health Law. If care is provided outside New York State, the hospice must be certified under a similar certification process required by the state in which the hospice is located.

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

G. Medical Supplies. The Plan Covers medical supplies that are required for the treatment of a disease or injury which is Covered under this SPD. Maintenance supplies (e.g., ostomy supplies) also are Covered for conditions Covered under this SPD. All such supplies must be in the appropriate amount for the treatment or maintenance program in progress. The Plan doesn't Cover over-the-counter medical supplies. See the Diabetic Equipment, Supplies, and Self-Management Education section on Page 46 for a description of diabetic supply Coverage.

H. Prosthetics.

Internal Prosthesis. Surgically implanted prosthetic devices and special appliances will be Covered if they improve or restore the function of an internal body part that has been removed or damaged due to disease or injury. This includes implanted breast prostheses following a Covered mastectomy. Coverage also includes repair and replacement due to normal growth or normal wear and tear. Coverage does not include artificial organs.

External Prosthetic Devices. The Plan Covers prosthetic devices that are worn externally and temporarily or permanently replace all or part of an external body part which has been lost or damaged because of an Injury or disease. Purchase of the device must be Preauthorized. Coverage is for standard equipment only and is limited to devices that replace a limb or an external body part including:

- Artificial arms, legs, feet, and hands
- Artificial eyes, ears, nose
- Breast prosthesis.

Coverage is available for repair and replacement unless it is due to theft, loss, misuse, malicious damage, or gross neglect. External breast prostheses following a mastectomy or partial mastectomy also are Covered and are not subject to any lifetime benefit. Coverage under this provision includes mastectomy bras. Lymphedema stockings for the arm are covered as determined by you and your attending physician.

Wigs. Wigs may be covered when a Participant has severe hair loss due to certain injuries or diseases or as a side effect of the treatment of a disease (e.g. chemotherapy).

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

Inpatient Services

If You Are Hospitalized When Your Coverage Begins

If you are an inpatient in a Hospital, Skilled Nursing Facility, or Inpatient Rehabilitation Facility on the day your coverage begins, the Plan will pay Benefits for Covered Services related to that Inpatient Stay as long as you receive Covered Services in accordance with the terms of the Plan and the Covered Services are received on or after the day your coverage begins.

You should notify Oxford of your hospitalization within 48 hours of the day your coverage begins, or as soon as is reasonably possible. In-Network Benefits are available only if you receive Covered Services from In-Network Providers.

Please refer to the Schedule of Benefits chapter of this SPD on Page 14 for Cost-Sharing requirements and day or visit limits.

A. Hospital Services. The Plan Covers inpatient Hospital services for Acute care or treatment given or ordered by a Health Care Professional for an illness, injury, or disease of a severity that must be treated on an inpatient basis including:

- Private (if medically necessary and approved in advance) and semi-private room and board;
- General, special, and critical nursing care;
- Meals and special diets;
- The use of operating, recovery, and cystoscopic rooms and equipment;
- The use of intensive care, special care, or cardiac care units and equipment;

- Diagnostic and therapeutic items, such as drugs and medications, sera, biologicals and vaccines, intravenous preparations and visualizing dyes and administration, but not including those which are not commercially available for purchase and readily obtainable by the Hospital;
- Dressings and casts;
- Supplies and the use of equipment in connection with oxygen, anesthesia, physiotherapy, chemotherapy, electrocardiographs, electroencephalographs, X-ray examinations, and radiation therapy, laboratory and pathological examinations;
- Blood and blood products except when participation in a volunteer blood replacement program is available to you;
- Radiation therapy, inhalation therapy, chemotherapy, pulmonary rehabilitation, infusion therapy, and cardiac rehabilitation;
- Short-term physical, speech, and occupational therapy; and
- Any additional medical services and supplies which are provided while you're a registered bed patient and which are billed by the Hospital.

The Cost-Sharing requirements in the Schedule of Benefits chapter of this SPD (see Page 14) apply to a continuous Hospital confinement, which is consecutive days of in-Hospital service received as an inpatient or successive confinements when discharge from and readmission to the Hospital occur within a period of not more than 90 days.

B. Observation Services. The Plan Covers observation services in a Hospital. Observation services are Hospital outpatient services provided to help a Physician decide whether to admit or discharge you. These services include use of a bed and periodic monitoring by nursing or other licensed staff.

C. Inpatient Medical Services. The Plan Covers medical visits by a Health Care Professional on any day of inpatient care Covered under this SPD.

D. Inpatient Stay for Maternity Care. The Plan covers inpatient maternity care in a Hospital for the mother, and inpatient newborn care in a Hospital for the infant, for at least 48 hours following a normal delivery and at least 96 hours following a cesarean section delivery, regardless of whether such care is Medically Necessary. The care provided may include parent education, assistance and training in breast or bottle-feeding, and the performance of any necessary maternal and newborn clinical assessments. The Plan will also Cover any additional days of such care the

Plan determine are Medically Necessary.

In the event the mother elects to leave the Hospital and requests a home care visit before the end of the 48-hour or 96-hour minimum Coverage period, the Plan will cover a home care visit. The home care visit will be provided within 24 hours after the mother's request or her discharge from the hospital, whichever is later. The Plan's Coverage of this home care visit will be in addition to home health care visits under this SPD and will not be subject to any Cost-Sharing amounts in the Schedule of Benefits chapter of this SPD (see Page 14).

E. Inpatient Stay for Mastectomy Care. The Plan Covers inpatient services for Participants undergoing a lymph node dissection, lumpectomy, mastectomy, or partial mastectomy for the treatment of breast cancer and any physical complications arising from the mastectomy, including lymphedema, for a period of time determined to be medically appropriate by the participant and their attending Physician.

F. Autologous Blood Banking Services. The Plan Covers autologous blood banking services only when they are being provided in connection with a scheduled, Covered inpatient procedure for the treatment of a disease or injury for the individual banking the blood. In such instances, the Plan Covers storage fees for a reasonable storage period that is appropriate for having the blood available when it is needed.

G. Habilitation Services. The Plan Covers inpatient Habilitation Services consisting of physical therapy, speech therapy, and occupational therapy up to the limit listed in your Schedule of Benefits (see Page 14).

H. Rehabilitation Services. The Plan Covers Rehabilitation Services consisting of physical therapy, speech therapy, and occupational therapy up to the limit reflected in your Schedule of Benefits (see Page 14).

I. Skilled Nursing Facility. The Plan Covers services provided in a Skilled Nursing Facility in a semi-private room, as described in "Hospital Services" above. Custodial, convalescent, or domiciliary care isn't Covered (See the Exclusions and Limitations section of this chapter on Page 51). An admission to a Skilled Nursing Facility must be supported by a treatment plan prepared by your Provider and approved by Oxford. The Plan Covers non-custodial care for up to 60 consecutive days per condition per calendar year.

J. End of Life Care. If you are diagnosed with advanced cancer and you have fewer than 60 days to live, the Plan will Cover Acute care provided in a licensed Article 28 Facility or Acute care Facility that specializes in the care of terminally ill patients. Your attending Physician and the Facility's medical director must agree that your care will be appropriately provided at the Facility. If the Plan disagrees with your admission to the Facility, the Plan has the right to initiate an expedited external appeal to an External Appeal Agent. The Plan will Cover and reimburse the Facility for your care, subject to any applicable limitations in this SPD, until the External Appeal Agent renders a decision in the Plan's favor.

The Plan will reimburse Out-of-Network Providers for this end of life care as follows:

- The Plan will reimburse a rate that has been negotiated between Oxford and the Provider.
- If there is no negotiated rate, the Plan will reimburse Acute care at the Facility's current Medicare Acute care rate.
- If it is an alternate level of care, the Plan will reimburse at 75 percent of the appropriate Medicare Acute care rate.

K. Limitations/Terms of Coverage

- When you're receiving inpatient care in a Facility, the Plan will not Cover additional charges for special duty nurses, charges for private rooms (unless a private room is Medically Necessary and approved in advance), or medications and supplies you take home from the Facility. If you occupy a private room, and the private room is not Medically Necessary, the Plan's Coverage will be based on the Facility's maximum semi-private room charge. You will have to pay the difference between that charge and the private room charge.
- The Plan does not Cover radio, telephone, or television expenses, or beauty or barber services.
- The Plan does not Cover any charges incurred after the day the Plan advises you it's no longer Medically Necessary for you to receive inpatient care, unless the denial is overturned by an External Appeal Agent.

Mental Health and Substance Use Services

Please refer to the Schedule of Benefits section of this SPD (see Page 14) for Cost-Sharing requirements and day or visit limits that apply to these benefits, which are no more restrictive than those that apply to medical and surgical benefits in accordance with the federal Mental

Health Parity and Addiction Equity Act of 2008.

A. Mental Health Care Services

Inpatient Services. The Plan Covers inpatient mental health care services relating to the diagnosis and treatment of mental, nervous, and emotional disorders comparable to other similar Hospital, medical, and surgical coverage provided under this SPD. Coverage for inpatient services for mental health care is limited to Facilities defined in New York Mental Hygiene Law Section 1.03(10) such as:

- A psychiatric center or inpatient Facility under the jurisdiction of the New York State Office of Mental Health;
- A state or local government run psychiatric inpatient Facility;
- A part of a Hospital providing inpatient mental health care services under an operating certificate issued by the New York State Commissioner of Mental Health;
- A comprehensive psychiatric emergency program or other Facility providing inpatient mental health care that has been issued an operating certificate by the New York State Commissioner of Mental Health;
- and, in other states, to similarly licensed or certified Facilities.

The Plan also Covers inpatient mental health care services relating to the diagnosis and treatment of mental, nervous, and emotional disorders received at Facilities that provide residential treatment, including room and board charges. Coverage for residential treatment services is limited to Facilities defined in New York Mental Hygiene Law Section 1.03(33) and to residential treatment facilities that are part of a comprehensive care center for eating disorders identified pursuant to Article 27-J of the Public Health Law; and, in other states, to Facilities that are licensed or certified to provide the same level of treatment.

Outpatient Services. The Plan Covers outpatient mental health care services, including but not limited to partial hospitalization program services and intensive outpatient program services, relating to the diagnosis and treatment of mental, nervous, and emotional disorders. Coverage for outpatient services for mental health care includes Facilities that have been issued an operating certificate pursuant to Article 31 of the New York Mental Hygiene Law or are operated by the Office of Mental Health and, in other states, to similarly licensed or certified Facilities; and services provided by a licensed psychiatrist or psychologist; a licensed clinical social worker who has at least three years of additional experience in psychotherapy; a licensed mental health counselor; a licensed marriage and

family therapist; a licensed psychoanalyst; a psychiatric nurse, licensed as a nurse practitioner or clinical nurse specialist; or a professional corporation or a university faculty practice corporation thereof.

Limitations/Terms of Coverage. The Plan does not Cover:

- Benefits or services deemed to be cosmetic in nature on the grounds that changing or improving an individual's appearance is justified by the individual's mental health needs;
- Mental health benefits or services for individuals who are incarcerated, confined, or committed to a local correctional facility or prison, or a custodial facility for youth operated by the New York State Office of Children and Family Services; or
- Services solely because they are ordered by a court.

B. Substance Use Services

Inpatient Services. The Plan Covers inpatient substance use services relating to the diagnosis and treatment of alcoholism, substance use, and dependency. This includes Coverage for detoxification and rehabilitation services as a consequence of chemical use and/or substance use. Inpatient substance use services are limited to Facilities in New York State that are certified by the Office of Alcoholism and Substance Abuse Services (OASAS), and in other states, to those Facilities that are licensed or certified by a similar state agency or which are accredited by the Joint Commission as alcoholism, substance abuse, or chemical dependence treatment programs.

The Plan also Covers inpatient substance use services relating to the diagnosis and treatment of alcoholism, substance use, and dependency received at Facilities that provide residential treatment, including room and board charges.

Coverage for residential treatment services is limited to OASAS-certified Facilities defined in 14 NYCRR 819.2(a)(1), 820.3(a)(1) and (2) and to services provided in such Facilities in accordance with 14 NYCRR Parts 817 and 819; and, in other states, to those Facilities that are licensed or certified by a similar state agency or are accredited by the Joint Commission as alcoholism, substance abuse, or chemical dependence treatment programs to provide the same level of treatment.

Outpatient Services. The Plan Covers outpatient substance use services relating to the diagnosis and treatment of alcoholism, substance use, and dependency, including but not limited to partial hospitalization program services, intensive outpatient program services, and medication-assisted treatment. Such Coverage is limited to Facilities in New York State that are certified by OASAS or licensed by OASAS as outpatient clinics or medically supervised ambulatory sub-

stance abuse programs and, in other states, to those that are licensed or certified by a similar state agency or are accredited by the Joint Commission as alcoholism, substance abuse, or chemical dependence treatment programs. Coverage in an OASAS-certified Facility includes services relating to the diagnosis and treatment of a substance use disorder provided by an OASAS-credentialed Provider.

Coverage is also available in a professional office setting for outpatient substance use services relating to the diagnosis and treatment of alcoholism, substance use and dependency or by Physicians who have been granted a waiver pursuant to the federal Drug Addiction Treatment Act of 2000 to prescribe Schedule III, IV, and V narcotic medications for the treatment of opioid addiction during the Acute detoxification stage of treatment or during stages of rehabilitation.

The Plan also Covers up to 20 outpatient visits per calendar year for family counseling. A family member will be deemed to be covered, for the purposes of this provision, so long as that family member 1) identifies himself or herself as a family member of a person suffering from substance use and/or dependency and 2) is covered under the same family SPD that covers the person receiving, or in need of, treatment for substance use, and/or dependency. The Plan's payment for a family member therapy session will be the same amount, regardless of the number of family members who attend the family therapy session.

SECTION 3: EXCLUSIONS AND LIMITATIONS

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

1. Medically Necessary. In general, the Plan will not Cover any health care service, procedure, treatment, test, or device, that Oxford determines is not Medically Necessary. If an External Appeal Agent certified by the State overturns Oxford's denial, however, the Plan will Cover the service, procedure, treatment, test, or device for which coverage has been denied, to the extent that such service, procedure, treatment, test, device or Prescription Drug is otherwise Covered under the terms of this SPD
2. An adopted newly born infant's initial hospital stay if the biological parent has coverage available for the infant's care.
3. Blood, blood plasma, and blood derivatives other than those described as Covered Services. Synthetic blood, apheresis, or plasmapheresis, the collection and storage of blood, and the cost of securing the services of blood donors are not Covered.

4. Care for conditions that by federal, state, or local law must be treated in a public facility including, but not limited to, commitments for mental illness. Additionally, to the extent allowed by law, the Plan does not Cover care or treatment provided in an Out-of-Network Hospital that is owned or operated by any federal, state, or other governmental entity.

5. Cosmetic procedures, unless Medically Necessary, including cosmetic, reconstructive, or plastic surgery that is done for a condition that does not meet the specific criteria stated in “Reconstructive and Corrective Surgery.” This includes, but is not limited to, cosmetic surgery, plastic, or reconstructive surgery that is performed primarily to improve the appearance of any portion of the body including but not limited to surgery for sagging or extra skin; any augmentation or reduction procedure (e.g., mammoplasty); liposuction; rhinoplasty and rhinoplasty done in conjunction with Covered nasal or Covered sinus surgery. Complications of such surgeries are Covered only if they are Medically Necessary and are otherwise Covered. Remedial work is not Covered. Cosmetic surgery will not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection, or diseases of the involved part, and reconstructive surgery because of congenital anomaly or disease of a Dependent child that has resulted in a functional defect.

6. Comfort or convenience items including, but not limited to, barber services; guest meals and accommodations; telephone, television or radio charges; travel expenses; or take-home supplies. The Plan also does not Cover the purchase or rental of household fixtures or equipment including, but not limited to, escalators; elevators; swimming pools; exercise cycles; treadmills, weight training or muscle strengthening equipment; air purifiers; air conditioners; water purifiers; allergenic pillows, mattresses or waterbeds.

7. Aviation. The Plan does not Cover services arising out of aviation, other than as a fare-paying passenger on a scheduled or charter flight operated by a scheduled airline.

8. Convalescent and Custodial Care. The Plan does not Cover services related to rest cures, custodial care or transportation. “Custodial care” means help in transferring, eating, dressing, bathing, toileting, and other such related activities. Custodial care does not include Covered Services determined to be Medically Necessary.

9. Coverage outside of the United States Mexico and Canada. The Plan does not Cover care or treatment provided outside of the United States, its possessions, Canada or Mexico except for Emergency Services, Pre-Hospital Emergency Medical Services, and ambulance services to treat your Emergency condition.

10. Dental Services. The Plan does not Cover dental services for care or treatment due to accidental injury to sound natural teeth after 12 months of the accident; dental care or treatment necessary due to congenital disease or anomaly; dental care or treatment as specifically stated in the Outpatient and Professional Services section of this Chapter (Page 40).

11. The following are not Covered as diabetic services or supplies: services or supplies that are not both Medically Necessary and prescribed by the Participant’s Physician or qualified health professional; membership in health clubs, diet plans or clubs even if recommended by a Physician or any other Provider for purpose of losing weight; any counseling or courses in diabetes management other than as described as Covered under this SPD; stays at special facilities or spas for the purpose of diabetes education/management; special foods, diet aids and supplements related to dieting.

12. Durable Medical Equipment (other than as specifically Covered under this SPD). The Plan also does not cover blood pressure monitoring devices; car seats; arch supports; cervical collars; corrective shoes; false teeth; hearing aids; tilt tables; in-flight oxygen for non-emergency travel; special supplies or equipment; or special appliances.

13. Experimental or Investigational Treatment. The Plan does not Cover any health care service, procedure, treatment, device, or Prescription Drug that is experimental or investigational. However, the Plan will Cover experimental or investigational treatments, including treatment for your rare disease or patient costs for your participation in a clinical trial as described in the Outpatient and Professional Services section of this chapter (Page 40), when Oxford’s denial of services is overturned by an External Appeal Agent certified by the State. However, for clinical trials the Plan will not Cover the costs of any investigational drugs or devices; non-health services required for you to receive the treatment; the costs of managing the research; or costs that would not be Covered under this SPD for non-investigational treatments. See the Utilization Review and External Appeal sections of this SPD (Page 58) for a further explanation of your Appeal rights

14. Improper use of an emergency room or emergency admissions. Routine care and treatment for conditions that Oxford determines were not Emergencies, when received in an emergency room, are not Covered.

15. Infertility treatments and supplies (except as otherwise Covered under this SPD), even if the treatment or supply is for a purpose other than the correction of infertility. The following services and supplies are not Covered:

- Cost for an ovum donor or donor sperm;
- Sperm storage costs;
- Chromosomal analyses;
- Testicular biopsy;
- Elective abdominal surgeries related to lysis of adhesions or asymptomatic varicoceles;
- Radiographic imaging to determine tubal patency;
- Blood analyses related to immunological diagnosis of infertility;
- Cryopreservation and storage of embryos (unless the participant has not yet reached her lifetime limit of four egg retrievals);
- In-vitro services for women who have undergone tubal ligation;
- Any infertility services if the male has undergone a vasectomy; and
- All costs for and relating to surrogate motherhood (maternity services are covered for participants acting as surrogate mothers)

Treatment of an underlying medical condition will not be denied (if the treatment is otherwise covered under the SPD) solely because the medical condition results in infertility.

The following are Exclusions only for facilities adhering to principles of the Ethical and Religious Directives for Catholic Health Services as approved by the United States Conference of Catholic Bishops.

- Advanced infertility services including: in-vitro fertilization (IVF), gamete intrafallopian transfer (GIFT) and zygote intrafallopian transfer (ZIFT), culture and fertilization of oocyte(s), culture and fertilization of oocyte(s) with co-culture of embryos, assisted oocyte fertilization microtechnique (any method), assisted embryo hating microtechnique (any method), oocyte identification from follicular fluid, preparation of embryo for transfer (any method), and ultrasonic guidance for aspiration of ova, imaging and supervision.
- Therapeutic and elective terminations of pregnancy.

16. Applied Behavior Analysis. The Plan does not cover ABA therapy, including the design, implementation, and

evaluation of environmental modifications, using behavioral stimuli and consequences, including the use of direct observation, measurement and functional analysis of the relationship between environment and behavior to produce socially significant improvement in human behavior.

17. Learning and behavioral disorders. Services for the evaluation or treatment (including remedial education) of learning disabilities or minimal brain dysfunction; mental retardation; developmental and learning disorders or behavioral problems. The Plan also does not Cover behavioral training, visual perceptual or visual motor training related to learning disabilities or cognitive rehabilitation. Behavioral and learning disorders related to congenital abnormalities such as Down's Syndrome are not Covered.

18. Government Facility. The Plan does not Cover care or treatment provided in a Hospital that is owned or operated by any federal, state or other governmental entity, except as otherwise required by law (i.e., military services-related injuries).

19. Military Service. The Plan does not Cover an illness, treatment, or medical condition due to service in the armed forces or auxiliary units.

20. No-fault automobile insurance. The Plan does not Cover any benefits to the extent provided for any loss or portion thereof for which mandatory automobile no-fault benefits are recovered or recoverable. This exclusion applies even if you do not make a proper or timely claim for the benefits available to you under a mandatory no-fault Plan.

21. Non-eligible institutions. Any services or supplies furnished by a non-eligible institution, which is defined as other than a Hospital or Skilled Nursing Facility, and which is primarily a place of rest, a place for the aged, or any similar institution, regardless of how denominated.

22. Non-medical services and long-term rehabilitation services for physical therapy or the treatment of alcoholism or drug abuse, including rehabilitation services in a specialized inpatient or residential facility, except as specifically Covered under this SPD.

23. No-show charges. If a Provider charges a fee for a missed appointment, you will be responsible for the payment of the fee.

24. Occupational conditions, ailments, or injuries, arising out of and in the course of employment. Such conditions,

ailments, or injuries are not Covered if they are subject to coverage, in whole or in part, under any workers' compensation, occupational disease, or similar law. This applies even if the Participant's rights have been waived or qualified.

25. Outpatient prescription drugs.

26. Self-injectable medications. This exclusion does not apply to drugs for the treatment of diabetes and medications which, due to their characteristics (as determined by Oxford), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting.

27. Non-injectable medications given in a Physician's office. This exclusion does not apply to non-injectable medications that are required in a Medical Emergency and consumed in the Physician's office.

28. Over-the-counter drugs and treatments.

29. Growth hormone therapy.

30. Rehabilitation services or physical therapy on a long-term basis. Speech or occupational therapy to correct a condition that is not the result of a disease, Injury, or a congenital defect for which surgery has been performed.

31. Foot Care. The Plan does not Cover routine foot care in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain, or symptomatic complaints of the feet. However, the Plan will Cover foot care when you have a specific medical condition or disease resulting in circulatory deficits or areas of decreased sensation in your legs or feet.

This exclusion does not apply to preventive foot care for Participants who are at risk of neurological or vascular disease arising from diseases such as diabetes for which Benefits are provided as described in this SPD including nail trimming, corn and callous removal, cleaning, soaking, or any other hygienic maintenance or care.

32. Services for which the day or visit limit identified in the Schedule of Benefits has been met.

33. Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.

34. Services, solely because such services are ordered by

a court or services that have been ordered as a condition of probation or parole. However, these services may be Covered if Oxford agrees that the services are Medically Necessary, are otherwise Covered, the Participant has not exhausted his/her benefit for the contract/Calendar Year, and the treatment is provided in accordance with our policies and procedures.

35. Sex, marital, or religious counseling, including sex therapy and treatment of sexual dysfunction.

36. Special foods and diets, supplements, vitamins, and enteral feedings, except as what is otherwise outlined in this SPD. When coverage of special foods, diets, and enteral feedings are available, it is subject to periodic review for Medical Necessity. Infant formulas are not Covered.

37. Special medical reports not directly related to treatment. Appearances in court or at a hearing.

38. Third-party requests for physical examinations, diagnostic services, and immunizations in connection with obtaining or continuing employment; obtaining or maintaining any license issued by a municipality, state, or federal government; obtaining insurance coverage; foreign travel; school admissions or attendance, including examinations required for participation in athletic activities. Court ordered psychological or behavioral evaluations or counseling related to marital disputes, divorce proceedings, or child custody proceedings are not Covered.

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

40. Treatment provided in connection with services for individuals who are presently incarcerated, confined, or committed to a local correctional facility or prison, or a custodial facility for youth operated by the office of children and family services.

41. Unnecessary Care. In general, the Plan will not Cover any health care service that Oxford determines is

not Medically Necessary. However, if an external appeal agent certified by the state overturns Oxford's denial, the Plan shall Cover the procedure, treatment, service, pharmaceutical product, or durable medical equipment for which coverage has been denied, to the extent that such procedure, treatment, service, pharmaceutical product, or durable medical equipment is otherwise Covered under the terms of this SPD.

42. Any charges by an Out-of-Network Provider for Covered Services that are in excess of Oxford's Fee Schedule are excluded from coverage and are the Participant's responsibility.

43. Vision correction services and supplies including, but not limited to, eyeglasses (lenses and frames) and all manner of contact lenses or corrective lenses.

44. The Plan does not Cover the cost of hearing aids or the examination for the prescription or fitting of a hearing aid.

45. Weight Control. All services, supplies, programs, and surgical procedures for the purpose of weight control other than as specifically covered in this SPD.

46. War. Services received as a result of war or any act of war, whether declared or undeclared, or caused during service in the armed forces of any country. This exclusion does not apply if you're a civilian injured or otherwise affected by war, any act of war, or terrorism in non-war zones.

47. Workers' Compensation. The Plan does not Cover services if benefits for such services are provided under any state or federal workers' compensation, employers' liability, or occupational disease law.

48. Services Not Listed. Any service, supply, or treatment not specifically listed in this SPD as a Covered Service, supply, or treatment.

49. Services Provided by a family member. The Plan does not Cover services performed by a member of the covered person's immediate family, meaning a child, spouse, mother, father, sister, or brother of you or your spouse.

50. Services separately billed by hospital employees. The Plan does not Cover services rendered and separately billed by employees of hospitals, laboratories, or other institutions.

51. Services with no charge. The Plan does not Cover services for which no charge is normally made. Any supply or treatment for which the Participant has no legal obligation to reimburse the Provider.

52. Medicare or other government program. The Plan does not Cover services if benefits are provided for such services under the federal Medicare program or other governmental program (except Medicaid). When you're eligible for Medicare, the Plan will reduce your benefits by the amount Medicare would have paid for the Covered Services. Except as otherwise required by law, this reduction is made even if you fail to enroll in Medicare or you do not pay your Medicare premium. Benefits for Covered Services will not be reduced if the Plan is required by federal law to pay first or if you're not eligible for premium-free Medicare Part A.

53. Reversal of genital surgery or reversal of surgery to revise secondary sex characteristics.

54. Voice modification surgery.

55. Facial feminization surgery, including but not limited to, facial bone reduction, face "lift," facial hair removal, and certain facial plastic procedures.

56. Treatment of gender dysphoria for participants covered under facilities adhering to principles of the Ethical and Religious Directives for Catholic Health Services as approved by the United States Conference of Catholic Bishops.

57. Wigs are not covered for male pattern baldness; female pattern baldness; natural aging; or premature aging.

SECTION 4: PARTICIPANT RIGHTS AND RESPONSIBILITIES

What are my rights as a participant?

As a Participant you have the following rights:

1. The right to obtain complete and current information concerning a diagnosis, treatment, and prognosis from any In-Network Provider in terms that you or your authorized representative can readily understand. You have the right to be given the name, professional status, and function of any personnel delivering Covered Services to you.

You have the right to receive all information from an In-Network Provider necessary for you to give your informed consent prior to the start of any procedure or treatment.

You also have the right to refuse treatment to the extent

permitted by law. Oxford and your Physician will make every effort to arrange a professionally acceptable alternative treatment. However, if you still refuse the recommended treatment and Oxford and your In-Network Provider believe no professionally acceptable alternative exists, Oxford will not be responsible for the cost of further treatment for that condition. You will be notified accordingly.

If a Participant is not capable of understanding any of this information, an explanation will be provided to his or her guardian, designee, or a family participant.

2. The right to be provided with information about Oxford's services, policies, procedures, appeal procedures, and Oxford's In-Network Providers that accurately provides relevant information in a manner that is easily understood.

3. The right to quality health care services, which are provided in a professional manner that respects your dignity and protects your privacy. You also have the right to participate in decision-making regarding your health care.

4. The right to privacy and confidentiality of your health records, except as otherwise provided by law or contract. You have the right to all information contained in your medical records unless access is specifically restricted by the attending physician for medical reasons.

5. The right to file an appeal if complaints or concerns arise about Oxford's medical or administrative services or policies.

6. The right, when Medically Necessary, to emergency care without unnecessary delay.

7. The right to be advised if any of the In-Network Providers participating in your care propose to engage in or perform human experimentation or research affecting your care or treatment. You or a legally responsible party acting on your behalf may, at any time, refuse to participate in or continue in any experimentation or research program to which you have previously given informed consent.

8. The right to sign-language interpreter services in accordance with applicable laws and regulations, when such services are necessary to enable you as a person with special communication needs to communicate effectively with your Provider.

What are my responsibilities?

Your responsibilities include:

1. Entering into this Plan with the intent of following the

policies and procedures as outlined in this SPD.

2. Taking an active role in your health care through maintaining good relations with your Provider and following prescribed treatments and guidelines.

3. Providing, to the extent possible, information that professional staff need in order to care for you as a Participant.

4. Using the emergency room only as described in this SPD.

5. To notify your Plan Administrator of any change in name, address, or any other important information.

SECTION 5: CLAIMS PROCEDURES

In-Network Benefits

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

Keep in mind, you're responsible for paying any Copay or Coinsurance owed to an In-Network Provider at the time of service or when you receive a bill from the provider.

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

Out-of-Network Benefits

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

How to submit a claim

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

- Your name and address;
- Patient's name, age, and relationship to the

Participant;

- ID number as shown on the front of your ID card;
- Name, address, and tax identification number of the Provider of the service(s);
- Diagnosis from the Physician;
- Date of service; and
- Itemized bill from the Provider that includes:
 - Current Procedural Terminology codes
 - Description of, and the charge for, each service
 - Date the sickness or Injury began.

Failure to provide all the information listed above may delay any reimbursement that may be due to you.

For medical claims, the above information should be filed with Oxford at the address on the back of your ID card.

After Oxford has processed your claim, you will receive payment for Benefits that the Plan allows. It's your responsibility to pay the Out-of-Network Provider the charges you incurred, including any difference between what you were billed and what the Plan paid.

Payment of Benefits

You may not assign your Benefits under the Plan or any cause of action related to your Benefits under the Plan to an Out-of-Network provider without Oxford's consent. When you assign your Benefits under the Plan to an Out-of-Network provider with Oxford's consent, and the Out-of-Network Provider submits a claim for payment, you and the Out-of-Network Provider represent and warrant that the Covered Services were actually provided and were medically appropriate.

When Oxford has not consented to an assignment, Oxford will send the reimbursement directly to you (the Participant) for you to reimburse the Out-of-Network Provider upon receipt of their bill. However, Oxford reserves the right, in its discretion, to pay the Out-of-Network Provider directly for services rendered to you. When exercising its discretion with respect to payment, Oxford may consider whether you have requested that payment of your Benefits be made directly to the Out-of-Network Provider. Under no circumstances will Oxford pay Benefits to anyone other than you or, in its discretion, your provider.

Direct payment to an Out-of-Network provider shall not be deemed to constitute consent by Oxford to an assignment or to waive the consent requirement. When Oxford in its discretion directs payment to an Out-of-Network provider, you remain the sole beneficiary of the payment, and the Out-of-Network Provider does not thereby become a beneficiary. Accordingly, legally required notices concerning your Benefits will be directed to you, although Oxford may in its discretion send information concern-

ing the Benefits to the Out-of-Network Provider as well. If payment to an Out-of-Network Provider is made, the Plan reserves the right to offset Benefits to be paid to the provider by any amounts that the provider owes the Plan, including amounts owed as a result of the assignment of other plans' overpayment recovery rights to the Plan.

Form of Payment of Benefits

Payment of Benefits under the Plan shall be in cash or cash equivalents, or in the form of other consideration that Oxford in its discretion determines to be adequate. Where Benefits are payable directly to a provider, such adequate consideration includes the forgiveness in whole or in part of amounts the provider owes to other plans for which Oxford makes payments, where the Plan has taken an assignment of the other plans' recovery rights for value.

Limitations (Timeframe for Filing Claims)

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

Claim Information

Please allow up to 30 business days for the processing of In-Network claims. Claims for Out-of-Network Covered Services will be paid within 60 business days after Oxford receives proof of the claim.

If necessary, Oxford's Claims Department will contact you for more information regarding your claim in order to speed up the processing. If you would like to inquire about the status of a claim, call the Benefits Fund at (877) RN BENEFITS [762-3633].

Explanation of Benefits (EOB)

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

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

Claim Denials and Appeals

Types of Claims

The timing of the claims appeal process is based on the type of claim you are appealing. If you wish to appeal a claim, it helps to understand whether it is an:

- Urgent care request for Benefits.
- Pre-service request for Benefits.
- Post-service claim.
- Concurrent claim.

If Your Claim is Denied

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

How to Appeal a Denied Claim

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

This communication should include:

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

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

Oxford Appeals
P.O. Box 29139
Hot Springs, AR 71903

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

Urgent Appeals that Require Immediate Action

Your appeal may require immediate action if a delay in treatment could significantly increase the risk to your health or the ability to regain maximum function, or cause severe pain. If your situation is urgent, your review will be conducted as quickly as possible. If you believe your situation is urgent, you may request an expedited review, and, if applicable, file an external review at the same

time. For help, call Oxford at the number listed on your health plan ID card or the Benefits Fund at (877) RN BENEFITS [762-3633]. Generally, an urgent situation is when your life or health may be in serious jeopardy or when, in the opinion of your doctor, you may be experiencing severe pain that cannot be adequately controlled while you wait for a decision on your claim or appeal.

Review of an Appeal

Oxford will conduct a full and fair review of your appeal. The appeal may be reviewed by:

- An appropriate individual(s) who did not make the initial benefit determination; and
- A Health Care Professional with appropriate expertise who was not consulted during the initial benefit determination process.

Once the review is complete, if Oxford upholds the denial, you will receive a written explanation of the reasons and facts relating to the denial.

Filing a Second Appeal

If you are not satisfied with the first level appeal decision, you have the right to request a Second Level Appeal from Oxford in writing within 60 business days from receipt of the First Level Appeal determination. Once the review is complete, if Oxford upholds the denial you will receive a written explanation of the reasons and facts relating to the denial.

Please Note: Upon written request and free of charge, any Covered Persons may examine their claim and/or appeals file. Covered Persons may also submit evidence, opinions, and comments as part of the internal claims review process. Oxford will review all claims in accordance with the rules established by the U.S. Department of Labor.

Once you have exhausted the appeals procedure outlined in this chapter, you may also file a voluntary appeal to the Board of Trustees. Please see Page 5 in Chapter 1 of this SPD regarding the process for filing such an appeal.

Federal External Review Program

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

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

- Clinical reasons;
- The exclusions for Experimental or Investigational Services or unproven Services;

- Rescission of coverage (coverage that was cancelled or discontinued retroactively); or
- As otherwise required by applicable law.

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

An external review request should include all of the following:

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

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

Standard External Review

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

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

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

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

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

a random selection process.

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

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

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

In reaching a decision, the IRO will review the claim anew and not be bound by any decisions or conclusions reached by Oxford. The IRO will provide written notice of its determination (the final external review decision) within 45 calendar days after it receives the request for the external review (unless it requests additional time and you agree). The IRO will deliver the notice of final external review decision to you and Oxford, which will include the clinical basis for the determination.

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

Expedited External Review

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

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

- An adverse benefit determination of a claim or appeal if the adverse benefit determination involves a medical condition for which the time frame for completion of an expedited internal

appeal would seriously jeopardize the life or health of the individual or would jeopardize the individual's ability to regain maximum function and you have filed a request for an expedited internal appeal; or

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

Immediately upon receipt of the request, Oxford will determine whether the individual meets both of the following:

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

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

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

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

Timing of Appeals Determinations

Separate schedules apply to the timing of claims appeals, depending on the type of claim. There are three types of claims:

Urgent care request for Benefits - A request for Benefits provided in connection with urgent care services, as defined in Section 9, Glossary (see Page 70);

Pre-Service request for Benefits - A request for Benefits which the Plan must approve or in which you must notify Oxford before non-urgent care is provided; and

Post-Service - A claim for reimbursement of the cost of non-urgent care that has already been provided.

Please note that Oxford's decision is based only on whether or not Benefits are available under the Plan for the proposed treatment or procedure.

You may have the right to external review through an Independent Review Organization (IRO) upon the completion of the internal appeal process. Instructions regarding any such rights, and how to access those rights, will be provided in Oxford's decision letter to you.

The tables on the following pages describe the time frames which you and Oxford are required to follow:

Urgent Care Request for Benefits*	
Type of Request for Benefits or Appeal	Timing
If your request for Benefits is incomplete, Oxford must notify you within:	24 hours
You must then provide completed request for Benefits to Oxford within:	48 hours after receiving notice of additional information required
Oxford must notify you of the benefit determination within:	72 hours
If Oxford denies your request for Benefits, you must appeal an adverse benefit determination no later than:	180 days after receiving the adverse benefit determination
Oxford must notify you of the appeal decision within:	72 hours after receiving the appeal

**You do not need to submit urgent care appeals in writing. You should call Oxford as soon as possible to appeal an urgent care request for Benefits.*

Pre-Service Request for Benefits*	
Type of Request for Benefits or Appeal	Timing
If your request for Benefits is filed improperly, Oxford must notify you within:	5 days
If your request for Benefits is incomplete, Oxford must notify you within:	15 days
You must then provide completed request for Benefits information to Oxford within:	45 days
Oxford must notify you of the benefit determination:	
<ul style="list-style-type: none"> ■ if the initial request for Benefits is complete, within: 	15 days
<ul style="list-style-type: none"> ■ after receiving the completed request for Benefits (if the initial request for Benefits is incomplete), within: 	15 days
You must appeal an adverse benefit determination no later than:	180 days after receiving the adverse benefit determination
Oxford must notify you of the first level appeal decision within:	15 days after receiving the first level appeal
You must appeal the first level appeal (file a second level appeal) within:	60 days after receiving the first level appeal decision
Oxford must notify you of the second level appeal decision within: <i>(Voluntary Trustee appeals must be filed within 60 days after receiving the second level appeal decision.)</i>	15 days after receiving the second level appeal

**Oxford may require a one-time extension for the initial claim determination of no more than 15 days only if more time is needed due to circumstances beyond control of the Plan.*

Post-Service Claims	
Type of Claim or Appeal	Timing
If your claim is incomplete, Oxford must notify you within:	30 days
You must then provide completed claim information to Oxford within:	45 days
Oxford must notify you of the benefit determination:	
■ if the initial claim is complete, within:	30 days
■ after receiving the completed claim (if the initial claim is incomplete), within:	30 days
You must appeal an adverse benefit determination no later than:	180 days after receiving the adverse benefit determination
Oxford must notify you of the first level appeal decision within:	30 days after receiving the first level appeal
You must appeal the first level appeal (file a second level appeal) within:	60 days after receiving the first level appeal decision
Oxford must notify you of the second level appeal decision within:	30 days after receiving the second level appeal

Concurrent Care Claims

If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an Urgent Care request for Benefits as defined above, your request will be decided within 24 hours, provided your request is made at least 24 hours prior to the end of the approved treatment. Oxford will make a determination on your request for the extended treatment within 24 hours from receipt of your request.

If your request for extended treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an Urgent Care request for Benefits and decided according to the timeframes described above. If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new request and decided according to post-service or pre-service timeframes, whichever applies.

Limitation of Action

You cannot bring any legal action against the Benefits Fund or Oxford to recover reimbursement until 90 days after you have properly submitted a request for reimbursement as described in this section and all required reviews of your claim have been completed. If you want to bring a legal action against the Benefits Fund or Oxford, you must do so within three years from the expiration of the time period in which a request for reimbursement must be submitted or you lose any rights to bring such an action against the Benefits Fund or Oxford.

You cannot bring any legal action against the Benefits

Fund or Oxford for any other reason unless you first complete all the steps in the appeal process described in this section. After completing that process, if you want to bring a legal action against the Benefits Fund or Oxford you must do so within three years of the date you are notified of the final decision on your appeal or you lose any rights to bring such an action against the Benefits Fund.

Employee Retirement Income Security Act Rights

After all required levels of Appeals have been completed, the Participant may have the right to file a civil action under 502(a) of the Employee Retirement Income Security Act.

SECTION 6: COORDINATION OF BENEFITS

Coordination of Benefits applies to you if you are covered by more than one health benefits plan, including any one of the following:

- Another employer sponsored health benefits plan.
- A medical component of a group long-term care plan, such as skilled nursing care.
- No-fault or traditional “fault” type medical payment benefits or personal injury protection benefits under an auto insurance policy.
- Medical payment benefits under any premises liability or other types of liability coverage.
- Medicare or other governmental health benefit.

If coverage is provided under two or more plans, COB determines which plan is primary and which plan is secondary. The plan considered primary pays its benefits first, without regard to the possibility that another plan may

cover some expenses. Any remaining expenses may be paid under the other plan, which is considered secondary. The secondary plan may determine its benefits based on the benefits paid by the primary plan. How much this Plan will reimburse you, if anything, will also depend in part on the allowable expense. The term, “allowable expense,” is further explained below.

Determining Which Plan is Primary

Order of Benefit Determination Rules

If you are covered by two or more plans, the benefit payment follows the rules below in this order:

- This Plan will always be secondary to medical payment coverage or personal injury protection coverage under any auto liability or no-fault insurance policy;
- When you have coverage under two or more medical plans and only one has COB provisions, the plan without COB provisions will pay benefits first;
- A plan that covers a person as an employee pays benefits before a plan that covers the person as a dependent;
- If you are receiving COBRA continuation coverage under another employer plan, this Plan will pay Benefits first;
- Your dependent children will receive primary coverage from the parent whose birth date occurs first in a calendar year. If both parents have the same birth date, the plan that pays benefits first is the one that has been in effect the longest. This birthday rule applies only if:
 - The parents are married or living together whether or not they have ever been married and not legally separated; or
 - A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage;
- If two or more plans cover a dependent child of divorced or separated parents and if there is no court decree stating that one parent is responsible for health care, the child will be covered under the plan of:
 - The parent with custody of the child; then
 - The spouse of the parent with custody of the child; then
 - The parent not having custody of the child; then
 - The spouse of the parent not having custody of the child;
- Plans for active employees pay before plans

covering laid-off or retired employees;

- The plan that has covered the individual claimant the longest will pay first; and
- Finally, if none of the above rules determines which plan is primary or secondary, the allowable expenses shall be shared equally between the plans meeting the definition of Plan. In addition, this Plan will not pay more than it would have paid had it been the primary plan.

Determining Primary and Secondary Plan: Examples

The following examples illustrate how the Plan determines which plan pays first and which plan pays second:

1. Let’s say you and your spouse both have family medical coverage through your respective employers. You are unwell and go to see a Physician. Since you’re covered as a Participant under this Plan, and as a Dependent under your Spouse’s plan, this Plan will pay Benefits for the Physician’s office visit first.
2. Again, let’s say you and your spouse both have family medical coverage through your respective employers. You take your dependent child to see a Physician. This Plan will look at your birthday and your spouse’s birthday to determine which plan pays first. If you were born on June 11 and your spouse was born on May 30, your spouse’s plan will pay first.

When this Plan is Secondary

If this Plan is secondary, it determines the amount it will pay for a Covered Service by following the steps below.

- The Plan determines the amount it would have paid based on the allowable expense.
- If this Plan would have paid the same amount or less than the primary plan paid, this Plan pays no Benefits.
- If this Plan would have paid more than the primary plan paid, the Plan will pay the difference.

You will be responsible for any Copay, Coinsurance or Deductible payments as part of the COB payment. The maximum combined payment you can receive from all plans may be less than 100 percent of the allowable expense.

Determining the Allowable Expense if this Plan is Secondary

What is an Allowable Expense?

For purposes of COB, an allowable expense is a health care expense that is covered at least in part by one of the health benefit plans covering you.

When the provider is an In-Network provider for both the primary plan and this Plan, the allowable ex-

pense is the primary plan's network rate. When the provider is an In-Network provider for the primary plan and an Out-of-Network provider for this Plan, the allowable expense is the primary plan's network rate. When the provider is an Out-of-Network provider for the primary plan and an In-Network provider for this Plan, the allowable expense is the reasonable and customary charges allowed by the primary plan. When the provider is an Out-of-Network provider for both the primary plan and this Plan, the allowable expense is the greater of the two Plans' reasonable and customary charges. If this Plan is secondary to Medicare, please also refer to the discussion in the section below, titled "Determining the allowable expense when this Plan is secondary to Medicare."

When a Covered Person Qualifies for Medicare

Determining Which Plan is Primary

As permitted by law, this Plan will pay Benefits second to Medicare when you become eligible for Medicare, even if you don't elect it. There are, however, Medicare-eligible individuals for whom the Plan pays Benefits first and Medicare pays benefits second:

- Employees with active current employment status age 65 or older and their spouses age 65 or older.
- Individuals with end-stage renal disease, for a limited period of time.
- Disabled individuals under age 65 with current employment status and their Dependents under age 65.

Determining the Allowable Expense When this Plan is Secondary to Medicare

If this Plan is secondary to Medicare, the Medicare approved amount is the allowable expense, as long as the provider accepts reimbursement directly from Medicare. If the provider accepts reimbursement directly from Medicare, the Medicare approved amount is the charge that Medicare has determined that it will recognize and which it reports on an "explanation of Medicare benefits" issued by Medicare (EOMB) for a given service. Medicare typically reimburses such providers a percentage of its approved charge – often 80 percent.

If the provider does not accept assignment of your Medicare benefits, the Medicare limiting charge (the most a provider can charge you if they don't accept Medicare – typically 115 percent of the Medicare-approved amount) will be the allowable expense. Medicare payments, combined with Plan Benefits, will not exceed 100 percent of the allowable expense.

Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this Plan and other plans. Oxford may get the facts needed from, or give them to, other organizations or persons for the purpose of applying these rules and determining benefits payable under this Plan and other plans covering the person claiming benefits.

Oxford does not need to tell, or get the consent of, any person to do this. Each person claiming benefits under this Plan must give Oxford any facts needed to apply those rules and determine benefits payable. If you do not provide Oxford the information needed to apply these rules and determine the Benefits payable, your claim for Benefits will be denied.

Overpayment and Underpayment of Benefits

If you are covered under more than one medical plan, there is a possibility that the other plan will pay a benefit that the Plan should have paid. If this occurs, the Plan may pay the other plan the amount owed.

If the Plan pays you more than it owes under this COB provision, you should pay the excess back promptly. Otherwise, the Benefits Fund may recover the amount in the form of salary, wages, or benefits payable under any Benefits Fund-sponsored benefit plans, including this Plan. The Benefits Fund also reserves the right to recover any overpayment by legal action or offset payments on future Eligible Expenses.

If the Plan overpays a health care provider, the Benefits Fund reserves the right to recover the excess amount, from the provider pursuant to Refund of Overpayments, below.

Refund of Overpayments

If the Plan pays for Benefits for expenses incurred on account of a Covered Person, that Covered Person, or any other person or organization that was paid, must make a refund to the Plan if:

- The Plan's obligation to pay Benefits was contingent on the expenses incurred being legally owed and paid by the Covered Person, but all or some of the expenses were not paid by the Covered Person or did not legally have to be paid by the Covered Person;
- All or some of the payment the Plan made exceeded the Benefits under the Plan.
- All or some of the payment was made in error.

The amount that must be refunded equals the amount the Plan paid in excess of the amount that should

have been paid under the Plan. If the refund is due from another person or organization, the Covered Person agrees to help the Plan get the refund when requested.

If the refund is due from the Covered Person and the Covered Person does not promptly refund the full amount owed, the Plan may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, future Benefits for the Covered Person that are payable under the Plan. If the refund is due from a person or organization other than the Covered Person, the Plan may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part

- future Benefits that are payable in connection with services provided to other Covered Persons under the Plan; or
- future benefits that are payable in connection with services provided to persons under other plans for which Oxford makes payments, pursuant to a transaction in which the Plan's overpayment recovery rights are assigned to such other plans in exchange for such plans' remittance of the amount of the reallocated payment.

The reallocated payment amount will equal the amount of the required refund or, if less than the full amount of the required refund, will be deducted from the amount of refund owed to the Plan. The Plan may have other rights in addition to the right to reallocate overpaid amounts and other enumerated rights, including the right to commence a legal action.

SECTION 7: SUBROGATION AND REIMBURSEMENT

The Plan has a right to subrogation and reimbursement. References to "you" or "your" in this Subrogation and Reimbursement section shall include you, your estate, and your heirs and beneficiaries unless otherwise stated.

Subrogation applies when the plan has paid benefits on your behalf for a sickness or injury for which any third party is allegedly responsible. The right to subrogation means that the Plan is substituted to and shall succeed to any and all legal claims that you may be entitled to pursue against any third party for the benefits that the Plan has paid that are related to the sickness or injury for which any third party is considered responsible.

Subrogation – example

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

cost of those benefits.

The right to reimbursement means that if it is alleged that any third party caused or is responsible for a sickness or injury for which you receive a settlement, judgment, or other recovery from any third party, you must use those proceeds to fully return to the Plan 100 percent of any benefits you receive for that sickness or injury. The right of reimbursement shall apply to any benefits received at any time until the rights are extinguished, resolved, or waived in writing.

Reimbursement – example

Suppose you are injured in a boating accident that is not your fault and you receive benefits under the Plan as a result of your injuries. In addition, you receive a settlement in a court proceeding from the individual who caused the accident. You must use the settlement funds to return to the Plan 100 percent of any benefits you received to treat your injuries.

Third Parties

The following persons and entities are considered third parties:

- A person or entity alleged to have caused you to suffer a sickness, injury, or damages, or who is legally responsible for the sickness, injury, or damages;
- Any insurer or other indemnifier of any person or entity alleged to have caused or who caused the sickness, injury, or damages;
- Your employer in a workers' compensation case or other matter alleging liability;
- Any person or entity who is or may be obligated to provide benefits or payments to you, including benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners, or otherwise), workers' compensation coverage, other insurance carriers, or third party administrators;
- Any person or entity against whom you may have any claim for professional and/or legal malpractice arising out of or connected to a sickness or injury you allege or could have alleged were the responsibility of any third party; or
- Any person or entity that is liable for payment to you on any equitable or legal liability theory.

Subrogation and Reimbursement Provisions

You agree as follows:

1. You will cooperate with the Plan in protecting its legal and equitable rights to subrogation and reimbursement in

a timely manner, including but not limited to:

- Notifying the Plan, in writing, of any potential legal claim(s) you may have against any third party for acts which caused benefits to be paid or become payable.
- Providing any relevant information requested by the Plan.
- Signing and/or delivering such documents as the Plan or its agents reasonably request to secure the subrogation and reimbursement claim.
- Responding to requests for information about any accident or injuries.
- Making court appearances.
- Obtaining the Plan's consent or its agents' consent before releasing any party from liability or payment of medical expenses.
- Complying with the terms of this section.

Your failure to cooperate with the Plan is considered a breach of contract. As such, the Plan has the right to terminate your benefits, deny future benefits, take legal action against you, and/or set off from any future benefits the value of benefits the Plan has paid relating to any sickness or injury alleged to have been caused or caused by any third party to the extent not recovered by the Plan due to you or your representative not cooperating with the Plan. If the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, the Plan has the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to the Plan.

2. The Plan has a first priority right to receive payment on any claim against any third party before you receive payment from that third party. Further, the Plan's first priority right to payment is superior to any and all claims, debts, or liens asserted by any medical providers, including but not limited to, hospitals or emergency treatment facilities, that assert a right to payment from funds payable from or recovered from an allegedly responsible third party and/or insurance carrier.

3. The Plan's subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to you or your representative, your estate, your heirs and beneficiaries, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, pecuniary, consortium, and punitive damages. The Plan is not required to help you to pursue your claim for damages or personal injuries and no amount of associated costs, including attorneys'

fees, shall be deducted from the Plan's recovery without the Plan's express written consent. No so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall defeat this right.

4. Regardless of whether you have been fully compensated or made whole, the Plan may collect from you the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, no matter how those proceeds are captioned or characterized. Proceeds from which the Plan may collect include, but are not limited to, economic, non-economic, and punitive damages. No "collateral source" rule, any "Made-Whole Doctrine" or "Make-Whole Doctrine," claim of unjust enrichment, nor any other equitable limitation shall limit the Plan's subrogation and reimbursement rights.

5. Benefits paid by the Plan may also be considered to be benefits advanced.

6. If you receive any payment from any party as a result of sickness or injury and the Plan alleges some or all of those funds are due and owed to the Plan, you and/or your representative shall hold those funds in trust, either in a separate bank account in your name or in your representative's trust account.

7. By participating in and accepting benefits from the Plan, you agree that: any amounts recovered by you from any third party shall constitute Plan assets to the extent of the amount of Plan benefits provided on behalf of the participant; you and your representative shall be fiduciaries of the Plan (within the meaning of ERISA) with respect to such amounts; and you shall be liable for and agree to pay any costs and fees (including reasonable attorney fees) incurred by the Plan to enforce its reimbursement rights.

8. The Plan's rights to recovery will not be reduced due to your own negligence.

9. By participating in and accepting benefits from the Fund, you agree to assign to the Plan any benefits, claims, or rights of recovery you have under any automobile policy, including no-fault benefits, PIP benefits, and/or medical payment benefits, other coverage or against any third party, to the full extent of the benefits the Plan has paid for the sickness or injury. By agreeing to provide this assignment in exchange for participating in and accepting benefits, you acknowledge and recognize the Plan's right

to assert, pursue, and recover on any such claim, whether or not you choose to pursue the claim, and you agree to this assignment voluntarily.

10. The Plan may, at its option, take necessary and appropriate action to preserve its rights under these provisions, including but not limited to, providing or exchanging medical payment information with an insurer, the insurer's legal representative or other third party; filing an ERISA reimbursement lawsuit to recover the full amount of medical benefits you receive for the sickness or injury out of any settlement, judgment, or other recovery from any third party considered responsible and filing suit in your name or your estate's name, which does not obligate the Plan in any way to pay you part of any recovery the Plan might obtain. Any ERISA reimbursement lawsuit stemming from a refusal to refund benefits as required under the terms of the Plan is governed by a six-year statute of limitations.

11. You may not accept any settlement that does not fully reimburse the Plan, without its written approval.

12. The Plan has the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.

13. In the case of your death, giving rise to any wrongful death or survival claim, the provisions of this section apply to your estate, the personal representative of your estate, and your heirs or beneficiaries. In the case of your death, the Plan's right of reimbursement and right of subrogation shall apply if a claim can be brought on behalf of you or your estate that can include a claim for past medical expenses or damages. The obligation to reimburse the Plan is not extinguished by a release of claims or settlement agreement of any kind.

14. No allocation of damages, settlement funds, or any other recovery, by you, your estate, the personal representative of your estate, your heirs, your beneficiaries, or any other person or party, shall be valid if it does not reimburse the Plan for 100 percent of its interest unless the Plan provides written consent to the allocation.

15. The provisions of this section apply to the parents, guardian, or other representative of a Dependent child who incurs a sickness or injury caused by any third party. If a parent or guardian may bring a claim for damages arising out of a minor's sickness or injury, the terms of this subrogation and reimbursement clause shall apply to that claim.

16. If any third party causes or is alleged to have caused you to suffer a sickness or injury while you are covered under this Plan, the provisions of this section continue to apply, even after you are no longer covered.

17. In the event that you do not abide by the terms of the Plan pertaining to reimbursement, the Plan may terminate benefits to you or your dependents; deny future benefits; take legal action against you; and/or set off from any future benefits the value of benefits the Plan has paid relating to any sickness or injury alleged to have been caused or caused by any third party to the extent not recovered by the Plan due to your failure to abide by the terms of the Plan. If the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, the Plan has the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to the Plan.

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

Right of Recovery

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

- Made in error;
- Due to a mistake in fact;
- Advanced during the time period of meeting the calendar year Deductible; or
- Advanced during the time period of meeting the Out-of-Pocket Limit for the calendar year.

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

If the Plan provides a benefit for you or your Dependent that exceeds the amount that should have been paid, the Fund will:

- Require that the overpayment be returned when requested.
- Reduce a future benefit payment for you or your Dependent by the amount of the overpayment.

If the Plan provides an advancement of Benefits to you or your Dependent during the time period of meeting the Deductible and/or meeting the Out-of-Pocket Limit for the calendar year, the Plan will send you or your

Dependent a monthly statement identifying the amount you owe with payment instructions. The Plan has the right to recover benefits it has advanced by:

- Submitting a reminder letter to you or a covered Dependent that details any outstanding balance owed to the Plan.
- Conducting courtesy calls to you or a covered Dependent to discuss any outstanding balance owed to the Plan.

SECTION 8: OTHER IMPORTANT INFORMATION

Your Relationship with Oxford and the Benefits Fund

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

This means:

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

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

Relationship with Providers

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

In-Network Providers.

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

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

The Benefits Fund is solely responsible for:

- enrollment and classification changes (including classification changes resulting in your enrollment or the termination of your coverage);
- the timely payment of Benefits; and
- notifying you of the termination or modifications to the Plan.

Your Relationship with Providers

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

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

Interpretation of Benefits

The Trustees of the Benefits Fund have the sole and exclusive discretion to:

- interpret Benefits under the Plan;
- interpret the other terms, conditions, limitations, and exclusions of the Plan, including this SPD

- and any Riders and/or Amendments; and
- make factual determinations related to the Plan and its Benefits.

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

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

Information and Records

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

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

The Benefits Fund and Oxford have the right to release any and all records concerning health care services that are necessary to implement and administer the terms of the Plan, for appropriate medical review or quality assessment, or as the Benefits Fund is required to do by law or regulation. During and after the term of the Plan, the Benefits Fund and Oxford and its related entities may use and transfer the information gathered under the Plan in a de-identified format for commercial purposes, including research and analytic purposes (see the Notice of Privacy Practices on Page 8).

For complete listings of your medical records or billing statements, the Benefits Fund recommends that you

contact your health care Provider. Providers may charge you reasonable fees to cover their costs for providing records or completing requested forms.

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

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

Incentives to Providers

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

Examples of financial incentives for In-Network Providers are:

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

If you have any questions regarding financial incentives, you may call the Benefits Fund at (877) RN BENEFITS [762-3633]. You can ask whether your In-Network Provider is paid by any financial incentive, including those listed above; however, the specific terms of the contract, including rates of payment, are confidential and cannot be disclosed. In addition, you may choose to discuss these financial incentives with your In-Network Provider.

Incentives to You

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

[762-3633] if you have any questions.

Rebates and other payments

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

Workers' Compensation

Benefits provided under the Plan do not substitute for and do not affect any requirements for coverage by workers' compensation insurance.

SECTION 9: GLOSSARY

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

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

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

Allowed Amounts – See Eligible Expenses.

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

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

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

Autism Spectrum Disorder – Any pervasive developmental disorders set forth in the most recent edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, including but not limited to Autistic Disorder, Rett's Disorder, Childhood

Disintegrative Disorder, Asperger's Disorder and Pervasive Developmental Disorder Not Otherwise Specified.

Balance Billing – When an Out-of-Network Provider bills you for the difference between the Out-of-Network Provider's charge and the Eligible Expense. An In-Network Provider may not Balance Bill you for Covered Services.

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

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

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

COBRA – See Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

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

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

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

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

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

Cost-Sharing – Amounts you must pay for Covered Services, expressed as Coinsurance, Copayments, and/or Deductibles.

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

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

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

- provide assistance in activities of daily living, in-

cluding but not limited to, feeding, dressing, bathing, ostomy care, incontinence care, checking of routine vital signs, transferring, and ambulating;

- are provided for the primary purpose of meeting the personal needs of the patient or maintaining a level of function (even if the specific services are considered to be skilled services), as opposed to improving that function to an extent which might allow for a more independent existence; or
- do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

Custodial care does not include Covered services determined to be Medically Necessary.

Deductible – The amount you owe before the Plan begins to pay for Covered Services. The Deductible applies before any Copayments or Coinsurance are applied. The Deductible may not apply to all Covered Services. You may also have a Deductible that applies to a specific Covered Service that you owe before the Plan begins to pay for a particular Covered Service.

Definitive Drug Test – Test to identify specific medications, illicit substances, and metabolites and is qualitative or quantitative to identify possible use or non-use of a drug.

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

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

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

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

Eligible Expenses (Allowed Amount) – The maximum amount on which the Plan's payment is based for Covered Services. See Section 1, How the Fund's Hospital and Medical Benefits Work of this chapter for a description of how the Eligible Expense is calculated. If your Out-of-Network Provider charges more than the Eligible Expense you will have to pay the difference between the Eligible Expense and the Provider's charge, in addition to any Cost-Sharing requirements.

Eligible Expenses are determined solely in accordance

with Oxford's reimbursement policy guidelines. Oxford develops these guidelines, in its discretion, after review of all Provider billings in accordance with one or more of the following methodologies:

- As shown in the most recent edition of the Current Procedural Terminology (CPT), a publication of the American Medical Association, and/or the Centers for Medicare and Medicaid Services (CMS).
- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical staff and outside medical consultants pursuant to other appropriate source or determination that Oxford accepts.

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

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

Emergency Department Care – Emergency Services you get in a Hospital emergency department.

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

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

EOB – See Explanation of Benefits.

ERISA – See Employee Retirement Income Security Act of 1974.

Exclusions – What the Plan does not Cover as a Covered Service.

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

- Not approved by the U.S. Food and Drug Administration to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information

as appropriate for the proposed use;

- Subject to review and approval by any institutional review board for the proposed use (Devices that are FDA approved under the *Humanitarian Use Device* exemption are not considered to be Experimental or Investigational); or
- The subject of an ongoing Clinical Trial that meets the definition of a Phase I, II, or III Clinical Trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight.
- Clinical Trials for which Benefits are available as described under “Clinical Trials” in Section 2, Covered Health Services, on Page 41.
- If you are not a participant in a qualifying Clinical Trial as described in Section 2, Covered Health Services, and have a life threatening sickness or condition (one that is likely to cause death within one year of the request for treatment), Oxford may, at its discretion, consider an otherwise Experimental or Investigational Service to be a Covered Health Service for that sickness or condition. Prior to such consideration, Oxford must determine that, although unproven, the service has significant potential as an effective treatment for that sickness or condition.

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

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

Habilitation Services – Health care services that help a person keep, learn, or improve skills and functioning for daily living. Habilitation Services include the management of limitations and disabilities, including services or programs that help maintain or prevent deterioration in physical, cognitive, or behavioral function. These services consist of physical therapy, occupational therapy, and speech therapy.

Health Care Professional – An appropriately licensed, registered, or certified Physician; dentist; optometrist; chiropractor; psychologist; social worker; podiatrist; physical therapist; occupational therapist; midwife; speech-language pathologist; audiologist; pharmacist; behavior analyst; or any other licensed, registered, or

certified Health Care Professional under applicable law that requires to be recognized who charges and bills patients for Covered Services. The Health Care Professional’s services must be rendered within the lawful scope of practice for that type of Provider in order to be covered under this Plan.

Home Health Agency – An organization authorized by law in the state in which it operates and renders home health care services to provide health care services in the home.

Hospice Care – Care to provide comfort and support for persons in the last stages of a terminal illness and their families that are provided by a hospice organization certified under applicable law required by the state in which the hospice organization is located.

Hospital – A short term, acute, general Hospital, which:

- Is primarily engaged in providing, by or under the continuous supervision of Physicians, to patients, diagnostic services, and therapeutic services for diagnosis, treatment, and care of injured or sick persons;
- Has organized departments of medicine and major surgery;
- Has a requirement that every patient must be under the care of a Physician or dentist;
- Provides 24-hour nursing service by or under the supervision of a registered professional nurse;
- Is duly licensed by the agency responsible for licensing such Hospitals; and
- Is not, other than incidentally, a place of rest, a place primarily for the treatment of tuberculosis, a place for the aged, a place for drug addicts, alcoholics, or a place for convalescent, custodial, educational, or rehabilitative care.

Hospital does not mean health resorts, spas, or infirmaries at schools or camps.

Hospitalization – Care in a Hospital that requires admission as an inpatient and usually requires an overnight stay.

In-Network – When used to describe a provider of health care services, this means a Provider that has a participation agreement in effect (either directly or indirectly) with Oxford or with its affiliate to participate in the Network.

In-Network Copayment – A fixed amount you pay directly to an In-Network Provider for a Covered Service when you receive the Covered Service. The amount can vary by the type of Covered Service.

In-Network Annual Out-of-Pocket Limit – The most you pay in Cost-Sharing before the Plan will

begin to pay 100 percent of the Eligible Expense for Covered Services received from In-Network Providers. This maximum never includes your premium, Balance Billing charges, or services the Plan does not Cover

Injury – Bodily damage other than sickness, including all related conditions and recurrent symptoms.

Inpatient Rehabilitation Facility – A long-term acute rehabilitation center, Hospital, or a special unit of a Hospital designated as an Inpatient Rehabilitation Facility, that provides rehabilitation services, including physical therapy, occupational therapy, and/or speech therapy on an inpatient basis, as authorized by law.

Inpatient Stay – An uninterrupted confinement following formal admission to a Hospital, Skilled Nursing Facility, or Inpatient Rehabilitation Facility.

Medicaid – A federal program administered and operated individually by participating state and territorial governments that provides medical benefits to eligible low-income people needing health care. The federal and state governments share the program's costs.

Medically Necessary – Your Plan Covers benefits described in this SPD as long as the health care service, procedure, treatment, test, device, Prescription Drug, or supply (collectively, "service") is Medically Necessary. The fact that a Provider has furnished, prescribed, ordered, recommended, or approved the service does not make it Medically Necessary or mean that your Plan has to Cover it.

Oxford may base its decision on a review of your medical records; the Claims Administrator's medical policies and clinical guidelines; medical opinions of a professional society, peer review committee or other groups of Physicians; reports in peer-reviewed medical literature; reports and guidelines published by nationally-recognized health care organizations that include supporting scientific data; professional standards of safety and effectiveness, which are generally recognized in the United States for diagnosis, care, or treatment; the opinion of Health Care Professionals in the generally-recognized health specialty involved; and the opinion of the attending Providers, which have credence but do not overrule contrary opinions.

Services will be deemed Medically Necessary only if:

- They are clinically appropriate in terms of type, frequency, extent, site, and duration, and considered effective for your illness, injury, or disease;
- They are required for the direct care and treatment or management of that condition;
- Your condition would be adversely affected if the services were not provided;
- They are provided in accordance with generally-accepted standards of medical practice;

- They are not primarily for the convenience of you, your family, or your Provider;
- They are not more costly than an alternative service or sequence of services, that is they are at least as likely to produce equivalent therapeutic or diagnostic results;
- When setting or place of service is part of the review, services that can be safely provided to you in a lower cost setting will not be Medically Necessary if they are performed in a higher cost setting. For example, your Plan will not provide coverage for an inpatient admission for surgery if the surgery could have been performed on an outpatient basis.

See the Claims Procedures section of this SPD on Page 58 for your right to an internal appeal and external appeal of the Oxford determination that a service is not Medically Necessary.

Medicare – Parts A, B, C, and D of the insurance program established by Title XVIII, United States Social Security Act, as amended by 42 U.S.C. Sections 1394, et seq. and as later amended.

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

Out-of-Network Coinsurance – Your share of the costs of a Covered Service, calculated as a percent of the Eligible Expense for the Covered Service that you are required to pay to an Out-of-Network Provider.

Out-of-Network Copayment – A fixed amount you pay directly to an Out-of-Network Provider for a Covered Service when you receive the Covered Service. The amount can vary by the type of Covered Service.

Out-of-Network Deductible – The amount you owe before the Plan begins to pay for Covered Services received from Out-of-Network Providers. The Out-of-Network Annual Deductible applies before any Coinsurance or Copayments are applied. The Out-of-Network Annual Deductible may not apply to all Covered Services. You may also have an Out-of-Network Annual Deductible that applies to a specific Covered Service that you owe before the Plan begins to pay for a particular Covered Service.

Out-of-Network Provider – A Provider who doesn't have a contract with Oxford to provide services to you. You will pay more to see a Non-Participating Provider.

Out-of-Pocket Limit – The maximum amount you pay in Cost-Sharing before the Plan begins to pay 100 percent of the Eligible Expenses for Covered Services.

This limit never includes your premium, Balance Billing charges, or the cost of health care services the Plan does not Cover. Refer to the Schedule of Benefits on Page 14 for the Out-of-Pocket Limit amount.

Participating Provider – A Provider who has a contract with Oxford to provide services to you.

Participant – A full- or part-time Participant at a Participating employer who meets the eligibility requirements specified in the Plan, as described under Chapter 6: *Eligibility* of this SPD. A Participant must live and/or work in the United States.

Physician or Physician Services – Health care services a licensed medical Physician (Doctor of Medicine or Doctor of Osteopathy) provides or coordinates.

Plan – The New York State Nurses Association Benefits Fund.

Plan Administrator – The Board of Trustees of the Benefits Fund.

Preauthorization – A decision by Oxford prior to your receipt of a Covered Service, procedure, treatment plan, device, or Prescription Drug that the Covered Service, treatment plan, device, or Prescription Drug is Medically Necessary.

Prescription Drug – A medication, product, or device that has been approved by the Food and Drug Administration and that can, under federal or state law, be dispensed only pursuant to a prescription order or refill and is on Oxford's formulary. A Prescription Drug includes a medication that, due to its characteristics, is appropriate for self-administration or administration by a non-skilled caregiver.

Presumptive Drug Test – Test to determine the presence or absence of drugs or a drug class in which the results are indicated as negative or positive result.

Primary Care Provider – An In-Network Physician who typically is an internal medicine, family practice, or pediatric Physician and who directly provides or coordinates a range of health care services for you.

Provider – A Physician, Health Care Professional, or Facility licensed, registered, accredited, or certified as required by state law. A provider also includes a vendor or dispenser of diabetic equipment and supplies, durable medical equipment, medical supplies, or any other equipment or supplies that are Covered under this SPD that is licensed, registered, certified, or accredited as required by state law.

Rehabilitation Services – Health care services that help a person keep, get back, or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt, or disabled. These services consist of physical therapy, occupational therapy, and

speech therapy in an inpatient and/or outpatient setting.

Semi-private Room – A room with two or more beds. When an Inpatient Stay in a Semi-private Room is a Covered Service, the difference in cost between a Semi-private Room and a private room is a benefit only when a private room is necessary in terms of generally accepted medical practice, or when a Semi-private Room is not available.

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

Skilled Nursing Facility – An institution or a distinct part of an institution that is currently licensed or approved under state or local law; primarily engaged in providing skilled nursing care and related services as a Skilled Nursing Facility, extended care Facility, or nursing care Facility approved by the Joint Commission, or the Bureau of Hospitals of the American Osteopathic Association, or as a Skilled Nursing Facility under Medicare; or as otherwise determined by Oxford to meet the standards of any of these authorities.

Specialist – A Physician who focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions.

Schedule of Benefits – The section of this SPD (see Page 14) that describes the Copayments, Deductibles, Coinsurance, Out-of-Pocket Limits, and/or other limits on Covered Services.

Spouse – The person to whom the Subscriber is legally married, including a same sex Spouse.

Summary Plan Description (SPD) – A summary of the Covered Services available to you under the NYSNA Benefits Fund. In addition to this SPD, the Plan includes: the Schedule of Benefits, amendments, addendums, and Summary of Material Modifications.

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

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

study treatment group.

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

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

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

UCR (Usual, Customary, and Reasonable) – The cost of a medical service in a geographic area based on what Providers in the area usually charge for the same or similar medical service.

Urgent Care – Medical care for an illness, Injury, or condition serious enough that a reasonable person would seek care right away, but not so severe as to require Emergency Department Care. Urgent Care may be rendered in an In-Network Physician's office or Urgent Care Center.

Urgent Care Center – A licensed facility (other than a Hospital) that provides Urgent Care.

Utilization Review – A review to determine whether services are or were Medically Necessary or experimental or investigational (including treatment for a rare disease or a clinical trial).

The Plan's Benefits are administered by the Benefits Fund. Oxford is the Claims Administrator and processes claims for the Plan and provides appeal services; however, Oxford and the Benefits Fund are not responsible for any decision you or your Dependents make to receive treatment, services, or supplies from a Provider. Oxford and the Benefits Fund are neither liable nor responsible for the treatment, services, or supplies you receive from Providers.

SECTION 10: ADDITIONAL HEALTH CARE NOTICES

Women's Health and Cancer Rights Act

As required by the Women's Health and Cancer Rights Act of 1998, the Plan provides Benefits under the Plan for mastectomy, including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting

from a mastectomy (including lymphedema).

If you are receiving Benefits in connection with a mastectomy, Benefits are also provided for the following Covered Health Services, as you determine appropriate with your attending Physician:

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

The amount you must pay for such Covered health services (including copayments and any annual Deductible) are the same as are required for any other Covered health service. Limitations on Benefits are the same as for any other Covered health service.

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

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

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

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

Nondiscrimination and Accessibility Requirements

Oxford on behalf of itself and its affiliated companies complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Oxford does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Oxford provides free aids and services to people with disabilities to communicate effectively with Oxford, such as:

- Qualified sign language interpreters

- Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Free language services to people whose primary language is not English, such as, qualified interpreters
- Information written in other languages.

If you need these services, please call the number on your Oxford ID card, TTY 711, or the Benefits Fund at (877) RN BENEFITS [762-3633].

If you believe that Oxford and the Benefits Fund have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance in writing by mail or email with the Civil Rights Coordinator identified below. A grievance must be sent within 60 calendar days of the date that you become aware of the discriminatory action and contain the name and address of the person filing it along with the problem and the requested remedy.

A written decision will be sent to you within 30 calendar days. If you disagree with the decision, you may file an appeal within 15 calendar days of receiving the decision.

Oxford Health Plans LLC Civil Rights Coordinator
Oxford Civil Rights Grievance
P.O. Box 30608
Salt Lake City, UT 84130

You may also call the toll-free phone number listed on your Oxford ID card, TTY 711, or e-mail at UHC_Civil_Rights@UHC.com

If you need help filing a grievance, the Civil Rights Coordinator identified above is available to help you. You can also file a complaint directly with the U.S. Dept. of Health and Human Services online, by phone, or mail:

Online <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

Phone: (800) 368-1019, (800) 537-7697 (TDD)

Mail: U.S. Dept. of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201

Health Care Reform Notice

Patient Protection and Affordable Care Act Patient Protection Notices

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

For children, you may designate a pediatrician as the

Primary Care Provider.

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

Chapter 10: Prescription Drug Benefits

The Benefits Fund contracts with Express Scripts to provide prescription drug coverage, including a 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.

In-network benefits

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

A list of in-network pharmacies is available through the Express Scripts Web site at www.express-scripts.com.

If you receive prescription drugs from an in-network pharmacy, present your prescription drug identification card, along with your prescription. You will be charged the appropriate copayment. (Refer to Chapter 2 for your facility's plan.)

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 (up to a 34 day supply)

- Tier 1: \$0/generic
- Tier 2: \$10/preferred brand
- Tier 3: \$20/non-preferred brand

Mail order pharmacy or Smart90 program (up to a 90 day supply)

- Tier 1: \$0/generic
- Tier 2: \$20/preferred brand
- Tier 3: \$40/non-preferred brand

Benefit Coverage Plan B – No deductible

Retail pharmacy (up to a 34 day supply)

- Tier 1: \$7/generic
- Tier 2: \$20/preferred brand
- Tier 3: \$35/non-preferred brand

Mail order pharmacy or Smart90 program (up to a 90 day supply)

- Tier 1: \$15/generic
- Tier 2: \$40/preferred brand
- Tier 3: \$70/non-preferred brand

Benefit Coverage Plan C – Yearly deductible \$100/person; \$250/family

Retail pharmacy (up to a 34 day supply)

- Tier 1: \$12/generic
- Tier 2: \$25/preferred brand
- Tier 3: \$40/non-preferred brand

Mail order pharmacy or Smart90 program (up to a 90 day supply)

- Tier 1: \$25/generic
- Tier 2: \$50/preferred brand
- Tier 3: \$80/non-preferred brand

Maximum network pharmacy out-of-pocket cost

The maximum network pharmacy out-of-pocket cost represents the most you will pay each calendar year for your share of the cost of covered prescription drug benefits, including pharmacy copayments and coinsurance. The out-of-pocket network pharmacy maximum will change each year based on the maximum out-of-pocket allowable under the Affordable Care Act and participants will be notified of the change by the Fund on an annual basis. For 2019, the out-of-pocket network pharmacy maximum was set at \$6,900 for individuals and \$13,800 for families.

Penalties incurred under the Benefits Funds' clinical pharmacy programs will not accumulate toward the maximum network pharmacy out-of-pocket cost. In addition, the cost difference between the brand-name drug and the generic drug that you must pay under the Benefit Fund's mandatory generic program (if there is a direct generic alternative available) is not a covered prescription drug benefit and will not accumulate toward the maximum network pharmacy out-of-pocket cost.

The out-of-pocket maximum helps you plan for pharmacy expenses. The maximum provides some financial protection for those participants who incur significant qualifying out-of-pocket costs for prescription drugs under Benefits Fund coverage if you use a network pharmacy. If your covered prescription drug out-of-pocket expenses in a calendar year exceed the annual maximum, the Fund pays 100 percent of eligible expenses for covered services through the end of the calendar year. *Please note: the pharmacy out-of-pocket*

maximum is separate from the out-of-pocket maximum for hospital and medical costs.

Out-of-network benefits

The out-of-network benefits allow you to use any pharmacy that doesn't participate in the Express Scripts network. If you choose to use a nonparticipating pharmacy, you must pay for the prescription and complete an Express Scripts Prescription Drug Reimbursement claim form. Send the completed form and paid itemized receipt to Express Scripts, ATTN: Commercial Claims, P.O. Box 14711, Lexington, KY 40512-4711 or fax to (608) 741-5475 for reimbursement. Claims must be submitted within one year of the date of service for which the claim is made. 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 prescriptions filled 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 (up to a 34 day supply)

Reimbursed at the contracted amount minus applicable in-network copayment.

Benefit Coverage Plan B - No deductible

Retail pharmacy (up to a 34 day supply)

Reimbursed at the contracted amount minus applicable in-network copayment.

Benefit Coverage Plan C - Yearly deductible \$100/person; \$250/family

Retail pharmacy (up to a 34 day supply)

Reimbursed at the contracted amount minus applicable in-network copayment.

Maintenance Medications

Benefits Fund participants and their covered dependents taking maintenance medications must have those prescriptions filled by Express Scripts' mail service pharmacy or the Smart90 program (see below for more information on Smart90). 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.

You can get up to 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 electronically submitted to a retail pharmacy. The second prescription would be for the remainder of the year to be filled in 90-day supplies through Express Scripts' 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 to submit only one prescription for mail order if you don't have to begin the medication right away.

As a convenience, Express Scripts offers the Smart90 program as a way for participants to receive maintenance medications at participating retail pharmacies. Maintenance medications in 90-day refills may be filled at all Walgreens pharmacies and pharmacies within the Walgreens network. Please visit www.express-scripts.com for a current list of Smart90 pharmacies in the Walgreens network.

While most prescriptions are electronically submitted by a provider, you can also mail in your prescription to the Express Scripts mail-order pharmacy. To do so, you must:

- Request an Express Scripts Home Delivery Order form from the Fund office or download a form from the Fund's Web site at www.rnbenefits.org or Express Scripts' Web site at www.express-scripts.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 Express Scripts Home Delivery Service, PO Box 66566, St. Louis, MO 63166-6566.

Your order should be delivered within 14 days of the date Express Scripts 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 Express Scripts' toll-free number at (855) 521-0777 or by accessing Express Scripts' Web site at www.express-scripts.com. Delivery charges apply only if you request expedited delivery. In some states, doctors are mandated to electronically prescribe both controlled and non-controlled substances. They are authorized to issue an electronic prescription for controlled substances and allow a pharmacist to accept, annotate, dispense and electronically archive such prescriptions.

Covered medications

The medications covered under this plan include:

- **Fertility drugs.*** There is a \$5,000 lifetime maximum benefit for in vitro fertilization or covered

fertility drugs. (If you choose, this means this benefit may be used for in vitro fertilization under your medical coverage with the Benefits Fund.) Fertility drugs must be ordered through a participating fertility pharmacy, including Freedom Pharmacy or Accredo. If you are unable to obtain the drugs through a participating pharmacy, you may purchase them and submit a claim for direct reimbursement with an itemized receipt. Fertility drug claim forms must be submitted to the Benefits Fund at P.O. Box 12430, Albany, NY 12212-9501. You will be reimbursed up to the allowed amount permitted under the plan.

- **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).
- **Male sexual dysfunction drugs.** Impotency treatment for men with medically diagnosed erectile dysfunction is covered.
 - Coverage is limited to six pills or treatments per 30-day period.
 - Daily dose erectile dysfunction drugs are plan exclusions for the treatment of sexual dysfunction.
- **Approved diabetic medicines and supplies**, including:
 - Insulin,
 - Oral hypoglycemic agents,
 - Glucose-elevating agents,
 - Syringes and pens,
 - Alcohol swabs,
 - Glucose/acetone test strips/agents,
 - Lancets and lancet devices.

Diabetic medicines and supplies must be filled through the Express Scripts mail order pharmacy or at a participating Smart90 location.

- **New drugs** coming on the market will be covered or excluded pursuant to the Benefits Fund plan design as described in this chapter. New drugs approved by the Food and Drug Administration will not be covered by the Fund until the Fund's pharmacy benefit manager completes an assessment of the new drug, which may take up to 180 days after the date of market launch. In extenuating circumstances, a participant may request an appeal that the medication be covered prior to

completion of the assessment. Participants should call a Fund participant service representative to request an appeal, which will be adjudicated in a prompt and timely manner.

- **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 a mail order specialty pharmacy 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 30-day supply at a specialty pharmacy. The duration of coverage for any drug therapy is limited to the manufacturer's recommendations.

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

Exclusions

Prescription benefit payments will not be made for:

- New drugs approved by the Food and Drug Administration until completion of an assessment of the new drug by the Fund's pharmacy benefit manager, which may take up to 180 days from the date of market launch of the drug;
- 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, sanatorium, 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 (retail or mail-order) unless the Centers for Medicare and Medicaid Services utilization rate of the predicted days of use for the current prescription (currently 75 percent) has been met;
- Maintenance medications in quantities of up to 34-day supplies filled more than two times at any 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,
- Daily dose erectile dysfunction drugs are a plan exclusion for the treatment of sexual dysfunction.

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 cost adjustment review by calling Express Scripts at (800) 946-3979.

Step Therapy

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

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

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

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

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

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

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

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

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

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

Concurrent Drug Utilization Review

Express Scripts' Concurrent Drug Utilization Review (DUR) program supports patient safety at the point of service by preventing drug-related adverse events. Concurrent DUR performs online, real-time drug utilization analysis at the point of prescription dispensing, whether the dispensing occurs at the retail pharmacy or at the Express Scripts Pharmacy.

Each electronically transmitted claim is reviewed to identify the most pertinent clinical patient safety or uti-

lization concerns and generates an alert to the dispensing pharmacist in real time before the member receives the prescription(s).

Twelve standard modules review the claim for concerns relating to: drug-age, drug-disease, drug-drug interactions, gender, overutilization, underutilization, drug-allergies, pregnancy, additive toxicity, drug name confusion, therapy duplication, and prescriber consultation for combinations with limited medical use. These edits (along with refill too soon, which is a plan benefit design program) encourage appropriate medication use and support increased patient safety and decreased adverse events.

Concurrent DUR reduces wasteful medical spending by helping to reduce emergency room utilization, hospitalizations, and urgent care visits through identification and correction of clinical safety and utilization concerns.

Drug Quantity Management

Express Scripts' Drug Quantity Management program reduces wasteful spending in the pharmacy benefit by aligning the dispensed quantity of prescription medication with dosage guidelines approved by the Food and Drug Administration (FDA) or clinical evidence. This supports safe, effective, and efficient use of drugs while giving patients access to quality care. In addition, dosing consolidation ensures that the pharmacy dispenses the most cost-effective product strength. For example, our Drug Quantity Management program guides a member to take one 40 mg tablet instead of two 20 mg tablets when appropriate.

Express Scripts' Drug Quantity Management program delivers value to you by:

- Dispensing the most cost-effective product strength;
- Identifying administrative errors through ongoing audits;
- Limiting medication stockpiling and associated waste;
- Encouraging clinically appropriate prescribing patterns.

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 Express Scripts at (800) 753-2851.

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 Express Scripts receives complete information.

Prior Authorization Lists

- A select group of high-cost drugs with proven potential of inappropriate use.
- Advantage List: An expanded list of high-cost drugs with proven potential for inappropriate use.
- A select list of high cost drugs that have been traditionally under-managed.
- A list of drugs with significant utilization for lifestyle indications and off-label inappropriate use.
- An actively managed list that targets existing and new, high-cost oral oncology medications with potential for inappropriate use
- Includes quantity limits on most drugs
- An evidence-based list requiring a pharmacogenomic test prior to approval, as test results guide therapy.
- An actively managed program that targets new high-cost drugs with a low or unknown potential for off-label use.
- An actively managed list that targets a subset of high-cost specialty medications with proven potential for inappropriate use.
- High Risk Prior Authorization for Medicare designed to drive patient safety by monitoring the dispensing of Centers for Medicare & Medicaid Services-classified, high-risk medications.

Post-service claims

If you receive a covered prescription from an in-network pharmacy and pay up front you may return to the pharmacy within seven days and get reimbursed minus the applicable in-network copayment with your identification card and paid receipt.

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

To receive your reimbursement, complete a Prescription Drug Reimbursement claim form (available from the Benefits Fund office or our Web site at www.rnbenefits.org). Send the completed form, along with an itemized bill for the covered drugs, to: Express Scripts ATTN: Commercial Claims, PO Box 14711, Lexington, KY, 40512-4711 or fax to (608) 741-5475. 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 Express Scripts receives complete information.

Appealing prior authorization denied claims

If your prior authorization claim is denied, you will receive written notice from Express Scripts 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: Express Scripts, PO Box 66588, St. Louis, MO 63166-6588 ATTN CLINICAL APPEALS DEPARTMENT. 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 Express Scripts by contacting the Member Services Department at (855) 521-0777. After completing the form, the participant mails or faxes the form and any relevant and supporting documentation to: Express Scripts, PO Box 66588, St. Louis, MO 63166-6588 ATTN CLINICAL APPEALS DEPARTMENT. Supporting documentation may include a letter written by your provider in support of the appeal, a copy of the denial letter sent by Express Scripts, 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 Express Scripts' 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. Express Scripts 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 Express Scripts 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.

Once you have exhausted the appeals procedures outlined in this chapter, you may file a voluntary appeal to the Board of Trustees. Please see Page 6 in Chapter 1 of this SPD regarding the process for filing such an appeal.

Chapter 11: Dental Benefits

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

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

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 90 for more information about orthodontics.

Two different benefits options are available: Network and Out-of-network. You may choose either benefit option each time you or your dependents need dental services. Family members are not required to select the same benefit option.

Network providers and benefits

The network option allows you to see a provider of your choice in the Aetna Preferred Provider Organization, which covers a wide range of dental services and supplies. You may pay less out of your own pocket when you choose a network provider. The Aetna Preferred Provider Organization includes licensed dentists. A list of network providers is available through the DocFind® feature on Aetna's Web site at www.aetna.com or by calling the Fund office toll-free at (877) RN BENEFITS [762-3633]. When making an appointment, always verify that the dentist is an Aetna PPO provider. Network providers have agreed to provide covered services and supplies at a negotiated charge. Participants share the cost of covered services and supplies by paying a portion of certain expenses (the payment percentage). Your payment percentage is based on the negotiated charge. In no event will you have to pay any amounts above the negotiated charge for a covered service or supply. You have no further out-of-pocket expenses when the plan covers in network services at 100 percent. You also have no deductible.

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

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

major restorative, prosthodontic installation, and orthodontic services.

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

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

Out-of-network providers and benefits

The out-of-network option allows you the freedom to see a licensed dental provider who is not in the dental network. Your out-of-pocket expenses will generally be higher if you choose an out-of-network provider.

Before the plan begins to pay benefits, you must satisfy a yearly deductible for 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.

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

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

Payments are made based on the recognized charge, the maximum amount that will be paid by the plan for a covered expense from an out-of-network provider. In determining what the recognized charge will be, the dental program takes into consideration (for the geographic area where the service is performed):

If your out-of-network provider charges more than the recognized charge, you'll be responsible for any expenses incurred above the recognized charge (For more information on recognized charges, see Page 96.)

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.

Coordination of Benefits

When coordination of benefits applies

This Coordination of Benefits (COB) provision applies to this Plan when you or your covered dependent has dental coverage under more than one plan. The Order of Benefit Determination Rules below determines which plan will pay as the primary plan. The primary plan pays first without regard to the possibility that another plan may cover some expenses. A secondary plan pays after the primary plan and may reduce the benefits it pays so that payments from all group plans do not exceed 100 percent of the total allowable expense.

Important terms

When used in this provision, the following words and phrases have the meaning explained herein.

Allowable Expense – A dental service or expense, including, coinsurance and copayments and without reduction of any applicable deductible, that is covered at least in part by any of the Plans covering the person. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an allowable expense and a benefit paid. An expense or service that is not covered by any of the Plans is not an allowable expense. Any expense that a dental care provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an allowable expense. The following are examples of expenses and services that are not allowable expenses:

- If a person is covered by two or more Plans that compute their benefit payments on the basis of reasonable or recognized charges, any amount in excess of the highest of the reasonable or recognized charges for a specific benefit is not an allowable expense.
- If a person is covered by two or more Plans that provide benefits or services on the basis of negotiated charges, an amount in excess of the highest of the negotiated charges is not an allowable expense.
- The amount a benefit is reduced or not reimbursed by the primary Plan because a covered person does not comply with the Plan provisions is not an allowable expense.

If a person is covered by one Plan that computes its benefit payments on the basis of reasonable or recognized charges and another Plan that provides its benefits or ser-

vices on the basis of negotiated charges, the primary plan's payment arrangements shall be the allowable expense for all the Plans. However, if the secondary plan has a negotiated fee or payment amount different from the primary plan and if the provider contract permits, that negotiated fee will be the allowable expense used by the secondary plan to determine benefits.

When a Plan provides benefits in the form of services, the reasonable cash value of each service rendered shall be deemed an allowable expense and a benefit paid.

Custodial Parent – A parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.

Plan – Any Plan providing benefits or services by reason of health care or treatment, which benefits or services are provided by one of the following:

- Group or nongroup, blanket, or franchise dental insurance policies issued by insurers, including dental care service contractors;
- Other prepaid coverage under service Plan contracts, or under group or individual practice;
- Uninsured arrangements of group or group-type coverage;
- Labor-management trustee Plans, labor organization plans, employer organization Plans, or employee benefit organization Plans;
- Medical benefits coverage in a group, group-type, and individual automobile "no-fault" and traditional automobile "fault" type contracts;
- Medicare or other governmental benefits;
- Other group-type contracts. Group type contracts are those which are not available to the general public and can be obtained and maintained only because membership in or connection with a particular organization or group.

This Plan is any part of the contract that provides benefits for dental expenses.

Primary Plan/Secondary Plan – The order of benefit determination rules state whether this Plan is a Primary Plan or Secondary Plan as to another Plan covering the person. When this Plan is a primary Plan, its benefits are determined before those of the other Plan and without considering the other Plan's benefits. When this Plan is a Secondary Plan, its benefits are determined after those of the other Plan and may be reduced because of the other Plan's benefits. When there are more than two Plans covering the person, this Plan may be a Primary Plan as to one or more other Plans, and may be a Secondary Plan as to a different Plan or Plans.

Which plan pays first

When two or more Plans pay benefits, the rules for determining the order of payment are as follows:

- The primary Plan pays or provides its benefits as if the secondary Plan or plans did not exist.
- A Plan that does not contain a coordination of benefits provision that is consistent with this provision is always primary. There is one exception: coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the Plan provided by the contract holder.
- A Plan may consider the benefits paid or provided by another Plan in determining its benefits only when it is secondary to that other Plan.
- The first of the following rules that describes which Plan pays its benefits before another Plan is the rule to use:

1. Non-Dependent or Dependent. The Plan that covers the person other than as a dependent, for example as an employee, member, subscriber or retiree is primary and the Plan that covers the person as a dependent is secondary. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the person as a dependent; and primary to the plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two plans is reversed so that the plan covering the person as an employee, member, subscriber or retiree is secondary and the other plan is primary.

2. Child Covered Under More than One Plan. The order of benefits when a child is covered by more than one Plan is:

- A. The primary Plan is the plan of the parent whose birthday is earlier in the year if:
- The parents are married or living together whether or not married;
 - A court decree awards joint custody without specifying that one party has the responsibility to provide dental care coverage or if the decree states that both parents are responsible for dental coverage. If both parents have the same birthday, the Plan that covered either of the parents longer is primary.

B. If the specific terms of a court decree state that one of the parents is responsible for the child's dental care expenses or dental care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. If the parent

with responsibility has no dental coverage for the dependent child's dental care expenses, but that parent's spouse does, the Plan of the parent's spouse is the primary Plan.

C. If the parents are separated or divorced or are not living together whether or not they have ever been married and there is no court decree allocating responsibility for dental coverage, the order of benefits is:

The Plan of the custodial parent;

- The Plan of the spouse of the custodial parent;
- The Plan of the noncustodial parent; and then
- The Plan of the spouse of the noncustodial parent.

For a dependent child covered under more than one Plan of individuals who are not the parents of the child, the order of benefits should be determined as outlined above as if the individuals were the parents.

3. Active Employee or Retired or Laid off Employee. The Plan that covers a person as an employee who is neither laid off nor retired or as a dependent of an active employee, is the primary Plan. The Plan covering that same person as a retired or laid off employee or as a dependent of a retired or laid off employee is the secondary Plan. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule will not apply if the Non-Dependent or Dependent rules above determine the order of benefits.

4. Continuation Coverage. If a person whose coverage is provided under a right of continuation provided by federal or state law also is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree (or as that person's dependent) is primary, and the continuation coverage is secondary. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule will not apply if the Non-Dependent or Dependent rules above determine the order of benefits.

5. Longer or Shorter Length of Coverage. The Plan that covered the person as an employee, member, subscriber longer is primary.

If the preceding rules do not determine the primary Plan, the allowable expenses shall be shared equally between the Plans meeting the definition of Plan under this provision. In addition, this Plan will not pay more than it would have paid had it been primary.

How coordination of benefits works

In determining the amount to be paid when this Plan is secondary on a claim, the secondary Plan will calculate the benefits that it would have paid on the claim in the

absence of other dental coverage and apply that amount to any allowable expense under this Plan that was unpaid by the primary Plan. The amount will be reduced so that when combined with the amount paid by the primary Plan, the total benefits paid or provided by all Plans for the claim do not exceed 100 percent of the total allowable expense.

In addition, a secondary Plan will credit to its Plan deductible any amounts that would have been credited in the absence of other coverage.

Under the COB provision of this Plan, the amount normally reimbursed for covered benefits or expenses under this plan is reduced to take into account payments made by other Plans. The general rule is that the benefits otherwise payable under this Plan for all covered benefits or expenses will be reduced by all other Plan benefits payable for those expenses. When the COB rules of this Plan and another Plan both agree that this Plan determines its benefits before such other Plan, the benefits of the other Plan will be ignored in applying the general rule above to the claim involved. Such reduced amount will be charged against any applicable benefit limit of this coverage.

Right to receive and release needed information

Certain facts about dental care coverage and services are needed to apply these COB rules and to determine benefits under this Plan and other Plans. Aetna has the right to release or obtain any information and make or recover any payments it considers necessary in order to administer this provision.

Facility of payment

Any payment made under another Plan may include an amount, which should have been paid under this Plan. If so, Aetna may pay that amount to the organization, which made that payment. That amount will then be treated as though it were a benefit paid under this Plan. Aetna will not have to pay that amount again. The term “payment made” means reasonable cash value of the benefits provided in the form of services.

Right of recovery

If the amount of the payments made by Aetna is more than it should have paid under this COB provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the covered person. The “amount of the payments made” includes the reasonable cash value of any benefits provided in the form of services.

Recovery of overpayments

If a benefit payment is made by the Plan, to you or on your behalf, which exceeds the benefit amount that you are entitled to receive, the Plan has the right to re-

quire the return of the overpayment. The Plan has the right to reduce by the amount of the overpayment, any future benefit payment made to or on behalf of a Participant in the Plan. Another way that overpayments are recovered is by reducing future payments to the provider by the amount of the overpayment. These future payments may involve this Plan or other health plans that are administered by the Plan’s third-party administrator, Aetna. Under this process, Aetna reduces future payments to providers by the amount of the overpayments they received, and then credits the recovered amount to the plan that overpaid the provider. Payments to providers under this Plan are subject to this same process when Aetna recovers overpayments for other plans administered by Aetna.

This right does not affect any other right of recovery the Plan may have with respect to overpayments.

Advance claim review

An advanced claim review determines, in advance, the benefits the plan will pay for proposed services and helps you and your dentist make informed decisions about the care you’re considering. It is not a guarantee of benefit payment, rather an estimate of the amount or scope of benefits to be paid.

An advance claim review is recommended whenever a course of dental treatment is likely to cost more than \$350. Before treating you, your dentist should submit a claim form for an advance claim review to Aetna showing the treatment plan and fees. Aetna may request supporting X-rays and other diagnostic records. Aetna will then review the proposed treatment plan and provide you and your dentist with a statement outlining the benefits payable for each dental service according to the terms of this dental plan. You and your dentist can then decide how to proceed.

An advance claim review is recommended whether you go to a PPO dentist or a nonparticipating dentist. It is voluntary and is not necessary for emergency treatment or routine care such as teeth cleaning or check-ups. In determining the amount of benefit payable, Aetna will take into account alternate procedures, services, or courses of treatment for the dental condition in question in order to accomplish the anticipated result.

Course of dental treatment

A course of dental treatment is a planned program of one or more services or supplies provided by one or more dentists to treat a dental condition that was diagnosed by the attending dentist as a result of an oral exam. A course of treatment starts on the date your dentist first renders a

service to correct or treat the dental condition.

Dental emergency

The plan pays a benefit at the network level of coverage even if the services and supplies weren't provided by a network provider up to the dental emergency maximum. The care provided must be a covered service or supply. You must submit a claim to Aetna describing the care given. Additional dental care to treat your dental emergency will be covered at the appropriate coinsurance level.

Covered services

The plan doesn't pay a benefit for all dental expenses you incur. Your dental services and supplies must meet the following rules to be covered by the plan:

- The services and supplies must be medically necessary,
- The services and supplies must be covered by the plan,
- You must be covered by the plan when you incur the expense.

Covered expenses include charges made by a dentist for the services and supplies that are listed in the dental care schedule, a list of dental expenses that are covered by the plan. There are several categories of covered expenses:

- Preventive
- Diagnostic
- Restorative
- Oral surgery
- Endodontics
- Periodontics
- Orthodontics

These covered services and supplies are grouped as Type A, Type B, or Type C.

Type A expenses (diagnostic and preventive care)

Visits and X-rays

- Office visit during regular office hours for oral examination (limited to two visits per calendar year)
- Prophylaxis (cleaning, limited to two treatments per calendar year for adults and children; limit is combined with the periodontal maintenance frequency)
- Topical application of fluoride (limited to one course of treatment per year for dependent children to age 19 under)
- Bitewing X-rays (limited to two sets per calendar year)
- Complete X-ray series, including bitewings if necessary, or panoramic film (limited to one set

every three years)

- Vertical bitewing X-rays (limited to one set every three years)
- 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
- Sealant (limited to once per tooth every three years for permanent molars only for children to age 18)

Type B expenses (basic restorative care)

Visits and exams

- Professional visit after hours (payment will be made on the basis of services rendered or visit, whichever is greater)
- Emergency palliative treatment, per visit.
- Biopsy and histopathologic examination of oral tissue
- Diagnostic casts.

Oral surgery (Includes local anesthetics and routine postoperative care)

- Extractions
 - Erupted tooth or exposed root
 - Coronal remnants
 - Surgical removal of erupted tooth/root tip
 - Postoperative visit (sutures and complications) after multiple extractions and impaction
- Impacted teeth
 - Removal of tooth
- Alveolar or gingival reconstructions
 - Alveolectomy (edentulous) per quadrant
 - Alveolectomy (in addition to removal of teeth) per quadrant
 - Alveoplasty with ridge extension, per arch
 - Removal of exostosis
 - Excision of hyperplastic tissue per arch
 - Excision of pericoronal gingiva
- Odontogenic cysts and neoplasms
 - Incision and drainage of abscess
 - Removal of odontogenic cyst or tumor
- Other surgical procedures
 - Sialolithotomy: removal of salivary calculus
 - Closure of salivary fistula
 - Dilation of salivary duct
 - Transplantation of tooth or tooth bud
 - Removal of foreign body from bone (independent procedure)
 - Maxillary sinusotomy for removal of tooth fragment or foreign body

- Closure of oral fistula of maxillary sinus
- Sequestrectomy for osteomyelitis or bone abscess, superficial
- Condylectomy of temporomandibular joint
- Meniscectomy of temporomandibular joint
- Radical resection of mandible with bone graft
- Crown exposure to aid eruption
- Removal of foreign body from soft tissue
- Frenectomy
- Suture of soft tissue injury
- Injection of sclerosing agent into temporomandibular joint
- Treatment of trigeminal neuralgia by injection into second and third divisions.

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

Periodontics

- Occlusal adjustment (other than with an appliance or by restoration)
- Root planing and scaling, per quadrant (limited to four separate quadrants per year)
- Root planing and scaling, one to three teeth per quadrant (limited to once per site every year)
- Gingivectomy, per quadrant
- Gingivectomy, one to three teeth per quadrant
- Gingival flap procedure, including root planing, per quadrant
- Gingival flap procedure, including root planing, one to three teeth per quadrant
- Periodontal maintenance procedures, no perio history required (limited to two per calendar year; combined with prophylaxis frequency)
- Localized delivery of antimicrobial agents
- Osseous surgery, including flap entry and closure, per quadrant
- Osseous surgery, including flap entry and closure, one to three teeth per quadrant
- Soft tissue graft procedures

Endodontics

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

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

a single restoration.)

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

Space maintainers (Only when needed to preserve space resulting from premature loss of primary teeth; includes all adjustments within six months after installation.)

- Fixed (unilateral or bilateral)
- Removable (unilateral or bilateral)
- Removable inhibiting appliance to correct thumbsucking
- Fixed or cemented inhibiting appliance to correct thumbsucking.
- Occlusal guard for bruxism covered, no limitation.

Type C expenses (major restorative care)

Restorative (Inlays, onlays, labial veneers, and crowns are covered only as treatment for decay or acute traumatic injury and only when teeth cannot be restored with a filling material or when the tooth is an abutment to a fixed bridge. [Limited to one per tooth every five years – see “Replacement Rule”].)

- Inlays/onlays
- Labial veneers
 - Laminate, chairside
 - Resin laminate, laboratory
 - Porcelain laminate, laboratory
- Crowns
 - Resin
 - Resin with noble metal

- Resin with base metal
- Porcelain/ceramic substrate
- Porcelain with noble metal
- Porcelain with base metal
- Base metal (full cast)
- Noble metal (full cast)
- 3/4 cast metallic or porcelain/ceramic
- Post and core

Prostodontics Replacement of existing bridges or dentures is limited to one every five years (see “Replacement Rule”).

- Bridge abutments (see Inlays and Crowns)
- Pontics
 - Base metal (full cast)
 - Noble metal (full cast)
 - Porcelain with noble metal
 - Porcelain with base metal
 - Resin with noble metal
 - Resin with base metal
- Removable bridge (unilateral)
 - One piece casting, chrome cobalt alloy clasp attachment (all types) per unit, including pontics
- Dentures and partials (Fees for dentures and partial dentures include relines, rebases, and adjustments within six months after installation; fees for relines and rebases include adjustments within six months after installation; specialized techniques and characterizations are not eligible)
 - Complete upper denture
 - Complete lower denture
 - Partial upper or lower, resin base (including any conventional clasps, rests, and teeth)
 - Partial upper or lower, cast metal base with resin saddles (including any conventional clasps, rests, and teeth)
 - Stress breakers
 - Interim partial denture (stayplate), anterior only
 - Office reline
 - Laboratory reline
 - Special tissue conditioning, per denture
 - Rebase, per denture
 - Adjustment to denture more than six months after installation
- Adding teeth to existing partial denture
 - Each tooth
 - Each clasp

Orthodontics

- Comprehensive orthodontic treatment of adolescent dentition

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

The maximum amount payable for each individual for orthodontic treatment is \$1,000 per course of treatment separated by two years. The orthodontic treatment maximum is separate from the yearly maximum. A course of 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 88, is subject to change.)

Rules and limits of the dental plan

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

Alternate Treatment Rule

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

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

Replacement Rule

Crowns, inlays, onlays and veneers, complete dentures, removable partial dentures, fixed partial dentures

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

- while you were covered by the plan, you had a tooth (or teeth) extracted after the existing denture or bridge was installed. As a result, you need to replace or add teeth to your denture or bridge;
- the present crown, inlay and onlay, veneer, complete denture, removable partial denture, fixed partial denture (bridge), or other prosthetic service was installed at least five years before its replacement and cannot be made serviceable;
- you had a tooth (or teeth) extracted while you were covered by the plan; your present denture is an immediate temporary one that replaces that tooth (or teeth); a permanent denture is needed, and the temporary denture cannot be used as a permanent denture.

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

Coverage for Dental Work Begun Before You Are Covered by the Plan

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

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

Coverage for Dental Work Completed After Termination of Coverage

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

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

- Root canals.

Ordered means:

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

Appeals procedure

Claim determinations

Urgent care claims

Aetna will notify you of an urgent care claim determination as soon as possible, but not more than 72 hours after the claim is made. If more information is needed to make an urgent claim determination, Aetna will notify you within 24 hours of receipt of the claim. You will then have 48 hours after receiving such notice to provide Aetna with the additional information. Aetna will notify you within 48 hours of the receipt of the additional information or at the end of the 48-hour period given to the physician to provide Aetna with the information, whichever is earliest.

If you fail to follow plan procedures for filing a claim, Aetna will notify you within 24 hours following the failure to comply.

Pre-service claims

Aetna will notify you of a claim determination as soon as possible but not later than 15 calendar days after the pre-service claim is made. Aetna may determine that, due to matters beyond its control, an extension of this 15 calendar day claim determination period is required. Such an extension (which will be no longer than 15 additional calendar days) will be allowed if Aetna notifies you within the first 15 calendar day period. If this extension is needed because Aetna requires additional information to make a claim determination, the notice of the extension will specifically describe the required information. You will have 45 calendar days from the date of the notice to provide Aetna with the required information.

Post-service claims

Aetna will notify you of a claim determination as soon as possible, but not later than 30 calendar days after the post-service claim is made. Aetna may determine that, due to matters beyond its control, an extension of this 30 calendar day claim determination period is required. Such an extension (which will be no longer than 15 additional calendar days) will be allowed if Aetna notifies you within the first 30 calendar day period. If this extension is needed because Aetna requests additional information to make a

claim determination, the notice of the extension will specifically describe the required information. You will have 45 calendar days from the date of the notice to provide Aetna with the required information.

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

Following a request for a concurrent care claim extension, Aetna will notify you of a claim determination for emergency or urgent care as soon as possible but not later than 24 hours provided the request is received at least 24 hours prior to the expiration of the approved course of treatment. Aetna will notify you no later than 15 calendar days with respect to all other care.

Concurrent care claim reduction or termination (decision to reduce or terminate a previously approved course of treatment)

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

Complaints

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

Appeals of adverse benefit determinations (a denial, reduction, termination of, or failure to provide or make payment, in whole or part, for a service, supply or benefit)

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

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

The notice of an adverse benefit determination will

include the address where the appeal can be sent.

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

Level One appeal

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

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

You may submit written comments, documents, records, and other information relating to your claim, whether or not the comments, documents, records, or other information were submitted in connection with the initial claim. A copy of the specific rule, guideline, or protocol relied upon in the adverse benefit determination will be provided free of charge upon request by you or your authorized representative. You may also request that the plan provide you, free of charge, copies of all documents, records, and other information relevant to the claim.

Level Two appeal

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

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

Once you have exhausted the appeals procedures outlined in this chapter, you may also file a voluntary appeal to the Board of Trustees. Please see Page 6 in Chapter 1 of this SPD regarding the process for filing such an appeal. If you do not agree with the final determination on review you have the right to bring a civil action, if applicable.

Exhaustion of process

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

Exclusions to the plan

Not every dental care service or supply is covered by the plan, even if prescribed, recommended, or approved by your physician or dentist. This plan covers only those services and supplies that are medically necessary and included in the Covered Services section on Page 88. In addition, some services are specifically limited or excluded. This section describes expenses that aren't covered or subject to special limitations.

Coverage is not provided for the following:

- Any instruction for diet, plaque control, and oral hygiene.
- Cosmetic services and supplies including plastic surgery, reconstructive surgery, cosmetic surgery, personalization or characterization of dentures, or other services and supplies which improve, alter, or enhance appearance, augmentation, and vestibuloplasty. In addition, other substances to protect, clean, whiten, bleach, or alter the appearance of teeth, whether or not for psychological or emotional reasons, are not covered except as outlined in the Covered Services section. Facings on molar crowns and pontics will always be considered cosmetic.
- Crown, inlays and onlays, and veneers unless it is treatment for decay or traumatic injury and teeth cannot be restored with a filling material or the tooth is an abutment to a covered partial denture or fixed bridge.
- Dental implants, braces, mouth guards, and other devices to protect, replace, or reposition teeth and removal of implants.
- Dental services and supplies that are covered in whole or in part:
 - Under any other part of this plan; or
 - Under any other plan of group benefits provided by the contractholder.

- Dentures, crowns, inlays, onlays, bridges, or other appliances or services used for the purpose of splinting, to alter vertical dimension, to restore occlusion, or correcting attrition, abrasion, or erosion.
- Except as covered in the Covered Services section, treatment of any jaw joint disorder and treatments to alter bite or the alignment or operation of the jaw, including temporomandibular joint disorder treatment, orthognathic surgery, and treatment of malocclusion or devices to alter bite or alignment.
- First installation of a denture or fixed bridge, and any inlay and crown that serves as an abutment to replace congenitally missing teeth or to replace teeth all of which were lost while the person was not covered.
- General anesthesia and intravenous sedation, unless specifically covered and only when done in connection with another necessary covered service or supply.
- Orthodontic services and supplies, except as covered in the Covered Services section. Service and supplies not covered include:
 - Replacement of broken appliances;
 - Re-treatment of orthodontic cases;
 - Changes in treatment necessitated by an accident;
 - Maxillofacial surgery;
 - Myofunctional therapy;
 - Treatment of cleft palate;
 - Treatment of micrognathia;
 - Treatment of macroglossia;
 - Lingually placed direct bonded appliances and arch wires (i.e. invisible braces); or
 - Removable acrylic aligners (i.e. invisible aligners).
- Pontics, crowns, cast or processed restorations made with high noble metals (gold or titanium).
- Prescribed drugs, pre-medication, or analgesia.
- Replacement of a device or appliance that is lost, missing, or stolen; the replacement of appliances that have been damaged due to abuse, misuse, or neglect; and an extra set of dentures.
- Services and supplies done where there is no evidence of pathology, dysfunction, or disease other than covered preventive services.
- Services and supplies provided for your personal comfort or convenience or the convenience of any other person, including a provider.
- Services and supplies provided in connection with treatment or care that is not covered under

the plan.

- Space maintainers except when needed to preserve space resulting from the premature loss of deciduous teeth.
- Surgical removal of impacted wisdom teeth only for orthodontic reasons.
- Treatment by a provider other than a dentist. However, the plan will cover some services provided by a licensed dental hygienist under the supervision and guidance of a dentist. These include scaling of teeth, cleaning of teeth, and topical application of fluoride.

Additional items not covered

Charges made for the following are not covered except to the extent listed under the Covered Services section on Page 88:

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

including:

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

Definitions

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

- Your eligibility for coverage;
- The results of any Utilization Review activities;

- A determination that the service or supply is experimental or investigational; or
- A determination that the service or supply is not medically necessary.

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

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

Deductible – The part of your covered expenses you pay before the plan starts to pay benefits.

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

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

Dentist – A legally qualified dentist or a physician who is licensed to do the dental work he/she performs.

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

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

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

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

Jaw joint disorder – A temporomandibular joint dysfunction or any similar disorder of the jaw joint; or a myofascial pain dysfunction; or any similar disorder in the relationship between the jaw joint and the related muscles and nerves.

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

- In accordance with generally accepted standards

of dental practice;

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

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

Negotiated charge – The maximum charge a preferred care provider has agreed to make as to any service or supply for the purpose of the benefits under this Plan.

Network provider – A dental provider who has contracted to furnish services or supplies for a negotiated charge but only if the provider is, with Aetna's consent, included in the directory as a network provider for the service or supply involved and the class of employees to which you belong.

Nonoccupational illness – An illness that does not arise out of (or in the course of) any work for pay or profit or result in any way from an illness that does. An illness will be deemed to be nonoccupational regardless of cause if proof is furnished that the person is covered under any type of workers' compensation law and is not covered for that illness under such law.

Nonoccupational injury – An accidental bodily injury that does not arise out of (or in the course of) any work for pay or profit, or result in any way from an injury which does.

Occupational injury/illness – An injury or illness that arises out of (or in the course of) any activity in connection with employment or self-employment whether or not on a full-time basis, or results in any way from an injury or illness which does.

Occurrence – A period of disease or injury. An occurrence ends when 60 consecutive days have passed during which the covered person receives no medical treatment, services, or supplies and doesn't take any medication or have any medication prescribed for a disease or injury.

Orthodontic treatment – Any medical or dental

service or supply furnished to prevent, diagnose, or correct a misalignment of the teeth, the bite, the jaws, or jaw-joint relationship, whether or not for the purpose of relieving pain. Not included is the installation of a space maintainer or a surgical procedure to correct malocclusion.

Out-of-network provider – A dental provider who has not contracted with Aetna, an affiliate, or a third-party vendor to furnish services or supplies for this plan.

Payment percentage – Both the percentage of covered expenses that the plan pays and the percentage of covered expenses that the participant pays. The percentage that the plan pays is referred to as the “plan payment percentage” and varies by the type of expense.

Physician – A duly licensed member of a medical profession who has an MD or DO degree; is properly licensed or certified to provide medical care under the laws of the jurisdiction where he practices; and provides medical services that are within the scope of his 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 his 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 – The amount of an out-of-network provider’s charge that is eligible for coverage. You are responsible for all amounts above the recognized charge. The recognized charge may be less than the provider’s full charge. In all cases, the recognized charge is determined based on the geographic area where you receive the service or supply. A service or supply provided by a provider is treated as covered expenses under the other health care coverage category when:

- You get services or supplies from an out-of-network provider. This includes when you get care from out-of-network providers during your stay in a network hospital.
- You could not reasonably get the services and supplies needed from a network provider.

The other health care coverage does not apply to services or supplies you receive in an out-of-network emergency room. When the other health care coverage applies, you will pay the other health care cost share.

Except as otherwise specified below, the recognized charge for each service or supply is the lesser of what the

provider bills and, for dental expenses, 80 percent of the prevailing charge rate.

We have the right to apply Aetna reimbursement policies. Those policies may further reduce the recognized charge. These policies take into account factors such as:

- The duration and complexity of a service;
- When multiple procedures are billed at the same time, whether additional overhead is required;
- Whether an assistant surgeon is necessary for the service;
- If follow up care is included;
- Whether other characteristics modify or make a particular service unique;
- When a charge includes more than one claim line, whether any services described by a claim line are part of or incidental to the primary service provided and
- The educational level, licensure, or length of training of the provider.

Aetna reimbursement policies are based on our review of:

- The Centers for Medicare and Medicaid Services’ (CMS) National Correct Coding Initiative (NCCI) and other external materials that say what billing and coding practices are and are not appropriate
- Generally accepted standards of medical and dental practice and
- The views of physicians and dentists practicing in the relevant clinical areas.

We use commercial software to administer some of these policies. Some policies are different for professional services than for facility services.

Geographic Area and Prevailing Charge Rates are defined as follows:

Geographic Area

The geographic area is made up of the first three digits of the US Postal Service zip code. If we determine we need more data for a particular service or supply, we may base rates on a wider geographic area such as an entire state.

Prevailing Charge Rates

The percentile value reported in a database prepared by FAIR Health, a nonprofit company. FAIR Health changes these rates periodically. **Aetna** updates its systems with these changes within 180 days after receiving them from FAIR Health. If the FAIR Health database becomes unavailable, **Aetna** has the right to substitute an alternative database that **Aetna** believes is comparable.

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 12: Vision Benefits

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

You are entitled to the following plan benefits every 24 months:

- A comprehensive eye examination with a variety of checkups, which include a health review, simple visual acuity tests, refraction test, visual field test, glaucoma test, slit lamp evaluation, and dilation (when professionally indicated). A comprehensive eye health exam can detect a number of eye diseases, as well as signs of systemic conditions such as diabetes, thyroid disease, high blood pressure, and neurological impairments. Every eye examination administered by a Davis Vision provider is consistent with clinical guidelines published by the Eye American Optometric Association and the American Academy of Ophthalmology. An eye refraction determines whether eyeglasses are needed and, if so, the required prescription (dependent children up to age 18 are eligible every 12 months), and
- A complete pair of eyeglasses (frames and lenses) or contact lenses in lieu of eyeglasses.

You have the option of choosing an in-network Davis Vision provider for this benefit, or any other provider who is not in the Davis Vision network. You may split your benefits by receiving your eye examination and eyeglasses (or contact lenses) on different dates or through different provider locations, although all services must be rendered entirely by an in-network provider or an out-of-network provider. You cannot split benefits between in-network and out-of-network providers.

Also, complete eyeglasses must be obtained at one time from one provider. Continuity of care will best be maintained when all available services are obtained at one time from either an in-network or out-of-network provider.

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

In-network benefits

Davis Vision's in-network providers are licensed optometrists and ophthalmologists who are extensively reviewed and credentialed to ensure that the strictest standards for quality service are maintained. A list of network providers located nearest the participant is available upon request and without charge. To obtain a list, call the Fund office toll-free at (877) RN BENEFITS [762-3633]. A list of in-network providers also is available from Davis Vision at (800) 999-5431 or by signing in to your Davis Vision Member Portal at www.davisvision.com/members.

To receive services from an in-network provider :

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

The provider's office will verify your eligibility for services and schedule your appointment for an eye examination. Claim forms and ID cards aren't required.

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

- Any Fashion or Designer level frames from Davis Vision's Frame Collection, covered in full after the in-network copayment. If you select another frame in the in-network provider's office, a \$150 credit will be applied, plus a 20 percent discount off the balance. The credit will also apply at retail locations that don't carry the Frame Collection. Participants are responsible for the cost over \$150 (less the applicable discount). In lieu of the Davis Vision frame collection, participants may choose any frame from a Visionworks location covered in full, after the in-network copayment, excluding Maui Jim; or
- An initial supply of disposable/planned replacement contact lenses from Davis Vision's Contact Lens Collection, covered in full after the in-network copayment for quantities as shown below. Evaluation, fitting, and follow-up care is also covered. Visually required contact lenses are covered in full with prior approval. Once the contact lens option is selected and the lenses are fitted, they cannot be exchanged for eyeglasses.

The costs for these in-network services include a:

- \$10 copayment for your eye examination;
- \$30 copayment for eyeglass lenses and/or frames from the Davis Vision Frame Collection or any frames from a Visionworks locations; or
- \$25 copayment for an initial supply of disposable/planned replacement contact lenses (including evaluation, fitting, and follow-up). If lenses are disposable, the plan covers for four boxes/multi-packs. If lenses are planned replacement, the plan covers two boxes/multi-packs

The lenses and coatings included in the coverage are:

- Plastic or glass single vision, bifocal, or trifocal lenses, in any prescription range;
- Glass grey #3 prescription lenses;
- Post-cataract lenses;
- Oversized lenses;
- Tinting of plastic lenses;

- Polycarbonate lenses for dependent children, monocular patients, and patients with prescriptions +/- 6.00 diopters or greater;
- Scratch-resistant coating.

A one-year unconditional warranty for breakage covers all eyeglasses supplied from Davis Vision's Frame collection (excludes lost eyeglasses).

The following items are not covered by this vision care program:

- Medical treatment of eye disease or injury, which is covered under your medical benefit;
- Vision therapy;
- Special lens designs or coatings (other than those previously noted);
- Replacement of lost eyewear;
- Nonprescription (plano) lenses;
- Contact lenses and eyeglasses in the same benefit cycle;
- Services not performed by licensed personnel; and
- Two pairs of eyeglasses, in lieu of a bifocal.

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

- \$20 for a Premier frame from the "Collection;"
- \$50 for standard progressive addition lenses; \$90 for premium progressive addition lenses or \$140 for ultra progressive addition multifocal lenses (while these can be worn by most people, you can switch to conventional bifocals at no additional cost if you are unable to adapt to progressive addition lenses, but the copayment for the progressive addition multifocals won't be refunded);
- \$12 for ultraviolet coating;
- \$20 for blended invisible bifocals;
- \$20 for glass photochromic lenses;
- \$30 for polycarbonate lenses;
- \$35 for standard antireflective coating, \$48 for premium antireflective coating, or \$60 for Ultra antireflective coating;
- \$20 for single vision scratch protection;
- \$40 for multifocal scratch protection;
- \$75 for polarized lenses;
- \$55 for high-index (thinner and lighter) lenses;
- \$65 for plastic photosensitive lenses;
- \$30 for intermediate vision lenses.

You, your spouse, and your eligible dependents also can receive:

- Discounted laser vision correction, often referred to as LASIK. (For more information, visit davisvision.com)

Out-of-network benefits

If you receive services from an out-of-network provider, services will be reimbursed up to a \$75 maximum allowance every two years for the eye exam and the eyeglasses (frame and lenses) or contact lenses if you submit a claim form.

When using an out-of-network provider, you must:

- Pay the provider directly for all charges, and
- Submit your out-of-network claim for reimbursement to: Vision Care Processing Unit, PO Box 1525, Latham, NY 12110. Claims for services performed outside the United States must be submitted for payment in English, with charges indicated in U.S. dollars. Only one claim per service may be submitted for reimbursement each benefit cycle. Claim forms may be found on the Benefits Fund Web site at www.rnbenefits.org or by calling (877) RN BENEFITS [762-3633], or
- Additionally, members with out-of-network benefits can also submit a claim using Davis Vision's mobile app. Simply log in to the mobile app, fill in all relevant expenses, and take a photo of your receipt. After submitting, you can track the progress of your out-of-network claim.

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

Appealing or grieving a coverage decision

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

Grievance rights

If all or part of your claim was denied based on the services not being available or covered under your benefit the grievance rights that follow apply. You have the right to grieve, or disagree, with our decision.

Expedited grievance rights

As a participant, you have the right to request an expedited grievance for the circumstances below:

- You may request an expedited grievance if the service you requested was denied and you and/or your health care provider feel that a delay in care would significantly increase the risk to your health.
- Your health care provider needs to explain why the delay would cause immediate or serious threat to your health.
- You, your representative, or your health care provid-

er may file your expedited grievance in writing or by telephone within 60 business days after you receive our notification letter. Contact information is included at the end of this notice.

- If you request an expedited grievance and it's determined that an expedited grievance is not merited, then your grievance will be processed as a standard grievance and you'll receive a decision no later than 30 days after receipt of the expedited grievance.
- If you request an expedited grievance and it is determined that an expedited grievance is merited, you will be notified by telephone of the decision within 48 hours of Davis Vision's receipt of all necessary information. Written notice will be sent to you within three business days of making the determination.
- If you complete the expedited grievance process and the initial denial is upheld, you may file an expedited grievance appeal.

Standard grievance rights

As a participant, you have the right to request a standard grievance if you do not agree with the denial issued. A standard grievance may be requested in all circumstances.

- You, your representative, or your health care provider may file a standard grievance in writing or by telephone within 60 business days after you receive our notification letter. Contact information is included at the end of this notice.
- Standard grievance decisions are made as fast as your condition requires and no later than 30 days of receipt of necessary information. You'll be notified in writing of the decision within 30 days of filing a standard grievance.

Expedited appeal rights

As a participant, you have the right to request an expedited appeal for the circumstances below:

- You may request an expedited appeal if the service you requested was denied:
 - based upon lack of medical necessity and you and/or your health care provider feel that a delay in care would significantly increase the risk to your health; or
 - based upon lack of medical necessity and you're already receiving or continuing care for a certain condition.
- Your health care provider needs to explain why the delay would cause immediate or serious threat to your health or the health of your child.
- You, your representative, or your health care provider may file your expedited appeal in writing or by telephone within 60 days after you receive our notification letter. Contact information is included

at the end of this notice.

- If you request an expedited appeal and it's determined that an expedited appeal is not merited, then your appeal will be processed as a standard appeal and you'll receive a decision no later than 30 days after receipt of the expedited appeal.
- If you request an expedited appeal and it's determined that an expedited appeal is merited, you'll be notified by telephone of the decision no later than two working days of receipt of necessary information. Written notice will be sent to you within 24 hours of making the determination.
- If you complete the expedited appeal process and the initial denial is upheld, you may file a standard appeal or an external appeal.

Standard appeal rights

As a participant, you have the right to request a standard appeal if you don't agree with the initial adverse determination issued by Davis Vision. A standard appeal may be requested in all circumstances.

- You, your representative, or your health care provider may file an appeal in writing or by telephone within 180 days after you receive our notification letter. Contact information is included at the end of this notice.
- You may apply for an external appeal within 45 days after you receive the initial adverse determination if we both agree to waive the internal standard appeal process.
- If you complete the standard appeal process and the initial denial is upheld, you, your representative, or your health care provider may apply for an external appeal within 45 days of receiving our notification letter.
- Standard appeal decisions are made as fast as your condition requires and within 30 days of receipt of necessary information. You'll be notified in writing of the decision within two business days of rendering the determination.

How to appeal or grieve a coverage decision

Send written appeals to Davis Vision Inc. Attention: Complaints at Appeals Department, PO Box 791, Latham, NY 12210. Once you have exhausted the appeals procedures outlined in this chapter, you may file a voluntary appeal to the Board of Trustees. Please see Page 6 in Chapter 1 of this SPD regarding the process for filing such an appeal.

Chapter 13: Paid Family Leave Benefits

The NYSNA Benefits Fund has contracted with The Hartford Life Insurance Company to administer New York State Paid Family Leave (PFL) coverage for you at no cost to the participant. For questions regarding your Paid Family Leave benefits, contact the Benefits Fund at (877) RN BENEFITS [762-3633]. You have Paid Family Leave benefits as described in this section.

The New York State Paid Family Leave Program provides those employed in New York state, even if they reside out-of-state, job-protected, paid leave to:

- bond with a new child (birth, adoption, or fostering);
- care for a loved one (spouse, domestic partner, child, parent, parent-in-law, grandparents and/or grandchild) with a serious health condition (illness, injury, impairment, or physical or mental condition); or
- help relieve family pressures when someone is called to active military service (qualifying exigency leave for overseas deployment can be taken for a spouse, domestic partner, child, grandchild, parent, parent-in-law, or grandparent's leave).

Paid Family Leave cannot be used for one's own disability or qualifying military event. This benefit cannot be used for pre-natal conditions; it can only be used after the birth of your baby.

Eligibility

- Participants with a regular schedule of 20 or more hours per week are eligible after 26 consecutive weeks of employment.
- Participants with a regular schedule of less than 20 hours per week are eligible for coverage after 175 days worked.

Participants may take the maximum benefit length (shown in the chart below) in any given 52-week period. The 52-week period starts on the first day the participant takes PFL. Paid Family Leave benefits were designed to phase in over four years, starting January 1, 2018. Twelve weeks of leave, beginning in 2021, is the maximum under PFL.

Year	Weeks of Leave	Benefit <i>*capped at the designated percentage of the NYS Average Weekly Wage</i>
2018	8 weeks	50%
2019	10 weeks	55%
2020	10 weeks	60%
2021	12 weeks	67%

Paid Family Leave time must be taken in full day increments but can be taken intermittently. Participants do not have to take sick leave and/or vacation time before using PFL. An employer may permit you to use sick or vacation leave for full pay but may not require you to use this time for leave. For more details, refer to your NYSNA collective bargaining agreement and/or employer policy.

While on leave, your medical coverage is protected. All participants are guaranteed to be able to return to their job.

Bonding with a child

- PFL for bonding begins after birth. It is not available for prenatal conditions.
- Regarding maternity leave/paternity leave: Check with your employer on how New York State Paid Family Leave and federal Family Medical Leave Act works with your employer's leave policies and any applicable provisions in your NYSNA collective bargaining agreement.
- Participants can take bonding leave any time during the first 12 months after the birth, adoption, or foster placement of a child.
- Paid Family Leave can be taken intermittently within the first 12 months for bonding with a child.
- You may take leave before the actual adoption of the child if an absence from work is required for the adoption to proceed.
- You may file both a short-term disability and Paid Family Leave claim simultaneously, but you cannot be paid short-term disability and Paid Family Leave benefits simultaneously. You may switch from short-term disability to Paid Family Leave any time after the birth of your child or at the end of your short-term disability period.*

Filing a claim

To file a claim for Paid Family Leave, contact The Hartford at (800) 549-6514, Monday through Friday, 8 a.m. to 9 p.m. You should identify yourself as a NYSNA Benefits Fund participant and provide the Policy ID #020737.

Claims need to be filed within 30 days of leave; if not, all or a portion of the leave could be denied. If your claim for Paid Family Leave is denied and you disagree with the denial reason, you may request to have the denial reviewed by an independent arbitrator. Information explaining how to file a request for arbitration of your denial of Paid Family Leave benefits can be found on your denial letter, by going

to www.nyspfla.com, or by contacting the Benefits Fund at (877) RN BENEFITS [762-3633]. You may also file a voluntary appeal to the Board of Trustees. Please see Page 6 in Chapter 1 of this SPD regarding the process for filing such an appeal.

***Paid Family Leave used in conjunction with short-term disability:** *You cannot take short-term disability and Paid Family Leave at the same time. However, if you qualify for short-term disability (for example, after giving birth), you may take short-term disability and then Paid Family Leave. You cannot take more than 26 weeks of combined short-term disability and Paid Family Leave in a 52-week period.*

Chapter 14: Short-term Disability Benefits

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

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

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

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

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

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

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

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

Benefits are payable for each period of disability at the weekly rate of 66²/3 percent of regular weekly compensation up to a maximum of \$215 per week, and for the maximum period of 26 weeks in a 52-week period.

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

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

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

- The first day you are employed by another employer

subject to New York State Disability Benefits Law, or

- The sixth day of work for a noncovered employer.

Filing a claim

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

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

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

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

Appealing a denied claim

If your short-term weekly disability claim is denied, you'll receive a Notice of Total or Partial Rejection of Claim for Disability Benefits (Form DB-451) that will explain completely why the claim was denied and will provide all necessary instructions for appealing your denied claim. The notice will be written in a culturally and linguistically appropriate manner, including how to attain access to language services or a copy in the applicable non-English language.

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

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

To file an appeal, send two copies of a statement to the Workers' Compensation Board, Disability Benefits Bureau, PO Box 9029, Endicott, NY 13761-9029. The statement must say that your claim for disability benefits has been rejected, request a review of the rejection of the claim, and provide complete details on the specific reasons for your request. Attach any pertinent medical or employment records, along with any other evidence that supports your request for review, including any information received from your employer or insurance company. Once an appeal request is received, a decision must be made within 45 days (one 45-day extension is allowed for special circumstances).

Chapter 15: Long-Term Disability Benefits

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

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

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

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

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

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

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

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

- In payment under an annuity or pension plan, except for reduced early retirement benefits;
- From a group life insurance plan because of disability, but only if such benefits do not reduce the amount of your life insurance or if you have an option to refuse them;

- From Social Security, including dependent benefits by reason of your disability or retirement;
- As a periodic benefit for disability under any employee benefit plan, or any government agency or program required by law.

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

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

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

No benefits are payable for disabilities due to:

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

Filing a claim

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

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

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

furnish the supplemental information.

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

Appealing a denied claim

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

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

Claims usually are denied for the following reasons:

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

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

The claimant will have access, upon request, to all relevant information, including the claimant's entire claim file, materials identifying any medical or vocational expert whose advice was used in making the benefit determination, and any other documents that reflect the plan's general policy regarding the claim.

- The plan cannot impose fees or costs as a condition to filing or appealing a claim.
- Arbitration is permitted, but only with full disclosure regarding the process, arbitrator, relationships, right to representation, and only if the claimant agrees after completing internal appeal.
- Review must be de novo (new). The decision-maker on an appealed claim must be dif-

ferent from (and not subordinate to) the person deciding the initial claim. The claimant also must have the opportunity to submit new evidence.

- The plan must consult with appropriate health care professionals in deciding appealed claims involving medical judgment.
- The plan may not require more than two levels of review of denied claims (if there's more than one level, both levels must be completed within the time frame applicable to one level).
- The plan must have procedures and safeguards for ensuring and verifying consistent decision-making.
- If the plan fails to make timely decisions or otherwise fails to comply with the regulation, claimants may go to court to enforce their rights.

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

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

Chapter 16: Life Insurance Benefits

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

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

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

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

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

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

Beneficiary designation

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

You may name anyone you wish as your beneficiary. You may designate more than one beneficiary, specify amounts, percentage shares, and the order of payment. If you name more than one beneficiary and do not specify the amounts, percentage shares, or the order of payment, the benefit amount will be divided equally among the named beneficiaries. The share of any beneficiary who has died before you will go equally to the surviving beneficiaries, unless your designation states otherwise.

If your beneficiary is not living when your life insurance becomes payable, or no beneficiary is named, payment will be made in accordance with the terms of the policy to:

1. the executors or administrators of your estate; or
2. all to your surviving spouse;
3. if your spouse is not living, in equal shares to your surviving children; or
4. if no child is living, in equal shares to your surviving parents.

If the beneficiary is a minor or otherwise incompetent as determined by law or a court proceeding, payment will be made to his or her legal guardian.

If you become totally disabled

If you become totally disabled before your 60th birthday, your life insurance coverage will be continued during your disability, up to your normal retirement date, at no cost. Coverage will continue as long as you submit annual proof of disability to The Hartford.

Disabled means you are prevented by injury or sickness from doing any work for profit for which you are, or could become, qualified by education, training, or experience. In addition, you will be considered disabled if you have been diagnosed with a life expectancy of 12 months or less.

To qualify for waiver of premium you must be covered under the Fund; be disabled and provide proof of loss that you have been disabled for nine consecutive months, starting on the date you were last actively at work; and provide this proof within one year of your last day of work as an active employee. Subsequent proofs of total disability must be furnished as required by The Hartford.

Your benefit may be payable before approval of waiver of premium if you die within one year of your last day of work as an active employee, but before you qualify for waiver of premium. The Hartford will pay the amount of life insurance which is in force for you provided you were continuously disabled; the disability lasted or would have lasted nine months or more; and premiums had been paid for your coverage.

The Hartford will waive premium payments and continue your coverage, while you remain disabled, until the date you attain normal retirement age if you're disabled prior to age 60.

If your coverage ends

If your Benefits Fund coverage ends for any reason, you have the option of converting your life insurance coverage or any portion of it through The Hartford to an individual policy without having to submit Evidence of Insurability. Reasons for coverage ending may include,

but aren't limited to, termination of employment, termination of the policy, or change in the classes eligible for insurance. Conversion isn't available for any amount of life insurance for which you weren't eligible and covered under the policy.

To qualify, contact the Fund, which will send appropriate forms for you to complete and submit directly to The Hartford within the later of:

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

Accelerated Benefit

An accelerated death benefit is available through your life insurance coverage if you're diagnosed as terminally ill while you're under normal retirement age and covered under the Fund for an amount of life insurance of at least \$10,000. The Hartford will pay you the accelerated benefit in a lump sum amount, provided The Hartford receives proof of the terminal illness.

The accelerated benefit will not be available to you unless you've been actively at work. You must request in writing that a portion of your amount of life insurance be paid as an accelerated benefit.

The amount of life insurance payable upon your death will be reduced by any accelerated benefit amount paid under this benefit. In addition, your remaining amount of life insurance will be subject to any reductions in the policy and will not increase once an accelerated benefit has been paid. There will be no effect on premium due after the accelerated benefit amount is paid under this benefit.

You may request a minimum accelerated benefit amount of 25 percent of the amount of insurance or \$50,000 if less, and a maximum of \$500,000. However, in no event will the accelerated benefit amount exceed 80 percent of your amount of life insurance. This option may be exercised only once.

For example, if you're covered for a life insurance benefit amount under the Fund of \$100,000 and are terminally ill, you can request any portion of the amount of life insurance benefits from \$25,000 to \$80,000 to be paid now instead of to your beneficiary upon death. However, if you decide to request only \$25,000 now, you cannot request the additional \$55,000 in the future. A person who submits proof satisfactory to us of his or her terminal illness will also meet the definition of disabled for waiver of premium.

Any benefits received under this benefit may be tax-

able. You should consider consulting a tax advisor for further information.

Filing a claim

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

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

Appealing a denied claim

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

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

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

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

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

Once you have exhausted the appeals procedures outlined in this chapter, you may file a voluntary appeal to the Board of Trustees. Please see Page 6 in Chapter 1 of this SPD regarding the process for filing such an appeal.

Chapter 17: Accidental Death and Dismemberment Benefits

The New York State Nurses Association Benefits Fund provides an accidental death and dismemberment and loss of sight benefit for you. For questions or service regarding your AD&D benefit, contact the Benefits Fund at (877) RN BENEFITS [762-3633].

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

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

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

Filing a claim

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

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

Appealing a denied claim

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

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

On any denied claim, a participant or his/her representative may appeal to the Benefits Department manager

for a full and fair review. The claimant may:

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

A decision will be made by the Benefits Department manager, who will review the documentation and make a decision within 45 days (one 45-day extension is allowed for special circumstances). If the denial is upheld, the Fund office will send you a letter of denial and an explanation.

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

Exclusions

No benefit will be paid for any loss resulting from:

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

Chapter 18: Statement of ERISA Rights

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

Receive information about your plan and benefits

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

Prudent actions by plan fiduciaries

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

Enforce your rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of the plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to \$149 a day, not to exceed \$1,496 per request (adjusted for inflation pursuant to the Federal Civil Penalties Inflation Adjustment Act of 1990, as amended) until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with your questions

If you have any questions about your plan, you should contact the plan administrator. If you have any questions

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

Name of the plan

The New York State Nurses Association Benefits Fund.

Plan identification number

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

Policies and contracts

The Benefits Fund is responsible for the payment of premiums to The Hartford Life Insurance Company (life insurance and paid family leave benefits) and Davis Vision (vision benefit). Other benefits, including medical, dental, short-term disability, and prescription drug coverage are self-insured by the Fund and the Fund pays administrative fees to Oxford, Aetna, The Hartford Life Insurance Company, and Express Scripts, Inc. to administer these benefits. Each carrier and its insurance products are subject to the laws of the state of New York. Benefits are subject to collection pursuant to the individual insurance policy or contract. At your request, the Benefits Fund will provide you with a copy of the policy or contract.

Plan year

The Plan and all of its fiscal records are kept on a calendar year basis ending on each December 31.

Classes included

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

Pension Plan on whose behalf the Pension Plan is obligated to make contributions to the Fund on such terms as determined by the Trustees.

Legal action

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

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

Information Directory

Oxford (Medical and hospital coverage)

Locate an Oxford provider:

- By phone – (877) RN BENEFITS (Fund office)

- Online – www.oxhp.com or www.uhc.com

Precertification:

- By phone – (800) 666-1353

Claim forms may be mailed to:

Oxford Health Plans
Attn: Claims Department
PO Box 29130
Hot Springs, AR 71903

Radiology claim forms may be mailed to:

eviCore
PO Box 680
Lake Katrine, NY 12449

Chiropractic claim forms may be mailed to:

Optum Healthcare Solutions
PO Box 5800
Kingston, NY 12402

Davis Vision (Vision coverage)

Locate a provider:

- By phone – (800) 999-5431 or (877) RN BENEFITS (Fund office)

- Online www.davisvision.com

Mail claim forms to:

Vision Care
Processing Unit
PO Box 1525
Latham, NY 12110

Express Scripts (ESI) (Prescription drug coverage)

Locate a pharmacy:

- **By phone** - (877) RN BENEFITS (Fund office)
- Online - www.express-scripts.com

Mail claim forms to:

Express Scripts Home Delivery Service
PO Box 66566
St. Louis, MO 63166-6566

Order a 30+ day supply for home delivery:

- By phone – (855) 521-0777
- Online – www.express-scripts.com

Aetna (Dental coverage) Group No. 812455

Locate a provider:

- By phone – (877) RN BENEFITS (Fund office)

- Online – www.aetna.com/docfind/

Mail claim forms to:

Aetna
PO Box 14094
Lexington, KY 40512-4094

The Hartford **Paid Family Leave Program**

Claims can be made by calling The Hartford at (800) 549-6514, Monday through Friday, 8 a.m. to 9 p.m. ET. **Important: Participants should identify themselves as NYSNA Benefits Fund participants and give the Policy ID #: 020737.**